DHHS COVID-19 Hotel

Isolation Facility

Operational Plan

29th March 2020

COVID-19

Coronaviruses (CoV) are a large family of viruses that cause illness ranging from the common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS-CoV) and Severe Acute Respiratory Syndrome (SARS-CoV). A novel coronavirus (COVID-19) is a new strain that has not been previously identified in humans.

In December 2019, China reported cases of a viral pneumonia caused by a previously unknown pathogen that emerged in Wuhan, a city of 11 million people in central China. The initial cases were linked o exposures in a seafood market in Wuhan where a large range of live animal and animal products were sold. The pathogen was identified as novel (new) coronavirus (recently named Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), which is closely related genetically to the virus that caused the 2003 outbreak of Severe Acute Respiratory Syndrome (SARS). SARS-CoV-2 causes the illness now known as Coronavirus disease 2019 (COVID-19). Currently, there is no specific treatment (no vaccine and no antiviral) against the new virus.

The current outbreak of novel coronavirus (COVID-19) that was first reported from Wuhan, China, on 31 December 2019.

Due to heightened global concerns around the pandemic potential of COVID-19, following a meeting of the World Health Organisation (WHO) International Health Regulations Emergency Committee, The Director- General declared the outbreak of COVID-19 a Public Health Emergency of International Concern on the 30th of January 2020. The WHO declared COVID-19 a Pandemic on the 11th of March 2020.

The Australian Prime Minister has announced on the 15th of March 2020 that all persons arriving in Australia must isolate in hotels for 14 days.

Clinical Presentation:

The range of symptoms reported include

- Fever
- Cough
- Sore throat
- Fatigue
- Shortness of breath / difficulty breathing

In Australia the people most at risk of getting the virus are those who have

- Recently travelled overseas, particularly to high risk countries
- Been in close contact with someone who has a confirmed case of COVID-19

Other people most at risk of serious infection are

- People with compromised immune symptoms
- Elderly greater than 65 years
- Aboriginal and Torres Strait Islander people (as they have high rates of chronic illness
- People with chronic medical conditions
- People in group residential settings
- People in detention facilities
- Very young children and babies (the risk to children and babies is unclear)

Case definition:

Probable case

A person with fever (≥38°C) or history of fever (e.g. night sweats, chills) OR acute respiratory infection (e.g. cough, shortness of breath, sore throat) AND who is a household contact of a confirmed case of COVID-19, where testing has not been conducted.

Suspect case A person who meets the following epidemiological and clinical criteria:

Epidemiological Criteria	Clinical Criteria	Action
Epidemiological criteria Clinical criteria Action Very high risk • Close contact (see Contact definition below) in the 14 days prior to illness onset with a confirmed case • International travel in the 14 days prior to illness onset • Cruise ship passengers and crew who have travelled in the 14 days prior to illness onset	• Fever (≥38°C) or history of fever OR acute respiratory infection (e.g. cough, shortness of breath, sore throat)	Test
High risk setting 1. Two or more cases of illness clinically consistent with COVID-19 (see clinical criteria) in the following settings: • Aged care and other residential care facilities • Military operational settings • Boarding schools • Correctional facilities • Detention centres • Aboriginal rural and remote communities, in consultation with the local PHU • Settings where COVID-19 outbreaks have occurred, in consultation with the local PHU 2. Individual patients with illness clinically consistent with COVID-19 (see clinical criteria) in a geographically localised area with elevated risk of community transmission, as defined by PHUs	Fever (≥38°C) or history of fever (e.g. night sweats, chills) OR acute respiratory infection (e.g. cough, shortness of breath, sore throat)	Test (on site for aged care residents, where feasible)
Moderate risk • Healthcare workers, aged or residential care workers	Fever (≥38°C) or history of fever (e.g. night sweats, chills) OR acute respiratory infection (e.g. cough, shortness of breath, sore throat)	Test
Background risk (No epidemiological risk factors)	Hospitalised patients with fever (≥38°C) AND acute respiratory symptoms (e.g. cough, shortness of breath, sore throat) of an unknown cause	Test

Rationale for current case definitions

The case definitions are based on what is currently known about the clinical and epidemiological profile of cases of COVID-19 presenting to date both in Australia and internationally. Health authorities are constantly monitoring the spectrum of clinical symptoms as cases arise, and, if there are any significant shifts, they will be reflected in the above definitions in future versions of this document.

The 14 day period is based upon what is currently known to be the upper time limit of the incubation period. As more precise information about the incubation period emerges, this will be reviewed. 25/03/2020
https://www1.health.gov.au/internet/main/publishing.nsf/Content/7A8654A8CB144F5FCA2584F8001F91E2/$File/interim-COVID-19-SoNG-v2.3.pdf

Infectious period

Infectious period of COVID-19 remains unknown, however there is some evidence to support the occurrence of pre-symptomatic or asymptomatic transmission (1). As a precautionary approach, cases are considered to be infectious 24-hours prior to onset of symptoms. Cases are considered to pose a risk of onward transmission and require isolation until criteria listed in the release from isolation section have been met.

Laboratory Testing

When collecting respiratory specimens, transmission-based precautions should be observed whether or not respiratory symptoms are present. For most patients with mild illness in the community, collection of upper respiratory specimens (throat swab followed by each nasal passage swab with the one floq swab) is a low risk procedure and can be performed using contact and droplet precautions: Please see Attachment SOP

Hotel Zones

The site is separated into 3 Zones

Red Zone Confirmed COVID-19 resident.

Is a resident who tests positive to a specific COVID-19 PCR test and reported by DHHS. These residents will be in the Red Zone. See attached SOP for Resident arrival and SOP for resident care in the Red Zone.

Orange zone residents Quarantined

Residents categorized as returned travellers will be monitored for the development of symptoms for 14 days after return from overseas(i.e. the maximum incubation period) in the Orange Zone. This also applies to contacts of suspected cases and should also be considered for contact management if there is likely to be a delay in confirming or excluding COVID-19 infection in the suspected case, such as delayed testing.

Residents in the orange zone are required to maintain social distancing at all times to prevent contact from others who are quarantining as all residents may be infected with COVID-19 and not yet be symptomatic.

Green Zone staff area

All other areas of the site that are not Red and Orange are Green and classed as COVID-19 free. Universal precautions and close attention to hand hygiene are applicable in this area. Cough etiquette, maintaining social distancing of 1.5 meters and staff to refrain from close greetings and hand shaking.

PPE for Zones. These need to match hospital care for nursing and support staff

Red Zone / Positive residents - Full Airborne transmission precautions, including routine use of a P2/N95 mask, disposable gown, gloves, and eye protection for clinical staff. Support staff cleaning to wear full PPE as clinical. Meal drop requires a surgical mask and no gown meals dropped outside residents' rooms. No resident contact.

Orange Zone / Quarantine - Full Airborne transmission precautions for clinical direct patient contact. P2/N95 mask for CONTACT Nurse and a surgical mask for the clean nurse. Support staff cleaning P2 mask, Gloves and glasses, no gown. Meal delivery surgical mask, gloves.

All staff entering the red zone should practice hand hygiene on entry & exit.

Green Zone - Universal precautions including close attention to hand hygiene. Cough etiquette. No hand shaking, maintain social distancing.

Referral Pathway for Medical Transfer

Residents requiring hospitalization will be referred by the Nurse /Medical practitioner to the DHHS COVID-19 Health line for assessment for appropriate transfer

Ambulance service will list Hotel as an area of concern in case of independent calls and will ask on site staff to assess need for attendance in case of low acuity calls

Transfer Medically Unwell Individuals Under CoVid19 Isolation to RCH/Alfred Hospitals

Nurse identifies patient requiring transfer to hospital.
Patient has developed ANY CoVid19 symptom
(Fever, Sore Throat, Cough, Fatigue, Shortness of Breath)
and has become medically unwell or
developed any other problem that may require hospitalization

If non-urgent contact DHHS
If URGENT to directly contact the Admitting Officer at
RCH 93456153/Alfred 1800253733 92762960
Inform hospital of patient and details
000 Ambulance request warning of potential CoVid19 case

Ambulance Transfer to RCH/Alfred
Staff PPE: Gown, Gloves, P2/N95 mask, eye protection
Patient PPE: Surgical Mask

Patient Transfer from Ambulance to Hospital
Transfer Requirements:
- All relevant staff must be notified prior to transfer
- Patient transferred on trolley or bed
- Clear transfer pathway of patients, visitors, staff

PPE
Staff: Gown, Gloves, P2/N95 mask, eye protection
Patient: surgical mask
Arrival at Hospital designated CoVid19 AV Reception area
Patient managed under routine AIRBORNE & CONTACT
transmission based precautions in a negative pressure room
Routine AIRBORNE & CONTACT transmission based precautions
include: **PPE**: Gown Gloves, P2/N95 mask, eye protection
(when entering isolation room or transporting patient)
Patient: Surgical mask – if leaving isolation room

Shift Clinic Issues Log should be kept with feeding into report by DHHS manager

- Number of symptomatic patients
- Medical issues
- Requirements for prescription
- Stores resupply
- Any operational issues
- Other issues
- Addressed early am and midafternoon for actioning

Pharmacy

Southgate Pharmacy
REDACTED
southgatepharmacy@bigpond.com

Pathology

Pathology collection is per attachment

Swab sample transport times are 1000, 1700hrs from

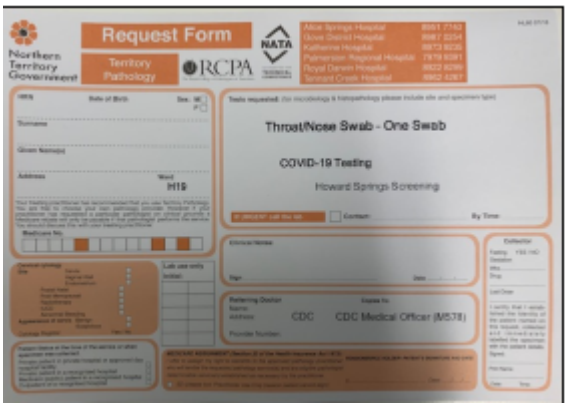
Extra Floq swabs are obtained through request from laboratory

Contacts TBA

Laboratory 04

Pathologist 04

Pathology form as below to be completed with Name address / DOB / Hotel



Rubbish Removal / Clinical Waste

Hotel services will arrange Biohazard bags in each room and doffing areas on each floor

Fire evacuation SOP

As per Facilities plan. Clinical staff will be required to attend evacuation areas in PPE if required

Security / Evacuation SOP

As per Hotel Facilities plan

Communications

Notifications for residents will go out in the morning of any changes to systems and evening.

The facility will send messages via food drop times to remind residents of required actions, eg reminders to place their mask on before opening the door

Translation into various languages will need to be considered

Residents room all have the emergency 24/7 contact number

Training and Signage also may be useful to remind staff of donning and doffing requirements.

Staff

Communications will be assisted by nominated phone list.

Nurse 24 hr line

Medical support off-site(daily visits) see daily roster

Business Centre

Contacts

EM Managers

DHHS REDACTED REDACTED

DHHS EM Director Merrin Bamert

FEMO Program Manager REDACTED

Medical FEMO REDACTED

Doctor REDACTED

Pharmacy REDACTED email Southgatepharmacy@bigpond.com

Pathology Courier VDRL REDACTED

Mental Health Triage North West Mental health

Nurse Phones 24 hrs by hotel

Crown Promenade

Crown Metropole REDACTED

Crown Plaza REDACTED

Phones to be in red/orange zone in zip lock bags and decontaminated on doffing

PPE monitoring

Health Staff

- PPE at the Donning area
- Biohazard waste bags and Hand Sanitizer at Doffing area each floor

Nursing staff will conduct Initial medical screening by phone after arrival to document medical history

Medications, allergies and initial and daily COVID-19 screening questions.

If symptomatic there should be a room visit in full PPE with temperature recorded and consideration of Covid-19 testing

Refer to Medical screening/ daily screening tool

24 hr on call Medical support will be available for on call subject to demand. Request nurse to triage appropriate requests overnight.

Onsite Nurse

- Initial Medical screen/ covid screening 5 questions daily
- Will Receive calls from reception related to medical needs
- Assess need for medical review and triage over the phone
- On call if required will attend resident in PPE or deal with issue by telephone if appropriate
- If Orange resident with COVID-19 positive swab move to Red Zone Floor to segregate from others in room where appropriate(not appropriate to have unaccompanied minors.
- Other medical emergency as per medical transfer flow Alfred or RCH
- Dail 000

Medical staff clothing

- All staff are to change into scrubs on arrival to work
- Scrubs to be removed before leaving the Clinic at end of shift
- Closed footwear

PPE, Infection control and Zone FAQ's |

Do I need to change my gloves regularly while in the Red and Orange Zone?

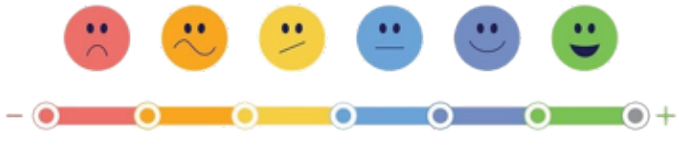
Yes. If assessing residents in rooms and after collecting a respiratory swab, then gloves should be changed as this would be classified as a healthcare space. If gloves become visibly

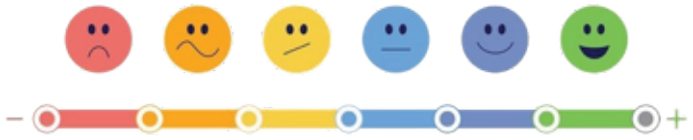
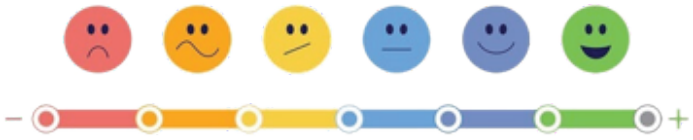
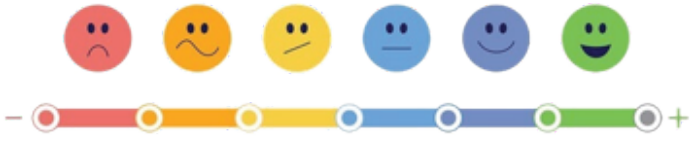
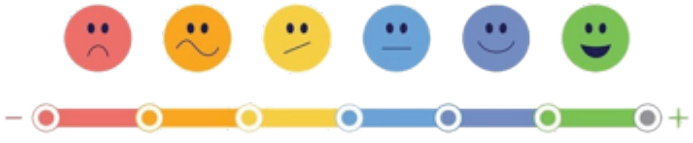
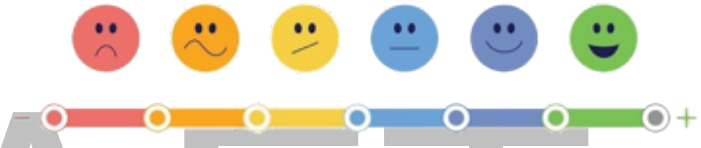
contaminated or uncomfortable then gloves can be replaced within the quarantine space ensuring hand hygiene is performed.

What type of mask should I be wearing?

A mask should be of a P2 or N95 standard if a staff member entering into the Red Zone and Normal Surgical Mask in Orange zone if involved with the direct care of a symptomatic patient, including the collection of viral swabs. P2/N95 masks require changing every four hours and if there is a breach or wet. Surgical Masks can be changed every 2 hrs. Although prolonged direct patient contact is not desirable.

Resident satisfaction survey weekly

Survey:	
How satisfied are you with your sleep? 	How satisfied are you with your meals? 

How satisfied are you with the physical activity options? 	How satisfied are you with the entertainment options? 
How happy are you with the medical care you are receiving? 	How concerned are you with contracting COVID19 virus? 
How satisfied are you that you are being protected from COVID19? 	Is the information provided to you daily appropriate to keep you informed? 
Is there anything else we can consider providing you to support you during your stay? Would you like to speak to one of our Health Clinicians?	

Swab Procedure

- Pre-label one floq swab and pathology request with patient details Hotel Room number and anticipated time of test prior to room entry ideally 2 nurse procedure batch once or twice daily 10 am and 3 pm.
- nurse 1 to take tympanic temperature of patient and memorise
- remove swab from tube.
- Firstly, swab throat. Extend swab into oral area until you hit the back of throat. Roll swab around to left, right, left.
- Remove from oral area.

- Secondly, place same swab up one nasal passage until you meet resistance. Roll swab around then remove. NB: this is NOT a nasopharyngeal swab
- Lastly place swab up the other nasal passage. Roll/twist swab then remove.
- Nurse 1 place the swab back into the tube. Nurse 2 to hold
- passes information sheet to patient and informs them they will be contacted if the results are positive (approximately 48-72hours)
- Nurse 2 checks patients details on the swab tube match details on the request form in the specimen bag, then places swab into bag, seals it and wipes the outside of the bag with a Clinell wipe before placing bag in the second Bag and transfer envelope. Please ensure Nurse phone for hotel notification is on pathology form for VDRL.
- Use a Clinell wipe to open door. Dispose of wipe in rubbish bin just outside the door
- Doff as per doffing sequence, placing used PPE into yellow bin on CONTACT side.
- remove PPE as per procedure, and re-enter health clinic. , before washing hands with soap and water.

Supply of Swabs

When the box of FLOQ swabs is, half-used call … and request another box be sent with next pathology drop off/pick up.

Transport of samples

- Specimens are stored in fridge in staff area until collection times of 1000 and 1500hrs.
- Gloves to be worn
- Samples are to be removed from fridge prior to the pick-up times

- Samples placed in the transfer envelope
- Pathology courier called with batched specimens

.

- all used protective eyewear is placed into a bucket with Milton solution to soak for 30 minutes.
- The nurse ties up the yellow rubbish bag containing used PPE and replaces it with a new yellow bag which has been provided by the CONTACT nurse inside.
- The nurse places the tied bag into large yellow wheelie bin on the CONTACT side
- The nurse still in PPE wipes down with Clinell wipes all surfaces and equipment

Security staff accompanying Nurses to patients rooms where required

- security staff in PPE (masks and Gloves) to accompany all nurses visiting hotel rooms
- Escort health clinician to entrance and wait outside unless requested to enter
- full PPE is required to enter rooms

Red zone entry point

- Positive COVID-19 resident will be accepted for hotel isolation with mild illness.
- Must have a medical review within 24 hrs of arrival
- Two staff in full PPE to assist resident to allocated room
- They will collect the diagnostic equipment from the health clinic (thermometer, oxygen saturation probe, pen, this equipment must be returned to medical clinic prior to leaving)
- Deteriorating patients will be managed as per medical retrieval pathway. 000 if required for emergent deterioration or Ambulance transfer to appropriate hospital facility for care needs. The Hotel Facility is not equipped for advanced inpatient care.
- All residents who are in high risk groups, unwell, breathless or hypoxic O2 sat <95% should be considered for hospital transfer

RED Zone resident care

- Daily health check of symptoms with chart Tick box (Fever, Sore throat, Cough, Fatigue, SOB) 0830-1030. HR reg/irreg Respirations, Temp
- Psychosocial conversation and identify any other medical concerns
- For Entry psycho/social visit x 2 nurses
- As per current discharge process. 2 negative swabs.
- When resident free from symptoms the first swab is taken. If negative then a further swab is taken in 24 hrs. Recorded on swab record data base
- If both are negative the resident can be discharged.
- Transport arrangements may be required and resident does require a negative free certificate to decrease stigma in the community.
- For emergencies residents can call the 24/7 phone line
- All residents are required to wear masks within the zone areas including children

Orange Zone

- Print out list of group in zone (tracks correct room, name, resident ID)
- Daily health check of symptoms with chart tick box (Fever, Sore throat, Cough, Fatigue, SOB)
- If symptoms of COVID-19 are identified management of COVID-19 suspected illness
- Swab to be taken as per swab SOP
- Sign outside room saying "awaiting results" Recorded on swab record data base
- Recreational activities as charted per day if not found to be symptomatic
- Psychosocial conversation and identify any other medical concerns at 1600 - 1700 review

Swab Record chart

- All swabs taken from within the red zone and the orange zone to be recorded on Swab record with resident's name, ID, date room number
- nurse review daily

Attachment 3

Recreational SOP's To Be confirmed

Access is for Orange residents only who are screened symptom free

- Recreational access Orange groups assigned at designated time roster and screened symptom free
- Residents will be marked off as per list
- Supervised by 1 x staff member in PPE
- Guests must wear mask and maintain social distancing
- Residents are tracked into area
- Rostered time slots will be managed through the health clinic and residents will be marked off the list
- Hand hygiene prior to entering and after leaving

An afterhours on call medical service is required

Mental Health 24/7 support phone 1300874243

North Western Mental health Triage for specialist triage and secondary consultation
On Site Clinician/ Nurse should screen first and discuss referrals

Draft daily schedule

0800 handover from night nurse

……etc

References:

WHO
https://www.who.int/emergencies/diseases/novel-coronavirus-2019

CDNA SoNG
https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm

National Critical Care and Trauma Response Centre: AUSMAT Operational Plan | Howard Springs February 2020.

Australian Health Sectors Emergency Response Plan for Novel Coronavirus (COVID-19)
https://www.health.gov.au/sites/default/files/documents/2020/02/australian-health-sector-emergency-response-plan-for-novel-coronavirus-covid-19_2.

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(Fever, Sore Throat, Cough, Fatigue, Shortness of Breath)
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Inform hospital of patient and details
000 Ambulance request warning of potential CoVid19 case

Ambulance Transfer to RCH/Alfred
Staff PPE: Gown, Gloves, P2/N95 mask, eye protection
Patient PPE: Surgical Mask

Patient Transfer from Ambulance to Hospital
Transfer Requirements:
- All relevant staff must be notified prior to transfer
- Patient transferred on trolley or bed
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PPE
Staff: Gown, Gloves, P2/N95 mask, eye protection
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Arrival at Hospital designated CoVid19 AV Reception area

Patient managed under routine AIRBORNE & CONTACT
transmission based precautions in a negative pressure room

Routine AIRBORNE & CONTACT transmission based precautions
include: **PPE**: Gown Gloves, P2/N95 mask, eye protection
(when entering isolation room or transporting patient)
Patient: Surgical mask – if leaving isolation room

Victorian State Control Centre

Operation Soteria

Mandatory Quarantine for all Victorian Arrivals

Approved for distribution

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

Distribution

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

Document Details

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

Abbreviations/Acronyms

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

Contents

1 Introduction

1.1 Purpose

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

1.2 Scope

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

1.3 Audience

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

1.4 Background

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

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

The objectives for people returning from overseas to Victoria are:

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

1.5 Mission

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

1.6 Inter-agency cooperation

Agencies engaged to deliver Operation Soteria include:

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

1.7 Process Flow

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

These phases include the following:

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

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

2 Governance

2.1 Governance

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

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

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

2.2 Legislative powers

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

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

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

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

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

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

2.2 Organisational Structure

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

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

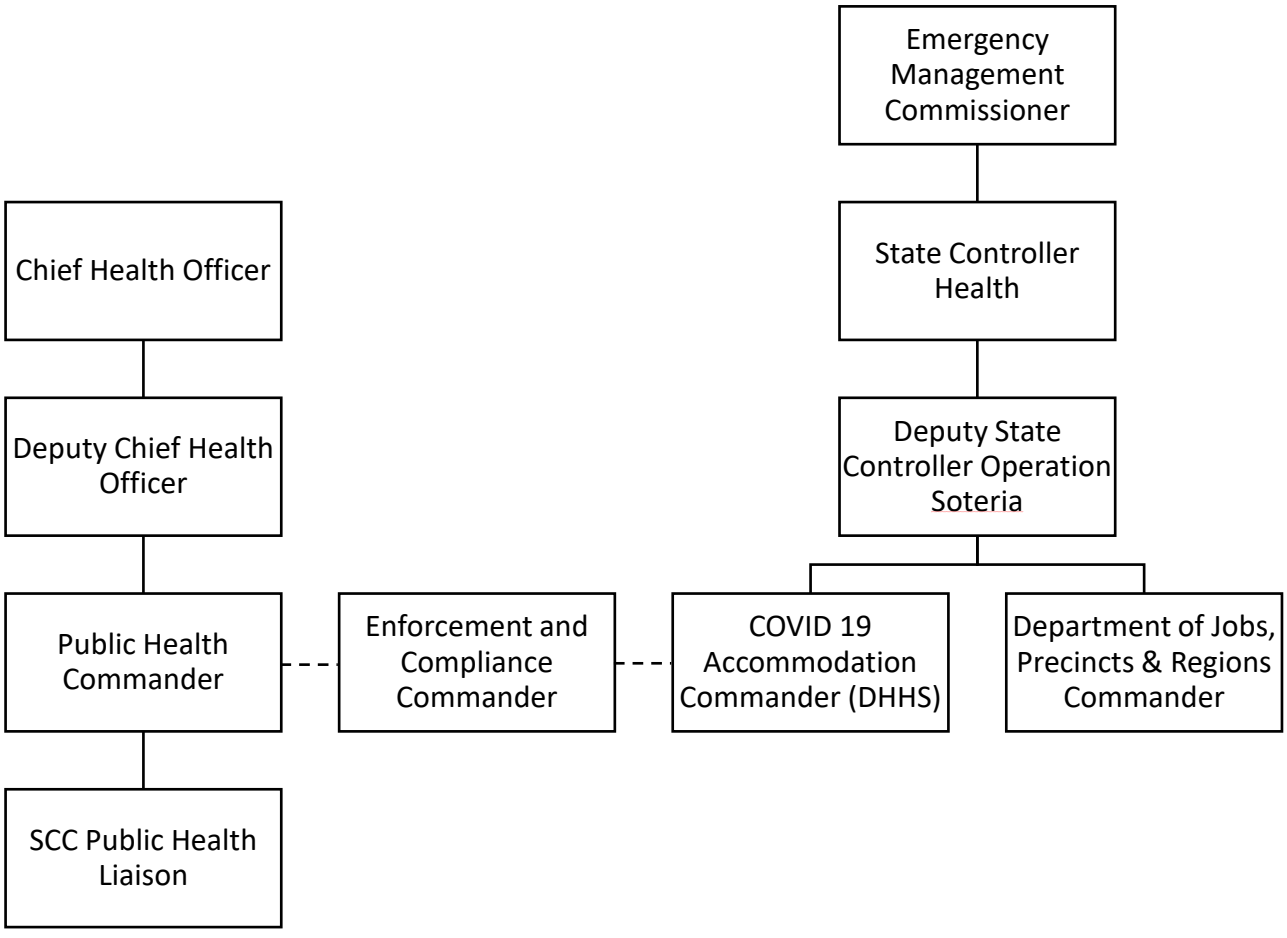


Figure 1: Operation Soteria governance structure

2.3 Roles and Responsibilities

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

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

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

The DHHS Commander COVID-19 Accommodation is responsible for:

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

2.4 Department of Health and Human Services (DHHS)

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

2.4.1 Airside operations - biosecurity

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

2.4.2 Airport Operations - reception

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

2.4.3 Public Health Directions

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

2.4.4 Health Coordination

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

2.4.5 Health and Wellbeing of passengers at accommodation

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

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

2.4.6 Communications including public communications

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

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

REDACTED

2.5.1 Airside operations

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

2.6 AFP

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

2.7 Department of Foreign Affairs and Trade

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

2.8 Department of Transport (DoT)

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

2.9 Ambulance Victoria

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

2.10 Victoria Police (VicPol)

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

REDACTED

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

2.11 Department of Jobs, Precincts & Regions (DJPR)

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

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

3 Detention Authorisation

Section approver: Enforcement and Compliance Commander.

Last review date: 24 April 2020

3.1 Purpose

The purpose of this Detention Authorisation section is to:

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

3.2 Processes may be subject to change

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

3.3 Enforcement and Compliance Command for Mandatory Quarantine

Deliverables of the enforcement and compliance function

Enforcement and Compliance Command is responsible for:

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

Authorised officer* and Chief Health Officer obligations

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

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

3.4 Direction and detention notices

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

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

More information can be obtained from:

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

3.5 Exemptions and exceptional circumstances

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

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

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

3.7 Processes and Procedures

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

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

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

3.7.1 Enforcement and compliance information

Further information is available at the links below

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

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

4 Operations

Section approver: COVID-19 Accommodation Commander.

Last review date: 24 April 2020

4.1 Purpose

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

4.2 Method

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

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

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

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

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

4.3 Processes and Procedures

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

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

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

5 Health and Welfare

Section approver: Public Health Commander.

Last review date: 24 April 2020

5.1 Purpose

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

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

Clinical governance framework

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

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

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

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

5.2 Standards

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

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

Standard 1. Rights of people in mandatory quarantine

Criterion 1.1 Charter of Human Rights and Responsibilities

Criterion 1.2 People with disabilities

Criterion 1.3 Use of translators

Criterion 1.4 Feedback and complaints process

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

Criterion 2.1 Health and welfare risk factors

Criterion 2.2 Schedule for screening

Criterion 2.3 Methods of screening

Criterion 2.4 Staff undertaking screening

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

Standard 3. Provision of health and welfare services

Criterion 3.1 Meeting the needs of people in mandatory quarantine

Criterion 3.2 Provision of on-site clinical services

Criterion 3.3 Provision of welfare services

Criterion 3.4 Provision of pharmacy and pathology services

Criterion 3.5 COVID-19 guidelines in mandatory quarantine

Standard 4. Health promotion and preventive care

Criterion 4.1 Smoking

Criterion 4.2 Fresh air

Criterion 4.3 Exercise

Criterion 4.4 Alcohol and drugs

Standard 5. Infection control

Criterion 5.1 Personal protective equipment (PPE)

Criterion 5.2 Cleaning and waste disposal

Criterion 5.3 Laundry

Criterion 5.4 Isolation protocols

Standard 6. Allergies and dietary requirements

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

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

Criterion 7.2 Information security

Criterion 7.3 Transfer of personal information (including medical records)

Criterion 7.4 Retention of personal information (including medical records)

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

5.3 Guidelines

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

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

At the airport

Airport health screening

Management of an unwell person at the airport

Refusal of testing

- At the airport
- At the hotel

At the hotel

Quarantine and isolation arrangements

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

Confirmed cases entering detention

- Current infectious cases
- Recovered cases

Throughout detention

Clinical assessment and testing for COVID-19

- Timing of testing
- Pathology arrangements
- Communication of results

Case management

- Management of suspected cases
- Management of confirmed cases

Hospital transfer plan

- Transfer from hospital to hotel

Exiting detention

Release from isolation

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

Exit arrangements

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

Operational guidance for mandatory quarantine

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

Infection control and hygiene

- Cleaning
- Laundry

- Personal protective equipment

Further information is available at the links below

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

Further information is available at the links below:

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

6 Information and Data Management

6.1 Information management systems

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

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

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

6.2 Data access, storage and security

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

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

6.2.1 Privacy

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

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

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

6.2.2 Sending information by email

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

6.2.3 Electronic security of passenger/detainee information

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

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

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

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

6.3 Medical records

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

6.3.1 Requirement for accessible medical records

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

6.3.2 Confidentiality and access to medical records

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

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

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

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

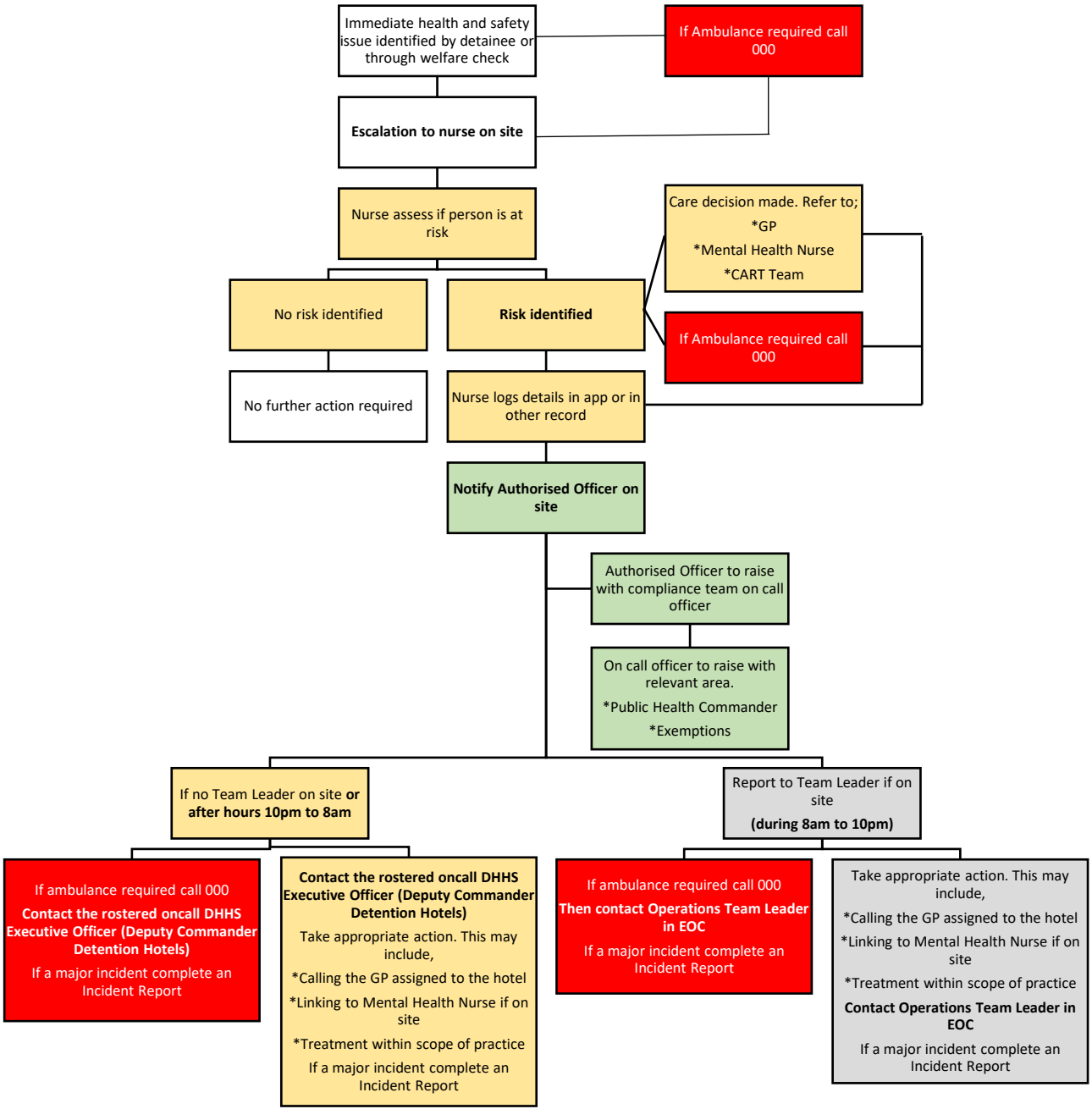
7 Issues escalation and incident reporting

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

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

7.1 Hotel escalation process

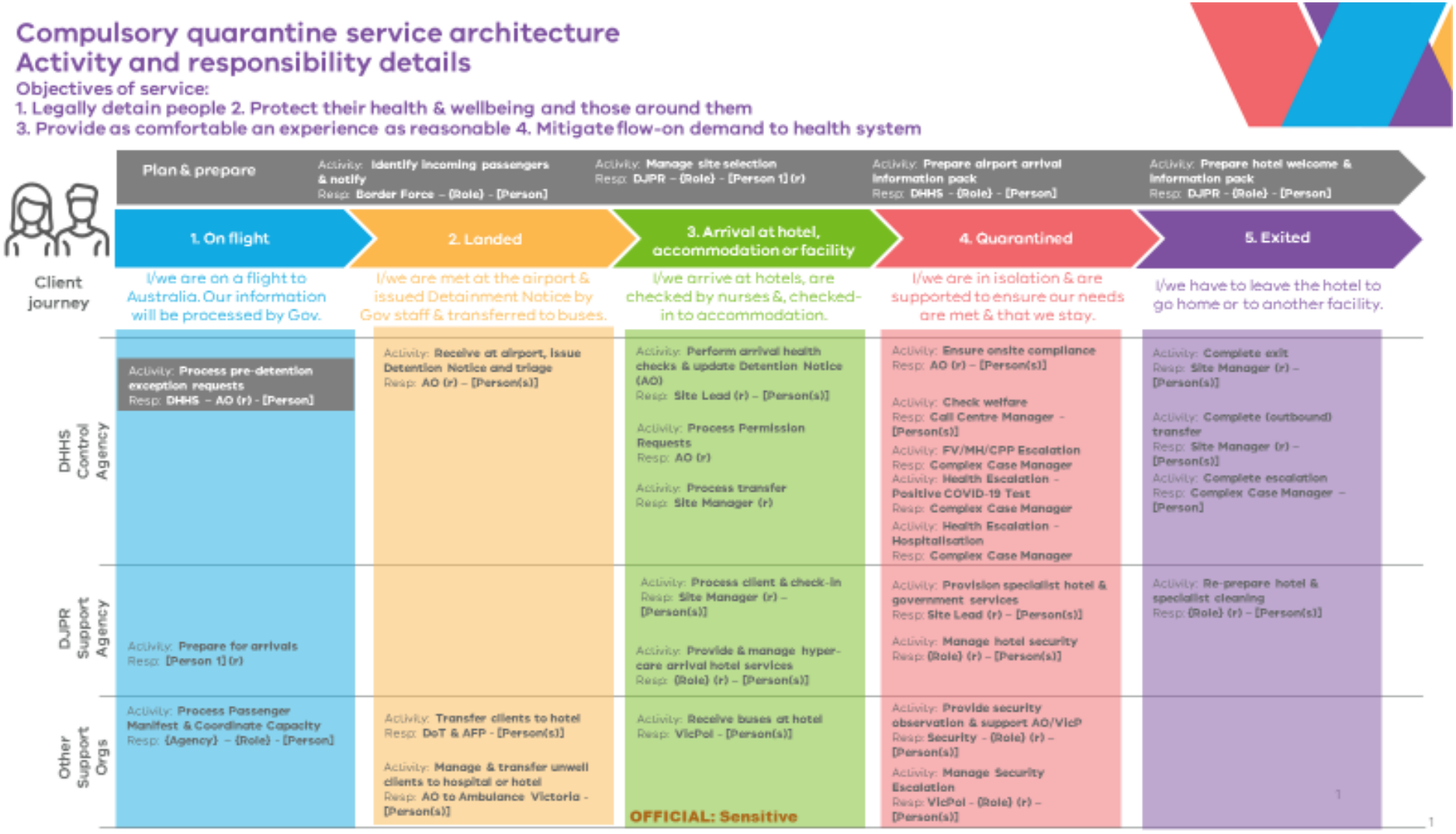
The escalation process in Figure 2 below must be followed for all health and medical risks arising in quarantine hotels.



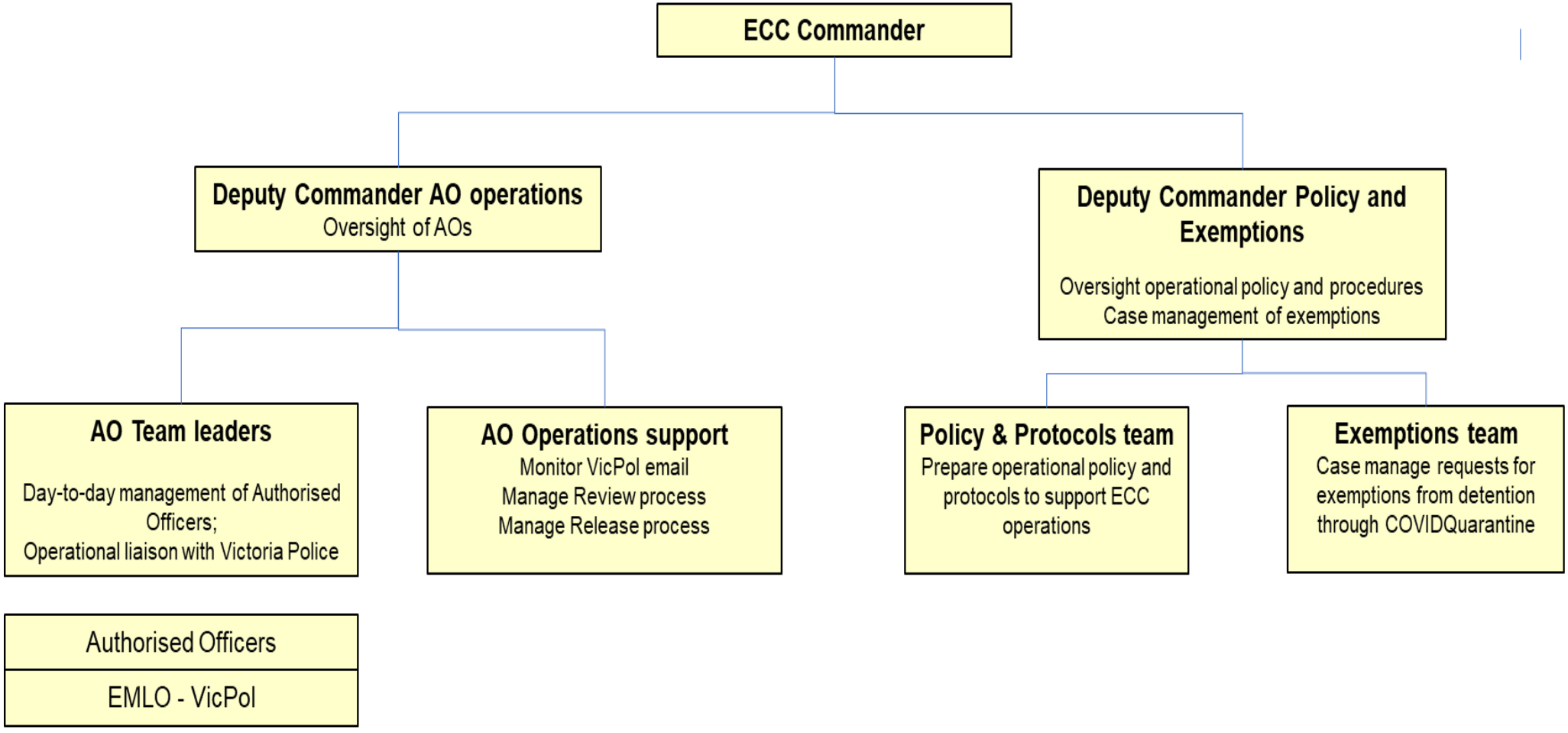
7.2 Incident reporting

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

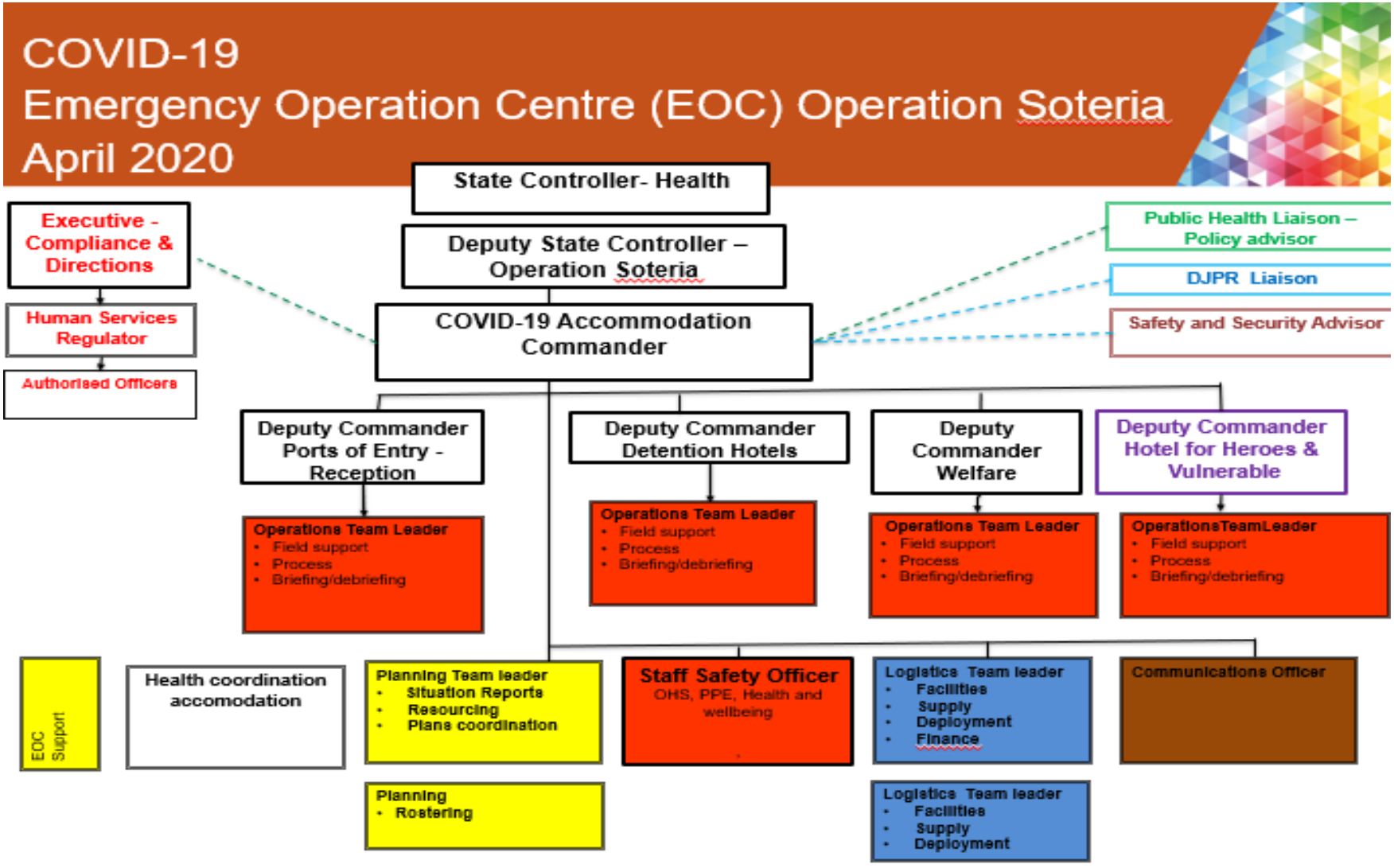
Appendix 1 - Operation Soteria process phases



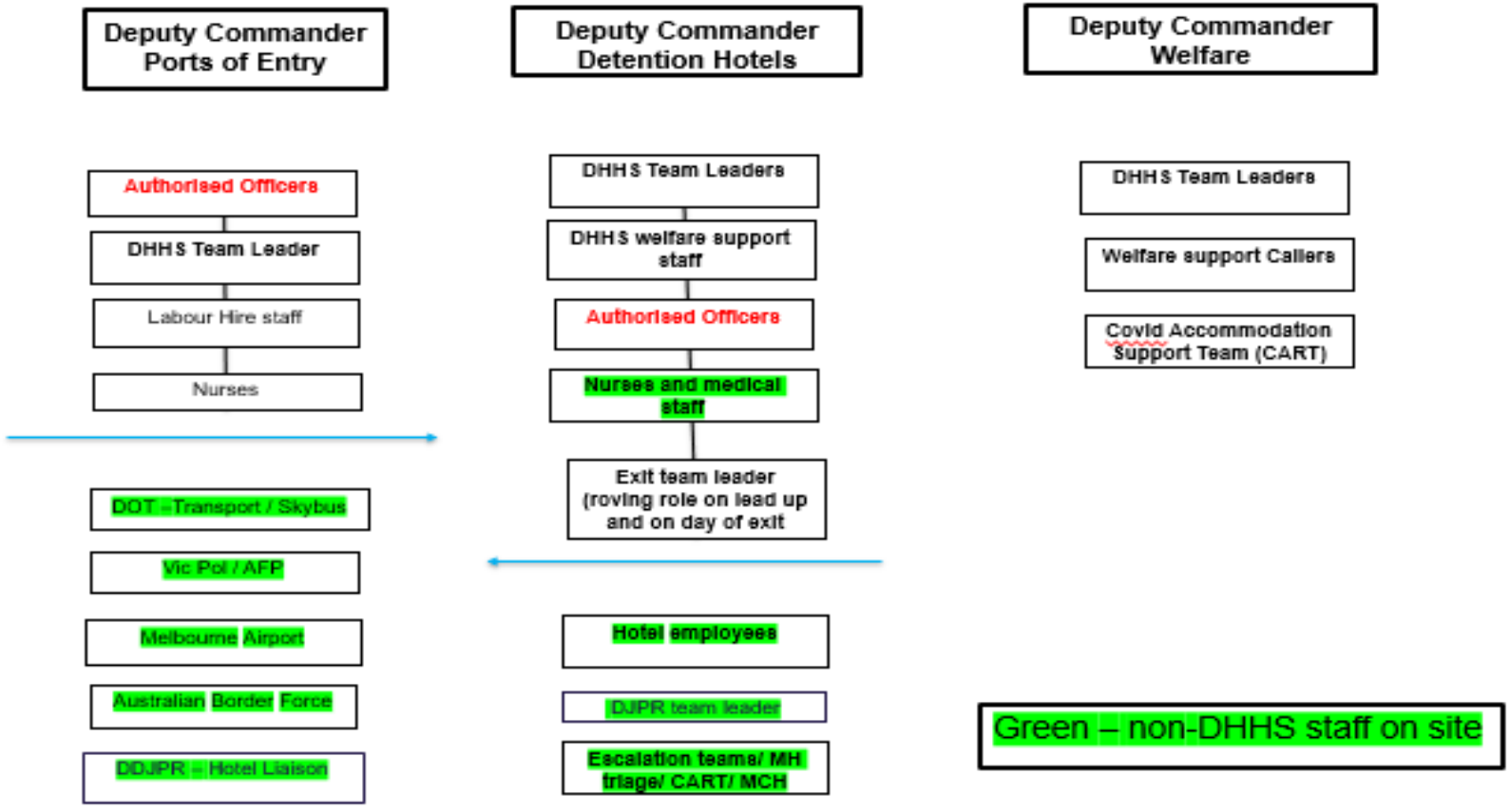
Appendix 2 - Enforcement and Compliance Command structure



Appendix 3. Emergency Operations Centre Structure



Operation Soteria – on site teams



Appendix 4 - DHHS COVID-19 Quarantine – incident reporting

1. Introduction

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

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

This document was last reviewed on 21 April 2020.

2. Reviewing and endorsing incident reports

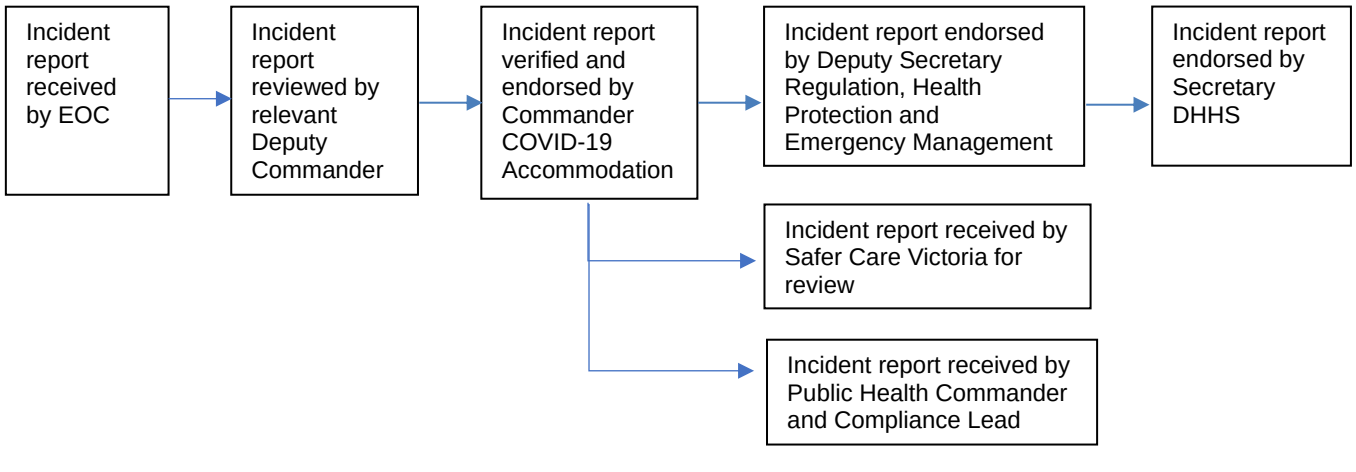
This section outlines the steps required for reviewing and endorsing incident reports, once provided to the DHHS Commander COVID-19 Accommodation via dhhsopsoteriaeoc@dhhs.vic.gov.au following verbal report via phone from the relevant Deputy Commander. Figure 1 below provides an overview of the process.

2.1. Overview

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

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

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



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

2.2. Deputy Commander receives an incident report

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

2.2.1. Reports about passengers/detainees who are also clients

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

2.3. Review of the incident report

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

They must review the incident report and:

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

2.4. Verify and endorse the incident category

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

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

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

2.5. File the completed incident report

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

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

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

2.6. Incident report records management and privacy

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

2.7. Local investigation and causal analysis

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

Incident investigations should:

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

3. Privacy

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

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

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

3.1. Sending information by email

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

3.2. Electronic security of passenger/detainee information

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

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

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

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

DHHS Quarantine – incident reporting template

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

1. Service provider details

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

2. Incident dates

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

3. Incident description

Location of incident	
Detailed incident description	

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

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

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

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

6. Service provider response details

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

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

7. Incident report authorisation – EOC Command

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

8. Incident report authorisation – Deputy Secretary

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

9. Incident report authorisation - Secretary

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

TRANSCRIPT - PRESS CONFERENCE

TRANSCRIPT
15 Mar 2020
Prime Minister
E&OE

PRIME MINISTER: Good afternoon everyone, today was an historic gathering and I welcome Dr Kelly as well to be with us here today, the Deputy Chief Medical Officer.

An historic gathering of the first ever National Cabinet, bringing together the Premiers and Chief Ministers of our States and Territories concurrently, together with myself as a part of the national response, the coordinated national response to the spread of the coronavirus here in Australia. The many things that we have to do to continue to contain the spread of the virus here in Australia, it goes across both federal and state governments. And so ensuring that we're working incredibly closely together, that we are highly aligned both in the information we're receiving, it's understanding the actions that we need to take is incredibly important as we implement the measures that will keep Australians safe into the future, and ensure that we come through this together.

It's always important to be extremely clear and up front with Australians, and that's certainly what we've sought to do as a government. I commend Dr Kelly and Dr Murphy, who have been doing an outstanding job in providing regular briefings to the Australian people about the issues in relation to the coronavirus and indeed their state and territory colleagues as well. They've been providing that information. As you know, the National Campaign, Public Information Campaign is out in newspapers and televisions and things today and social media has already been in place now for several days and we initiated. Several weeks ago, I announced that we were putting in place and activating the Australian health sector emergency response plan for the novel coronavirus COVID-19. We've commenced that plan with the initial phase and today the National Security Committee met before the National Cabinet, and we've moved now to the next phase, which is the target action stage. And there are major decisions that were taken today that reflect changing where we are heading. The facts and the science, the medical advice will continue to drive and support the decisions that we are making as a National Cabinet, as indeed as a federal Cabinet at the Commonwealth level. But the truth is that while many people will contract this virus that it's clear, just as people get the flu each year, it is a more severe condition than the flu, but for the vast majority, as I said last week, for the majority, around 8 in 10 is our advice, it will be a mild illness and it will pass. However, for older Australians and those that are more vulnerable, particularly those in remote communities and those with pre-existing health conditions, it is a far more serious virus, and that is our concern. Our aim in all of this is to protect the most vulnerable. The most at risk. And I want to take you through again the decisions we're taking today and we have been taking.

We know that the virus cannot be absolutely stopped. Of course not. No one can do that. But we can slow the spread and we anticipate that will be what our task will be over about the next six months. No one can know for certain how long this will run. It could be shorter than that. It could be longer than that. But the measures that we're putting in place as a government is making those types of assumptions. But that is being updated on a daily basis.

Now what I have here, this is, there are a range of different scenarios that are pulled together by modellers around the country and none of them is a prediction, all of them just simply show the possible spread of the virus and what that could mean ultimately, when we work through things like ICU beds and ED presentations, and GP's and so on. If you don't take measures that seek to contain the spread, and mitigate the spread, then you have scenarios that look like this. You have scenarios where you get a very severe effect on the spread of the virus. You may move through it much more quickly, but what happens is the virus reaches more people, and that puts maximum pressure on your health system. And that obviously has far more drastic implications for the most vulnerable in our community.

Now the extent of that peak depends on the rate of transmission you might see in some countries where there's a much higher rate of transmission by any one person then the peak would be higher. And the impact will be more severe, but in other scenarios like this, it is still significant, but it can be less in terms of how many people it reaches. The job of our plan, the job of working together is what we call a flattening the peak, and to get this result as opposed to that result, what we're looking to do is manage the flow so we suppress the demand on our health systems and ensure that we can continue to provide the care that Australians need.

In this sort of scenario, which is what we're working to achieve, this means with some changes to the way that ICU departments are managed and things of that nature. The advice we've had to date and the excellent work that's being done by the chief medical officer working with the states and territories, means that that can be dealt with. That doesn't mean there won't be busy times in our hospitals. It doesn't mean there won't be stresses on the system and there won't be days where patience will be required, and there won't be frustrations. It's not what it means. What it means is, if we continue to manage the spread of how the virus impacts in Australia, then we will be able to ensure that we can continue to provide the services and support, particularly to the most vulnerable Australians who are most at risk from the Coronavirus. So slowing the spread, you free up the beds. That's what happens when you get this right and we've seen other countries going down this path. Australia has also been going down this path and the way we've been managing everything from travel bans to the way we've had quarantine arrangements in place and self-isolation, these arrangements have been ensuring that the number of cases we've had in Australia up until now, and they are growing now, they have been kept well below what we've been seeing in many other countries.

We have a first class health system here in Australia, but no hospital system on its own can deal with this at its most extreme position, whether that's in the United Kingdom or anywhere else. And last night, I had the opportunity to talk to Prime Minister Boris Johnson and we were talking through these very types of scenarios and and it was important for us to be swapping notes on those issues as I was with Prime inister Arden yesterday, as we discussed the arrangements that she put in place yesterday in New Zealand. And indeed, we've been considering ourselves.

We're going to have to get used to some more changes in the way we live our lives over the next six months or so, there will be further intrusions. There will be further restrictions on people's movement and their behaviour. But the point is, you do it in a timely way. You do it in a managed way. You do it in a careful way. Just because something is not necessary today doesn't mean it won't be necessary in 3 weeks from now or 3 months from now, just as something we're announcing today wasn't necessary 2 months ago.

Today, as the rate of community transmission starts to pick up, then new measures are put in place. And what you simply do as I'm explaining, as you put these new measures in, as you see these curves unfolding, then you can flatten the curve as you move forward. Some places, schools, workplaces, others will make various decisions along the way. And they can work off the best advice that they have available. Australians are smart people, they're commonsense people. Occasionally, in recent weeks and months, we've seen some examples, not of that behaviour, and that's regrettable. But for the vast majority of Australians, they're commonsense people and we have to rely on their judgment as well. The government can't manage every hour of your life and tell you what to do every hour of the day, but we can't ask you to listen to the information and make your best judgments as you care for yourself and your family and those around you. We're relying on that Australian spirit of looking after each other, as we get through the difficult months that are ahead.

Today, I now want to move to the decisions that we have taken that were consistent with the plan that I've outlined to you. First of all, the National Security Committee met before the National Cabinet today and we resolved to do the following things; to help stay ahead of this curve we will impose a universal precautionary self-isolation requirement on all international arrivals to Australia, and that is effective from midnight tonight. Further, the Australian government will also ban cruise ships from foreign ports from arriving at Australian ports after an initial 30 days and that will go forward on a voluntary basis. The National Cabinet also endorsed the advice of the AHPPC today to further introduce social distancing measures. Before I moved to those, I just wanted to be clear about those travel restrictions that I've just announced. All people coming to Australia will be required, will be required I stress, to self isolate for 14 days. This is very important. What we've seen in recent, in the recent weeks is more countries having issues with the virus. And that means that the source of some of those transmissions are coming from more and more countries. Bans have been very effective to date. And what this measure will do is ensure that particularly Australians who are the majority of people coming to Australia now on these flights, when they come back to Australia, they're self-isolation for 14 days will do an effective job in flattening this curve as we go forward. Similarly, the arrangements for cruise ships will have the same effect in specific cases where we have Australians on cruise ships. Then there will be some bespoke arrangements that we put in place directly under the command of the Australian Border Force to ensure that the relevant protections are put in place. We're seeking to assist Australians to come home by ensuring that the flights continue to run, but when they come home, they'll be spending another 14 days in self isolation. And so I've covered also the issue of the cruises.

When it comes to social distancing I want to read to you the key sections of the advice that we've provided today to the National Cabinet. The AHPPC believes that social distancing measures are now required and will need to be introduced progressively to reduce disruption. This has the most benefit in delaying transmission. The AHPPC advises, as we flagged last Friday, that in general non-essential gatherings of more than 500 people should not occur. They also advise that at this early stage, not to prevent the operation of essential functions, including schools, universities and workplaces, or prevent the operation of public transport. However, the principle of social distancing should still apply in these settings. The AHPPC advises, is for static non-essential gatherings of persons that they should not go ahead, if there are more than 500 people you'll be in such a gathering. Now what do I mean by that? A static gathering is when you're sitting as you are here in this room for prolonged periods. That would occur at a stadium, it would occur in a theatre, that would occur in events such as those where people are together in close proximity for a sustained period of time. The advice is that those gatherings should not continue at that scale. The AHPPC advises and Dr Kelly may wish to touch on this, but that includes how you can mitigate those events, when they are in much larger rooms that obviously reduces the risk. If the gathering is outdoors in much more open gatherings, well, obviously that reduces the risk.

There are a lot of common sense principles which should be fairly obvious, I think. And the way people respond to those I think will be very helpful. So what the National Cabinet has agreed today is that we will adopt that recommendation and we will be preventing non-essential static gatherings of more than 500 people occurring across the states and territories. The states and territories will be moving to put in place the appropriate arrangements under their state based legislation to ensure that is supported. They'll be doing the same thing in relation to the self-isolation requirements of Australians and others coming to this country by air to support the decision of the National Security Committee. Now that legislation is a matter for the states and territories. They'll be working on that promptly. But from here on in, from Monday, it's important that people act in accordance with that advice. Now, the obvious question is, how would that be enforced? Well, the states and territories wisely are not going to create event police or social distancing police or things of that nature. That would not be a wise use of police resources around the country. But the legislation impact would mean that if a person did fail to observe the 14 day self-isolation or if an event was organised, that would be contrary, once those provisions are put in place to state law, and there'd be nothing preventing I'm sure the states from ensuring that that was dated from Monday. But they will be specific details that the states will naturally work together on and ensure as much consistency as possible across their jurisdictions.

A few other things that were decided today, was about the priorities of what we must be addressing as a National Cabinet in the days and the weeks ahead, having addressed the issue of mass gatherings of 500 persons or more And let me be clear. That obviously doesn't mean, as I said on Friday, it doesn't mean train stations, it doesn't mean shopping centres. It doesn't even necessarily mean markets like Salamanca down in Hobart or things of that nature. These are static mass gatherings where people are together for long periods of time. For large events, very large events like the Royal Easter Show, which has already been here in New South Wales, cancelled, I mean that is an event which was cancelled, as the Premier reminded us this morning, to prevent people coming from all around the state into t Sydney and potentially being exposed to the virus through that type of an interaction and within the Easter Show you are together with large groups of people for long periods of time. So there will still need to be a lot of judgement exercised at a state and territory level in relation to specific events. That will include Anzac Day. We will be putting out specific guidelines working together with the RSL about those gatherings and particularly regarding the participation of more vulnerable Australians out of our more elderly veterans community. We had a long discussion about what the most important priority is now having made that decision about mass gatherings, the first of those is putting in arrangements and restrictions around the visiting of aged care facilities and the AHPPC is working on that today and they'll be providing us with further advice about how that will work. They are also doing work on remote communities, particularly that is going to affect the parts of South Australia, Western Australia, Northern Territory, Queensland especially. And so they're doing some important work there about the arrangements and protocols that would need to be in place. They are also doing work on further restrictions on gatherings in enclosed spaces. And the National Cabinet will meet on Tuesday night and consider that advice so I can stand here before you on Wednesday and provide you with further announcements in terms of the further decisions that are made in relation to aged care and gatherings involving enclosed areas.

We also had some wide discussions today about schools, and I can totally understand, as a parent of two daughters in school here in Sydney, that people are naturally anxious about the issue of schools. As the British chief medical officer observed just over the last couple of days, the issue of wide-scale closure of schools, it might be anti-intuitive, but the advice is this could actually be a very negative thing in terms of impacting on how these curves operate. That happens for two reasons. When you take children out of schools and put them back in the broader community, the ability for them to potentially engage with others increases that risk. And that's the understanding we have. There's also issues of herd immunity that relate to children as well. And Dr. Kelly, might want to touch on those issues. The other issue is the disruption impact that can have and put at great risk the availability of critical workers such as nurses and doctors and others who are essential in the community because they would have to remain home and look after their children. And so while it may seem counter-intuitive, there is very good reason why you would not be moving to broad scale closures of schools that could actually make the situation worse, not better. And so the states and territories are not moving in that direction. We will consider this again further on Friday at our meeting, after Tuesday night, to consider further advice on those issues. So for now, the continuing practice, which is especially being put in place in New South Wales and Victoria, where they've had the most experience of this, individual decisions are made on particular schools based on the cases that are presented there and the circumstances that exist in those communities. And that is done in conjunction with their state health officers to make the right decisions in those very specific locations.

So with all of those matters, I think I've touched on all the decisions that we've made today as a National Cabinet and as a meeting of the National Security Committee, and we will continue to meet regularly. There was a very strong spirit of unity and cooperation. And again, I want to thank the premiers and the chief ministers for their support in bringing together this national cabinet. It has now been established formally under the Commonwealth government's cabinet guidelines. And it has the status of a meeting of Cabinet that would exist at a federal level, as does the meetings of the AHPPC and the national coordinating mechanism, which is feeding up into those arrangements.

So some important changes today. There will be more changes in the future. We'll be seeking to forecast those for you as much as possible. Remember, when we're taking these decisions, we're taking them to allow time for people to adopt them. These are not absolute measures that if they are introduced today then, if I were introduced the day before, that Australia was put at risk that's not the case. What we're doing is implementing the measures well in advance of where they might have otherwise been done. What we've seen overseas with some of the restrictions that you've seen in many of those other countries, they were introduced when the number of cases and the amount of spread in their communities was far more advanced than where we are in Australia today. And so what we're introducing today means we're getting well ahead of where those other countries have been when they've had far

greater numbers of cases. So we'll continue to stay ahead of this. We'll continue to keep our heads when it comes to this. And we will continue to take the medical advice which will guide what is first and foremost a health crisis in this country.

One last point I should have made, is the states will also be considering moving their movement to public health emergency status under their various state arrangements. in some places like Queensland they've already moved to that some time ago. Now, the other states are now working over the next few days to make their own decisions on that. That is entirely a matter for those states and territories. And they'd be seeking to align how they do that over the next few days. And I think that's a productive thing they can do and ensure we're getting on a consistent footing. But with that, I'm gonna hand over to Dr. Kelly.

DR. PAUL KELLY, DEPUTY CHIEF MEDICAL OFFICER: Thank you, Prime Minister. So that's a lot of information there. I won't give too much more, just to reiterate the Prime Minister's statement that what we are doing and as we've always been doing throughout this, as we've learnt more about the virus, how it spreads, the effect it has on people's health, and particularly the issues that are pertinent to Australia as distinct from other countries in the world. This is a proportionate response. And so what we are doing is the proportionate response, staged and informed by the information as it progresses. So things are changing on a daily basis. And as the Prime Minister has said, that doesn't mean that it was wrong yesterday. It was right for yesterday, today is a new day. And the next day will be another new day. We'll have more information and we'll be able to go forward. The Prime Minister has mentioned the modelling that is being done. It is continuing to be redefined and and be more accurate as it goes forward. But it is not, it's not the definite future it is to guide the decisions that are being made, that the graph that we see on the right hand side, your left, is the graph we see when there is a new virus entering our community where no one has immunity against that virus. That is the issue with this coronavirus. It's not like flu. It's not like any other viruses and diseases where we have vaccination. And that important issue of herd immunity that we talk about a lot in vaccination is exactly the challenge that we have at the moment. There is no herd immunity. Everyone is susceptible to this virus in Australia. And so that's why these unusual and proportionate measures that we are taking now to prevent the worst case scenario, which is that very high peak, is really important. And as we go through, there will be other measures that may need to be introduced depending on how things work out in the coming weeks or months.

What is different about Australia, of course, is that we're not yet in winter. All of the places where we're seeing this virus really escalate very quickly now through other parts of the world, are in the northern hemisphere. They're in the in the in the later part of the winter months, they have flu seasons as well. And all of the environmental elements that allow viruses to spread quickly are actually there in North America, in China, in other parts of northern Asia and across to Europe. We've seen exactly what has happened there, and in particular, not taking enough action, probably early enough in most of those countries. And we can see the effects on the healthcare system and the unfortunate death rates that we're seeing around the world. In Australia, we now have almost 250 cases. That doesn't sound like a lot. But if you think back just a week, that's quite a few more than we had last week. Next week we'll have more. At the moment it's mostly in relation to travel. And so those new restrictions and new measures that have been put at the border in terms of 14 days quarantine for everyone coming back from overseas, from whatever country is the next proportionate step to take to decrease those travel related illnesses. But we are also starting to see, particularly here in Sydney, but also in other other cities and into our regional areas, some human to human transmission in Australia, not necessarily related to travel. That will be the next step, more proportionate measures will need to be taken as that develops. So these are difficult times and the disruption to society is very much felt by us in the health side of government. But we are continuing to give our measured advice to government and we're very happy that that's being listened to and put it into account with the other measures in terms of social, economic and other considerations. So Prime Minister I might leave it there.

PRIME MINISTER: Thank you Dr. Kelly. And just on social distancing also, that means that the social distancing practices that we're encouraging are being expanded. So there's no more handshakes. That is a new move we've moved to, and that's something that I'll be practicing, my Cabinet members, that you expect to see leaders and others now practicing. This was not something that was necessarily a key requirement weeks ago, but it's just another step up now. It's a precautionary step. And we'll be practising that. The Cabinet itself will now be meeting more regularly by video, by video conferencing, rather than all Cabinet members being in one place that will apply to the national security committee, and National Cabinet, as it did today, met through video conferencing, similarly leaders and other politicians you can expect to see not travelling as much as they were before. Not engaging as many public events. I've cancelled a number of events for next week. That is just simply to try and manage the normal process- as you'd expect, too, as we move into this next phase which we've agreed to do today. I'll be working particularly with the Speaker and the President of the Senate to look at the, they've already been working on that for some time, actually, about the arrangements we'll put in place, obviously consulting with the Leader of the opposition on those issues. We have important work to do when Parliament resumes on Monday week. We can focus on that and get that done in very practical arrangements to achieve that. Questions?

JOURNALIST: Prime Minister, how long will this travel, new travel arrangement last this ban?

PRIME MINISTER: It's indefinite. It's reviewed every week.

JOURNALIST: Explain to us how does it work? How do people self isolate? They come off, out of the airport. They get in a taxi they stay in a hotel room for two weeks? And an Australian goes home and stays in their bedroom for 2 weeks?

PRIME MINISTER: That's it. And Australian Border Force will be moving over the course of this weekend to ensure that people statutorily declare that if they're entering the country, that they understand that that is the requirement. What will happen, Chris, and this is what we've seen in other countries that have done this, is that the visitor traffic will dry up very, very, very quickly. And it's important that the flights keep going because they bring Australians home. I should also note that Pacific Islanders who are on their way home, to their home country, will be allowed to transit through Australia. They won't be allowed to remain in Australia, they're allowed to travel. Otherwise, they have no way of getting home and that's us being part of the Pacific family and helping them. New Zealand put exactly the same set of arrangements in place for Pacific Islanders coming home by New Zealand. The arrangements I've announced today are those that were put in place by New Zealand yesterday, and they in fact will come into effect at the same time.

JOURNALIST: Will there be a central database Prime Minister, that state authorities can access so they know who's been overseas. And if they should be self isolating, I just don't understand how it's going to be policed?

PRIME MINISTER: Well, again, I mean, this has been in place now for many months, for over a month now in terms of travellers coming from China and other places. And the truth is, the self-isolation has worked out in practice quite well because Australians have followed the instructions. And up until now, that has been a voluntary arrangement. There has been no potential sanction that might apply against a person for not following that requirement. Once state authorities are in a position to give that its legal enforcement then that will be a change. I mean, so if your mate has been Bali and they come back and they turn up at work, and they're sitting next to you, well, they'll be committing an offence. And so I think it's up to all of us to ensure that, we are ensuring this is put in place.

I mean, Australians will exercise common sense. They have been to date, and this provides the backstop of a legal enforcement but the the idea that there'd be significant resources dedicated to that task would not be practical, because remember, when you get an overwhelming number of people following that advice, then you're getting the effect which you want, which is that.

JOURNALIST: What's the penalty for committing the offence of not self-isolating?

PRIME MINISTER: That will be a matter for the states and territories under their own public health [inaudible].

JOURNALIST: [inaudible] What would would look like though? Would that mean fines or is it jail time?

PRIME MINISTER: Yes. Again, it's a matter for state authorities as to what penalties they place on that. The National Cabinet ensures that we have some coordination, but ultimately states and territories will make their own decisions.

JOURNALIST: Sorry, will there be any screening at borders of temperatures or anything like that? Or just all be self-isolation?

PRIME MINISTER: Yes. No no there will be. And there has been already. And for those for those, for those persons who come back and present with symptoms, they will be directed through the Australian Border Force to be given protective equipment. This group that we're now applying this requirement to is low risk. And we also do think, and the health advice is, is this that to provide the PPE equipment to everyone who comes through our airports would be an unnecessary depletion of that resource. We know those resources from our stockpile for health workers, those working in aged care facilities and so on. And so they will be able to return home. They are at a low risk, is the assessment. But for those who may be presenting with some concern or symptoms then they'll be provided with that equipment at the airports, as we already are for those who are coming from Iran or those who are coming from China, from South Korea and Italy.

JOURNALIST: What measures will the government be taking to prevent the spread by public transport?

PRIME MINISTER: Well, already the state governments have been doing a fair bit of that. And that is a matter that I know will be sort of worked on through the national coordinator messages which feeds up to the National Cabinet about what experience and best practice can be shared. The National Cabinet, yes, it's making decisions on things like I've talked about today to support with legislation, self-isolation arrangements and things of that nature. But the other thing that the National Cabinet is doing is sharing this practice information about how state governments are just practically dealing with; whether it's transport or indeed the very helpful discussion we had with both the New South Wales and the Victorian Premier sharing their experience about how they're dealing with schools. The Northern Territory Chief Minister, Michael Gunner, has some very specific issues that he has to deal with about access of essential services and workers going into remote communities in the Northern Territory. And he's already working with us. And so the Northern Territory and the arrangements that are there will become the model for what is done in remote indigenous communities in many other states and territories. So this is a highly collaborative process and we're all learning from each other and all supporting each other.

JOURNALIST: How will social distancing be instructed to schools and kids in schools. Will schools be given specific advice to tell their kids or will it be up to schools. How this health, social distancing, as you mentioned, is going to work?

PRIME MINISTER: The national information campaign is already running with information that will be available to all Australians, but it's pretty straightforward. A metre and a half. We're about a metre and a half away. Ensuring that, you know, you refrain from that sort of physical contact, which might be the handshake or even something a bit more intimate unless you're with your close family and friends. It's all common sense. You know, we don't need to tell Australians how to get out of bed in the morning and how to put their shoes and socks on and things like that. Australians understand. And I'm not making light of this, I'm not. These are important, normal, common-sense social interaction measures that people can take. And they are very intuitive. And it's all about reducing the amount of direct

physical contact that you have with others. That's a clear principle, which I think Australians can understand. And I would expect teachers, or those at preschool, or in churches or wherever. I know I got a message from my church during the course of the week after Friday and they were putting measures in place and good for the. School clubs and others are doing the same thing. It's just Australians getting together, working out how they're going to adjust. See, I really want Australians to get on with their lives as commonly as possible. But there will be disruptions and they will adjust. Australians, of course, can adjust. But what I hope won't happen, and I'm sure it won't, is that we won't lose our sense of Australian-ness in all of this, we will support each other. If you've got someone who's in self isolation particularly, there might be an elderly person who might live in your apartment or down the road, and they would be wisely exercising even greater precautions about their social interactions. So make them a casserole and leave it on the door or things like this. I think just Australia's helping each other out over the next few months. You know in the shopping centre aisle, you know, make sure someone who might be a bit more vulnerable than you can get what they're looking to get as well and I think just being good to each other is the right thing to do.

JOURNALIST: PM on the new travel arrangements, have you had a chat to, I know you said you spoke to Boris Johnson last night, but have you spoken to any other world leaders and specifically the White House? Because we're seeing a lot of cases coming from the US?

PRIME MINISTER: Yeah well it's our major source now coming out of the United States. And yes, we have had a lot of interaction with the United States and we will continue to, the Foreign Minister was only there this week. She returned yesterday. And so we've had a lot of interaction with the United States with the UK. The Five Eyes groups, and New Zealand I speak to the Prime Minister almost every other day. And one of the things I should mention that I spoke to Prime Minister Johnson about is when it comes to the G20, I'm also aware that Prime Minister Modi is keen to organise a link up between all the G20 leaders. I think that's, I think that's a commendable initiative. Australia obviously supports that. I've communicated that. That's a matter for the Saudi government who's the President of the G20 this year. But the Prime Minister and I agreed last night that an even more urgent meeting that could be needed would be a further meeting of the G20 finance ministers and central bank governors. This is a health crisis, but it has very serious economic impacts. Those economic impacts have been clearly affecting financial markets. To date, that has been managed, but we've seen some highly volatile and quite disruptive activity on our financial markets. We want to be assured through our cooperation, as occurred through the GFC amongst that very G20 group, that we can make sure that there is no further damage or undermining of financial markets and the Central Bank Governors and Finance Ministers are the best place to do that. Truth is that they only had a meeting a few weeks ago and at that meeting, things were at a very different stage as they are today. And I think that demonstrates I mean, there's a lot of wisdom in hindsight at the moment. But what we have to realise is this has been a very fast moving event. And so far, the decisions we've taken has put us in a good position. But you've got to stay in that position by constantly making additional decisions. And that's what the National Cabinet was set up to do.

JOURNALIST: When it comes to shopping and gathering supplies, what's the advice there? Because Victoria's Chief Medical Officer said 14 days of supplies are required. The federal chief medical officer said this morning, two to three days. What is the official advice?

PRIME MINISTER: I refer you, I understand, to the comments of Premier Andrews, made this morning that the medical officer in Victoria, I understand, has been misrepresented in what he said about that. And what you've heard from Dr. Murphy this morning is consistent with what the view is around the states and territories. But I'd refer you to, I understand Premier Andrews brought this to my attention today. What was said has been misrepresented about that 14 day arrangement. And I mean, people should exercise common-sense. See, the thing is, the shops are going to remain open. You know, the electricity companies will still be selling the power. The phones are still going to work. The lights are going to continue to come on. The schools will continue to come together. The trains will continue to run. The airports will continue to function. This is not a cyclone or a physical event like that that shuts down parts of our cities in terms of a physical sense. It is something quite different. This is a biological virus that is affecting human to human transmission. And so I think we just need to get that into some sort of perspective in terms of how we moderate our response.

JOURNALIST: The NRL, though, says that it is actually not in that category that is in danger of being closed down. And they're now asking for potentially hundreds of million in support from your your package. But is that something you'd entertain?

PRIME MINISTER: Oh, we'll look at all of all of those issues. I understand that already today, I think over half a million they've put into the clubs, and there'll obviously be a lot of disruption, whether it's the NRL or the AFL or any of the large sporting competitions, but equally in the cultural community as well. They'll be there'll be events that won't be able to go ahead, there'll be cultural events that won't be able to go ahead. And it's important that what we're saying on the banning of gatherings of more than 500 persons, that is going to be supported by state legislation. So it's it's not an advisory. It's not, there's no discretion. There'll be requirements. And that has obvious implications for things like insurances, things of that nature. But we'll deal with those issues one after the other. Right now, though my real focus is on the further mitigations we have to put in place. The most important, having made this decision about further isolation of people coming to Australia. That does ensure that we have the strongest borders anywhere in the world when it comes to these sorts of issues. Australia has always been well known for its border protection on all matters and it's certainly the case when it comes to managing this issue. But in addition to that, it's also about ensuring that as a government, we keep taking decisions which keep us ahead of the curve.

JOURNALIST: What happens to, people who are going on domestic life, reconsidering that travel is a domestic flight, one of these static locations that you're talking about?

PRIME MINISTER: That's not our advice. Dr Kelly you might want to talk about flights?

DR. KELLY: Yes. So that wouldn't be the advice at the moment, but as I said before, we'd be looking at all measures as they go forward. There are both, domestic flights and generally short although there are some further destinations which are longer. But at the moment, there is no advice about restricting domestic travel.

JOURNALIST: When you have a look at those graphs, and the feeling in the community at the moment is, is one of anxiety, should Australians be afraid?

PRIME MINISTER: Australians should be careful. Australians should be listening to the advice that is provided, Australians should be exercising their common sense. But the thing I'm counting on more than anything else to achieve that outcome rather than that outcome, is that Australians be Australian. Now Australians can deal with this, we can deal with some change to our daily lives. We can deal with the surprises that may come as we get further information. We can deal with making common sense judgments every day. We can deal with looking after each other. We can deal with having to show a bit of patience from time to time. And the odd frustration or disappointment Australians can deal with all of that. So long as Australians keep being Australian we'll get through this together.

Thank you all very much. Ta.

PRIME MINISTER OF AUSTRALIA
The Hon Scott Morrison MP

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

Public Health and Wellbeing Act 2008 (Vic)
Section 200

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

PART 1 — NON-ESSENTIAL MASS GATHERINGS

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

Directions

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

Definitions

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

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

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

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

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

Example: Federation Square or Bourke Street Mall.

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

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

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

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

PART 2 — SELF-QUARANTINE FOLLOWING OVERSEAS TRAVEL

Direction

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

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

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

c. must not leave the premises, except:

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

ii. in any other emergency situation;

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

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

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

a. a member of the flight crew;

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

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

PENALTIES

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

Compliance with direction or other requirement

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

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

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

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

.....

Brett Sutton
Chief Health Officer

16 / 3 /2020

Australian
BORDER FORCE

Border measures in place for COVID-19

Border measures in place for COVID-19

20 March 2020

This factsheet provides the responsibilities of the Australian Border Force (ABF), Department of Agriculture, Water and the Environment (DAWE), Commonwealth, State and Territory Health Departments, and airlines in managing the enhanced border measures for COVID-19.

A travel ban will be placed on all foreign nationals who do not meet the travel exemptions and are not in Australia before 2100 AEDST 20 March 2020, and therefore will not be allowed to enter Australia. All exempt travellers will be required to self-isolate for 14 days from the time of arrival in Australia.

Overseas – at check in

- *Airline responsibilities*
  - Advice to be provided to all foreign nationals they will not be permitted into Australia arriving after 2100AEDST 20 March 2020 unless exempt.
  - Airport signage in some countries are also providing visibility of the restrictions for entry into Australia.
  - Questions are asked regarding traveller health.
  - Some airlines have ceased kiosk check-in so interaction with an airline staff member occurs.
- *ABF responsibilities*
  - Airline Liaison Officers (ALOs) in major transit hubs engage regularly with airlines to facilitate Australian travellers and educate airlines on the enhanced border measures for Australia.
  - Travellers exempt from the enhanced border measures are facilitated at check-in. All other travellers attempting to check-in will be stopped by the airline through an electronic message.
  - If the ABF receive a call from the airline, further questions are asked to assess the traveller's origins. Further questions on the health of the travellers are also asked at this stage.

During flight

- *Airline responsibilities*
  - Inflight messaging via audio and in leaflet form.
  - DAWE has provided in-flight messaging to airlines to facilitate this requirement.
  - Airlines provide both the Incoming Passenger Cards and the health factsheet to travellers prior to arrival.

On arrival at international airports in Australia

- *Airline responsibilities*
  - Obligation to notify DAWE of any/all unwell travellers on-board the aircraft.
- *ABF responsibilities*
  - Assessment of travellers identified that pose a higher risk are targeted upon arrival.
  - ABF officer presence at arrival and baggage halls to facilitate the interaction and questioning of travellers through active monitoring.
  - ABF officers to refer any travellers presenting as ill in the primary, baggage hall or screening areas to a Biosecurity officer for health assessment.
  - ABF officers are to distribute and collect Isolation Declaration Cards to all passengers entering Australia. The ABF officers will collect the health card prior to the primary line.
  - ABF officers will refer passengers who declare they will not self-isolate to a Biosecurity officer. If the traveller is exempt, the biosecurity officer will then take down the passenger's name, number and address and collect the health declaration and let the passenger go. If the traveller is not exempt, they will be considered for Refused Immigration Clearance. If this occurs, the ABF will retain the card as part of the required justification to effect cancellation.
  - ABF officers will collect Isolation Declaration Cards and stockpile for handover to State or Territory Health Partners at multiple times throughout the day.

- *DAWE responsibilities*
  - If the airline advises of ill traveller/s, DAWE will undertake a health assessment of the traveller on-board. This assessment (which may include seeking guidance from a State or Territory Health human biosecurity officer), is designed to assess for COVID-19 as well as other listed human diseases. The ill traveller will not require additional health screening at the health screening area in terminal, but Biosecurity officers may escort to the biosecurity health room is further assessment is required. If there are no issues, the Biosecurity officer grants permission for the flight to disembark.
  - Masks provided after disembarkation by DAWE Biosecurity officers or state or territory health officials in the health screening area.
- *Commonwealth, state and territory health departments' responsibilities*
  - Conduct health assessment of travellers which includes questioning and temperature checks.
  - If ABF officers question travellers at the primary line and deem further assessment is necessary, a further health screening will be facilitated.
  - Determine and facilitate treatment action.

Post-border

- *State and territory health departments' responsibilities*
  - Contact tracing when a traveller is identified being symptomatic. Health agencies inform travellers on a flight where there has been close contract to positive COVID-19 traveller for further treatment/isolation options.
- *State and territory law enforcement responsibilities*
  - Compliance activities in relation to self-isolation may be undertaken by relevant state or territory law enforcement agencies.

RE: COVID-19 - Melbourne and Avalon Airport Report - 16 March 2020

From: REDACTED (DHHS)" REDACTED

To: "StateEmergencyManagementCentre SEMC (DHHS)" <semc@health.vic.gov.au>, "NorthandWest EOC (DHHS)" <northandwest.eoc@dhhs.vic.gov.au>, "Infectious Diseases (DHHS)" <infectious.diseases@dhhs.vic.gov.au>, "Brett Eastwood (DHHS)" REDACTED

Cc: REDACTED (DHHS)"REDACTED ,REDACTED (DHHS)" REDACTED (DHHS)" (DHHS)" DHHS)"

Date: Mon, 16 Mar 2020 19:50:22 +1100

Hi all,

Please see below update on no. of passengers undergoing health screening at Melbourne Airport.

Direct Flights ex China – Monday 16 March 2020.

Flight:	Pax:
CZ321	29
MU737	15
CZ343	1

Note: Airlines are now starting to increase the number of direct flights from China.

Melbourne Airport Primary Line Health Screening Assessments:
Sunday 15 March
Count: 113

Avalon Airport Primary Line Health Screening Assessments:
Sunday 15 March
Count: 10

Primary line assessments:

- As of 16 March all people arriving in Australia from overseas are being advised to self isolate for 14 days.
- All travellers coming from countries of interest (China, Iran, Korea and Italy) continue to undergo health screening as per current protocol.
- For all other people arriving in Australia, biosecurity staff meet passengers at the aircraft and provide travellers a fact sheet in relation to the self-isolation requirement. The aircrew also make an announcement over the PA system both in the aircraft and throughout the airport.
- If people arriving from other countries are not well, they are provided a mask and requested to undergo health assessments through the primary line as for those travelling from countries of interest.
- Additional health screening points throughout the primary line of the airport have been established.

Regards

REDACTED
Emergency Management and Health Protection | North Division
Department of Health & Human Services | 145 Smith St, Fitzroy Victoria 3065
REDACTED
W. www.dhhs.vic.gov.au

Australian Government

ISOLATION DECLARATION CARD – Coronavirus (COVID-19)

HEALTH ALERT NOTICE: All people entering Australia must isolate for 14 days. Please refer to the Information sheet for international travellers for further information.

I _____ **(full name)**

understand I am required by state and territory laws to isolate for 14 days at a designated place.

Usual address: _____

City: _____

State/ Territory: _____

Postcode: _____

Phone number: ( )

Passport number: _____

Signature: _____

Date: __ __ / __ __ / __ __ __ __

1. Should you choose not to comply with this health requirement, you may be subject to visa cancellation or to State and Territory non-compliance measures.
2. Completion of this card is voluntary.
3. Information sought on this form is required to administer immigration, customs, quarantine, statistical, health and other currency laws of Australia and its collection is authorised by legislation. It will be disclosed only to agencies administering these areas and authorised or required to receive it under Australian law. Form 1442i Privacy notice is available from the department's website www.border.gov.au/allforms/

Australian Government
Department of Health

Novel coronavirus (COVID-19)

Information for international travellers

There is currently a global outbreak of novel coronavirus (COVID-19).

Symptoms of COVID-19 are similar to other respiratory illnesses and can include fever, sore throat, cough, tiredness and shortness of breath. This information sheet should be read in conjunction with the 'What you need to know' and 'Isolation guidance' information sheets. Go to www.health.gov.au/covid19-travellers for the list of high risk countries and information sheets.

Who is required to stay at home?

All travellers must isolate for a period of 14 days after they have entered Australia. If you need to transit domestically, you may complete this transit and then begin your precautionary 14 day self-isolation period. If you have a layover, you must remain in the airport or self-isolate in your accommodation for the transit period. Refer to the 'Isolation guidance' information sheet for further information.

If you have returned from a country or region that is at higher risk for COVID-19, you may also be required to undergo enhanced health screening on arrival in Australia.

What do I do if I am sick right now?

If you are experiencing symptoms of COVID-19, let a member of the airline or ship crew know now. If you are in the airport or seaport contact a biosecurity officer now.

What do I do if I get sick while in Australia?

If you become unwell, you must:

- Stay in your home or hotel.
- Isolate yourself from others and use a separate bathroom if available.
- Put on a surgical mask if you are near other people. If you don't have one, cover your cough and sneeze.
- Wash your hands frequently with soap and water and use alcohol-based hand rub.
- Call a doctor and tell them your recent travel history.

If you have serious symptoms such as difficulty breathing, call 000, ask for an ambulance and notify the ambulance officers of your recent travel history.

How can I prevent the spread of coronavirus?

Practising good hand and sneeze/cough hygiene is the best defence against most viruses:

- Wash your hands frequently with soap and water, including before and after eating, and after going to the toilet.
- Cover your cough and sneeze, dispose of tissues, and wash your hands.
- If unwell, avoid contact with others (stay more than 1.5 metres from people).

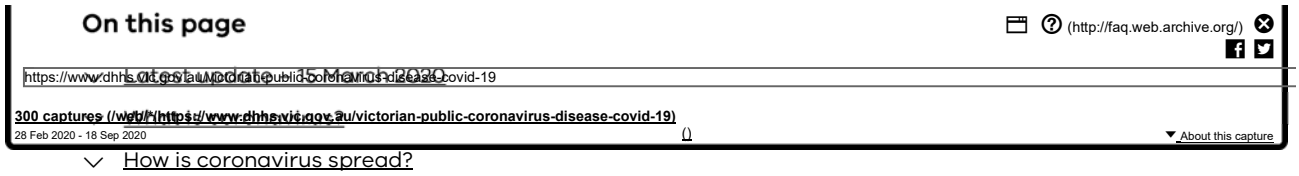
More information

For the latest advice, information and resources, go to www.health.gov.au
Call the National Coronavirus Help Line on 1800 020 080. It operates 24 hours a day, seven days a week. If you require translating or interpreting services, call 131 450.
The phone number of each state or territory public health agency is available at www.health.gov.au/state-territory-contacts

If you have concerns about your health, speak to a doctor.

About coronavirus (COVID-19)

Information and advice about coronavirus - symptoms, travel and what to do to reduce the risk of infection.



Latest update – 15 March 2020

Coronavirus (COVID-19) statement from Doctor Brett Sutton, Victoria's Chief Health Officer (/web/20200315152315/https://www.dhhs.vic.gov.au/coronavirus-statement-doctor-brett-sutton)

What is coronavirus?

Coronaviruses are a large family of viruses which may cause illness in animals or humans.

COVID-19 is a new virus that can cause an infection in people, including a severe respiratory illness.

The most recently discovered coronavirus causes coronavirus disease COVID-19.

How is coronavirus spread?

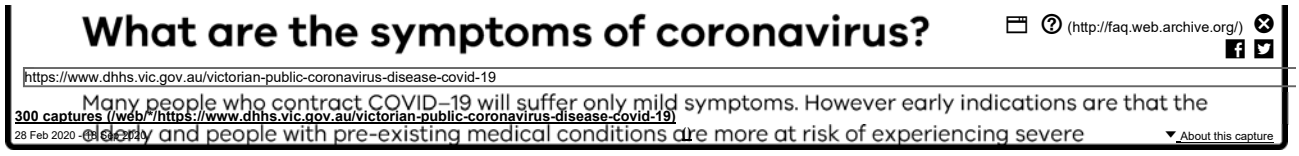
COVID-19 spreads through close contact with an infected person; mostly face-to-face or within a household. It cannot jump across a room or be carried for long distances in the air so we should all go about our lives as normal.

What is close contact?

Close contact means greater than 15 minutes face-to-face or the sharing of a closed space for more than two hours with a confirmed case.

A close contact could include any person meeting any of the following criteria:

- living in the same household or household-like setting (for example, a boarding school or hostel)
- direct contact with the body fluids or laboratory specimens of a confirmed case
- a person who spent two hours or longer in the same room
- face-to-face contact for more than 15 minutes with the case in any other setting not listed above.



symptoms.

The most common coronavirus symptoms reported include:

- Fever
- Breathing difficulties such as breathlessness
- Cough
- Sore throat
- Fatigue or tiredness.

Who is most at risk of coronavirus?

Anyone who has been overseas in the past 14 days or is a close or casual contact of a confirmed case of COVID-19 is at the highest risk of infection.

If you have been overseas in the past 14 days you must:

- stay at home (self-quarantine)
- avoid public settings - this means you should not attend work, school, childcare or university or go to other public places such as restaurants, cinemas or shopping centres and should not use public transport or taxis
- do this for 14 days after arriving in Australia (other than when seeking medical care)
- only people who usually live in the household should be in the home. Do not allow visitors into the home.
- you should stay in a different room to other people as much as possible.

Had close contact with a confirmed case

- If you have been in close contact with someone who has COVID-19, stay at home (self-quarantine).

Elderly or have pre-existing medical conditions

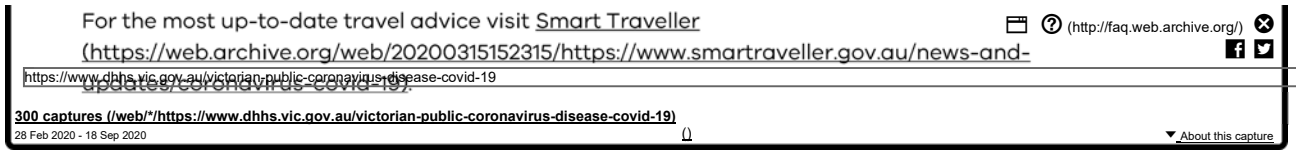
Many people will suffer only mild symptoms, however, early indications are that the elderly and people with pre-existing medical conditions such as heart and lung disease are more at risk of experiencing severe symptoms. Read the Coronavirus disease (COVID-19) factsheet for people aged over 65 years (Word) (https://web.archive.org/web/20200315152315/https://www.dhhs.vic.gov.au/coronavirus-disease-covid-19-factsheet-people-aged-over-65-years) for more information.

What if I have travelled overseas?

If you have returned from international travel after midnight 15 March 2020 and begin to feel unwell and develop a fever or shortness of breath, a cough or respiratory illness, you should call the dedicated hotline on 1800 675 398 for advice. This number is staffed 24 hours a day, seven days a week.

Should I cancel my travel plans?

The current Australian Government advice is to reconsider the need to travel outside of Australia.



What are the current international travel restrictions?

The government has also implemented travel restrictions on anyone coming into Australia from overseas from midnight 15 March 2020. This means anyone arriving in Australia from this date must self-isolate at home or in their hotel. There are also strict travel restrictions on visitors from China, South Korea, Italy and Iran who are not Australian citizens or permanent residents. Visitors from mainland China, South Korea, Italy and Iran who are not Australian citizens or permanent residents, or their dependants will not be allowed entry into Australia.

These restrictions are temporary and will be reviewed.

For the most up-to-date information on travel restrictions visit Smart Traveller (https://web.archive.org/web/20200315152315/https://www.smartraveller.gov.au/news-and-updates/coronavirus-covid-19) or the Australian Department of Health coronavirus (https://web.archive.org/web/20200315152315/https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert) websites.

I am feeling unwell, what should I do?

If you are in any of these risk categories and begin to feel unwell and develop a fever or shortness of breath, a cough or respiratory illness either during your period of isolation (self-quarantine), or in the 14 days since arriving home from international travel, you should seek immediate medical attention.

Call ahead to your GP or emergency department and mention your overseas travel before you arrive at the doctor's office so they can prepare appropriate infection control measures.

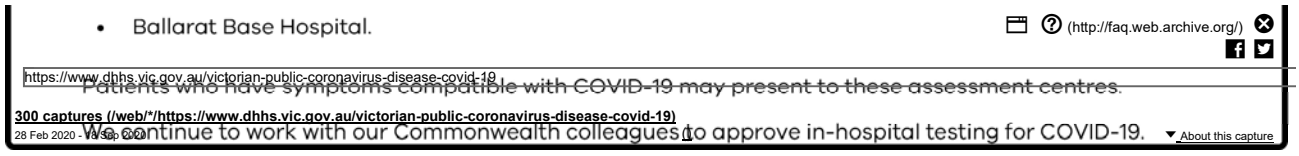
You can use our self-assessment tool (https://web.archive.org/web/20200315152315/https://www.dhhs.vic.gov.au/self-assessment-risk-coronavirus-covid-19) to help you decide if you should be tested.

If you have serious symptoms, such as difficulty breathing, call 000 and ask for an ambulance and tell the operator your recent travel history.

Where are the coronavirus assessment centres?

Assessment centres have been established at 12 Melbourne hospitals. You don't need to call ahead if you attend one of the following clinics:

- The Alfred Hospital
- Albury Wodonga
- Austin Hospital
- Barwon Health – Geelong
- Box Hill Hospital
- Monash Clayton
- Northern Hospital.
- Peninsula Health – Frankston
- The Royal Melbourne Hospital
- St Vincent's Hospital Melbourne
- Sunshine Hospital
- Wonthaggi Hospital



I have been asked to self-isolate, what does this mean?

This document has been developed to support Australians who have been asked to self-isolate due to COVID-19.

- Factsheet – confirmed case (Word) (https://web.archive.org/web/20200315152315/https://www.dhhs.vic.gov.au/novel-coronavirus-confirmed-case-what-you-need-know)
- Factsheet – suspected case (Word) (https://web.archive.org/web/20200315152315/https://www.dhhs.vic.gov.au/novel-coronavirus-suspected-case-what-you-need-know)
- Factsheet – close contact (Word) (https://web.archive.org/web/20200315152315/https://www.dhhs.vic.gov.au/novel-coronavirus-close-contact-what-you-need-know)
- Factsheet – casual contact (Word) (https://web.archive.org/web/20200315152315/https://www.dhhs.vic.gov.au/novel-coronavirus-casual-contact-what-you-need-know)
- Home Isolation Guidance - Australian Federal Government (https://web.archive.org/web/20200315152315/https://www.health.gov.au/resources/publications/coronavirus-covid-19-isolation-guidance)

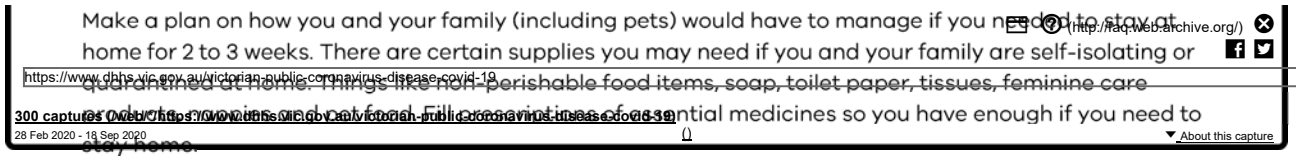
If you are concerned please call the Coronavirus Hotline on 1800 675 398.

What can I do to reduce my risk of coronavirus infection?

- Wash hands often with soap and running water, for at least 20 seconds. Dry with paper towel or hand dryer.
- Try not to touch your eyes, nose or mouth.
- 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.
- Stay at home if you feel sick. If you take medication make sure you have enough.
- Phone your doctor or the hotline – 1800 675 398 – if you need medical attention. They will tell you what to do.
- Continue healthy habits: exercise, drink water, get plenty of sleep.
- Wearing a face mask is not necessary if you are well.
- Buy an alcohol-based hand sanitiser with over 60 per cent alcohol.

How should I be prepared for the coronavirus outbreak?

Everyone should now take steps to prepare for the possibility of transmission of coronavirus in Victoria in the coming weeks or months.



Think about elderly friends, neighbours, and people with a disability in your community and how you would support each other too.

More information and resources

For content translated into community languages visit our translated resources (translated-resources-coronavirus-disease-covid-19) page.

Video - Victoria's Chief Health Officer, Dr Brett Sutton (https://web.archive.org/web/20200315152315/https://www.youtube.com/watch?v=WJU_T9D60xU&feature=youtu.be) addresses some of the challenges and myths our community is facing due to the COVID-19 (coronavirus disease) outbreak and provides advice on how we can work together to respond appropriately - 5 February 2020.

Victoria's Chief Health Officer, Dr Brett Sutton video transcript (Word) (/web/20200315152315/https://www.dhhs.vic.gov.au/victorias-chief-health-officer-dr-brett-sutton-coronavirus-video-transcript) and Simplified Chinese video transcript (https://web.archive.org/web/20200315152315/https://www.dhhs.vic.gov.au/information-chinese-community-victoria#brett-sutton202025).

Find out about your workplace entitlements and obligations (https://web.archive.org/web/20200315152315/https://www.fairwork.gov.au/about-us/news-and-media-releases/website-news/coronavirus-and-australian-workplace-laws) on the Fair Work website if you're affected by the coronavirus disease.

- Reduce your risk of coronavirus (PDF) (/web/20200315152315/https://www.dhhs.vic.gov.au/reduce-your-risk-coronavirus-poster)
- Wash your hands regularly poster (https://web.archive.org/web/20200315152315/https://www2.health.vic.gov.au/about/publications/policiesandguyour-hands-regularly-poster)
- Wash your hands regularly poster - Simplified Chinese (PDF) (/web/20200315152315/https://www.dhhs.vic.gov.au/wash-your-hands-regularly-poster-simplified-chinese)
- Wash your hands regularly poster - Arabic (PDF) (/web/20200315152315/https://www.dhhs.vic.gov.au/wash-your-hands-regularly-poster-arabic)
- Cover your cough and sneeze poster (https://web.archive.org/web/20200315152315/https://www2.health.vic.gov.au/about/publications/policiesandguyour-cough-sneeze-poster)
- Cover your cough and sneeze poster - Simplified Chinese (PDF) (/web/20200315152315/https://www.dhhs.vic.gov.au/cover-your-cough-and-sneeze-poster-simplified-chinese)
- Cover your cough and sneeze poster - Arabic (PDF) (/web/20200315152315/https://www.dhhs.vic.gov.au/cover-your-cough-and-sneeze-poster-arabic)
- Coronavirus disease (COVID-19) Factsheet for the Victorian public - updated 03 March 2020 (/web/20200315152315/https://www.dhhs.vic.gov.au/coronavirus-disease-covid-19-factsheet-victorian-public-updated-21-february-2020)
- Novel coronavirus (2019-nCoV) factsheet for Victorians - Simplified Chinese (/web/20200315152315/https://www.dhhs.vic.gov.au/novel-coronavirus-2019-ncov-factsheet-victorians-simplified-chinese)
- Coronavirus disease 2019 (COVID-2019) factsheet for a homestay VCE student and their host families – Simplified Chinese (/web/20200315152315/https://www.dhhs.vic.gov.au/coronavirus-disease-2019-covid-2019-factsheet-homestay-vce-student-and-their-host-families)

- Coronavirus disease (COVID-19) factsheet for people aged over 65 years (Word) (/web/20200315152315/https://www.dhhs.vic.gov.au/coronavirus-disease-covid-19-factsheet-people-aged-over-65-years)
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- Myth busting - Novel Coronavirus (https://web.archive.org/web/20200315152315/https://www.betterhealth.vic.gov.au/blog/blogcollectionpage/nov coronavirus-mythbusting) on the Better Health Channel

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Back to top

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Health.vic (https://web.archive.org/web/20200315152315/http://www.health.vic.gov.au/)

HousingVic (https://web.archive.org/web/20200315152315/http://housing.vic.gov.au/)

Better Health Channel (https://web.archive.org/web/20200315152315/https://www.betterhealth.vic.gov.au/)

Seniors Online (https://web.archive.org/web/20200315152315/https://www.seniorsonline.vic.gov.au/)

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About coronavirus (COVID-19)

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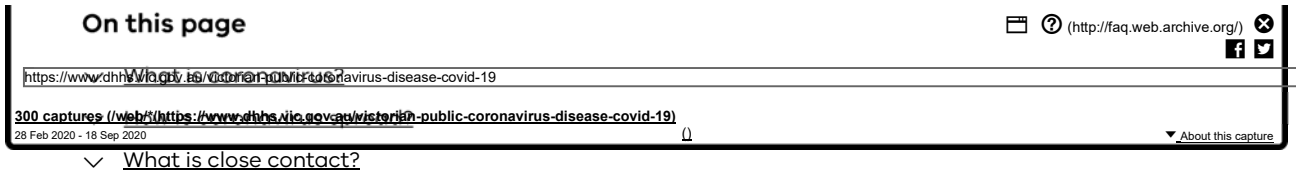
Information and advice about coronavirus - symptoms, travel and what to do to reduce the risk of infection.



What is coronavirus?

Coronaviruses are a large family of viruses which may cause illness in animals or humans.

COVID-19 is a new virus that can cause an infection in people, including a severe respiratory illness.

The most recently discovered coronavirus causes coronavirus disease COVID-19.

How is coronavirus spread?

COVID-19 spreads through close contact with an infected person; mostly face-to-face or within a household. It cannot jump across a room or be carried for long distances in the air so we should all go about our lives as normal.

What is close contact?

Close contact means greater than 15 minutes face-to-face or the sharing of a closed space for more than two hours with a confirmed case.

A close contact could include any person meeting any of the following criteria:

- living in the same household or household-like setting (for example, a boarding school or hostel)
- direct contact with the body fluids or laboratory specimens of a confirmed case
- a person who spent two hours or longer in the same room
- face-to-face contact for more than 15 minutes with the case in any other setting not listed above.

What are the symptoms of coronavirus?

Many people who contract COVID–19 will suffer only mild symptoms. However early indications are that the elderly and people with pre-existing medical conditions are more at risk of experiencing severe symptoms.

The most common coronavirus symptoms reported include:

- Fever
- Breathing difficulties such as breathlessness
- Cough
- Sore throat
- Fatigue or tiredness.

Who is most at risk of coronavirus?

If you have travelled overseas or have had close contact with a confirmed case of COVID-19 you are are at highest risk of infection.

Elderly or have pre-existing medical conditions

Many people will suffer only mild symptoms, however, early indications are that the elderly and people with pre-existing medical conditions such as heart and lung disease are more at risk of experiencing severe symptoms. Read the Coronavirus disease (COVID-19) factsheet for people aged over 65 years (Word) (https://web.archive.org/web/20200317142047/https://www.dhhs.vic.gov.au/coronavirus-disease-covid-19-factsheet-people-aged-over-65-years) for more information.

What if I have travelled overseas?

If you have been overseas upon your return you must stay at home (self-quarantine) for 14 days, other than when seeking medical care.

You must also:

- avoid public settings - this means you should not attend work, school, childcare or university or go to other public places such as restaurants, cinemas or shopping centres and should not use public transport or taxis
- not allow visitors into your home - only people who usually live in the household should be in the home.
- stay in a different room to other people as much as possible.

If you begin to feel unwell and develop a fever or shortness of breath, a cough or respiratory illness, you should call the dedicated hotline on 1800 675 398 for advice. This number is staffed 24 hours a day, seven days a week.

Should I cancel my travel plans?

The current Australian Government advice is to reconsider the need to travel outside of Australia.

For the most up-to-date travel advice visit Smart Traveller (https://web.archive.org/web/20200317142047/https://www.smartraveller.gov.au/news-and-updates/coronavirus-covid-19).

What are the current international travel restrictions?

The government has also implemented travel restrictions on anyone coming into Australia from overseas from midnight 15 March 2020.

This means anyone arriving in Australia from this date must self-isolate at home or in their hotel.

These restrictions are temporary and will be reviewed.

For the most up-to-date information on travel restrictions visit Smart Traveller (https://web.archive.org/web/20200317142047/https://www.smartraveller.gov.au/news-and-updates/coronavirus-covid-19) or the Australian Department of Health coronavirus (https://web.archive.org/web/20200317142047/https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert) websites.

I am feeling unwell, what should I do?

If you are in any of these risk categories and begin to feel unwell and develop a fever or shortness of breath, a cough or respiratory illness either during your period of isolation (self-quarantine), or in the 14 days since arriving home from international travel, you should seek immediate medical attention.

Call ahead to your GP or emergency department and mention your overseas travel before you arrive at the doctor's office so they can prepare appropriate infection control measures.

You can use our self-assessment tool to help you decide if you should be tested.

If you have serious symptoms, such as difficulty breathing, call 000 and ask for an ambulance and tell the operator your recent travel history.

Where are the coronavirus assessment centres?

Assessment centres have been established at 19 Victorian hospitals. You don't need to call ahead if you attend one of the following clinics:

- The Alfred Hospital
- Albury Wodonga
- Austin Hospital
- Ballarat Base Hospital
- Barwon Health – Geelong
- Bendigo Hospital
- Box Hill Hospital
- Casey Hospital
- Echuca Hospital
- Kyneton District Health
- Monash Clayton
- Northern Hospital
- Peninsula Health – Frankston
- Phillip Island Health Hub
- The Royal Children's Hospital
- The Royal Melbourne Hospital
- St Vincent's Hospital Melbourne
- Sunshine Hospital
- Wonthaggi Hospital

Patients who have symptoms compatible with COVID-19 may present to these assessment centres.

We continue to work with our Commonwealth colleagues to approve in-hospital testing for COVID-19.

This document has been developed to support Australians who have been asked to self-isolate due to COVID-19.

- Factsheet – confirmed case (Word) (https://web.archive.org/web/20200317142047/https://www.dhhs.vic.gov.au/novel-coronavirus-confirmed-case-what-you-need-know)
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If you are concerned please call the Coronavirus Hotline on 1800 675 398.

What can I do to reduce my risk of coronavirus infection?

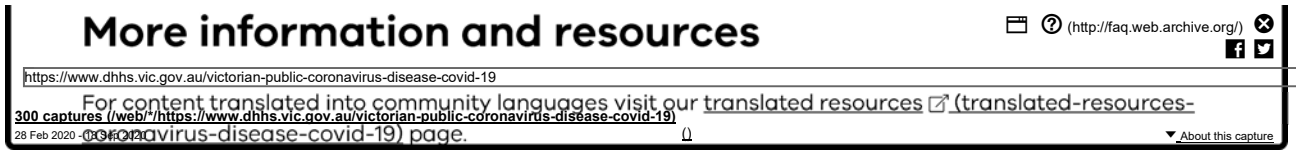
- Wash hands often with soap and running water, for at least 20 seconds. Dry with paper towel or hand dryer.
- Try not to touch your eyes, nose or mouth.
- Cover your nose and mouth with a tissue when you cough or sneeze. If you don't have a tissue cough or sneeze into your upper sleeve or elbow.
- Stay at home if you feel sick. If you take medication make sure you have enough.
- Phone your doctor or the hotline – 1800 675 398 – if you need medical attention. They will tell you what to do.
- Continue healthy habits: exercise, drink water, get plenty of sleep.
- Wearing a face mask is not necessary if you are well.
- Buy an alcohol-based hand sanitiser with over 60 per cent alcohol.

How should I be prepared for the coronavirus outbreak?

Everyone should now take steps to prepare for the possibility of transmission of coronavirus in Victoria in the coming weeks or months.

Make a plan on how you and your family (including pets) would have to manage if you needed to stay at home for 2 to 3 weeks. There are certain supplies you may need if you and your family are self-isolating or quarantined at home. Things like non-perishable food items, soap, toilet paper, tissues, feminine care products, nappies and pet food. Fill prescriptions of essential medicines so you have enough if you need to stay home.

Think about elderly friends, neighbours, and people with a disability in your community and how you would support each other too.



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- Reduce your risk of coronavirus (PDF) (/web/20200317142047/https://www.dhhs.vic.gov.au/reduce-your-risk-coronavirus-poster)
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- Wash your hands regularly poster - Simplified Chinese (PDF) (/web/20200317142047/https://www.dhhs.vic.gov.au/wash-your-hands-regularly-poster-simplified-chinese)
- Wash your hands regularly poster - Arabic (PDF) (/web/20200317142047/https://www.dhhs.vic.gov.au/wash-your-hands-regularly-poster-arabic)
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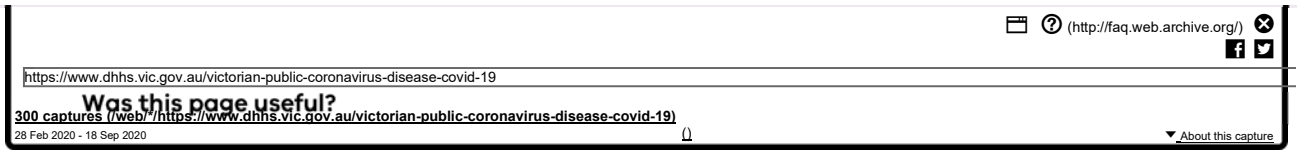
- Myth busting - Novel Coronavirus (https://web.archive.org/web/20200317142047/https://www.betterhealth.vic.gov.au/blog/blogcollectionpage/nov coronavirus-mythbusting) on the Better Health Channel



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Coronavirus disease – self-quarantine for international arrivals to Australia

What you need to know

Australia has implemented new measures to help limit the spread of coronavirus disease 19 (COVID-19). You are receiving this information as you have arrived in Victoria from overseas and are required to self-quarantine for a period of 14 days

Please read this information carefully.

What is novel coronavirus?

Coronaviruses are a large family of viruses which may cause illness in animals or humans.

The most recently discovered coronavirus (COVID-19) is a new virus that can cause an infection in people, including a severe respiratory illness.

Who needs to self-quarantine?

The self-quarantine applies to **all people** arriving in Victoria on an international flight, or on a connecting domestic flight from a flight that originated overseas, **except**:

- Flight crew members
- Citizens or permanent residents of a Pacific Island
- People intending to live indefinitely on a Pacific Island who are transiting through an airport in Victoria to the Pacific Island

What do I need to do?

Stay at home or in other suitable premises

- You must isolate yourself at home or a suitable premises in which to reside until 14 days after you arrived in Australia (ending at midnight on the 14th day after arrival):
  - You should not leave your house or the premises except to seek medical care or medical supplies.
  - You should stay in a different room to other people as much as possible. Use a separate bathroom if available.
  - Do not go to work, school, university or attend public places or events.
  - Do not use public transport, taxi or ride-hail services.
  - Where possible, get others such as friends or family, who are not required to be isolated, to get food or other necessities for you and provide to you in a way that minimises the opportunity for direct contact.
  - You must not permit other persons to enter your home or premises unless the other person is also self-quarantining for a period of 14 days as an international arrival, they live at the premises, or you require medical or emergency assistance.
- If you have difficulties getting food or necessities, call 1800 675 398 for support.

- If you need a translator first call 131 450, then request the hotline on 1800 675 398. More information is available on our website: dhhs.vic.gov.au/novelcoronavirus
- Please keep Triple Zero (000) for emergencies only.

How should I get from the airport to my home or the premises?

You are required to travel directly from the airport to your home or the premises in which you will be residing for self-quarantine.

Wherever possible, you are advised to use a personal mode of transport, such as a private car, to minimise exposure to others. If you need to use public transport (e.g. taxis, ride-hail services, trains, buses and trams), you must take the following precautions:

- Wear a surgical mask, if available
- Avoid direct contact with other passengers, drivers and transport staff
- Practise good hand hygiene and cough/sneeze hygiene

Going outside

If you live in a private house, then it is safe for you to go outside into your garden, balcony or courtyard, with the precaution of avoiding others who are not in self-quarantine.

If you live in an apartment it is also safe for you to go outside into the garden. You should, however, go quickly through any common areas on the way to the garden. Wear a surgical mask if you have to move through these areas and take precautions in touching surfaces. Avoid others who are not in self-quarantine.

You are allowed to leave the premises for the purpose of obtaining medical care, medical supplies or in an emergency situation.

Monitor your symptoms

- Monitor your health until 14 days after you arrived in Australia.
- Watch for any of these signs and symptoms:
  - fever
  - cough
  - shortness of breath
- Other early symptoms can include chills, body aches, sore throat, headache, runny nose, muscle pain or diarrhoea.

What if I develop symptoms?

If you develop any of the symptoms listed above:

- Call a doctor or hospital and tell them your travel history and that you have symptoms.
- Put on a mask, if you have one.
- Keep yourself away from others (for example, by staying in a different room).
- Do not go to work, school, university or attend public places or events. Do not use public transport, ride-hail services or taxi services.
- When you arrive at the general practice or hospital, tell them your travel history again.

Your doctor or staff at the hospital emergency department will utilise appropriate infection control measures and take you through to a room away from others.

The doctor will contact our department on 1300 651 160. They may organise to take nose and throat swabs to send for testing for the novel coronavirus.

If you are experiencing severe symptoms, such as shortness of breath:

- Call 000 and request an ambulance.
- Inform the ambulance officers of your travel history.

How can I prevent the spread of the virus?

Practising good hand and sneeze/cough hygiene is the best defence:

- Wash your hands often with soap and water before and after eating as well as after attending the toilet.
- Avoid all contact with others.
- Cough and sneeze into your elbow.

Should I wear a face mask?

You should wear a face mask, if you have one, when transferring from the hospital to your place of isolation. If you do not have a face mask, avoid direct contact with other passengers, drivers and transport staff, and also practise good hand hygiene and cough/sneeze hygiene.

If you are ill, you should put on a face mask if you have one to prevent spreading the infection to others. You may be given a face mask to wear by your doctor.

Looking after your well-being during quarantine

Being confined to a home for an extended period of time can cause stress and tension. Tips for looking after yourself include:

- Talk to the other members of the family about the infection. Understanding novel coronavirus will reduce anxiety.
- Reassure young children using age-appropriate language.
- Think about how you have coped with difficult situations in the past and reassure yourself that you will cope with this situation too. Remember that self-isolation won't last for long.
- Exercise regularly. Options could include exercise DVDs, dancing, floor exercises, yoga, walking around the backyard or using home exercise equipment, such as a stationary bicycle, if you have it. Exercise is a proven treatment for stress.
- Keep in touch with family members and friends via telephone, email or social media.
- Keep up a normal daily routine as much as possible.
- Arrange with your employer to work from home, if this is possible for your role.
- Ask your child's school to supply assignments, work sheets and homework by post or email, or if the student can join the class using online options.
- Don't rely too heavily on the television and technology. Treat self-isolation as an opportunity to do some of those things you never usually have time for, such as board games, craft, drawing and reading.
- If you are struggling to cope you call Lifeline on 13 11 14 or Beyond Blue on 1300 22 4636.

What are the penalties if I don't comply with self-quarantine?

The Victorian State Government has declared a State of Emergency throughout the State of Victoria, which allows the Chief Health Officer to exercise emergency powers under the *Public Health and Wellbeing Act 2008* (Vic). The requirement to self-quarantine for 14 days for international arrivals to Australia is a formal direction pursuant to the *Public Health and Wellbeing Act 2008* (Vic). Anyone who fails to comply with this direction commits an offence and may be fined up to $19,826.40 for an individual or up to $99,132 for a body corporate.

Where can I find out more information?

Call the Department of Health and Human Services on to discuss any questions you have. If you need a translator first call 131 450, then request the to be put through to the department on 1300 651 160.

For Victorian updates to the current incident, go to: https://www.dhhs.vic.gov.au/novelcoronavirus

For national updates: https://www.health.gov.au/news/latest-information-about-novel-coronavirus

For international updates: https://www.who.int/westernpacific/emergencies/novel-coronavirus

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

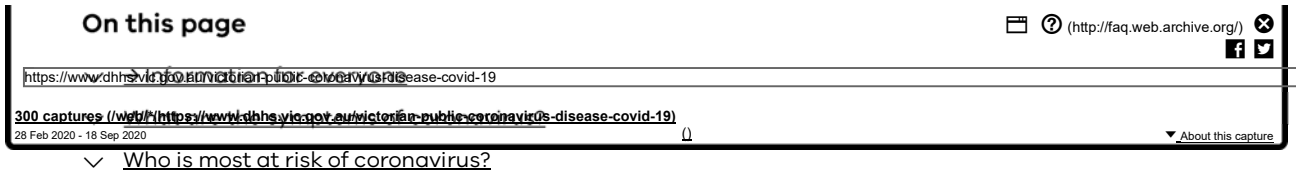
To receive this publication in an accessible format phone 1300 651 160, using the National Relay Service 131 450 if required, or email Public Health branch <public.health@dhhs.vic.gov.au>.

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

About coronavirus (COVID-19)

Print () Share

Information and advice about coronavirus - symptoms, travel and what to do to reduce the risk of infection.



- Who is most at risk of coronavirus?
- I am feeling unwell, what should I do?
- Where are the coronavirus assessment centres?
- How does coronavirus spread?
- How do you define 'close contact'?
- How can I reduce my risk of coronavirus (COVID-19) infection?
- Does the coronavirus survive on surfaces?
- What is the difference between coronavirus and the flu?
- What is the treatment for coronavirus?
- How do we know people who have had coronavirus are no longer infectious?
- Can pets be infected with coronavirus?
- What are some of the way to achieve physical distancing?
- → Information for overseas travellers
- Who can enter Australia from overseas?
- Does everyone arriving from overseas have to self-quarantine?
- How will I get home from the airport?
- Do other members of my family who have not travelled need to self-quarantine too?
- What are the penalties for not complying with these self-quarantine requirements?
- What happens at the end of self-quarantine after travel?
- What if I start feeling unwell during self-quarantine?
- I'm planning an overseas trip. Should I cancel?
- Is any traveller exempt from the need self-quarantine?
- Why are travellers to Pacific Islands excluded?
- What arrangements apply to cruise ships?
- What if I'm from overseas and I'm not eligible for Medicare?
- → Self-quarantine
- What can't I do during self-quarantine?
- What if I start feeling unwell during self-quarantine?
- How should I prepare for self-quarantine?
- Please don't stockpile or hoard items.
- What do I do at the end of 14 days self-quarantine?
- What if I am sharing a house with someone who is in self-quarantine?
- Caring for someone who is sick during an quarantine period
- Caring for others around you
- Coping with feelings of anxiety
- Can I go outside during self-quarantine?
- Can I receive deliveries during self-quarantine?
- → Mass gatherings
- Which mass gatherings are banned?
- What kinds of events or venues does this include?
- What types of mass gatherings are exempt?
- What should I do to protect people if I am organising a gathering that is not banned?

→ Information for everyone

What are the symptoms of coronavirus?

The most common coronavirus (COVID-19) symptoms reported are:

- Fever
- Breathing difficulties, breathlessness
- Cough
- Sore throat
- Fatigue or tiredness.

Many people who contract coronavirus (COVID–19) will suffer only mild symptoms. Elderly people and those with pre-existing medical conditions may experience more severe symptoms

Who is most at risk of coronavirus?

There are two groups in the community who are most at risk of coronavirus (COVID-19).

• Overseas travellers and close contacts

If you have recently travelled overseas or have had close contact with a confirmed case of coronavirus (COVID-19) you are at the highest risk of infection.

• Elderly or have pre-existing medical conditions

Many people will suffer only mild symptoms; however, early indications are that the elderly are more at risk of experiencing severe symptoms.

People with underlying illnesses that make them more vulnerable to respiratory disease, including those with diabetes, chronic lung disease, kidney failure and people with suppressed immune systems are also at a higher risk of serious disease.

Read the Coronavirus disease (COVID-19) factsheet for people aged over 65 years (Word) (/web/20200321061604/https://www.dhhs.vic.gov.au/coronavirus-disease-covid-19-factsheet-people-aged-over-65-years) for more information.

There is no evidence so far to suggest that people living with HIV, who are on effective anti-retroviral therapies with undetectable viral loads, are at increased risk of getting COVID-19 infection or developing severe disease. However, as HIV infection can result in suppression of the immune system and other comorbidities, people living with HIV should be considered a higher risk group than the general population.

Read the Coronavirus disease (COVID-19) factsheet for people living with HIV (Word) (/web/20200321061604/https://www.dhhs.vic.gov.au/coronavirus-disease-covid-19-factsheet-people-living-hiv) for more information.

I am feeling unwell, what should I do?

If you are in any of these risk categories and begin to feel unwell and develop a fever or shortness of breath, a cough or respiratory illness either during your period of isolation (self-quarantine), or in the 14 days since arriving home from international travel, you should seek immediate medical attention.

Call ahead to your GP or emergency department and mention your overseas travel before you arrive at the doctor's office so they can prepare appropriate infection control measures.

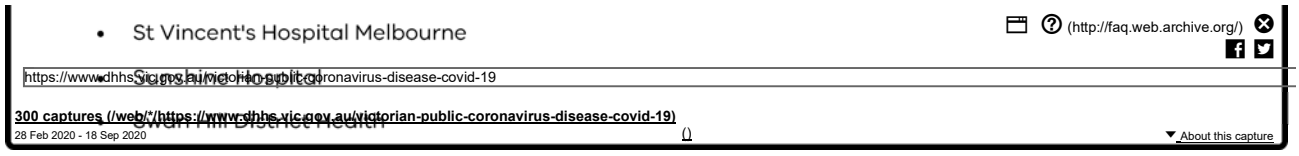
To help you decide if you should be tested, use our interactive coronavirus self-assessment tool (/web/20200321061604/https://www.dhhs.vic.gov.au/coronavirus-self-assessment).

If you have serious symptoms, such as difficulty breathing, call 000 and ask for an ambulance and tell the operator your recent travel history.

Where are the coronavirus assessment centres?

Assessment centres have been established at a number of Victorian hospitals. You don't need to call ahead (unless stated otherwise below) if you attend one of the following clinics:

- The Alfred Hospital
- Albury Wodonga Health - Woodonga
- Austin Hospital
- Ballarat Base Hospital
- Barwon Health – Geelong (please call (03) 4215 4445 prior to attending)
- Bendigo Hospital
- Box Hill Hospital
- Casey Hospital
- Dandenong Hospital
- Djerriwarrh Health Services – Bacchus Marsh
- Djerriwarrh Health Services – Melton
- Echuca Regional Health
- Goulburn Valley Health - Shepparton
- Monash Clayton
- Northern Hospital
- Northeast Health Wangaratta
- Peninsula Health – Frankston
- Phillip Island Health Hub
- The Royal Children's Hospital
- The Royal Melbourne Hospital
- South West Healthcare - Warrnambool



- Bass Coast Health - Wonthaggi

Patients who have symptoms compatible with COVID-19 may present to these assessment centres.

We continue to work with our Commonwealth colleagues to approve in-hospital testing for COVID-19.

How does coronavirus spread?

Health authorities around the world believe the virus is spread from **close contact** with an infected person, mostly through face-to-face or between members of the same household. People may also pick up the virus from surfaces contaminated by a person with the infection.

The virus is spread by people with symptoms when they cough or sneeze. That's why the best way to protect others is to practice good personal hygiene.

How do you define 'close contact'?

'Close contact' means having face-to-face contact for more than 15 minutes with someone who has a confirmed case of coronavirus (COVID-19)– or alternatively sharing a closed space with them for more than two hours.

Close contact can happen in many ways, but examples include:

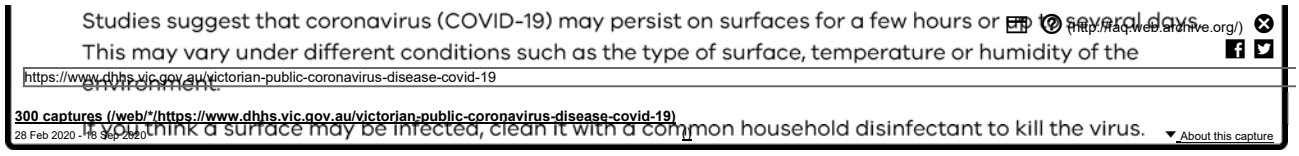
- living in the same household or household-like setting (for example, a boarding school or hostel)
- direct contact with the body fluids or laboratory specimens of a confirmed case
- being in the same room or office for two hours or more
- face-to-face contact for more than 15 minutes in some other setting such as in a car or a lift or sitting next to them on public transport.

How can I reduce my risk of coronavirus (COVID-19) infection?

- Keep a full arm-span (about 1.5 metres) between yourself and other people where possible
- Wash hands often with soap and running water, for at least 20 seconds. Dry with paper towel or hand dryer
- Try not to touch your eyes, nose or mouth
- Cover your nose and mouth with a tissue when you cough or sneeze. Dispose of the tissue
- If you don't have a tissue cough or sneeze into your upper sleeve or elbow
- Continue healthy habits: don't smoke, exercise, drink water, get plenty of sleep
- Buy an alcohol-based hand sanitiser with over 60 per cent alcohol
- Stay at home if you feel sick, and undertake physical distancing as outlined in the section below.

Wearing a face mask is not necessary if you are well.

Does the coronavirus survive on surfaces?



In general, to avoid contact with the virus, clean your hands with an alcohol-based hand rub or wash them with soap and water often. Avoid touching your eyes, mouth, or nose.

What is the difference between coronavirus and the flu?

The first symptoms of coronavirus (COVID-19) and influenza infections are often very similar.

They both cause fever and similar respiratory symptoms, which can then range from mild through to severe disease, and sometimes can be fatal.

Both viruses are also transmitted in the same way, by coughing or sneezing, or by contact with hands, surfaces or objects contaminated with the virus. You can reduce the risk of both infections with good hand hygiene, good cough etiquette and good household cleaning.

The speed of transmission is an important difference between the two viruses. The time from infection to appearance of symptoms (the incubation period) for influenza is shorter than that for coronavirus. This means that influenza can spread faster than coronavirus.

While the range of symptoms for the two viruses is similar, the proportion of people who develop severe disease appears to be higher for coronavirus.

International evidence consistently shows that most people have mild symptoms. While evidence varies from country to country, it is currently estimated that around 15% of people will experience severe infections and 5% will become critically ill. The proportions of severe and critical coronavirus infections are higher than for influenza infections.

What is the treatment for coronavirus?

There are currently no vaccines that protect against coronavirus (COVID-19).

While there is no specific treatment for coronavirus, early diagnosis and general supportive care are important.

Most of the time, symptoms will resolve on their own. People who have serious disease with complications can be cared for in hospital.

How do we know people who have had coronavirus are no longer infectious?

People with a confirmed coronavirus (COVID-19) infection stay in quarantine under the care of medical specialists until they are no longer experiencing symptoms of coronavirus infection.

Before they are released from quarantine, they have tests to see if they still have coronavirus and the specialist care team assesses they are no longer infectious.

Once they are discharged they have a follow up assessment by the medical team to make sure they remain well.

Can pets be infected with coronavirus?

While coronavirus (COVID-19) seems to have emerged from an animal source, it is now mainly spreading from person-to-person.

There is also no evidence that companion animals including pets can spread coronavirus. However, since animals can spread other diseases to people, it's always a good idea to wash your hands after being around animals.

What are some of the way to achieve physical distancing?

Physical distancing involves changing your social habits to reduce the risk of transmission of coronavirus. While effective, physical distancing cannot eliminate risk of transmission entirely and is not appropriate in many circumstances.

You could practice physical distancing going to and from work, including on public transport, and at work or social gatherings. For example, things you can do include:

- keeping a full arm-span (about 1.5 metres) between yourself and other people where possible
- avoiding crowds and mass gatherings where it is difficult to keep the appropriate distance away from others
- avoiding small gatherings in enclosed spaces, for example non-essential business meetings
- avoiding shaking hands, hugging, or kissing other people
- avoiding visiting vulnerable people, such as those in aged care facilities or hospitals, or people with compromised immune systems due to illness or medical treatment.

→ Information for overseas travellers

Who can enter Australia from overseas?

From 9:00pm on 20 March 2020, you cannot enter Australia unless you are:

- an Australian citizen
- a permanent resident of Australia
- a New Zealand citizen usually resident in Australia
- an immediate family member of an Australian citizen or permanent resident.

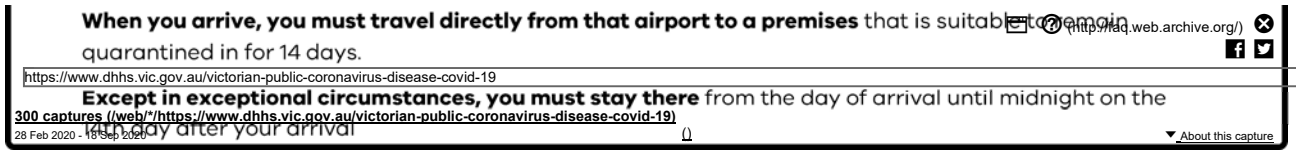
If you currently overseas and in one of these categories and wishing to return to Australia, you should do so as soon as possible.

For the most up-to-date information on travel restrictions, visit the Smart Traveller website (https://web.archive.org/web/20200321061604/https://www.smartraveller.gov.au/)

Does everyone arriving from overseas have to self-quarantine?

Yes. If you arrive at an airport in Victoria on a flight that originates from somewhere outside Australia, or travel on a connecting flight from another flight that originates outside Australia, you must self-quarantine for 14 days.

This means:



You must not leave the premises, except:

- for the purposes of obtaining medical care or medical supplies
- in an emergency situation
- in circumstances where it is possible to avoid close contact with other persons.

You must not allow any other person to enter the premises unless that person usually lives there, or the other person is also in self-quarantine (self-isolation) for the same 14-day period, or they are there for medical or emergency purposes.

How will I get home from the airport?

When travelling home or to a hotel to start self-quarantine it is recommended you take personal transport to minimise exposure to others.

If people need to use public transport, including taxis and ride-share services, they should follow hand hygiene precautions, cough etiquette and avoid direct contact with your driver or other passengers.

Do other members of my family who have not travelled need to self-quarantine too?

If you are self-quarantining after your arrival from overseas, other members of your household are not required to be quarantined unless they have also:

- returned from overseas
- been a close contact of a confirmed coronavirus (COVID-19) case.

What are the penalties for not complying with these self-quarantine requirements?

Under the State of Emergency in Victorian, a person who ignores this direction will be liable for fines of up to approximately $20,000, or up to approximately $100,000 in the case of companies and other bodies.

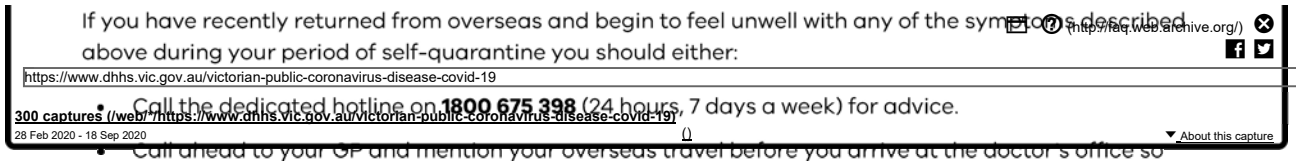
What happens at the end of self-quarantine after travel?

If, at the end of 14 days in self-quarantine, you remain well, you have passed the time in which you would become sick if you were exposed to coronavirus (COVID-19).

This means you will not get coronavirus (COVID-19) from your time overseas, and you can cease self-quarantine and return to work, school, university or other pursuit.

You do not require a medical certificate to return to other activities. In the absence of symptoms, there is no test that can be performed to predict whether or not you will become unwell.

What if I start feeling unwell during self-quarantine?



- they can prepare appropriate infection control measures.

If you have serious symptoms, such as difficulty breathing, call 000 and ask for an ambulance and tell the operator your recent travel history.

I'm planning an overseas trip. Should I cancel?

The Australian Government advises all Australians not to travel overseas at the moment.

For the most up-to-date travel advice go to the Smart Traveller website (https://web.archive.org/web/20200321061604/https://www.smartraveller.gov.au/).

Is any traveller exempt from the need self-quarantine?

You are **not** required to comply with the quarantine direction if you are:

- a member of the flight crew
- a citizen or permanent resident of a Pacific Island who is travelling through an airport in Victoria in transit to that Pacific Island
- a person intending to live indefinitely on a Pacific Island and who is travelling through an airport in Victoria in transit to the Pacific Island.

Why are travellers to Pacific Islands excluded?

This is consistent with New Zealand's travel restrictions and ensures people can return to the Pacific Islands.

What arrangements apply to cruise ships?

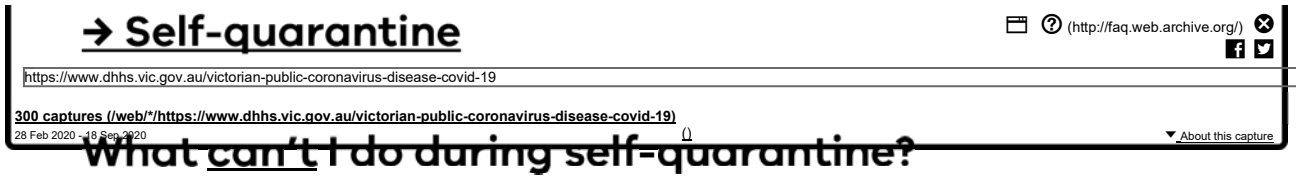
All international cruise ships have been banned from sailing into or out of Australian ports for 30 days from 15 March 2020.

What if I'm from overseas and I'm not eligible for Medicare?

Overseas travellers who fall ill in Australia (and are not eligible for Medicare) often have health or travel insurance.

For those who do not have adequate insurance coverage, Victorian hospitals will waive the costs of treatment. This includes waiving payment and debt recovery procedures for ambulance transfers of people suspected to have coronavirus (COVID-19), who are taken to Victorian hospitals for assessment.

These arrangements have been put in place to ensure payment issues are not a barrier for people from overseas with symptoms seeking early medical advice.



What can't I do during self-quarantine?

If you are required to self-quarantine, the following rules apply:

- you must not attend work, school, childcare or university
- you must not go to other public places such as restaurants, cinemas or shopping centres
- you must not use public transport or taxis
- you must not allow visitors into your home - only those who usually live in the household should be in the home
- you must stay in a different room to other people as much as possible.

What if I start feeling unwell during self-quarantine?

If you start to feel unwell – and especially if you develop any with any of the typical symptoms of coronavirus (COVID-19) during self-quarantine, you should either:

- call the dedicated coronavirus (COVID-19) hotline on **1800 675 398** (24 hours, 7 days a week) for advice
- call ahead to your GP and mention your overseas travel before you arrive at the doctor's office so they can prepare appropriate infection control measures.

If you have serious symptoms, such as difficulty breathing, call 000 and ask for an ambulance.

How should I prepare for self-quarantine?

Everyone should take steps to prepare for the possibility of transmission of coronavirus (COVID-19) in Victoria in the coming weeks or months.

Make a plan on how you and your family, including pets, would have to manage if you needed to stay at home for 2 to 3 weeks.

There are certain supplies you may need if you and your family are in quarantine at home. These include things like non-perishable food items, soap, toilet paper, tissues, feminine care products, nappies and pet food.

Ensure you have enough prescriptions of essential medicines if you need to stay home.

Please don't stockpile or hoard items.

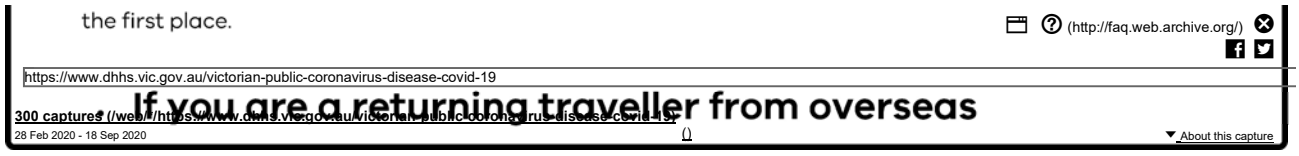
The Victorian Government urges Victorians not to needlessly stockpile essential items. It's important we think of others at this challenging time. Please only buy what you need!

Stay in frequent touch with your close family and friends and ask them to get food, medicines or other necessities for you when you're running low. You may need to ask for additional help from a carer, family, friends or neighbours.

If you don't have nearby support to help you do this, call the coronavirus (COVID-19) hotline on 1800 675 398 (24 hours, 7 days a week). The Department of Health and Human Services can arrange delivery of a free care package for people who do not have support available to them.

What do I do at the end of 14 days self-quarantine?

The process for coming out of self-quarantine differs depending on why you went into self-quarantine in



If, at the end of 14 days, you remain well, you have passed the time limit beyond which you would have fallen ill after being exposed to coronavirus (COVID-19). You can cease quarantine. You do not require a medical certificate to enable you to return to other activities. In the absence of symptoms, note there is no medical test available to predict whether you will become unwell.

- ### If you self-quarantined after coming into contact with a confirmed or suspected case of coronavirus (COVID-19)

  If, at the end of 14 days, you remain well, you have passed the time limit beyond which you would have fallen ill after being exposed to coronavirus (COVID-19). You can cease self-quarantine. No medical certificate is required to enable you to return to other activities.

- ### If you were a confirmed case of coronavirus (COVID-19)

  You cannot end isolation until you meet the relevant requirements. To find out more, call the dedicated coronavirus (COVID-19) hotline on **1800 675 398** (24 hours, 7 days a week).

- ### If you are feeling unwell

  If, at the end of 14 days, you are unwell with respiratory symptoms, you must stay in self-quarantine. Call the dedicated coronavirus hotline on **1800 675 398** (24 hours, 7 days a week) to find out what you should do next.

What if I am sharing a house with someone who is in self-quarantine?

There are different reasons for people to be in self-quarantine, and so if you are sharing a house with someone in this situation, the obligations on you will differ.

- ### If the person is well but has come into close contact with a confirmed case of coronavirus

  If the person you live with is in self-quarantine as a precaution and follows all the required steps for self-quarantine, nobody else in the house is required to self-quarantine.

- ### If the person is well but has a suspected case of coronavirus

  If the person you live with is in self-quarantine because it is suspected they may have coronavirus, there is no need for others in the house to self-quarantine unless the person becomes a confirmed case. At that point, all people in the household are regarded as having had close contact and are required to self-quarantine.

- ### If the person is unwell and has a confirmed case of coronavirus

Caring for someone who is sick during an quarantine period

If you are looking after a sick family member during a period of self-quarantine, there are some important things you should do to keep everyone in your home safe:

- Ensure the sick person remains in one room away from others in the household.
- Keep their door closed and windows open where possible.
- Keep the number of carers to a minimum and do not allow visitors from outside the household to visit.
- Always wash your hands with soap and water or use a hand sanitiser before and after entering the room.
- Keep the sick person's crockery and utensils separate from the rest of the household.
- If available, wear a surgical mask (single-use face mask) when you are in the sick person's room
- Clean and disinfect high touch surfaces such as tabletops, doors, computer keyboards, taps and handles often.
- Dispose of tissues and masks in a sealed plastic bag and put in the usual household waste
- If the person starts to feel worse, call the dedicated coronavirus hotline on **1800 675 398** (24 hours, 7 days a week) for advice
- If you need to visit your GP, call ahead and mention that you are currently in self-quarantine so they can prepare appropriate infection control measures.

If the person you are caring for develops serious symptoms, such as difficulty breathing, call 000 and ask for an ambulance.

Caring for others around you

Caring doesn't just benefit others, evidence shows it is one of the best ways to improve our own mental wellbeing.

Think about elderly friends, neighbours, and people with a disability in your community and how you can support each other during a period of self-quarantine. If you are not currently in self-quarantine but others around you are, think about how you might be able to help them out, such as with getting food and necessities.

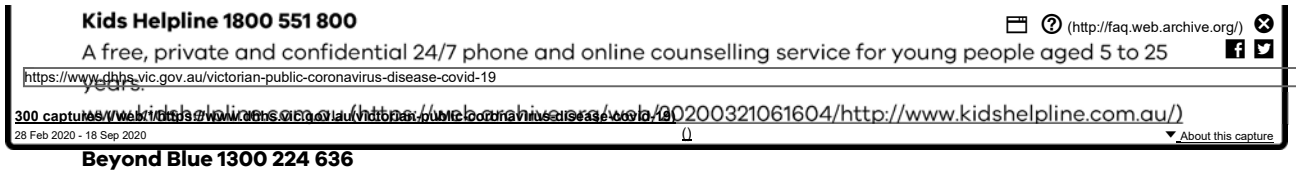
If you don't have nearby support to help you do this, call the coronavirus hotline on **1800 675 398** (24 hours, 7 days a week). The Department of Health and Human Services can arrange delivery of a free care package for people who do not have support available to them.

Coping with feelings of anxiety

It is normal to feel overwhelmed and stressed during a time like this. It's important to remind yourself that this is a normal reaction and it will pass.

There are plenty of ways to support other people, or be supported if you are feeling anxious or uncertain.

Lifeline Australia 13 11 14
A crisis support service offering short term support at any time for people who are having difficulty coping or staying safe.
www.lifeline.org.au (https://web.archive.org/web/20200321061604/http://www.lifeline.org.au/)



Beyond Blue 1300 224 636
Mental health information and support for all Victorians
www.beyondblue.org.au (https://web.archive.org/web/20200321061604/http://www.beyondblue.org.au/)

Eheadspace 1800 650 893
Online and telephone support and counselling for 12 - 25 year olds, their families and friends.

Stay connected

While you are in a period of self-quarantine, make sure you reach out to the people you trust, like friends, family, neighbours and workmates via phone, e-mail, Facetime, Facebook video, WhatsApp video or other online services.

Share how you feel and try linking with people who are in a similar situation as you. If possible, join an online forum, social media group or other online community to support others and yourself.

Set up healthy daily routines

A regular routine will help you feel happier and less bored. Your routine should include maintaining regular mealtimes, eating a healthy and balanced diet, getting enough sleep and keeping physically active around the house. Avoid excessive use of alcohol.

If you continue to work during self-quarantine, try to stick to your normal work times. If you have spare time, consider doing tasks that give you a sense of achievement.

If you smoke, consider quitting or at least reducing your smoking during this time, particularly if you are recovering from coronavirus.

Stay active

Physical activity is a proven way to reduce the effects of stress. Look for online content that could help you exercise, do yoga or learn a new healthy pastime. Dust off your home exercise equipment, and use the downtime to improve your fitness!

VicHealth has reviewed the best smartphone applications for healthy living. (https://web.archive.org/web/20200321061604/https://www.vichealth.vic.gov.au/media-and-resources/vichealth-apps)

Stay informed

It is normal to want to stay informed, and there are many sources of information about coronavirus in the media. Remember that too much exposure during quarantine, especially to confronting news content, could be harmful to your mental wellbeing. Set limits on the amount of time you spend watching or reading news or social media commentary.

Can I go outside during self-quarantine?

It's OK to go out into the backyard of your house or onto the balcony of your apartment or hotel room during self-quarantine, in fact it can help you feel calm and relaxed to get some sun and fresh air. Always observe the recommended physical distancing requirements from the people around you in the home, and wear a surgical mask if you have one.

Can I receive deliveries during self-quarantine?

Yes, although you should maintain appropriate physical distancing from the delivery person and they should not enter your home. They should leave your delivery outside your door. Consider making payment for the delivery online in advance or using a contactless payment method to minimise the chances of physical contact. Avoid paying by cash.

Which mass gatherings are banned?

To limit the spread of coronavirus, the Chief Health Officer has directed that the following types of gatherings must not take place:

- a gathering of 500 or more people in a single undivided **outdoor** space at the same time.
- a gathering of 100 or more people in a single undivided **indoor** space at the same time.

If you need help to understand this direction, call the Coronavirus hotline on **1800 675 398** (24 hours, 7 days a week).

What kinds of events or venues does this include?

The definition of mass gathering is broad. It can include, but is not limited to:

- concerts
- festivals
- fairs
- religious services
- private or corporate functions
- club events
- conventions.

If you are unsure if your planned event or gathering is included in the ban, call the Coronavirus hotline on **1800 675 398** (24 hours, 7 days a week).

It is strongly recommended that in any enclosed space there should be on average no more than one person per four square metres of floor space.

What types of mass gatherings are exempt?

A mass gathering does not include essential gatherings or venues of the following kinds:

- airports
- public transport, including public transport vehicles, stations, platforms and stops
- medical or health service facilities
- emergency services facilities
- disability or aged care facilities
- prisons, correctional facilities, youth justice centres or other place of custody
- courts and tribunals
- Parliament
- food markets, supermarkets, grocery stores, retail stores and shopping centres
- office buildings, factories and construction sites
- schools, universities, educational institutions or childcare facilities – except for activities that are deemed not necessary for the normal business of the facility. This means that events, for example, such as school assemblies, parent-teacher evenings and school sports events involving a mass gathering as defined above should not take place.
- hotels or motels

What should I do to protect people if I am organising a gathering that is not banned?

If you are organising a gathering with fewer than 500 outdoor attendees or fewer than 100 indoor attendees, the Victorian Chief Health Officer strongly recommends that you:

- remind attendees and staff not to attend if they are feeling unwell
- remind attendees and staff they must not attend if they have travelled overseas in the past 14 days
- ensure emergency management plans are up to date
- brief staff on how to practice good hygiene
- make provision for staff and attendees to practice good hygiene by having adequate hand washing or sanitising facilities available.

Victoria's Chief Health Officer strongly encourages people considering attending these gatherings to:

Stay home and not attend if you are feeling unwell

Practice good personal hygiene including:

- cleaning your hands thoroughly for at least 20 seconds with soap and water, or use an alcohol-based hand rub
- covering your nose and mouth when coughing and sneezing with tissue or a flexed elbow.

If you have travelled overseas in the past 14 days, you must not attend the event.

What are the penalties for not complying with the new penalties on mass gatherings?

Under the State of Emergency, a person who ignores the direction will be liable for fines of up to approximately $20,000, or up to approximately $100,000 in the case of companies and other bodies.

Note that these directions apply to any person who:

- owns, controls or operates premises on which people may gather
- organises people to gather on premises, or
- attends premises at which people are gathered.

→ Information for businesses

What are some of the things I can do right now?

Organisations and employers who are responsible for a workplace or venue should start to take actions now to reduce the risk of transmission of coronavirus.

The kinds of actions you should implement include:

- Deciding whether some activities, such as ceremonies, assemblies or celebrations can be postponed, reduced in size and frequency or cancelled altogether

- Cancelling non-essential activities such as business travel, study visits, extra-curricular activities and sporting events
- Encouraging flexible working arrangements including working from home and off-peak travel
- Ensuring you have adequate hygiene and sanitation supplies such as bleach, alcohol sanitisers and hand soap
- Providing and encouraging the use of hand sanitisers for use on entering buildings
- Ensure high standards of routine environmental cleaning
- Clean and disinfect high touch surfaces regularly, including desks and keyboards
- Open windows, enhance airflow, adjust air conditioning
- Promote preventive actions amongst your staff - lead by example.
- Where possible, avoid large indoor meetings and lunchrooms and use outdoor venues
- Plan for increased levels of staff absences
- Plan for what to do if staff arrive sick at work.

Businesses across the state can now access information on dealing with coronavirus (COVID-19) by calling the Business Victoria hotline on 13 22 15.

Operators calling the hotline will be able to get information about support services, including those available through Business Victoria, which offers mentoring to help operators develop business continuity and recovery plans.

The hotline will provide the latest information on the response to COVID-19 and how this affects businesses, including how to access financial support available through the national stimulus package.

In addition to calling the Business Victoria hotline, business operators can also find information at the Business Victoria website. (https://web.archive.org/web/20200321061604/https://www.business.vic.gov.au/)

→ Aged care facilities

Can I visit my family member in an aged care facility?

Access to residential aged care facilities has been restricted to essential services only, to prevent the introduction of coronavirus and transmission within the facility.

Family and loved ones can still visit aged care services, however, there are restrictions on these visits.

All visitors entering a residential care facility will be required to undergo enhanced screening before entering the facility and must comply with infection control measures as directed by the residential aged care facility.

Who is allowed to enter an aged care facility?

The only people other than family and loved ones who will be permitted to enter a residential aged care facility are essential service providers. These are:

- Regular staff of the service who provide clinical care, food services, administrative functions and cleaning
- Other visiting clinical staff such as visiting medical officers, general practitioners, geriatricians, palliative care physicians and other medical specialists, pharmacy services, specialist nurses, diagnostics services and allied health services such as physiotherapists.

Residential aged care facilities will be reviewing all visits and reducing movement in and out of the facility.

This means clinical visits will be limited to essential assessments and management for residents' health conditions, including to assess and manage coronavirus symptoms.

Other assessments and clinical activities may be postponed if it does not have adverse impacts on the health of the resident. Non-essential services, such as hairdressing, beauty treatments and some diversional activities will be cancelled.

Residents will be able to receive short visits with up to two visitors attending together, for the purposes of providing care and support to the resident.

Children under the age of 16 will not be able to visit.

Are there exceptions if my loved one is at the end of their life?

Family and loved ones will be able to provide support to a resident who is dying.

Restrictions on the number and age of visitors will not apply when support is being provided to a dying resident. Children under the age of 16 may visit where the resident is receiving end of life support.

Residential aged care services will continue to talk to family members about a resident's condition and decisions about end of life care will be made in discussion with family members.

What if a visitor providing essential services feels unwell?

No visitor will be able to enter or remain on the premises of a residential aged care facility in Victoria if they meet one or more of the following conditions:

- during the 14 days immediately preceding their visit, the person arrived in Australia from overseas
- during the 14 days immediately preceding the entry, the person had known contact with a person who has a confirmed case of coronavirus (COVID-19)
- the person has a temperature higher than 37.5 degrees or symptoms of acute respiratory infection
- the person does not have an up-to-date vaccination against influenza, if such a vaccination is available to the person.

What infection control measures apply to visitors?

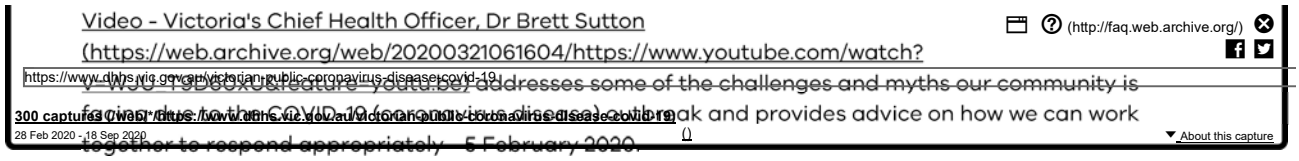
Residential aged care facilities are using the infection control guidelines for respiratory illness management to minimise the movement of visitors into and within the facility.

Essential visitors must:

- visit only the resident
- wear personal protective equipment as directed by staff
- enter and leave the facility directly without spending time in communal areas
- perform hand hygiene before entering and after leaving the resident's room.

More information and resources

For content translated into community languages visit our translated resources (translated-resources-coronavirus-disease-covid-19) page.



Victoria's Chief Health Officer, Dr Brett Sutton video transcript (Word) (/web/20200321061604/https://www.dhhs.vic.gov.au/victorias-chief-health-officer-dr-brett-sutton-coronavirus-video-transcript).

Self-isolation

These documents have been developed to support Australians who have been asked to self-isolate due to COVID-19.

- Factsheet – confirmed case (Word) (https://web.archive.org/web/20200321061604/https://www.dhhs.vic.gov.au/novel-coronavirus-confirmed-case-what-you-need-know)
- Factsheet – suspected case (Word) (https://web.archive.org/web/20200321061604/https://www.dhhs.vic.gov.au/novel-coronavirus-suspected-case-what-you-need-know)
- Factsheet – close contact (Word) (https://web.archive.org/web/20200321061604/https://www.dhhs.vic.gov.au/novel-coronavirus-close-contact-what-you-need-know)
- Home Isolation Guidance - Australian Federal Government (https://web.archive.org/web/20200321061604/https://www.health.gov.au/resources/publications/coronavirus-covid-19-isolation-guidance)
- Coronavirus disease – self-quarantine for international arrivals to Australia - What you need to know factsheet (Word) (/web/20200321061604/https://www.dhhs.vic.gov.au/coronavirus-disease-self-quarantine-international-arrivals-australia-what-you-need-know)

People with a disability and their carers

These factsheets include information and considerations specific to people with disability and people caring for them.

- People with disability and their carers - General health and wellbeing for home isolation (Word) (/web/20200321061604/https://www.dhhs.vic.gov.au/people-disability-and-carers-home-isolation-coronavirus)
- People with disability and their carers - General health and wellbeing for home isolation - Easy English (Word) (/web/20200321061604/https://www.dhhs.vic.gov.au/people-disability-and-carers-home-isolation-coronavirus-easy-english)

Workplace resources

Find out about your workplace entitlements and obligations (https://web.archive.org/web/20200321061604/https://www.fairwork.gov.au/about-us/news-and-media-releases/website-news/coronavirus-and-australian-workplace-laws) on the Fair Work website if you're affected by the coronavirus disease.

Additional resources:

- Reduce your risk of coronavirus (PDF) (/web/20200321061604/https://www.dhhs.vic.gov.au/reduce-your-risk-coronavirus-poster)
- Wash your hands regularly poster (https://web.archive.org/web/20200321061604/https://www2.health.vic.gov.au/about/publications/policiesandg your-hands-regularly-poster)

- Wash your hands regularly poster - Simplified Chinese (PDF) (/web/20200321061604/https://www.dhhs.vic.gov.au/wash-your-hands-regularly-poster-simplified-chinese)
- Wash your hands regularly poster - Arabic (PDF) (/web/20200321061604/https://www.dhhs.vic.gov.au/wash-your-hands-regularly-poster-arabic)
- Cover your cough and sneeze poster (https://web.archive.org/web/20200321061604/https://www2.health.vic.gov.au/about/publications/policiesandg your-cough-sneeze-poster)
- Cover your cough and sneeze poster - Simplified Chinese (PDF) (/web/20200321061604/https://www.dhhs.vic.gov.au/cover-your-cough-and-sneeze-poster-simplified-chinese)
- Cover your cough and sneeze poster - Arabic (PDF) (/web/20200321061604/https://www.dhhs.vic.gov.au/cover-your-cough-and-sneeze-poster-arabic)
- Coronavirus disease (COVID-19) Factsheet for the Victorian public - updated 03 March 2020 (/web/20200321061604/https://www.dhhs.vic.gov.au/coronavirus-disease-covid-19-factsheet-victorian-public-updated-21-february-2020)
- Novel coronavirus (2019-nCoV) factsheet for Victorians - Simplified Chinese (/web/20200321061604/https://www.dhhs.vic.gov.au/novel-coronavirus-2019-ncov-factsheet-victorians-simplified-chinese)
- Coronavirus disease (COVID-19) factsheet for people aged over 65 years (Word) (/web/20200321061604/https://www.dhhs.vic.gov.au/coronavirus-disease-covid-19-factsheet-people-aged-over-65-years)
- Home Isolation Guidance - Australian Federal Government (https://web.archive.org/web/20200321061604/https://www.health.gov.au/resources/publications/coronavirus-covid-19-isolation-guidance)
- Myth busting - Novel Coronavirus (https://web.archive.org/web/20200321061604/https://www.betterhealth.vic.gov.au/blog/blogcollectionpage/no coronavirus-mythbusting) on the Better Health Channel

Was this page useful?

Yes No

Updated on 21/03/2020

Back to top

Sitemap (/web/20200321061604/https://www.dhhs.vic.gov.au/sitemap)

Better Health Channel (https://web.archive.org/web/20200321061604/https://www.betterhealth.vic.gov.au/)

Seniors Online (https://web.archive.org/web/20200321061604/https://www.seniorsonline.vic.gov.au/)

Funded Agency Channel (https://web.archive.org/web/20200321061604/https://fac.dhhs.vic.gov.au/)

Make a complaint (/web/20200321061604/https://www.dhhs.vic.gov.au/victorian-public-coronavirus-disease-covid-19/complaint)

Leave website feedback (/web/20200321061604/https://www.dhhs.vic.gov.au/victorian-public-coronavirus-disease-covid-19/feedback)

The department acknowledges Aboriginal and Torres Strait Islander people as the Traditional Custodians of the land and acknowledges and pays respect to their Elders, past and present.

The department is committed to safe and inclusive work places, policies and services for people of LGBTIQ communities and their families.

Coronavirus disease – self-quarantine for international arrivals to Australia

What you need to know

Australia has implemented new measures to help limit the spread of coronavirus disease 19 (COVID-19). You are receiving this information as you have arrived in Victoria from overseas and are required to self-quarantine for a period of 14 days

Please read this information carefully.

What is novel coronavirus?

Coronaviruses are a large family of viruses which may cause illness in animals or humans.

The most recently discovered coronavirus (COVID-19) is a new virus that can cause an infection in people, including a severe respiratory illness.

Who needs to self-quarantine?

The self-quarantine applies to **all people** arriving in Victoria on an international flight, or on a connecting domestic flight from a flight that originated overseas, **except**:

- Flight crew members
- Citizens or permanent residents of a Pacific Island
- People intending to live indefinitely on a Pacific Island who are transiting through an airport in Victoria to the Pacific Island

What do I need to do?

Stay at home or in other suitable premises

- You must isolate yourself at home or a suitable premises in which to reside until 14 days after you arrived in Australia (ending at midnight on the 14th day after arrival):
  - You should not leave your house or the premises except to seek medical care or medical supplies.
  - You should stay in a different room to other people as much as possible. Use a separate bathroom if available.
  - Do not go to work, school, university or attend public places or events.
  - Do not use public transport, taxi or ride-hail services.
  - Where possible, get others such as friends or family, who are not required to be isolated, to get food or other necessities for you and provide to you in a way that minimises the opportunity for direct contact.
  - You must not permit other persons to enter your home or premises unless the other person is also self-quarantining for a period of 14 days as an international arrival, they live at the premises, or you require medical or emergency assistance.
- If you have difficulties getting food or necessities, call 1800 675 398 for support.

- If you need a translator first call 131 450, then request the hotline on 1800 675 398. More information is available on our website: dhhs.vic.gov.au/novelcoronavirus
- Please keep Triple Zero (000) for emergencies only.

How should I get from the airport to my home or the premises?

You are required to travel directly from the airport to your home or the premises in which you will be residing for self-quarantine.

Wherever possible, you are advised to use a personal mode of transport, such as a private car, to minimise exposure to others. If you need to use public transport (e.g. taxis, ride-hail services, trains, buses and trams), you must take the following precautions:

- Wear a surgical mask, if available
- Avoid direct contact with other passengers, drivers and transport staff
- Practise good hand hygiene and cough/sneeze hygiene

Going outside

If you live in a private house, then it is safe for you to go outside into your garden, balcony or courtyard, with the precaution of avoiding others who are not in self-quarantine.

If you live in an apartment it is also safe for you to go outside into the garden. You should, however, go quickly through any common areas on the way to the garden. Wear a surgical mask if you have to move through these areas and take precautions in touching surfaces. Avoid others who are not in self-quarantine.

You are allowed to leave the premises for the purpose of obtaining medical care, medical supplies or in an emergency situation.

Monitor your symptoms

- Monitor your health until 14 days after you arrived in Australia.
- Watch for any of these signs and symptoms:
  - fever
  - cough
  - shortness of breath
- Other early symptoms can include chills, body aches, sore throat, headache, runny nose, muscle pain or diarrhoea.

What if I develop symptoms?

If you develop any of the symptoms listed above:

- Call a doctor or hospital and tell them your travel history and that you have symptoms.
- Put on a mask, if you have one.
- Keep yourself away from others (for example, by staying in a different room).
- Do not go to work, school, university or attend public places or events. Do not use public transport, ride-hail services or taxi services.
- When you arrive at the general practice or hospital, tell them your travel history again.

Your doctor or staff at the hospital emergency department will utilise appropriate infection control measures and take you through to a room away from others.

The doctor will contact our department on 1300 651 160. They may organise to take nose and throat swabs to send for testing for the novel coronavirus.

If you are experiencing severe symptoms, such as shortness of breath:

- Call 000 and request an ambulance.
- Inform the ambulance officers of your travel history.

How can I prevent the spread of the virus?

Practising good hand and sneeze/cough hygiene is the best defence:

- Wash your hands often with soap and water before and after eating as well as after attending the toilet.
- Avoid all contact with others.
- Cough and sneeze into your elbow.

Should I wear a face mask?

You should wear a face mask, if you have one, when transferring from the hospital to your place of isolation. If you do not have a face mask, avoid direct contact with other passengers, drivers and transport staff, and also practise good hand hygiene and cough/sneeze hygiene.

If you are ill, you should put on a face mask if you have one to prevent spreading the infection to others. You may be given a face mask to wear by your doctor.

Looking after your well-being during quarantine

Being confined to a home for an extended period of time can cause stress and tension. Tips for looking after yourself include:

- Talk to the other members of the family about the infection. Understanding novel coronavirus will reduce anxiety.
- Reassure young children using age-appropriate language.
- Think about how you have coped with difficult situations in the past and reassure yourself that you will cope with this situation too. Remember that self-isolation won't last for long.
- Exercise regularly. Options could include exercise DVDs, dancing, floor exercises, yoga, walking around the backyard or using home exercise equipment, such as a stationary bicycle, if you have it. Exercise is a proven treatment for stress.
- Keep in touch with family members and friends via telephone, email or social media.
- Keep up a normal daily routine as much as possible.
- Arrange with your employer to work from home, if this is possible for your role.
- Ask your child's school to supply assignments, work sheets and homework by post or email, or if the student can join the class using online options.
- Don't rely too heavily on the television and technology. Treat self-isolation as an opportunity to do some of those things you never usually have time for, such as board games, craft, drawing and reading.
- If you are struggling to cope you call Lifeline on 13 11 14 or Beyond Blue on 1300 22 4636.

What are the penalties if I don't comply with self-quarantine?

The Victorian State Government has declared a State of Emergency throughout the State of Victoria, which allows the Chief Health Officer to exercise emergency powers under the *Public Health and Wellbeing Act 2008* (Vic). The requirement to self-quarantine for 14 days for international arrivals to Australia is a formal direction pursuant to the *Public Health and Wellbeing Act 2008* (Vic). Anyone who fails to comply with this direction commits an offence and may be fined up to $19,826.40 for an individual or up to $99,132 for a body corporate.

Where can I find out more information?

Call the Department of Health and Human Services on to discuss any questions you have. If you need a translator first call 131 450, then request the to be put through to the department on 1300 651 160.

For Victorian updates to the current incident, go to: https://www.dhhs.vic.gov.au/novelcoronavirus

For national updates: https://www.health.gov.au/news/latest-information-about-novel-coronavirus

For international updates: https://www.who.int/westernpacific/emergencies/novel-coronavirus

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

To receive this publication in an accessible format phone 1300 651 160, using the National Relay Service 131 450 if required, or email Public Health branch <public.health@dhhs.vic.gov.au>.

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

Coronavirus disease – self-quarantine for international arrivals to Australian seaports

What you need to know

Australia has implemented new measures to help limit the spread of coronavirus disease 19 (COVID-19). You are receiving this information as you have arrived in Victoria from overseas and are required to self-quarantine for a period of 14 days

Please read this information carefully.

What is novel coronavirus?

Coronaviruses are a large family of viruses which may cause illness in animals or humans.

The most recently discovered coronavirus (COVID-19) is a new virus that can cause an infection in people, including a severe respiratory illness.

Who needs to self-quarantine?

On 19 March 2020, a direction was made which applies to any person who disembarks at a port in Victoria from an international cruise ship or an Australian cruise ship between 1.30pm on 19 March 2020 and midnight 13 April 2020. This applies to any traveller entering Australia, inclusive of Australian citizens and permanent residents.

Any person disembarking from an abovenamed cruise ship must self-isolate for 14 days after disembarking in the port.

If you are an Australian citizen or permanent resident:

- For Australian citizens and residents you can travel immediately to your home or residence to self-isolate.
- If you have domestic connections to your final destination, you may travel to immediately to the airport for your flight.
  - If you are not travelling directly to the airport you must self-isolate at your hotel or other accommodation for 14 days

If you are an international visitor:

- If you have an onward domestic or international connection:
  - You may travel directly to the airport for your departing flight.
  - If you are travelling domestically, you must self-isolate for the remainder of the 14 day period once you have arrived at your final destination in your accommodation.
- If you do not have immediate existing domestic or international connections, you must self-isolate at your accommodation upon arrival in Victoria for the remainder of the 14 day period.

Crew members

For crew members who are continuing on with their ship, you must self-isolate whilst in Victoria, or for 14 days. You may depart with your ship if it is leaving prior to 14 days.

- NOTE: this does not apply if there have been people on your ship who are unwell and suspected of having COVID-19.
  - You will be provided further instructions if someone on board is suspected of having COVID-19

What do I need to do?

Stay at home or in other suitable premises

- You must isolate yourself at home or a suitable premises in which to reside until 14 days have passed since your last overseas port (ending at midnight on the 14th day after departure from the last port of embarkation):
  - You should not leave your house or the premises except to seek medical care or medical supplies.
  - You should stay in a different room to other people as much as possible. Use a separate bathroom if available.
  - Do not go to work, school, university or attend public places or events.
  - Do not use public transport, taxi or ride-hail services.
  - Where possible, get others such as friends or family, who are not required to be isolated, to get food or other necessities for you and provide to you in a way that minimises the opportunity for direct contact.
  - You must not permit other persons to enter your home or premises unless the other person is also self-quarantining for a period of 14 days as an international arrival, they live at the premises, or you require medical or emergency assistance.
- If you have difficulties getting food or necessities, call 1800 675 398 for support.
- If you need a translator first call 131 450, then request the hotline on 1800 675 398. More information is available on our website: dhhs.vic.gov.au/novelcoronavirus
- Please keep Triple Zero (000) for emergencies only.

How should I get from the seaport to my home or the premises?

You are required to travel directly from the seaport to your home or the premises in which you will be residing for self-quarantine.

Wherever possible, you are advised to use a personal mode of transport, such as a private car, to minimise exposure to others. If you need to use public transport (e.g. taxis, ride-hail services, trains, buses and trams), you must take the following precautions:

- Wear a surgical mask, if available
- Avoid direct contact with other passengers, drivers and transport staff
- Practise good hand hygiene and cough/sneeze hygiene

Going outside

If you live in a private house, then it is safe for you to go outside into your garden, balcony or courtyard, with the precaution of avoiding others who are not in self-quarantine.

If you live in an apartment it is also safe for you to go outside into the garden. You should, however, go quickly through any common areas on the way to the garden. Wear a surgical mask if you have to move through these areas and take precautions in touching surfaces. Avoid others who are not in self-quarantine.

You are allowed to leave the premises for the purpose of obtaining medical care, medical supplies or in an emergency situation.

Monitor your symptoms

- Monitor your health until 14 days after you arrived in Australia.
- Watch for any of these signs and symptoms:
  - fever
  - cough
  - shortness of breath
- Other early symptoms can include chills, body aches, sore throat, headache, runny nose, muscle pain or diarrhoea.

What if I develop symptoms?

If you develop any of the symptoms listed above:

- Call a doctor or hospital and tell them your travel history and that you have symptoms.
- Put on a mask, if you have one.
- Keep yourself away from others (for example, by staying in a different room).
- Do not go to work, school, university or attend public places or events. Do not use public transport, ride-hail services or taxi services.
- When you arrive at the general practice or hospital, tell them your travel history again.

Your doctor or staff at the hospital emergency department will utilise appropriate infection control measures and take you through to a room away from others.

The doctor will contact our department on 1300 651 160. They may organise to take nose and throat swabs to send for testing for the novel coronavirus.

If you are experiencing severe symptoms, such as shortness of breath:

- Call 000 and request an ambulance.
- Inform the ambulance officers of your travel history.

How can I prevent the spread of the virus?

Practising good hand and sneeze/cough hygiene is the best defence:

- Wash your hands often with soap and water before and after eating as well as after attending the toilet.
- Avoid all contact with others.
- Cough and sneeze into your elbow.

Should I wear a face mask?

You should wear a face mask, if you have one, when transferring from the hospital to your place of isolation. If you do not have a face mask, avoid direct contact with other passengers, drivers and transport staff, and also practise good hand hygiene and cough/sneeze hygiene.

If you are ill, you should put on a face mask if you have one to prevent spreading the infection to others. You may be given a face mask to wear by your doctor.

Looking after your well-being during quarantine

Being confined to a home for an extended period of time can cause stress and tension. Tips for looking after yourself include:

- Talk to the other members of the family about the infection. Understanding novel coronavirus will reduce anxiety.
- Reassure young children using age-appropriate language.
- Think about how you have coped with difficult situations in the past and reassure yourself that you will cope with this situation too. Remember that self-isolation won't last for long.
- Exercise regularly. Options could include exercise DVDs, dancing, floor exercises, yoga, walking around the backyard or using home exercise equipment, such as a stationary bicycle, if you have it. Exercise is a proven treatment for stress.
- Keep in touch with family members and friends via telephone, email or social media.
- Keep up a normal daily routine as much as possible.
- Arrange with your employer to work from home, if this is possible for your role.
- Ask your child's school to supply assignments, work sheets and homework by post or email, or if the student can join the class using online options.
- Don't rely too heavily on the television and technology. Treat self-isolation as an opportunity to do some of those things you never usually have time for, such as board games, craft, drawing and reading.
- If you are struggling to cope you call Lifeline on 13 11 14 or Beyond Blue on 1300 22 4636.

What are the penalties if I don't comply with self-quarantine?

The Victorian State Government has declared a State of Emergency throughout the State of Victoria, which allows the Chief Health Officer to exercise emergency powers under the *Public Health and Wellbeing Act 2008* (Vic). The requirement to self-quarantine for 14 days for international arrivals to Australia is a formal direction pursuant to the *Public Health and Wellbeing Act 2008* (Vic). Anyone who fails to comply with this direction commits an offence and may be fined up to $19,826.40 for an individual or up to $99,132 for a body corporate.

Where can I find out more information?

Call the Department of Health and Human Services on to discuss any questions you have. If you need a translator first call 131 450, then request the to be put through to the department on 1300 651 160.

For Victorian updates to the current incident, go to: https://www.dhhs.vic.gov.au/novelcoronavirus

For national updates: https://www.health.gov.au/news/latest-information-about-novel-coronavirus

For international updates: https://www.who.int/westernpacific/emergencies/novel-coronavirus

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

To receive this publication in an accessible format phone 1300 651 160, using the National Relay Service 131 450 if required, or email Public Health branch <public.health@dhhs.vic.gov.au>.

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

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

Airport arrivals

Public Health and Wellbeing Act 2008 (Vic)
Section 200

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

Preamble

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

Citation

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

Direction

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

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

PENALTIES

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

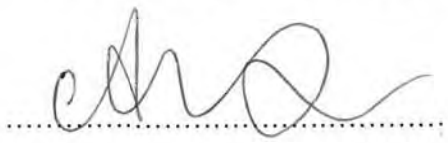
Compliance with direction or other requirement

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

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

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

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



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Dr Annaliese van Diemen

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

18 March 2020

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

Cruise Ship Docking

Public Health and Wellbeing Act 2008 (Vic)
Section 200

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

Preamble

1. The purpose of this direction is to make provision for the self-quarantine of persons arriving in Victoria on a cruise ship in order to limit the spread of Novel Coronavirus 2019 (2019-nCoV).

Citation

2. This direction may be referred to as the **Cruise Ship Docking Direction**.

Direction

3. This direction applies to a person who disembarks at a port in Victoria from an **international cruise ship** or an **Australian cruise ship** between 1:30pm on 19 March 2020 and midnight on 13 April 2020.

4. Subject to paragraphs 5 and 6, the person:
   a. must travel from the port in Victoria to a premises that is suitable for the person to reside in for a period of 14 days; and
   b. except in exceptional circumstances, must reside in that premises for the period beginning on the day of arrival and ending at midnight on the fourteenth (14^{th}) day after arrival; and
   c. must not leave the premises, except:
      i. for the purposes of obtaining medical care or medical supplies; or
      ii. in any other emergency situation; or
      iii. in circumstances where it is possible to avoid close contact with other persons; and
   d. must not permit any other person to enter the premises unless that other person usually lives at the premises, or the other person is also complying with this direction for the same 14 day period, or for medical or emergency purposes.

5. The person is not required to comply with paragraph 4 if the person:
   a. proceeds immediately from the port in Victoria to an airport in Victoria; and
   b. without leaving the airport, boards a flight to a place outside Victoria.
6. The person is not required to comply with paragraph 4 if the person proceeds

immediately from the port in Victoria to a medical facility because the person requires urgent medical care.

Definitions

7. For the purposes of this direction, **international cruise ship** means a foreign vessel that:
   a. has the capacity to carry 100 or more passengers; and
   b. is on a voyage from a port outside Australian territory.

8. For the purposes of this direction, **Australian cruise ship** means an Australian vessel that:
   a. has the capacity to carry 100 or more passengers; and
   b. is on a voyage from a port outside Australian territory.

9. For the purposes of this direction, the following expressions have the same meanings as they have in the Biosecurity Act 2015 of the Commonwealth:
   a. **Australian vessel**;
   b. **Australian territory**;
   c. **foreign vessel**;
   d. **passenger**;
   e. **port**.

PENALTIES

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

Compliance with direction or other requirement

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

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

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

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

.....

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

19 March 2020

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Victoria's hub for health services & business

2019 Coronavirus disease (COVID-19)

Status:
Active

Health alert:
AL20012

Date Issued:
14 Apr 2020 - (Update to Alert issued 5 April 2020)

Issued by:
Professor Brett Sutton, Chief Health Officer

Issued to:
Clinicians and the Victorian public

Key messages

- See the Victorian COVID-19 website for an updated case definition and new testing recommendations: **Health services and general practice - coronavirus disease (COVID-19)**
- Up-to-date **epidemiological data** is also now available on the department website.
- Testing criteria has been expanded to include all people with consistent clinical symptoms This will assist in finding cases that are being transmitted in the community to prevent community spread
- Doctors who are requesting COVID-19 testing are asked to ensure that a current contact phone number for the patient is included on all pathology request forms
- Advise all patients who have clinical symptoms but do not meet the testing criteria to remain home and not attend work, school or any public places until symptoms have completely resolved
- Notification is required, by telephone, for all confirmed cases of COVID-19 The department is following-up all close contacts of confirmed cases
- A State of Emergency has been declared in Victoria until 11 May 2020 to combat COVID-19
- A number of directions are now in force requiring important physical distancing interventions, issued in accordance with emergency powers arising from the declared state of emergency
- Self-assessment guidelines are available for the public together with guidelines for healthcare and residential care workers on **Coronavirus disease (COVID-19)** page of dhhs.vic website

- Any person with a fever or respiratory symptoms is advised to ring the 24-hour hotline 1800 675 398
- Healthcare workers who have had close contact with a confirmed case, or who are diagnosed with COVID-19, can now access free accommodation to support their isolation and quarantine if required

What is the issue?

COVID-19 is a notifiable condition under the Public Health and Wellbeing Regulations 2019 and all confirmed cases must be notified to the department. All people meeting the testing criteria should be tested.

People who have arrived in Australia after midnight on Saturday 28 March 2020 are subject to mandatory quarantine in specified hotels for 14 days.

Who is at risk?

The situation is evolving rapidly as we find out more about this disease. Most countries are now reporting rapid increases in cases.

As such, travellers returning from any country outside Australia should now be considered at high risk and therefore should be tested for COVID-19 and immediately isolated if they present with a clinically compatible illness.

People of all ages have been diagnosed with COVID-19, but those most at risk of severe illness are elderly people and those with pre-existing medical conditions.

Symptoms and transmission

Reported symptoms include fever or respiratory symptoms such as cough, sore throat and shortness of breath. Recent information on the transmission of the virus suggests that cases may be infectious up to 24 hours before the onset of symptoms, until at least 24 hours after symptoms resolve.

The World Health Organization has confirmed that the main driver of transmission is from symptomatic patients through coughing and sneezing. Transmission by people without symptoms is possible, but is likely to be rare.

Who should be tested?

People without symptoms should **not** be tested.

Patients who meet the following clinical criteria should be tested:

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

OR

Acute respiratory infection that is characterised by cough, sore throat or shortness of breath

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

*headache, myalgia, runny or stuffy nose, anosmia, nausea, vomiting, diarrhoea

Note: Healthcare workers and emergency workers remain a high priority for testing.

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

Recommendations

Advice for clinicians

Detailed information for medical practitioners is on the **Health service and general practice page** of DHHS website and the key guidance documents are the **GP quick guide and checklist** and more detailed **Health Services and General Practitioner guide**.

If you have a patient who meets the testing criteria above, key actions include:

- Place a surgical mask on the patient and isolate the patient in a single room with the door closed.
- Use droplet and contact precautions (single-use surgical face mask, eye protection, gown and gloves).
- Undertake testing in your hospital or through your primary pathology service:

– Take a single nasopharyngeal swab for viral testing. **To conserve swabs** the same swab that has been used to sample the oropharynx should be utilised for nasopharynx sampling.

– Take blood in a serum tube for storage at VIDRL.

- After a national expert review, it has been determined that there is negligible risk of aerosolisation from taking a nose and throat swab in a patient with an acute respiratory infection. This means a single use facemask (surgical mask) is now recommended for taking a nose and throat swab.
- If the patient has symptoms and signs suggestive of pneumonia, however, there is a possibility that the viral load might be higher. These patients should be referred to hospital for treatment, and airborne precautions, including a P2 respirator, should be used when collecting nasopharyngeal or oropharyngeal samples.

Advice for healthcare workers

- Anyone who works in healthcare or residential care who has been overseas should not attend work for 14 days since leaving that country. As of midnight, 28 March 2020, all travellers arriving into Melbourne from overseas will be quarantined for two weeks in hotel rooms and other accommodation facilities. Interstate travellers can return to their home state after fulfilling the mandatory quarantine requirements in Victoria.
- Any healthcare worker who has compatible illness, whether having travelled internationally or not, should not attend work and seek medical attention for consideration of testing for COVID-19.
- It is recommended that medical practitioners do not test or treat themselves and instead should seek medical care from another medical practitioner.
- Confirmed cases of COVID-19 and close contacts who are healthcare workers will be provided with free accommodation to support their isolation and quarantine, if required. They may choose to undertake their isolation or quarantine period at home, however.
- From midnight on 25 March, category three surgeries will not take place in public hospitals in Victoria until further notice.

Advice for patients

- Remember to practice physical distancing at all times. If you can stay home, you must stay home.

- Anyone who has been in close contact with a confirmed case of COVID-19 should remain in quarantine at home until 14 days after their last contact. More information will be provided to close contacts by the department.
- As of midnight on 28 March 2020, all travellers arriving into Melbourne from overseas will be quarantined for two weeks in hotel rooms and other accommodation facilities.
- Interstate travellers can return to their home states after fulfilling the mandatory quarantine requirements.
- If a person in quarantine feels unwell and develops a fever or an acute respiratory illness or other symptoms compatible with coronavirus they should seek medical attention.
- Call ahead to your GP or emergency department and mention your travel history.
- Please keep triple zero (000) for emergencies only.
- As the virus is predominantly spread through coughing and sneezing, the best way to protect others is to practice good cough hygiene and regular hand washing.

Clinical information

Health service and general practice page on the DHHS website

Consumer information

About coronavirus (COVID-19) page on the DHHS website

World Health Organization coronavirus page

Smartraveller website

Contacts

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

Medical practitioners needing clinical information can contact the Department of Health and Human Services Communicable Diseases Section on 1300 651 160 (24 hours).

Contact details

Chief Health Officer

50 Lonsdale Street, Melbourne, 3000 Victoria, Australia

Contact the Chief Health Officer

Page last reviewed: 14 Apr 2020

https://www2.health.vic.gov.au:443/about/news-and-events/healthalerts/2019-Coronavirus-disease--COVID-19

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2019 Coronavirus disease (COVID-19)

Status:
Resolved

Health alert:
AL20012

Date Issued:
27 Apr 2020 - (Update to Alert issued 14 April 2020)

Issued by:
Professor Brett Sutton, Chief Health Officer

Issued to:
Clinicians and the Victorian public

Key messages

- See the Victorian COVID-19 website for an updated case definition and new testing recommendations: **Health services and general practice - coronavirus disease (COVID-19)**
- Up-to-date **epidemiological data** is also now available on the department website.
- Testing criteria has been updated to further expand the symptoms which may be included as part of an acute respiratory infection as part of a drive to increase testing
- The new criteria also highlight healthcare and aged care workers as priority groups for testing and note the potential for co-infection. Also noted are the specific and limited circumstances where asymptomatic testing may be considered under direction from the department.
- Doctors who are requesting COVID-19 testing are asked to ensure that a current contact phone number for the patient is included on all pathology request forms
- Advise all patients who have clinical symptoms but do not meet the testing criteria to remain home and not attend work, school or any public places until symptoms have completely resolved
- Notification is required, by telephone, for all confirmed cases of COVID-19 The department is following-up all close contacts of confirmed cases
- A State of Emergency has been declared in Victoria until 11 May 2020 to combat COVID-19
- A number of directions are now in force requiring important physical distancing interventions, issued in accordance with emergency powers arising from the declared state of emergency
- Self-assessment guidelines are available for the public together with guidelines for healthcare and residential care workers on **Coronavirus disease (COVID-19)** page of dhhs.vic website

- Any person with a fever or respiratory symptoms is advised to ring the 24-hour hotline 1800 675 398
- Healthcare workers who have had close contact with a confirmed case, or who are diagnosed with COVID-19, can now access free accommodation to support their isolation and quarantine if required

What is the issue?

Coronavirus disease (COVID-19) has been declared a Public Health Emergency of International Concern by the World Health Organization. A state of emergency was declared on 16 March 2020 to help reduce the spread of coronavirus in Victoria.

COVID-19 is a notifiable condition under the Public Health and Wellbeing Regulations 2019 and all confirmed cases must be notified to the department. All people meeting the testing criteria should be tested.

People who have arrived in Australia after midnight on Saturday 28 March 2020 are subject to mandatory quarantine in specified hotels for 14 days.

Who is at risk?

The situation is evolving rapidly as we find out more about this disease. Most countries are now reporting rapid increases in cases.

As such, travellers returning from any country outside Australia should now be considered at high risk and therefore should be tested for COVID-19 and immediately isolated if they present with a clinically compatible illness.

People of all ages have been diagnosed with COVID-19, but those most at risk of severe illness are elderly people and those with pre-existing medical conditions.

Symptoms and transmission

Reported symptoms include fever or respiratory symptoms such as cough, sore throat and shortness of breath. Recent information on the transmission of the virus suggests that cases may be infectious up to 48 hours before the onset of symptoms, until at least 24 hours after symptoms resolve.

The World Health Organization has confirmed that the main driver of transmission is from symptomatic patients through coughing and sneezing. Transmission by people without symptoms is possible, but is likely to be rare.

Who should be tested?

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

Patients who meet the following clinical criteria should be tested:

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

OR

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

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

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

Notify the department of confirmed cases as soon as practicable by calling 1300 651 160, 24 hours a

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

Recommendations

Advice for clinicians

Detailed information for medical practitioners is on the **Health service and general practice page** of DHHS website and the key guidance documents are the **GP quick guide and checklist** and more detailed **Health Services and General Practitioner guide**.

If you have a patient who meets the testing criteria above, key actions include:

- Place a surgical mask on the patient and isolate the patient in a single room with the door closed.
- Use droplet and contact precautions (single-use surgical face mask, eye protection, gown and gloves).
- Undertake testing in your hospital or through your primary pathology service:

– Take a single nasopharyngeal swab for viral testing. **To conserve swabs** the same swab that has been used to sample the oropharynx should be utilised for nasopharynx sampling.

– Take blood in a serum tube for storage at VIDRL.

- After a national expert review, it has been determined that there is negligible risk of aerosolisation from taking a nose and throat swab in a patient with an acute respiratory infection. This means a single use facemask (surgical mask) is now recommended for taking a nose and throat swab.
- If the patient has symptoms and signs suggestive of pneumonia, however, there is a possibility that the viral load might be higher. These patients should be referred to hospital for treatment, and airborne precautions, including a P2 respirator, should be used for lower respiratory tract specimen collection.
- Since the last CHO Alert, the department has updated guidance relating to the conventional use of personal protective equipment and use when performing clinical procedures. These are available at **Health services and general practice - coronavirus disease (COVID-19)**.

Advice for healthcare workers

- Anyone who works in healthcare or residential care who has been overseas should not attend work for 14 days since leaving that country. As of midnight, 28 March 2020, all travellers arriving into Melbourne from overseas will be quarantined for two weeks in hotel rooms and other accommodation facilities. Interstate travellers can return to their home state after fulfilling the mandatory quarantine requirements in Victoria.
- Any healthcare worker who has compatible illness, whether having travelled internationally or not, should not attend work and seek medical attention for consideration of testing for COVID-19.
- It is recommended that medical practitioners do not test or treat themselves and instead should seek medical care from another medical practitioner.
- Confirmed cases of COVID-19 and close contacts who are healthcare workers will be provided with free accommodation to support their isolation and quarantine, if required. They may choose to undertake their isolation or quarantine period at home, however.
- Victoria’s public and private hospitals will begin doing more elective surgeries from next week. Category 2 and some category 3 elective surgeries will gradually resume from 27 April 2020.

Advice for patients

- Remember to practice physical distancing at all times. If you can stay home, you must stay home.
- An **Isolation (diagnosis) direction** was re-issued on 13 April 2020. This direction requires anyone diagnosed with coronavirus (COVID-19) to isolate at home or at another suitable location to slow the spread of the disease.
- Anyone who has been in close contact with a confirmed case of COVID-19 should remain in quarantine at home until 14 days after their last contact. More information will be provided to close contacts by the department.
- As of midnight on 28 March 2020, all travellers arriving into Melbourne from overseas will be quarantined for two weeks in hotel rooms and other accommodation facilities.
- Interstate travellers can return to their home states after fulfilling the mandatory quarantine requirements.
- If a person in quarantine feels unwell and develops a fever or an acute respiratory illness or other symptoms compatible with coronavirus they should seek medical attention.
- Call ahead to your GP or emergency department and mention your travel history.
- Please keep triple zero (000) for emergencies only.
- As the virus is predominantly spread through coughing and sneezing, the best way to protect others is to practice good cough hygiene and regular hand washing.

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Page last reviewed: 14 Apr 2020

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/ Coronavirus disease (COVID-19) (/web/20200315050201/https://www.dhhs.vic.gov.au/coronavirus)
/ Information for health services - Novel Coronavirus (/web/20200315050201/https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19) /

Coronavirus COVID-19 daily update

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> This Chief Health Officer update is intended to provide clinicians and the Victorian public with information about the number of confirmed cases of COVID-19 in Victoria, a list of current public exposure sites, as well as relevant public health response activities in Victoria. This update will be sent regularly.
>
> Chief Health Officer Alerts will continue to be issued when there are changes to the public health advice related to COVID-19.

Chief Health Officer Update 13/03/2020

Key messages

- In Victoria we currently have 36 total confirmed cases.
- Notification of suspected cases to the department is now only required for healthcare workers and residential aged care workers or residents. Notification is no longer required for all other suspected cases.

- As of 6 pm 11 March 2020, Italy has been added to the list of countries requiring self-isolation for return travellers.
- Any travellers returning from **any country** outside Australia should now be considered at risk.
- The World Health Organization has characterised COVID-19 as a pandemic.
- All potential public exposure sites are listed in the summary table below. Anyone who was at any of these sites should be aware of their health and seek medical advice if they become unwell.
- All close contacts of confirmed cases will be contacted by the department and told to home quarantine for 14 days.
- All other people who attended exposure sites are casual contacts and are not required to be home quarantined.

See the coronavirus information for Victorian health services and general practice (/web/20200315050201/https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19) for current case definition, guidance and testing recommendations.

Public exposure sites

The table is a summary of public exposure sites for the current COVID-19 cases in Victoria.

Date	Time	Location	Onset of symptoms up to
Tuesday 10/03/2020	12:30pm – 2:00pm	Mary Miller Café, Fitzroy North	24/03/2020
Tuesday 10/03/2020	8:00am – 9:30am	No. 19 Café, Ascot Vale	24/03/2020
Tuesday 10/03/2020	Arriving at 6:00am	Emirates flight EK0406 from Dubai to Melbourne	24/03/2020
Monday 09/03/2020	Departing at 6:00pm	Qantas flight QF459 from Sydney to Melbourne	23/03/2020
Monday 09/03/2020	Departing at 12:00pm	Qantas flight QF430 from Melbourne to Sydney	23/03/2020
Sunday 08/03/2020	5:15pm – 11:30pm	T20 Cricket World Cup Final, Melbourne Cricket Ground, MCC Members Level 2	22/03/2020
Sunday 08/03/2020	10:00am – 4:00pm	Myrtle Oval, Macleay Park, North Balwyn	22/03/2020
Sunday 08/03/2020	8:30am – 5:00pm	Ramsden Street Oval, Clifton Hill	22/03/2020
Sunday 08/03/2020	Arrived 7:00am	Virgin Australia flight VA24 from Los Angeles to Melbourne	22/03/2020

Saturday 07/03/2020	Evening	AAMI Park (Rebels vs Lions rugby game)	21/03/2020
Saturday 07/03/2020	6:00pm – 10:00pm	Albert Park Hotel	21/03/2020
Saturday 07/03/2020	2:00pm – 3:00pm	South Melbourne Market	21/03/2020
Saturday 07/03/2020	1:00pm – 6:00pm	Coles Waurn Ponds	21/03/2020
Saturday 07/03/2020	Unsure	Ashburton Park	21/03/2020
Saturday 07/03/2020	Arrived 7:00am	Virgin Australia flight VA24 from Los Angeles to Melbourne	21/03/2020
Friday 06/03/2020	Arrived 9am	Malaysia Airways flight MH0149 from Kuala Lumpur to Melbourne	20/03/2020
Friday 06/03/2020	6pm – 7pm	Pho Hung Vuong 2 Vietnamese Restaurant in Richmond	20/03/2020
Friday 06/03/2020	Arrived 9:40am	Qantas flight QF94 from Los Angeles to Melbourne	20/03/2020
Friday 06/03/2020	8:45am – 5:00pm	Coles Waurn Ponds	20/03/2020
Friday 06/03/2020	8:30am – 10:00am	South Melbourne Market	20/03/2020
Friday 06/03/2020	Arrived 00:15am	Emirates flight EK404 from Singapore to Melbourne	20/03/2020
Thursday 5/03/2020	7:30pm – 10:30pm	Cinema Nova, Carlton (Movie: The Amber Light)	19/03/2020
Thursday 5/03/2020	Departing around 5:40pm	VLine train from Southern Cross to Geelong	19/03/2020
Tuesday 3/03/2020	12:30 – 3:30pm	Wine by Sam - Seymour	17/03/2020
Tuesday 3/03/2020 – Thursday 5/03/2020	3/03/2020: 9:00am – 12:00pm 4/03/2020: 11:00am – 1:00pm 5/03/2020: 1:00pm – 4:30pm	La Trobe University, Bundoora Campus	17/03/2020 – 19/03/2020
Monday 02/03/2020	Arrived 4:20pm	Virgin Australia flight VA682 from Perth to Melbourne	16/03/2020
Monday 02/03/2020	Departing around 5:40pm	VLine train from Geelong to Southern Cross	16/03/2020
Monday 02/03/2020	Departing between 7:00 – 7:15pm	Metro train from Southern Cross to Camberwell	16/03/2020

Monday 02/03/2020 – Friday 06/03/2020	Patients and staff that attended the clinic any time between Monday 02/03/2020 – Friday 06/03/2020	Toorak Clinic 575 Malvern Rd, Toorak	14 days from visiting the clinic (16 – 20 March 2020)
Saturday 29/02/2020	Arrived 9:30am	United Airlines flight UA0060 from San Francisco to Melbourne	14/03/2020
Saturday 29/02/2020	Arrived 10:50am	Singapore Airlines flight SQ237 from Singapore to Melbourne	14/03/2020
Friday 28/02/2020	10:50am (Singapore time)	Malindo Air flight OD177 from Denpasar to Melbourne	13/03/2020

More information

Clinical information

Health services and general practice - coronavirus disease (COVID-19) (https://web.archive.org/web/20200315050201/https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19)

Consumer information

About coronavirus (COVID-19) - information for the general public (https://web.archive.org/web/20200315050201/https://www.dhhs.vic.gov.au/victorian-public-coronavirus-disease-covid-19)

World Health Organization - health topic - coronavirus (https://web.archive.org/web/20200315050201/https://www.who.int/health-topics/coronavirus)

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Coronavirus COVID-19 daily update

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> This Chief Health Officer update is intended to provide clinicians and the Victorian public with information about the number of confirmed cases of COVID-19 in Victoria as well as relevant public health response activities in Victoria. Chief Health Officer Alerts will continue to be issued when there are changes to the public health advice related to COVID-19.

> **21/03/2020**

What's new?

- As of 0930hrs 21 March 2020, Victoria has 229 total confirmed cases, and no deaths.

New testing criteria (as of Saturday 21 March 2020)

- People without symptoms should not be tested.

Clinical criteria:

Fever *

OR

Acute respiratory infection (for example, shortness of breath, cough, sore throat)

Epidemiological criteria:

Travelers from overseas with onset of symptoms within 14 days of return or;

Close contacts of confirmed COVID-19 cases with onset of symptoms within 14 days of last contact or;

Healthcare workers and residential aged care workers meeting clinical criteria or;

Aged and residential care residents meeting clinical criteria or;

Patients who are **Aboriginal or Torres Strait Islander people** meeting clinical criteria

* >38 degrees, without another immediately apparent cause such as urinary tract infection or cellulitis

The following patients should also be tested:

Patients admitted to hospital with acute respiratory tract infection AND fever*

Only confirmed cases should be notified. A confirmed case is a person who tests positive to a validated SARS-CoV-2 nucleic acid test or has the virus identified by electron microscopy or viral culture.

Advice on the use of ibuprofen, or other non-steroidal anti-inflammatories

- There have been some concerns internationally that use of ibuprofen, or other non-steroidal anti-inflammatories, during COVID-19 infection may lead to an increased risk of complications or death.
- There is insufficient high-quality evidence currently available to recommend ceasing use of non-steroidal anti-inflammatories during COVID-19 infection. Further advice will be provided as further evidence becomes available.

Quick reference guide and guidelines for health services and practitioners

and testing recommendations https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19 (https://web.archive.org/web/20200321211633/https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19)

Key messages

- The Victorian Government is working with the Australian Government to ensure that all vital personal protective equipment supplies are appropriately distributed to where they are needed across the Victorian health system.
- The Victorian Government has declared a State of Emergency in Victoria.
- The State of Emergency provides the Chief Health Officer with powers to enforce 14-day quarantine for all Australians returning to Australia and to do whatever is necessary to contain the spread of the virus and reduce the risk to the health of Victorians.
- Notification is required, by telephone, for all confirmed cases via 1300 651 160, immediately 24 hours per day.
- From 9pm 20 March 2020, any Australians returning from any country outside Australia should now be considered at risk and are required to self-isolate for 14 days.
- All close contacts of confirmed cases will be contacted by the department and told to home quarantine for 14 days.

More information

Clinical information

Health services and general practice - coronavirus disease (COVID-19) (https://web.archive.org/web/20200321211633/https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19)

Consumer information

About Coronavirus (COVID-19) - information for the general public (https://web.archive.org/web/20200321211633/https://www.dhhs.vic.gov.au/victorian-public-coronavirus-disease-covid-19)

World Health Organization - health topic - Coronavirus (https://web.archive.org/web/20200321211633/https://www.who.int/health-topics/coronavirus)

Smartraveller website (https://web.archive.org/web/20200321211633/https://www.smartraveller.gov.au/)

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

Medical practitioners needing clinical information or to notify suspected or confirmed cases can contact the Department of Health and Human Services Communicable Diseases Section on 1300 651 160 (24 hours).

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Coronavirus COVID-19 daily update

> This Chief Health Officer update is intended to provide clinicians and the Victorian public with information about the number of confirmed cases of COVID-19 in Victoria as well as relevant public health response activities in Victoria. Chief Health Officer Alerts will continue to be issued when there are changes to the public health advice related to COVID-19.

> **22/03/2020**

What's new?

- As of 0930hrs 22 March 2020, Victoria has 296 total confirmed cases, and no deaths.
- Overnight the Prime Minister and the Chief Medical Officer announced significant new restrictions on gatherings. The Victoria Government will be working to implement these restrictions over the coming weeks and months.
- Victoria will implement a shutdown of all non-essential activity across the state over the next 48 hours.

- School holidays will be brought forward in Victoria, starting on Tuesday 24 March.

New testing criteria came into effect on Saturday 21 March 2020

People without symptoms should not be tested.

Patients who meet at least one clinical AND at least one epidemiological criteria should be tested.

Clinical criteria:

Fever *
OR
Acute respiratory infection (for example, shortness of breath, cough, sore throat)

Epidemiological criteria:

Travelers from overseas with onset of symptoms within 14 days of return or;
Close contacts of confirmed COVID-19 cases with onset of symptoms within 14 days of last contact or;
Healthcare workers and residential aged care workers meeting clinical criteria or;
Aged and residential care residents meeting clinical criteria or;
Patients who are A**boriginal or Torres Strait Islander people** meeting clinical criteria
* ≥ 38 degrees, without another immediately apparent cause such as urinary tract infection or cellulitis

The following patients should also be tested:
Patients admitted to hospital with acute respiratory tract infection AND fever*

Only confirmed cases should be notified. A confirmed case is a person who tests positive to a validated SARS-CoV-2 nucleic acid test or has the virus identified by electron microscopy or viral culture.

Additional directions for aged care facilities and mass gatherings

Additional directions for aged care (/web/20200322215901/https://www.dhhs.vic.gov.au/state-emergency-direction-aged-care) and mass gatherings (/web/20200322215901/https://www.dhhs.vic.gov.au/state-emergency-direction-mass-gatherings-2) were signed by the Deputy Chief Health Officer in accordance with emergency powers arising from the declared state of emergency on 21 March 2020. The Aged Care

The Mass Gatherings Directions (no 2) (/web/20200322215901/https://www.dhhs.vic.gov.au/state-emergency-direction-mass-gatherings-2) replace the mass gatherings Directions made on 18 March 2020. These directions prohibit non-essential mass-gatherings in order to limit the spread of COVID-19.

Updated GP quick reference guide and the Guidelines for health services and practitioners

The Quick Reference guide and the guidelines for health services and practitioners are continuously updated as the situation evolves. Please ensure you have the latest version from our website. See the Victorian COVID-19 health services and general practice - coronavirus disease (COVID-19) (https://web.archive.org/web/20200322215901/https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19) page for current case definition, guidance and testing recommendations

Key messages

- People are prohibited from organising or attending non-essential mass gatherings, or to allow them to occur on premises they own, control or operate. Venues that don't comply with these new directions on mass gatherings face fines of up to $100,000. People who don't comply face fines of up to $20,000.
- The Victorian Government is working with the Australian Government to ensure that all vital personal protective equipment supplies are appropriately distributed to where they are needed across the Victorian health system.
- The Victorian Government has declared a State of Emergency in Victoria.
- The State of Emergency (/web/20200322215901/https://www.dhhs.vic.gov.au/state-emergency) provides the Chief Health Officer with powers to enforce 14-day quarantine for all Australians returning to Australia and to do whatever is necessary to contain the spread of the virus and reduce the risk to the health of Victorians.
- Notification is required, by telephone, for all confirmed cases via 1300 651 160, immediately 24 hours per day.
- From 9pm 20 March 2020, any Australians returning from any country outside Australia should now be considered at risk and are required to self-isolate for 14 days.
- All close contacts of confirmed cases will be contacted by the department and told to home quarantine for 14 days.
- Any healthcare or residential aged care worker with a fever or respiratory symptoms should be tested.
- All Australians are now advised not to travel overseas at this time regardless of destination, age or health.

- Anyone arriving in Australia from overseas, including Australian citizens and permanent residents will be required to self-isolate for 14 days from the date of arrival.

More information

Clinical information

Health services and general practice - coronavirus disease (COVID-19) (https://web.archive.org/web/20200322215901/https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19)

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About Coronavirus (COVID-19) - information for the general public (https://web.archive.org/web/20200322215901/https://www.dhhs.vic.gov.au/victorian-public-coronavirus-disease-covid-19)

World Health Organization - health topic - Coronavirus (https://web.archive.org/web/20200322215901/https://www.who.int/health-topics/coronavirus)

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Coronavirus COVID-19 daily update

> This Chief Health Officer update is intended to provide clinicians and the Victorian public with information about the number of confirmed cases of COVID-19 in Victoria as well as relevant public health response activities in Victoria. Chief Health Officer Alerts will continue to be issued when there are changes to the public health advice related to COVID-19.

23/03/2020

What's new?

- As of 0930hrs 23 March 2020, Victoria has 355 total confirmed cases, and no deaths.
- Overnight the Prime Minister and the Chief Medical Officer announced significant new restrictions on gatherings. The Victoria Government will be working to implement these restrictions over the coming weeks and months.
- Victoria implement a shutdown of all non-essential activity across the state at 1200 today.
- Essential services include health services, supermarkets, banks, pharmacies, petrol stations and convenience stores. Freight, logistics and home delivery are also considered essential and will remain open.
- School holidays will be brought forward in Victoria, starting on Tuesday 24 March.
- New restrictions have been introduced to reduce the spread of coronavirus into hospitals by people who may pose a risk and do not have an important reason to be there.

Additional directions for non-essential business, aged care facilities and mass gatherings

- A direction for non-essential business closure (https://web.archive.org/web/20200324085416/https://www.dhhs.vic.gov.au/sites/default/files/documents/202003/Dire Non-Essential-Business-Closure.pdf) was signed by the Deputy Chief Health Officer today in accordance with emergency powers arising from the declared state of emergency. This direction states a person who owns, controls or operates a non-essential business or undertaking in Victoria must not operate from noon on 23 March 2020.

direction-mass-gatherings-2)that were signed on 21 March 2020. The Aged Care Directions (https://web.archive.org/web/20200324085416/https://www.dhhs.vic.gov.au/sites/default/files/documents/202003/Age make provision for restricted access to residential aged care facilities to limit the spread of COVID-19 within a particularly vulnerable population.

Additional directions for aged care facilities and mass gatherings

- Additional directions for aged care (/web/20200324085416/https://www.dhhs.vic.gov.au/state-emergency-direction-aged-care) and mass gatherings (/web/20200324085416/https://www.dhhs.vic.gov.au/state-emergency-direction-mass-gatherings-2) were signed by the Deputy Chief Health Officer in accordance with emergency powers arising from the declared state of emergency on 21 March 2020. The Aged Care Directions (/web/20200324085416/https://www.dhhs.vic.gov.au/state-emergency-direction-aged-care) make provision for restricted access to residential aged care facilities to limit the spread of COVID-19 within a particularly vulnerable population.
- The Mass Gatherings Directions (no 2) (/web/20200324085416/https://www.dhhs.vic.gov.au/state-emergency-direction-mass-gatherings-2) replace the mass gatherings Directions made on 18 March 2020. These directions prohibit non-essential mass-gatherings in order to limit the spread of COVID-19.

Updated GP quick reference guide and the Guidelines for health services and practitioners

The Quick Reference guide and the guidelines for health services and practitioners are continuously updated as the situation evolves. Please ensure you have the latest version from our website. See the Victorian COVID-19 website (/web/20200324085416/https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19) for current case definition, guidance and testing recommendations.

Restrictions on hospital visitors and workers

New restrictions have been introduced to reduce the spread of coronavirus into hospitals by people who may pose a risk and do not have an important reason to be there.

All visitors can expect to be screened on entry and cannot visit if they:

- have been diagnosed with coronavirus and have not been discharged from isolation
- have arrived in Australia within 14 days of your planned visit
- have recently come into contact with a person who has a confirmed case of coronavirus
- have a temperature over 37.5 degrees or symptoms of acute respiratory infection.

The only people who may enter hospitals for work purposes are:

- a person who is an employee or contractor of the hospital
- a student under the supervision of an employee or contractor of the hospital
- a person providing health, medical or pharmaceutical goods or services to a patient of the hospital (whether paid or voluntary)
- a person providing goods or services necessary for the effective operation of the hospital (whether paid or voluntary)
- union and employer representatives
- a person involved in emergency management or law enforcement
- a person who enters an area of the hospital exempted from the restriction.

- People are prohibited from organising or attending non-essential mass gatherings, or to allow them to occur on premises they own, control or operate. Venues that don't comply with these new directions on mass gatherings face fines of up to $100,000. People who don't comply face fines of up to $20,000.
- The Victorian Government is working with the Australian Government to ensure that all vital personal protective equipment supplies are appropriately distributed to where they are needed across the Victorian health system.
- The Victorian Government has declared a State of Emergency in Victoria.
- The State of Emergency (/web/20200324085416/https://www.dhhs.vic.gov.au/state-emergency) provides the Chief Health Officer with powers to enforce 14-day quarantine for all Australians returning to Australia and to do whatever is necessary to contain the spread of the virus and reduce the risk to the health of Victorians.
- Notification is required, by telephone, for all confirmed cases via 1300 651 160, immediately 24 hours per day.
- From 9pm 20 March 2020, any Australians returning from any country outside Australia should now be considered at risk and are required to self-isolate for 14 days.
- All close contacts of confirmed cases will be contacted by the department and told to home quarantine for 14 days.
- Any healthcare or residential aged care worker with a fever or respiratory symptoms should be tested.
- All Australians are now advised not to travel overseas at this time regardless of destination, age or health.
- Australians who are already overseas and wish to return home are advised to return as soon as possible.
- Anyone arriving in Australia from overseas, including Australian citizens and permanent residents will be required to self-isolate for 14 days from the date of arrival.

More information

Clinical information

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Coronavirus COVID-19 daily update

> This Chief Health Officer update is intended to provide clinicians and the Victorian public with information about the number of confirmed cases of COVID-19 in Victoria as well as relevant public health response activities in Victoria. Chief Health Officer Alerts will continue to be issued when there are changes to the public health advice related to COVID-19.

> **25/03/2020**

What's new?

- As of 00:01hrs 25 March 2020, Victoria has 466 total confirmed cases, including 2 in intensive care and no deaths.
- The shutdown of all non-essential activity across the state commended at midday 23 March.
- The Prime Minister and the Chief Medical Officer announced further restrictions on businesses and places of gatherings which will come into effect from midnight 25 March.
- From midnight 25 March, no further category three surgeries will take place in public hospitals in Victoria.
- Up-to-date epidemiological data (https://web.archive.org/web/20200326111638/https://app.powerbi.com/view?r=eyJrIjoiODBmMmE3NWQtZWNlNC00OWRkLTk1NjYtMjM2YTY1MjI2NzdjIiwidCI6ImMwZTA2MDFmLTBmYWMtNDQ5Y) is now available on our website.
- Physical (social) distancing measures should be consistently applied, including clinical settings. The rule of 1 person for every 4 square metres must be to ensure a safe physical distance.

Current directions arising from the declared state of emergency

- A direction for hospital visitors (/web/20200326111638/https://www.dhhs.vic.gov.au/hospital-visitors-direction-signed)was signed on 23 March 2020. This direction prohibits non-essential visits to hospitals.
- A direction for non-essential business closure (/web/20200326111638/https://www.dhhs.vic.gov.au/direction-non-essential-business-closure) was signed on 23 March 2020. This direction states a person who owns, controls or operates a non-essential business or undertaking in Victoria must not operate from noon on 23 March 2020.

(/web/20200326111638/https://www.dhhs.vic.gov.au/state-emergency-direction-aged-care) make provision for restricted access to residential aged care facilities to limit the spread of COVID-19 within a particularly vulnerable population.

Key messages

- Victoria implemented a shutdown of all non-essential activity across the state on 23 March, these restrictions will be expanded from midnight 25 March in line with national recommendations just announced.
- Essential services include health services, supermarkets, banks, pharmacies, petrol stations and convenience stores. Freight, logistics and home delivery are also considered essential and will remain open.
- New restrictions on hospital visitors and workers have been introduced to reduce the spread of coronavirus. Visitors can expect to be screened on entrance and will not be allowed to visit if they meet risk criteria including having a temperature or symptoms of acute respiratory infection.
- Notification is required, by telephone, for all confirmed cases via 1300 651 160, immediately 24 hours per day.
- All close contacts of confirmed cases will be contacted by the department and told to home quarantine for 14 days.
- Victoria will expand its dedicated contact tracing services. From 26 March messages to close contacts will be sent via a new platform called Whisper, which will tell the person to respond back to the contact tracing team confirming they are self-isolating at home.
- Any healthcare or residential aged care worker with a fever or respiratory symptoms should be tested.
- The government is encouraging the community to limit their day-to-day activities outside their homes.
- Additional PPE and testing equipment is due to arrive in the coming weeks.

More information

Clinical information

Health services and general practice - coronavirus disease (COVID-19) (https://web.archive.org/web/20200326111638/https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19)

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Coronavirus COVID-19 daily update

> This Chief Health Officer update is intended to provide clinicians and the Victorian public with information about the number of confirmed cases of COVID-19 in Victoria as well as relevant public health response activities in Victoria. Chief Health Officer Alerts will continue to be issued when there are changes to the public health advice related to COVID-19.

> **28/03/2020**

What's new?

Developments in the outbreak

- As of 4 pm, 28 March 2020, Victoria has 685 total confirmed cases, 21 people are in hospitals including three people in intensive care. Three people have died. Almost two-thirds of cases are directly linked to overseas travel, and 21 were locally acquired with no known link to overseas travel or another confirmed case. In total 191 people have recovered.
- Doctors are encouraged to remind all patients that they should stay at home unless going to medical appointments or performing essential tasks.
- This week Australia recorded 3000 cases. That is expected to increase significantly within weeks unless people stay at home.
- If testing health care workers, doctors are reminded to clearly mark pathology slips with 'HCW' to ensure the swabs can be easily identified for priority testing.
- Doctors are reminded to ensure they include a mobile contact number for patients who have been tested on pathology slips
- Up-to-date epidemiological data (https://web.archive.org/web/20200328101539/https://app.powerbi.com/view?r=eyJrIjoiODBmMmE3NWQtZWNlNC00OWRkLTk1NjYtMjM2YTY1MjI2NzdjIiwidCI6ImMwZTA2MDFmLTBmYWMtNDQ5Y) is available on our website.
- From midnight 25 March, category three surgeries will not take place in public hospitals in Victoria until further notice.

Current directions arising from the declared state of emergency

- A direction for non-essential activity (No 2) (/web/20200328101539/https://www.dhhs.vic.gov.au/directions-non-essential-activities-no-2) was signed on 26 March 2020. This direction prohibits the operation of non-essential businesses and undertakings to slow the spread of coronavirus (COVID-19). These directions update the non-essential activity direction from 25 March.
- A prohibited gatherings directions (/web/20200328101539/https://www.dhhs.vic.gov.au/direction-prohibited-gatherings)was signed on 25 March 2020. This direction replaces the direction given on 22 March, adding two new categories, namely social sports gatherings and weddings and funerals.
- An isolation (diagnosis) direction (/web/20200328101539/https://www.dhhs.vic.gov.au/isolation-diagnosis-direction) was signed on 25 March 2020. This direction requires anyone diagnosed with coronavirus (COVID-19) to isolate at home or another suitable location to slow the spread of the disease.
- A direction for hospital visitors (/web/20200328101539/https://www.dhhs.vic.gov.au/hospital-visitors-direction-signed) was signed on 23 March 2020. This direction prohibits non-essential visits to hospitals.
- This follows directions for aged care (/web/20200328101539/https://www.dhhs.vic.gov.au/state-emergency-direction-aged-care), airport arrivals (/web/20200328101539/https://www.dhhs.vic.gov.au/state-emergency-direction-airport-arrivals) and cruise ships (/web/20200328101539/https://www.dhhs.vic.gov.au/state-emergency-direction-cruise-ships-docking) docking that were signed on 21 March 2020. The Aged Care Directions (/web/20200328101539/https://www.dhhs.vic.gov.au/state-emergency-direction-aged-care)make provision for restricted access to residential aged care facilities to limit the spread of COVID-19 within a particularly vulnerable population.

Key messages

Quarantine for Australians arriving in Melbourne from overseas

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

Supporting healthcare workers

- It's everyone's responsibility to support essential healthcare workers – such as doctors and nurses – to stay at work during the coronavirus (COVID-19) outbreak.
- Healthcare workers may need extra help to ensure their children have care so they can work during this period.
- Where possible, partners of essential healthcare workers – who are not healthcare workers themselves – should support them to continue working by taking care of children.
- Older people – such as grandparents – and other at-risk groups should not be engaged as carers to reduce their risk of infection.
- Victoria has expanded its dedicated contact tracing services. From 26 March messages to close contacts are sent via a new platform called Whispr, which requires the person to respond back to the contact tracing team confirming they are isolating at home.,
- Any healthcare or residential aged care worker with a fever or respiratory symptoms must be tested.
- Additional personal protective equipment and testing equipment are due to arrive in the coming weeks.

New Orders for Pharmacists and Prescription medications

- Pharmacists can supply prescription medications without a prescription for one month in emergency circumstances except for Schedule 8 medicines.
- Doctors prescribing Schedule 8 medicines for non-drug dependent patients will not be required to apply for a Schedule 8 treatment permit for the next six months, but instead, check SafeScript.
- Practitioners will need to apply for Schedule 8 treatment permits for drug dependent patients, including opioid replacement therapy.

- During the pandemic, health practitioners should take all reasonable steps to access SafeScript, as it is very effective in providing up-to-date information about a patient's prescribing and dispensing history.

More information

Clinical information

Health services and general practice - coronavirus disease (COVID-19) (https://web.archive.org/web/20200328101539/https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19)

Consumer information

About Coronavirus (COVID-19) - information for the general public (https://web.archive.org/web/20200328101539/https://www.dhhs.vic.gov.au/victorian-public-coronavirus-disease-covid-19)

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> **30/03/2020**

What's new?

Developments in the outbreak

- As of 1pm, 30 March 2020, Victoria has 821 total confirmed cases, 29 people are in hospitals including four people in intensive care. Four people have died. Almost two thirds of cases are directly linked to overseas travel, and 26 were locally acquired with no know link to overseas travel or another confirmed case. In total, 248 people have recovered.
- Of the total 821 cases, there have been 653 in metropolitan Melbourne and 146 in regional Victoria. A number of cases remain under investigation.
- This week, Australia's total exceeded 3000 cases. That is expected to increase significantly in coming weeks unless people stay at home.
- Doctors, nurses, midwives and mental health professionals can deliver temporary Medicare Benefits Schedule and Department of Veterans' Affairs items via telehealth, provided those services are bulk billed.
- Doctors are encouraged to remind all patients that they should stay at home unless going to medical appointments or performing essential tasks.
- If testing health care workers, doctors are reminded to clearly mark pathology slips with 'HCW' to ensure the swabs can be easily identified for priority testing.
- Doctors are reminded to ensure they include a mobile contact number on pathology slips for patients who have been tested.

- Physical (social) distancing measures should be consistently applied, if at all possible, including in clinical settings. The rule of 1 person for every 4 square metres must be maintained to ensure a safe physical distance.

Current directions arising from the declared state of emergency

- A direction to detain (/web/20200330173513/https://www.dhhs.vic.gov.au/state-emergency-direction-and-detention-notice) all people arriving in Victoria on or after midnight was signed on 28 March 2020. This direction allows anyone arriving from overseas to be placed in mandatory quarantine for 14 days in a nominated accommodation facility. This direction supersedes the previous airport and cruise ship directions (/web/20200330173513/https://www.dhhs.vic.gov.au/state-emergency-direction-revocation-airport-arrivals-and-cruise-ships-directions), which have now been revoked.
- A direction for non-essential activity (No 2) (/web/20200330173513/https://www.dhhs.vic.gov.au/directions-non-essential-activities-no-2) was signed on 26 March 2020. This direction prohibits the operation of non-essential businesses and undertakings to slow the spread of coronavirus (COVID-19). These directions update the non-essential activity direction from 25 March.
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Key messages

Quarantine for Australians arriving in Melbourne from overseas

- People aged over 70, aged over 60 with pre-existing conditions, or Indigenous people aged over 50 should stay home wherever possible for their own protection.
- As of midnight, 28 March 2020, all travellers arriving into Melbourne from overseas will be quarantined for two weeks in hotel rooms and other accommodation facilities.
- Interstate travellers can only return to their home states after fulfilling the mandatory 14-day quarantine requirements.

Supporting healthcare workers

- It's everyone's responsibility to support essential healthcare workers – such as doctors and nurses – to stay at work during the coronavirus (COVID-19) outbreak.
- Healthcare workers may need extra help to ensure their children have care so they can work during this period.
- Where possible, partners of essential healthcare workers – who are not healthcare workers themselves – should support them to continue working by taking care of children.

- Victoria has expanded its dedicated contact tracing services. From 26 March messages to close contacts are sent via a new platform called Whispr, which requires the person to respond back to the contact tracing team confirming they are isolating at home.
- Any healthcare or residential aged care worker with a fever or respiratory symptoms must be tested.

New Orders for Pharmacists and Prescription medications

- Two public health emergency orders came into effect on 26 March and can be found here:
- http://www.gazette.vic.gov.au/gazette/Gazettes2020/GG2020S158.pdf (https://web.archive.org/web/20200330173513/http://www.gazette.vic.gov.au/gazette/Gazettes2020/GG2020S158.pdf)
- Pharmacists can supply prescription medications without a prescription for one month in emergency circumstances except for Schedule 8 medicines.
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Clinical information

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Consumer information

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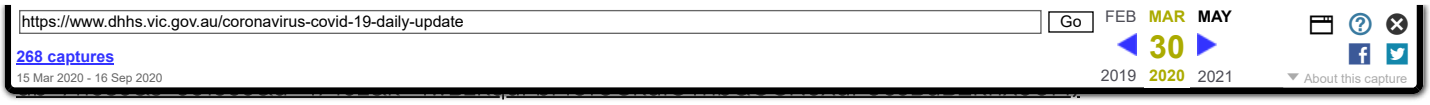

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Coronavirus COVID-19 daily update

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> **01/04/2020**

What's new?

Developments in the outbreak

- As of 1 April 2020, Victoria has 968 total confirmed cases, 26 people are in hospitals including six people in intensive care. Four people have died. Almost two thirds of cases are directly linked to overseas travel, and 39 were locally acquired with no know link to overseas travel or another confirmed case. In total, 343 people have recovered.
- Of the total 968 cases, there have been 771 in metropolitan Melbourne and 183 in regional Victoria. A number of cases remain under investigation.
- This week, Australia's total exceeded 4000 cases. That is expected to increase significantly in coming weeks unless people stay at home.
- A CHO alert was issued today – see the full alert here (https://web.archive.org/web/20200401222328/https://www2.health.vic.gov.au/about/news-and-events/HealthAlerts/2019%20Coronavirus%20disease%20-COVID-19).
- The case definition has changed. See the Health services and general practice - coronavirus disease (COVID-19) (https://web.archive.org/web/20200401222328/https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19) page for updated information, including new Quick Reference Guide and Guidelines for health services and general practitioners.
- Doctors, nurses, midwives and mental health professionals can deliver temporary Medicare Benefits Schedule and Department of Veterans' Affairs items via telehealth, provided those services are bulk billed.

- If testing health care workers, doctors are reminded to clearly mark pathology slips with 'HCW' to ensure the swabs can be easily identified for priority testing.
- Doctors are reminded to ensure they include a mobile contact number on pathology slips for patients who have been tested.
- Up-to-date epidemiological data (https://web.archive.org/web/20200401222328/https://app.powerbi.com/view?r=eyJrIjoiODBmMmE3NWQtZWNlNC00OWRkLTk1NjYtMjM2YTY1MjI2NzdjIiwidCI6ImMwZTA2MDFmLTBmYWMtNDQ5Y) is available on our website.
- Physical (social) distancing measures should be consistently applied, if at all possible, including in clinical settings. The rule of 1 person for every 4 square metres must be maintained to ensure a safe physical distance.

Current directions arising from the declared state of emergency

- A stay at home direction (/web/20200401222328/https://www.dhhs.vic.gov.au/stay-home-directions) was signed on 30 March 2020, ordering anyone in Victoria to stay at their usual place of residence, other than to work or study, buy essential goods or services, medical care or compassionate needs or exercise in accordance with public gathering guidelines. This direction replaces the Prohibited Gatherings direction.
- A restricted activity directio (/web/20200401222328/https://www.dhhs.vic.gov.au/restricted-activity-directions)n was signed on 30 March 2020, replacing the non-essential activity directions given on 25 March 2020. The new direction bans escort agencies and closes playgrounds, skateparks and outdoor communal gym equipment.
- A direction to detain (/web/20200401222328/https://www.dhhs.vic.gov.au/state-emergency-direction-and-detention-notice) all people arriving in Victoria on or after midnight was signed on 28 March 2020. This direction allows anyone arriving from overseas to be placed in mandatory quarantine for 14 days in a nominated accommodation facility. This direction supersedes the previous airport and cruise ship directions (/web/20200401222328/https://www.dhhs.vic.gov.au/state-emergency-direction-revocation-airport-arrivals-and-cruise-ships-directions), which have now been revoked.
- A direction for non-essential activity (No 2) (/web/20200401222328/https://www.dhhs.vic.gov.au/restricted-activity-directions) was signed on 26 March 2020. This direction prohibits the operation of non-essential businesses and undertakings to slow the spread of coronavirus (COVID-19). These directions update the non-essential activity direction from 25 March.
- A prohibited gatherings directions (/web/20200401222328/https://www.dhhs.vic.gov.au/direction-prohibited-gatherings) was signed on 25 March 2020. This direction replaces the direction given on 22 March, adding two new categories, namely social sports gatherings and weddings and funerals.
- An isolation (diagnosis) direction (/web/20200401222328/https://www.dhhs.vic.gov.au/isolation-diagnosis-direction) was signed on 25 March 2020. This direction requires anyone diagnosed with coronavirus (COVID-19) to isolate at home or another suitable location to slow the spread of the disease.
- A direction for hospital visitors (/web/20200401222328/https://www.dhhs.vic.gov.au/hospital-visitors-direction-signed) was signed on 23 March 2020. This direction prohibits non-essential visits to hospitals.
- This follows a direction for aged care, which was signed on 21 March 2020. The Aged Care Directions (/web/20200401222328/https://www.dhhs.vic.gov.au/state-emergency-direction-aged-care) make provision for restricted access to residential aged care facilities to limit the spread of COVID-19 within a particularly vulnerable population.

Key messages

Investing in healthcare

The Victorian Government is investing $1.3 billion in our healthcare sector to deliver additional capacity to manage the COVID-19 response. This will include:

- 4,000 ICU beds in addition to our existing 500 ICU beds

- Additional personal protective equipment including 551 million gloves, 100 million masks and 14.5 million gowns will be provided to healthcare professionals
- This funding is in addition to the $537 million already invested in the healthcare system as part of the COVID 19 response.

Additional capacity is being delivered commencing with refurbishment of the old Peter MacCallum Cancer Centre.

New rules for overseas arrivals

- Two thirds of confirmed coronavirus (COVID-19) cases to date are a result of transmission from overseas arrivals to their close contacts.
- All travellers arriving into Australia from overseas will now be placed in quarantine for 14-days to slow the spread of coronavirus.
- Returning travellers are being housed in hotels, motels, caravan parks, and student accommodation.
- States and territories are enforcing the 14-day quarantine period with support from the Commonwealth and Australian Defence Force (ADF).
- The costs of accommodation, public health and security are being covered by each individual jurisdiction.
- Those in quarantine are receiving care packages of food and other essentials during this time.
- Travellers returning from overseas are being housed in the state or territory they initially arrive in for 14 days.
- Victoria currently has 5,000 hotel beds available for travellers returning from overseas and is working with the hospitality sector to ensure that adequate and appropriate accommodation is available.
- Each newly returned traveller in compulsory quarantine in a hotel is receiving a care package of food and other essentials.
- Skybus is supplying 85 buses to transfer people arriving at the airport to their accommodation.
- Note: all international passengers that arrived at a Victorian airport prior to 28 March 2020 must self-quarantine for 14 days.

Hospital and aged-care restrictions

- Emergency powers under the Public Health and Wellbeing Act 2008 have been enacted to limit visits to patients in hospitals to partners, parents or guardians or care and support people.
- And the following people are not allowed to visit a hospital:
    - recently returned travellers
    - a person who has a confirmed case of coronavirus (COVID-19)
    - a person who has been in contact with a person who has a confirmed case of coronavirus (COVID-19) or
    - a person with a high-temperature or symptoms of acute respiratory illness.
- Visits to residents of aged care facilities are now restricted to two people per day for a short duration. Exceptions to this rule will be made for people receiving palliative care.
- Children under the age of 16 will only be permitted to visit aged care facilities in exceptional circumstances.
- These directions will be enforced by the Commonwealth Government.

Supporting healthcare workers

- It's everyone's responsibility to support essential healthcare workers – such as doctors and nurses – to stay at work during the coronavirus (COVID-19) outbreak.
- Healthcare workers may need extra help to ensure their children have care so they can work during this period.

- Older people – such as grandparents – and other at-risk groups should not be engaged as carers to reduce their risk of infection.

Health workforce response – expressions of interest

- Clinical and non-clinical healthcare workers are being asked to express their interest in working within the Victorian health system as part of the response to coronavirus (COVID-19).
- Visit https://healthworkforceresponse.dhhs.vic.gov.au/ (https://web.archive.org/web/20200401222328/https://healthworkforceresponse.dhhs.vic.gov.au/) for more information.

New orders for pharmacists and prescription medications

- During coronavirus (COVID-19), pharmacists can supply prescription medications without a prescription for one month in emergency circumstances except for Schedule 8 medicines.
- Doctors prescribing Schedule 8 medicines for non-drug dependent patients will not be required to apply for a Schedule 8 treatment permit for the next six months, but instead check SafeScript.
- Practitioners will need to apply for Schedule 8 treatment permits for drug dependent patients, including opioid replacement therapy.
- During the pandemic health practitioners should take all reasonable steps to access SafeScript, as it is a very effective in providing up-to-date information about a patient's prescribing and dispensing history.
- Two new public health emergency orders have come into effect and can be found here: http://www.gazette.vic.gov.au/gazette/Gazettes2020/GG2020S158.pdf (https://web.archive.org/web/20200401222328/http://www.gazette.vic.gov.au/gazette/Gazettes2020/GG2020S158.pdf)

More information

Clinical information

Health services and general practice - coronavirus disease (COVID-19) (https://web.archive.org/web/20200401222328/https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19)

Consumer information

About Coronavirus (COVID-19) - information for the general public (https://web.archive.org/web/20200401222328/https://www.dhhs.vic.gov.au/victorian-public-coronavirus-disease-covid-19)

World Health Organization - health topic - Coronavirus (https://web.archive.org/web/20200401222328/https://www.who.int/health-topics/coronavirus)

Smartraveller website (https://web.archive.org/web/20200401222328/https://www.smartraveller.gov.au/)

Contacts

A public information hotline is provided by Health Direct – 1800 675 398.

Medical practitioners needing clinical information or to notify suspected or confirmed cases can contact the Department of Health and Human Services Communicable Diseases Section on 1300 651 160 (24 hours).

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information including Chief Health Officer updates and emergency advice from the Department of Health and Human Services.

Follow the Chief Health Officer on Twitter (https://web.archive.org/web/20200401222328/https://twitter.com/VictorianCHO)

Subscribe to the COVID-19 stakeholder newsletter (https://web.archive.org/web/20200401222328/https://www.vision6.com.au/em/forms/subscribe.php?db=711689&s=361339&a=47492&k=4wB2KquFbMUfUCKdiOYnbQOCN3XdFUc5BdBZKhX0Ui4)

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The department acknowledges Aboriginal and Torres Strait Islander people as the Traditional Custodians of the land and acknowledges and pays respect to their Elders, past and present.

The department is committed to safe and inclusive work places, policies and services for people of LGBTIQ communities and their families.

Coronavirus COVID-19 daily update

> This Chief Health Officer update is intended to provide clinicians and the Victorian public with information about the number of confirmed cases of COVID-19 in Victoria as well as relevant public health response activities in Victoria. Chief Health Officer Alerts will continue to be issued when there are changes to the public health advice related to COVID-19.

> **02/04/2020**

What's new?

Developments in the outbreak

- As of 2 April 2020, Victoria has 1,036 total confirmed cases, 30 people are in hospitals including six people in intensive care. five people have died. 60% of cases are directly linked to overseas travel, and 57 were locally acquired (in Victoria) with no know link to overseas travel or another confirmed case. In total, 422 people have recovered.
- Of the total 1,036 cases, there have been 828 in metropolitan Melbourne and 193 in regional Victoria. A number of cases remain under investigation.
- This week, Australia's total exceeded 4,500 cases. That is expected to increase significantly in coming weeks unless people stay at home.
- The case definition has changed. See the Health services and general practice - coronavirus disease (COVID-19) (https://web.archive.org/web/20200402230041/https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19) page for updated information, including new Quick Reference Guide and Guidelines for health services and general practitioners. With reducing numbers of returning travellers, Victoria's testing criteria will now focus on an expanded range of frontline healthcare workers to include paid or unpaid workers in healthcare, residential care, disability care, homelessness support and child protection workers, as well as police officers
- Doctors, nurses, midwives and mental health professionals can deliver temporary Medicare Benefits Schedule and Department of Veterans' Affairs items via telehealth, provided those services are bulk billed.

- If testing health care workers, doctors are reminded to clearly mark pathology slips with 'HCW' to ensure the swabs can be easily identified for priority testing.
- Doctors are reminded to ensure they include a mobile contact number on pathology slips for patients who have been tested.
- Up-to-date epidemiological data (https://web.archive.org/web/20200402230041/https://app.powerbi.com/view?r=eyJrIjoiODBmMmE3NWQtZWNlNC00OWRkLTk1NjYtMjM2YTY1MjI2NzdjIiwidCI6ImMwZTA2MDFmLTBmYWMtNDQ5Y) is available on our website.
- Physical (social) distancing measures should be consistently applied, if at all possible, including in clinical settings. The rule of 1 person for every 4 square metres must be maintained to ensure a safe physical distance.

Current directions arising from the declared state of emergency

- A stay at home direction (/web/20200402230041/https://www.dhhs.vic.gov.au/stay-home-directions) was signed on 30 March 2020, ordering anyone in Victoria to stay at their usual place of residence, other than to work or study, buy essential goods or services, medical care or compassionate needs or exercise in accordance with public gathering guidelines. This direction replaces the Prohibited Gatherings direction.
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Key messages

Healthcare system

- A deal has been struck to ensure the state's major private hospital operators to ensure they can continue to care for Victorians during the coronavirus pandemic.
- The deal will see Victoria's public and private hospitals work together to relieve pressure on public hospitals and ensure the entire health system is operating at full capacity.

Flu Vaccinations

- From 1 April, Victorian pharmacists can administer approved vaccinations outside of their normal location – through the mobile and outreach services of a hospital, pharmacy or pharmacy depot, increasing access to immunisations for all Victorians.
- It is also easier for younger Victorians to get these immunisations from their local pharmacy. Appropriately trained pharmacists can now administer the flu shot to children 10 years of age and older.
- Pharmacists will also be able to administer the measles-mumps-rubella, meningococcal ACWY and whooping cough-containing vaccines to people 15 years of age and older – protecting young people from deadly diseases that, combined with the threat of coronavirus, could overwhelm the state's hospitals.

Hospital and aged-care restrictions

Emergency powers under the Public Health and Wellbeing Act 2008 have been enacted to limit visits to patients in hospitals to partners, parents or guardians or care and support people.
And the following people are not allowed to visit a hospital:

- recently returned travellers
- a person who has a confirmed case of coronavirus (COVID-19)
- a person who has been in contact with a person who has a confirmed case of coronavirus (COVID-19) or
- a person with a high-temperature or symptoms of acute respiratory illness.

- Visits to residents of aged care facilities are now restricted to two people per day for a short duration. Exceptions to this rule will be made for people receiving palliative care.
- Children under the age of 16 will only be permitted to visit aged care facilities in exceptional circumstances.

These directions will be enforced by the Commonwealth Government.

Supporting healthcare workers

- It's everyone's responsibility to support essential healthcare workers – such as doctors and nurses – to stay at work during the coronavirus (COVID-19) outbreak.
- Healthcare workers may need extra help to ensure their children have care so they can work during this period.
- Where possible, partners of essential healthcare workers – who are not healthcare workers themselves – should support them to continue working by taking care of children.
- Older people – such as grandparents – and other at-risk groups should not be engaged as carers to reduce their risk of infection.
- Health workforce response – expressions of interest
- Clinical and non-clinical healthcare workers are being asked to express their interest in working within the Victorian health system as part of the response to coronavirus (COVID-19).
- Visit https://healthworkforceresponse.dhhs.vic.gov.au/ (https://web.archive.org/web/20200402230041/https://healthworkforceresponse.dhhs.vic.gov.au/) for more information.

Health workforce response – expressions of interest

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More information

Clinical information

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Consumer information

About Coronavirus (COVID-19) - information for the general public (https://web.archive.org/web/20200402230041/https://www.dhhs.vic.gov.au/victorian-public-coronavirus-disease-covid-19)

World Health Organization - health topic - Coronavirus (https://web.archive.org/web/20200402230041/https://www.who.int/health-topics/coronavirus)

Smartraveller website (https://web.archive.org/web/20200402230041/https://www.smartraveller.gov.au/)

Contacts

A public information hotline is provided by Health Direct – 1800 675 398.

Medical practitioners needing clinical information or to notify suspected or confirmed cases can contact the Department of Health and Human Services Communicable Diseases Section on 1300 651 160 (24 hours).

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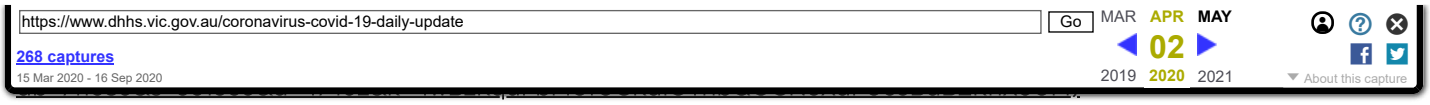

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Contact

Address: 50 Lonsdale Street
Melbourne, Victoria, Australia
3000

Phone: 1300 650 172 (https://web.archive.org/web/20200402230041/tel:1300 650 172)



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Coronavirus COVID-19 daily update

> This Chief Health Officer update is intended to provide clinicians and the Victorian public with information about the number of confirmed cases of COVID-19 in Victoria as well as relevant public health response activities in Victoria. Chief Health Officer Alerts will continue to be issued when there are changes to the public health advice related to COVID-19.

> **04/04/2020**

What's new?

Developments in the outbreak

- As of 4 April 2020, Victoria has 1,115 total confirmed cases (an increase of 30 since yesterday), 42 people are in hospitals including 10 people in intensive care. Sadly, eight people have died. 73 cases in Victoria have been identified from an unknown source (an increase of 11 since yesterday). In total, 527 people have recovered.
- Of the total 1,115 cases, there have been 894 in metropolitan Melbourne and 209 in regional Victoria. A number of cases remain under investigation.
- The total number of cases in Australia is currently 5,380. That is expected to increase significantly in coming weeks unless people stay at home.
- Up-to-date epidemiological data (https://web.archive.org/web/20200404110405/https://app.powerbi.com/view?r=eyJrIjoiODBmMmE3NWQtZWNlNC00OWRkLTk1NjYtMjM2YTY1MjI2NzdjIiwidCI6ImMwZTA2MDFmLTBmYWMtNDQ5Y) is available on our website.
- The Victorian Government now has 1000 people working-around-the-clock on contact tracing.
- New COVID-19 resources have been developed to provide guidance to GPs and health services including chronic disease management (https://web.archive.org/web/20200404110405/https://www.dhhs.vic.gov.au/factsheet-chronic-disease-management-coronavirus), palliative and end of life care (https://web.archive.org/web/20200404110405/https://www.dhhs.vic.gov.au/factsheet-palliative-and-end-life-care-coronavirusdocx), and advice for immunisations services.
- New mental health and wellbeing (https://web.archive.org/web/20200404110405/https://www.dhhs.vic.gov.au/mental-health-resources-coronavirus-

(https://web.archive.org/web/20200404110405/https://www.dhhs.vic.gov.au/coronavirus-stay-home-and-restricted-activities-directions-faq) directions has been developed and published on our website.

Updated advice to clinicians

- Deaths due to confirmed or suspected COVID-19 infection must be notified to the department as soon as possible. Call 1300 651 160 (24 hours, seven days).
- Hospital discharge of confirmed COVID-19 cases can be determined on clinical grounds without prior approval by DHHS. Patients are not required to stay in hospital for the duration of their infectious period.
- If testing health care workers, doctors are reminded to clearly mark pathology slips with 'HCW' to ensure the swabs can be easily identified for priority testing.
- Doctors are reminded to ensure they include a mobile contact number on pathology slips for patients who have been tested.
- Physical (social) distancing measures should be consistently applied, if at all possible, including in clinical settings. The rule of 1 person for every 4 square metres must be maintained to ensure a safe physical distance.

Key messages for the community

- Stay home. Protect the health system. Save lives.
- There are only four reasons to leave home:
  - shopping for what you need - food and essential supplies
  - medical, care or compassionate needs
  - exercise in compliance with the public gathering requirements
  - work and study if you can't work or learn remotely
- We're asking Victorians to stop looking for loopholes. The advice is clear, by staying at home you're saving lives.
- If you are caring for someone with COVID-19, further information is available here (https://web.archive.org/web/20200404110405/https://covid19evidence.net.au/).

Current directions arising from the declared state of emergency

A range of restrictions are in place an include, staying at home, restrictions on particular activities, detention, restrictions on airports and cruise ships, aged care, hospitals and isolation.

These are defined in a list of Directions from the Chief Health Officer are in effect and can be viewed at the department's website (/web/20200404110405/https://www.dhhs.vic.gov.au/state-emergency).

Healthcare system

- Doctors, nurses, midwives and mental health professionals can deliver temporary Medicare Benefits Schedule and Department of Veterans' Affairs items via telehealth, provided those services are bulk billed.
- The Minister for Health has established the Coronavirus (COVID-19) health workforce response website at https://healthworkforceresponse.dhhs.vic.gov.au (https://web.archive.org/web/20200404110405/https://healthworkforceresponse.dhhs.vic.gov.au/) to attract expressions of interest in working in the Victorian health system in both clinical and non-clinical roles. To date, more than 6,000 expressions of interest have been received.

Flu Vaccinations

- From 1 April, Victorian pharmacists can administer approved vaccinations outside of their normal location – through the mobile and outreach services of a hospital, pharmacy or pharmacy depot, increasing access to immunisations for all Victorians.<
- It is also easier for younger Victorians to get these immunisations from their local pharmacy. Appropriately trained pharmacists can now administer the flu shot to children 10 years of age and older.
- Pharmacists will also be able to administer the measles-mumps-rubella, meningococcal ACWY and whooping cough-containing vaccines to people 15 years of age and older – protecting young people from deadly diseases that, combined with the threat of coronavirus, could overwhelm the state's hospitals.

Expanded testing criteria

- With reducing numbers of returning travellers, Victoria's testing criteria will focus on an expanded range of frontline healthcare workers to include paid or unpaid workers in healthcare, residential care, disability care, homelessness support and child protection workers, as well as police officers.

More information

Clinical information

Health services and general practice - coronavirus disease (COVID-19) (https://web.archive.org/web/20200404110405/https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19)

Consumer information

About Coronavirus (COVID-19) - information for the general public (https://web.archive.org/web/20200404110405/https://www.dhhs.vic.gov.au/victorian-public-coronavirus-disease-covid-19)

World Health Organization - health topic - Coronavirus (https://web.archive.org/web/20200404110405/https://www.who.int/health-topics/coronavirus)

Smartraveller website (https://web.archive.org/web/20200404110405/https://www.smartraveller.gov.au/)

Contacts

A public information hotline is provided by Health Direct – 1800 675 398.

Medical practitioners needing clinical information or to notify suspected or confirmed cases can contact the Department of Health and Human Services Communicable Diseases Section on 1300 651 160 (24 hours).

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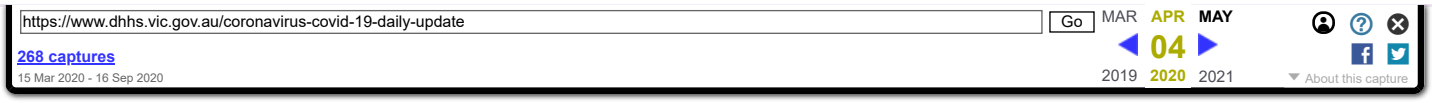

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Back to top

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Coronavirus COVID-19 daily update

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> This Chief Health Officer update is intended to provide clinicians and the Victorian public with information about the number of confirmed cases of COVID-19 in Victoria, a list of current public exposure sites, as well as relevant public health response activities in Victoria. This update will be sent regularly.
>
> Chief Health Officer Alerts will continue to be issued when there are changes to the public health advice related to COVID-19.

> **Chief Health Officer Update 19/03/2020**

What's new

- As of 0930hrs 19 March 2020, Victoria has 150 total confirmed cases, and no deaths.
- From midday on Friday 20 March, medical practitioners seeking advice about COVID-19 (outside of testing and notification procedures) can call 1300 651 160 and choose the

- Notification of suspected cases is no longer required.
- The Prime Minister announced that from 9pm 20 March 2020, Australia will extend its travel ban to include all foreign nationals. This means anyone not an Australian citizen, Australian residents, or their dependents will be denied entry to the country. Australians returning home from overseas will still need to self-quarantine for 14 days from the date they arrive in Australia.
- The Prime Minister also announced on 18 March 2020:
    - All Australians are advised to NOT travel overseas indefinitely.
    - The Governor-General has accepted the Commonwealth Government's recommendation that he declare a "human biosecurity emergency" under the Biosecurity Act 2015 given the risks COVID-19 poses to human health and the need to control its spread in Australia.
    - To lift the restriction on work constraints on student nurses who are in Australia.

Advice on the use of ibuprofen, or other non-steroidal anti-inflammatories

- International health officials are reportedly advising against the use of non-steroidal anti-inflammatory drugs, which includes ibuprofen and aspirin.
- There is little evidence or published studies that show taking ibuprofen, or other non-steroidal anti-inflammatories, leads to an increased risk of complications or death when taken during COVID-19 infection.
- If any evidence emerges to support a different approach our advice will be updated.

Quick reference guide and guidelines for health services and practitioners

- The Quick Reference guide and the guidelines for health services and practitioners are continuously updated as the situation evolves. Please ensure you have the latest version from our website. See the Victorian COVID-19 website for current case definition, guidance and testing recommendations https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19 (https://web.archive.org/web/20200319235831/https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19)

Key messages

- The Victorian Government is working with the Australian Government to ensure that all vital personal protective equipment supplies are appropriately distributed to where they are

- It is critical that clinicians limit testing to patients who meet the suspected case definition and use only one swab when testing.
- The Victorian Government has declared a State of Emergency in Victoria.
- The State of Emergency provides the Chief Health Officer with powers to enforce 14-day isolation for all Australians returning to Australia and to do whatever is necessary to contain the spread of the virus and reduce the risk to the health of Victorians.
- Notification is required, by telephone, for all confirmed cases via 1300 651 160, immediately 24 hours per day.
- From 9pm 20 March 2020, any Australians returning from any country outside Australia should now be considered at risk and are required to self-isolate for 14 days.
- The World Health Organization has characterised COVID-19 as a pandemic.
- We will no longer be providing summaries of public exposure sites as the exposures due to the large volume of exposure sites.
- All close contacts of confirmed cases will be contacted by the department and told to home quarantine for 14 days.

More information

Clinical information

Health services and general practice - coronavirus disease (COVID-19) (https://web.archive.org/web/20200319235831/https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19)

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The department is committed to safe and inclusive work places, policies and services for people of LGBTIQ communities and their families.

More COVID-19 cases confirmed in Victoria

15 Mar 2020

Eight new cases of coronavirus (COVID-19) were confirmed yesterday – bringing the total number of cases in Victoria to 57.

The new cases include six men and two women with ages ranging from their teens to 60s.

One is a student - a known contact of case 17, a teacher from Carey Grammar. The student was not at school during their infectious period. The school will remain closed until the holidays. And, as a precaution, 12 classmates will home-isolate.

All cases are recovering at home in isolation. All were acquired overseas or through close contact with known, confirmed cases of COVID-19.

At the present time, there remains only one confirmed case of COVID-19 in Victoria that may have been acquired through community transmission.

Victorian Chief Health Officer Professor Brett Sutton said we expect to see more and more cases of COVID-19 in Victoria.

“We are reviewing this rapidly evolving situation daily and will continue to provide up-to-date information to the community,” Professor Sutton said.

“I am focused on doing whatever is necessary to minimise the spread of infection and keep Victorians safe.

“For the virus to spread, extended close personal contact is most likely required. All Victorians should be aware of the signs and symptoms of COVID-19. “Close personal contact is at least 15 minutes face-to-face or more than 2 hours in the same room. At the moment, we urge the public to be mindful and take steps to minimise the risk of COVID-19.

“Everyone also has a role to play in protecting yourself and your family. Hands should be washed regularly with soap and water. Cough or sneeze into a tissue or your elbow. If you are ill, stay at home.”

The Department of Health and Human Services follows up and monitors all close contacts of confirmed cases and provides them with information and support. All close contacts must self-isolate for 14-days.

As we now have 57 confirmed cases of coronavirus (COVID-19) in Victorians, we will be moving away from reporting public exposure sites.

Extensive testing has shown that people who have passed through places where there was a confirmed case, known as casual contacts, have an extremely low risk of transmission.

Over a thousand casual contacts have been tested in Victoria to date without any positive findings.

This will help to ensure our hospitals, assessment centres and general practitioners can prioritise testing for those most at risk.

The Victorian Department of Health and Human Services has a hotline for public information on COVID-19 which is 1800 675 398. Large numbers of calls will result in some delays and we ask Victorians for their patience as we work to manage the volume. Further information is also available on **Coronavirus disease (COVID-19) section** on the DHHS website.

Contact details

Media unit

For all health media inquiries, contact our 24 hour media line. Please note this line does not provide health advice.

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50 Lonsdale Street, Melbourne, 3000 Victoria, Australia

Page last reviewed: 15 Mar 2020

https://www2.health.vic.gov.au:443/about/media-centre/mediareleases/more-covid19-cases-confirmed-victoria-15-march

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More COVID-19 cases confirmed in Victoria

17 Mar 2020

Twenty-three new cases of coronavirus (COVID-19) were confirmed yesterday - bringing the total number of cases in Victoria to 94.

The new cases include 11 men and 12 women, with people aged from early twenties to mid-sixties. Sixty-three of Victoria's confirmed cases were acquired overseas or through close contact with known, confirmed cases of COVID-19, and 29 cases are still being investigated.

At the present time, there are two confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission. Currently seven people are recovering in hospital. More than 14,200 Victorians have been tested to date.

Victoria's Chief Health Officer Professor Brett Sutton and the Department of Health and Human Services (DHHS) today recommended the closure of Toorak Primary School for 14 days, as a precaution following confirmation that a staff member at the school has tested positive for COVID-19.

The Department is conducting contact tracing and investigating which staff or students need to self-quarantine, and to determine any further actions required to reduce the risk of infection.

The health advice remains that mass school closures are not needed at this time.

Professor Brett Sutton said we will continue to see more cases of COVID-19 in Victoria.

"We are reviewing this rapidly evolving situation daily and will continue to provide up-to-date information to the community," Professor Sutton said.

"We are all focused on doing whatever is necessary to minimise the spread of infection and keep Victorians safe.

"For the virus to spread, extended close personal contact is most likely required. Close personal contact is at least 15 minutes face-to-face or more than two hours in the same room.

"At the moment, we urge the public to be mindful and take steps to minimise the risk of COVID-19. Everyone has a role to play in protecting yourself and your family. Hands should be washed regularly with soap and water. Cough or sneeze into a tissue or your elbow. If you are ill, stay at home."

The Department of Health and Human Services follows up and monitors all close contacts of confirmed cases and provides them with information and support. All close contacts must self-isolate for 14-days. All people arriving from any international destination must also self-isolate for 14 days as per Commonwealth Government direction.

Extensive testing has shown that people who have passed through places where there was a confirmed case, known as casual contacts, have an extremely low risk of transmission and are not currently recommended for testing. This will help to ensure our hospitals, assessment centres and general practitioners can prioritise testing for those most at risk.

The Victorian Department of Health and Human Services has a hotline for public information on COVID-19 which is 1800 675 398. Large numbers of calls will result in some delays and we ask Victorians for their

patience as we work to manage the volume. Further information is also available at the **DHHS website**.

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https://www2.health.vic.gov.au:443/about/media-centre/mediareleases/more-covid-19-cases-confirmed-in-victoria-17-march-2020

More COVID-19 cases confirmed in Victoria

18 Mar 2020

Twenty-seven new cases of coronavirus (COVID-19) were confirmed yesterday – bringing the total number of cases in Victoria to 121.

The new cases include 14 men and 13 women, with people aged from late teens to early seventies. The Department of Health and Human Services is continuing to investigate all new cases.

At the present time, there are two confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission. Currently six people are recovering in hospital. More than 15,200 Victorians have been tested to date.

Victoria's Chief Health Officer Professor Brett Sutton said we will continue to see more cases of COVID-19 in Victoria.

"We are reviewing this rapidly evolving situation daily and will continue to provide up-to-date information to the community," Professor Sutton said.

"We are all focused on doing whatever is necessary to minimise the spread of infection and keep Victorians safe.

"For the virus to spread, extended close personal contact is most likely required. Close personal contact is at least 15 minutes face-to-face or more than two hours in the same room.

"At the moment, we urge the public to be mindful and take steps to minimise the risk of COVID-19. Everyone has a role to play in protecting yourself and your family. Hands should be washed regularly with soap and water. Cough or sneeze into a tissue or your elbow. If you are ill, stay at home."

The Department of Health and Human Services follows up and monitors all close contacts of confirmed cases and provides them with information and support. All close contacts must self-isolate for 14-days. All people arriving from any international destination must also self-isolate for 14 days as per Commonwealth Government direction.

Extensive testing has shown that people who have passed through places where there was a confirmed case, known as casual contacts, have an extremely low risk of transmission and are not currently recommended for testing. This will help to ensure our hospitals, assessment centres and general practitioners can prioritise testing for those most at risk.

The Victorian Department of Health and Human Services has a hotline for public information on COVID-19 which is 1800 675 398. Large numbers of calls will result in some delays and we ask Victorians for their patience as we work to manage the volume. Further information is also available at **https://www.dhhs.vic.gov.au/coronavirus**

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More COVID-19 cases confirmed in Victoria - 19 March 2020

Media release
Thursday, 19 March 2020

Twenty-nine new cases of coronavirus (COVID-19) were confirmed yesterday – bringing the total number of cases in Victoria to 150.

The new cases include 17 men and 12 women, with people aged from their early twenties to their early seventies. The Department of Health and Human Services is continuing to investigate all new cases.

At the present time, there are two confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission. Currently seven people are recovering in hospital. More than 17,180 Victorians have been tested to date. Twenty-eight people have recovered.

Of the total 150 cases in Victoria, the majority have been identified in and around metropolitan Melbourne, with five in regional Victoria. A number of cases remain under investigation.

The regional Victorian cases have occurred in the local government areas of Greater Geelong (3 cases), Latrobe Valley and Ballarat.

Close contacts of the confirmed cases are notified and monitored by the Department of Health and Human Services and any public exposure sites are contacted and provided with advice about the transmission risks and any cleaning that may be required.

All close contacts must self-isolate for 14-days. All people arriving from any international destination must also self-isolate for 14 days as per Commonwealth Government direction.

Victoria's Chief Health Officer Professor Brett Sutton said we will continue to see more cases of COVID-19 in Victoria.

"We are reviewing this rapidly evolving situation daily and continue to provide up-to-date information to the community. We are all focused on doing whatever is necessary to minimise the spread of infection and keep Victorians safe," Professor Sutton said.

"For the virus to spread, extended close personal contact is most likely required. Close personal contact is at least 15 minutes face-to-face or more than two hours in the same room.

"At the moment, we urge the public to be mindful and take steps to minimise the risk of COVID-19. Everyone has a role to play in protecting yourself and your family. Hands should be washed regularly with soap and water. Cough or sneeze into a tissue or your elbow. If you are ill, stay at home."

Extensive testing has shown that people who have passed through places where there was a confirmed case have an extremely low risk of transmission and are not currently recommended for testing. This will help to ensure our hospitals, assessment centres and general practitioners can prioritise testing for those most at risk.

The Victorian Department of Health and Human Services has a hotline for public information on COVID-19 which is 1800 675 398. Large numbers of calls will result in some delays and we ask Victorians for their patience as we work to manage the volume.

Further information is also available from the Coronavirus page (https://www.dhhs.vic.gov.au/coronavirus).

Media inquiries

Department of Health and Human Services Media Unit (03) 9096 8860 or press@dhhs.vic.gov.au (mailto:press@dhhs.vic.gov.au)

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Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)

Case locations and outbreaks (/case-locations-and-outbreaks)

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Contact tracing data (/contact-tracing-data-covid-19)

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Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)

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Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

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Back to top

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More COVID-19 cases confirmed in Victoria - 20 March 2020

Media release
20 March 2020

Twenty-eight new cases of coronavirus (COVID-19) were confirmed yesterday – bringing the total number of cases in Victoria to 178. The new cases include 18 men and 10 women, aged from mid-teens to late sixties.

At present, there are two confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission. Currently six people are recovering in hospital. More than 19,337 Victorians have been tested to date. Thirty-nine people have recovered.

Of the total 178 cases in Victoria, the majority have been identified in and around metropolitan Melbourne, with seven in regional Victoria. A number remain under investigation.

The regional Victoria cases have occurred in the local government areas of Greater Geelong (5) Ballarat (1) and Latrobe (1).

Victoria's Chief Health Officer Professor Brett Sutton said we will continue to see more cases of COVID-19 in Victoria.

"We are reviewing this rapidly evolving situation daily and continue to provide up-to-date information to the community. We are all focused on doing whatever is necessary to minimise the spread of infection and keep Victorians safe," Professor Sutton said.

"For the virus to spread, extended close personal contact is most likely required. Close personal contact is at least 15 minutes face-to-face or more than two hours in the same room.

"At the moment, we urge the public to be mindful and take steps to minimise the risk of COVID-19. Everyone has a role to play in protecting yourself and your family. Hands should be washed regularly with soap and water. Cough or sneeze into a tissue or your elbow. If you are ill, stay at home."

Extensive testing has shown that people who have passed through places where there was a confirmed case have an extremely low risk of transmission and are not currently recommended for testing. This will help to ensure our hospitals, assessment centres and general practitioners can prioritise testing for those most at risk.

The Victorian Department of Health and Human Services has a hotline for public information on COVID-19 which is 1800 675 398. Large numbers of calls will result in some delays and we ask Victorians for their patience as we work to manage the volume.

Further information is also available from the Coronavirus page (https://www.dhhs.vic.gov.au/coronavirus).

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Department of Health and Human Services Media Unit (03) 9096 8860 or press@dhhs.vic.gov.au (mailto:press@dhhs.vic.gov.au)

CORONAVIRUS (/CORONAVIRUS)

Victoria's restriction levels (/victorias-restriction-levels-covid-19)

How to stay safe and well (/how-stay-safe-and-well-covid-19)

Getting tested (/getting-tested)

For health services and professionals (/health-services-and-professionals-coronavirus-covid-19)

Latest news and data (/latest-news-and-data-coronavirus-covid-19)

Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)

Case locations and outbreaks (/case-locations-and-outbreaks)

Coronavirus testing data by local government area (/coronavirus-testing-data-local-government-area)

Contact tracing data (/contact-tracing-data-covid-19)

Averages for easing restrictions (/averages-easing-restrictions-covid-19)

COVID-19 Infections Among Healthcare Workers (/victorian-healthcare-worker-covid-19-data)

Emerging from lockdown – model (/emerging-lockdown-model)

Tracking coronavirus in Victoria (/tracking-coronavirus-victoria)

Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)

Media hub - coronavirus (COVID-19) (/media-hub-coronavirus-disease-covid-19)

Promotional material (/promotional-material-coronavirus-covid-19)

Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

Business and industry (/business-sector-coronavirus-disease-covid-19)

Aboriginal and Torres Strait Islander communities (/coronavirus-information-aboriginal-and-torres-strait-islander-communities)

Was this page useful?

Yes No

Back to top

Updated on 20/03/2020

About the site

Copyright (/copyright)

Disclaimer (/disclaimer)

Privacy statement (/privacy-statement)

Accessibility (/accessibility)

Sitemap (/sitemap)

Our websites

Services (http://services.dhhs.vic.gov.au/)

Service providers (http://providers.dhhs.vic.gov.au/)

Health.vic (https://www2.health.vic.gov.au/)

HousingVic (http://housing.vic.gov.au/)

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Seniors Online (https://www.seniorsonline.vic.gov.au/)

Funded Agency Channel (https://fac.dhhs.vic.gov.au/)

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More COVID-19 cases confirmed in Victoria - 21 March 2020

> Media release
> 21 March 2020

Fifty-one new cases of coronavirus (COVID-19) were confirmed yesterday – bringing the total number of cases in Victoria to 229.

The new cases include 30 men and 19 women, with two further cases still under investigation. Ages range from early-teens to late seventies.

At present, there are two confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission. Currently five people are recovering in hospital. More than 20,500 Victorians have been tested to date. Fifty-one people have recovered.

Of the total 229 cases in Victoria, the majority have been identified in and around metropolitan Melbourne, with twelve in regional Victoria.

The regional Victoria cases have occurred in the Local Government Areas of Greater Geelong (5 cases) and Hepburn, Surf Coast, Warrnambool, Macedon Ranges, Mildura, Latrobe and Ballarat, that all have one case.

Victoria's Chief Health Officer Professor Brett Sutton said we will continue to see more cases of COVID-19 in Victoria.

"We will continue to provide up-to-date information to the community. We are all focused on doing whatever is necessary to minimise the spread of infection to keep Victorians safe," Professor Sutton said.

"For the virus to spread, extended close personal contact is most likely required. Close personal contact is at least 15 minutes face-to-face or more than two hours in the same room.

"We urge the public to take steps now to minimise the risk of COVID-19. Everyone has a role to play in protecting yourself and your family. Hands should be washed regularly with soap and water. Cough or sneeze into a tissue or your elbow. If you are ill, stay at home."

The Department of Health and Human Services follows up and monitors all close contacts of confirmed cases and provides them with information and support. All close contacts must self-isolate for 14-days and all people arriving from any international destination must also self-isolate.

The Victorian Department of Health and Human Services has a hotline for public information on COVID-19 which is 1800 675 398. Large numbers of calls will result in some delays and we ask Victorians for their patience as we work to manage the volume. Further information is also available at on the Coronarivus page (/coronavirus).

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Department of Health & Human Services Media Unit (03) 9096 8860 or press@dhhs.vic.gov.au (mailto:press@dhhs.vic.gov.au)

CORONAVIRUS (/CORONAVIRUS)

Victoria's restriction levels (/victorias-restriction-levels-covid-19)

How to stay safe and well (/how-stay-safe-and-well-covid-19)

Getting tested (/getting-tested)

For health services and professionals (/health-services-and-professionals-coronavirus-covid-19)

Latest news and data (/latest-news-and-data-coronavirus-covid-19)

Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)

Case locations and outbreaks (/case-locations-and-outbreaks)

Coronavirus testing data by local government area (/coronavirus-testing-data-local-government-area)

Contact tracing data (/contact-tracing-data-covid-19)

Averages for easing restrictions (/averages-easing-restrictions-covid-19)

COVID-19 Infections Among Healthcare Workers (/victorian-healthcare-worker-covid-19-data)

Emerging from lockdown – model (/emerging-lockdown-model)

Tracking coronavirus in Victoria (/tracking-coronavirus-victoria)

Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)

Media hub - coronavirus (COVID-19) (/media-hub-coronavirus-disease-covid-19)

Promotional material (/promotional-material-coronavirus-covid-19)

Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

Business and industry (/business-sector-coronavirus-disease-covid-19)

Aboriginal and Torres Strait Islander communities (/coronavirus-information-aboriginal-and-torres-strait-islander-communities)

Was this page useful?

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Back to top

Updated on 21/03/2020

About the site

Copyright (/copyright)

Disclaimer (/disclaimer)

Privacy statement (/privacy-statement)

Accessibility (/accessibility)

Sitemap (/sitemap)

Our websites

Services (http://services.dhhs.vic.gov.au/)

Service providers (http://providers.dhhs.vic.gov.au/)

Health.vic (https://www2.health.vic.gov.au/)

HousingVic (http://housing.vic.gov.au/)

Better Health Channel (https://www.betterhealth.vic.gov.au/)

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More COVID-19 cases confirmed in Victoria - 22 March 2020

Media release
22 March 2020

Sixty-seven new cases of coronavirus (COVID-19) were confirmed yesterday – bringing the total number of cases in Victoria to 296.

The new cases include 42 men and 25 women, with people aged from late teens to early eighties.

At the present time, there are three confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission. Currently six people are recovering in hospital, and 70 people have recovered. More than 22,900 Victorians have been tested to date.

Of the total 296 cases, there have been 256 in metropolitan Melbourne and 25 in regional Victoria. A number of cases remain under investigation.

Multiple cases have occurred in the regional local government areas of Greater Geelong (8) Ballarat (3), Surf Coast (2), Warrnambool (2) and Macedon Ranges (2) and Latrobe, Yarriambiack, Gannawarra, Hepburn, Moorabool, Mitchell, Mildura and Greater Shepparton have all recorded one case.

The Department of Health and Human Services follows up and monitors all close contacts of confirmed cases and provides them with information and support. All close contacts must self-isolate for 14-days.

All people arriving from any international destination must also self-isolate for 14 days as per Commonwealth Government direction.

While most Victorians are voluntarily complying with requests to isolate, Police have strong powers to enforce the direction if it's required. Under the State of Emergency people who don't comply with a directive could receive a fine of up to $20,000. Companies face fines of up to $100,000.

For the virus to spread, extended close personal contact is most likely required. Close personal contact is at least 15 minutes face-to-face or more than two hours in the same room.

Extensive testing has shown that people who have passed through places where there was a confirmed case, known as casual contacts, have an extremely low risk of transmission and are not currently recommended for testing. This will help to ensure our hospitals, assessment centres and general practitioners can prioritise testing for those most at risk.

Everyone has a role to play in protecting yourself and your family. Hands should be washed regularly with soap and water. Cough or sneeze into a tissue or your elbow. If you are ill, stay at home.

The Victorian Department of Health and Human Services has a hotline for public information on COVID-19 which is 1800 675 398. Large numbers of calls will result in some delays and we ask Victorians for their patience as we work to manage the volume. Further information is also available at https://www.dhhs.vic.gov.au/coronavirus (https://www.dhhs.vic.gov.au/coronavirus).

Media inquiries

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CORONAVIRUS (/CORONAVIRUS)

Victoria's restriction levels (/victorias-restriction-levels-covid-19)

How to stay safe and well (/how-stay-safe-and-well-covid-19)

Getting tested (/getting-tested)

For health services and professionals (/health-services-and-professionals-coronavirus-covid-19)

Latest news and data (/latest-news-and-data-coronavirus-covid-19)

Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)

Case locations and outbreaks (/case-locations-and-outbreaks)

Coronavirus testing data by local government area (/coronavirus-testing-data-local-government-area)

Contact tracing data (/contact-tracing-data-covid-19)

Averages for easing restrictions (/averages-easing-restrictions-covid-19)

COVID-19 Infections Among Healthcare Workers (/victorian-healthcare-worker-covid-19-data)

Emerging from lockdown – model (/emerging-lockdown-model)

Tracking coronavirus in Victoria (/tracking-coronavirus-victoria)

Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)

Media hub - coronavirus (COVID-19) (/media-hub-coronavirus-disease-covid-19)

Promotional material (/promotional-material-coronavirus-covid-19)

Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

Business and industry (/business-sector-coronavirus-disease-covid-19)

Aboriginal and Torres Strait Islander communities (/coronavirus-information-aboriginal-and-torres-strait-islander-communities)

Was this page useful?

Yes No

Back to top

Updated on 19/06/2020

About the site

Copyright (/copyright)

Disclaimer (/disclaimer)

Privacy statement (/privacy-statement)

Accessibility (/accessibility)

Sitemap (/sitemap)

Our websites

Services (http://services.dhhs.vic.gov.au/)

Service providers (http://providers.dhhs.vic.gov.au/)

Health.vic (https://www2.health.vic.gov.au/)

HousingVic (http://housing.vic.gov.au/)

Better Health Channel (https://www.betterhealth.vic.gov.au/)

Seniors Online (https://www.seniorsonline.vic.gov.au/)

Funded Agency Channel (https://fac.dhhs.vic.gov.au/)

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- Facebook (https://www.facebook.com/VicGovDHHS/)

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Leave website feedback (/website-feedback)



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Coronavirus update for Victoria – 23 March 2020

Media release
23 March 2020

Sixty-one new cases of coronavirus (COVID-19) were confirmed yesterday – bringing the total number of cases in Victoria to 355.

The new cases include 34 men and 25 women, with people aged early-teens to mid-eighties. Two cases remain under investigation.

At the present time, there are six confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission. Currently six people are recovering in hospital, and 97 people have recovered. More than 23,700 Victorians have been tested to date.

Of the total 355 cases, there have been 290 in metropolitan Melbourne and 35 in regional Victoria. A number of cases remain under investigation.

Multiple cases have occurred in the regional local government areas of Greater Geelong (9) Ballarat (4), Baw Baw (2), Greater Shepparton (2), Surf Coast (2), Warrnambool (2), Macedon Ranges (2) and Mitchell (2).

Bass Coast, East Gippsland, Gannawarra, Latrobe, Yarriambiack, Hepburn, Moorabool, Wellington, Mount Alexander and Mildura have all recorded one case.

Two earlier cases were removed after further investigation.

The Department of Health and Human Services follows up and monitors all close contacts of confirmed cases and provides them with information and support. All close contacts must self-isolate for 14 days.

All people arriving from any international destination must also self-isolate for 14 days as per Commonwealth Government direction.

While most Victorians are voluntarily complying with requests to isolate, Police have strong powers to enforce the direction if it's required. Under the State of Emergency people who don't comply with a directive could receive a fine of up to $20,000. Companies face fines of up to $100,000.

Victoria's Chief Health Officer Professor Brett Sutton said these are unprecedented times. The threat of coronavirus to public health is real and everyone must take social distancing seriously.

"Everyone who's unwell must isolate themselves and everyone who's been told they're in quarantine either as a returned traveller or close contact must do so," Professor Sutton said.

"Social distancing will save lives.

"Everyone needs to comply with restrictions in place to keep yourself, your loved ones and the whole community safe.

"We urge everyone to stay 1.5 metres away from everyone else, wash your hands often with soap and water and cough or sneeze into a tissue or your elbow."

The Victorian Department of Health and Human Services has a hotline for public information on COVID-19 which is 1800 675 398. Large numbers of calls will result in some delays and we ask Victorians for their patience as we work to manage the volume. More information is available on the Coronavirus (COVID-19) (https://www.dhhs.vic.gov.au/coronavirus) page on this site.

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CORONAVIRUS (/CORONAVIRUS)

Victoria's restriction levels (/victorias-restriction-levels-covid-19)

How to stay safe and well (/how-stay-safe-and-well-covid-19)

Getting tested (/getting-tested)

For health services and professionals (/health-services-and-professionals-coronavirus-covid-19)

Latest news and data (/latest-news-and-data-coronavirus-covid-19)

Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)

Case locations and outbreaks (/case-locations-and-outbreaks)

Coronavirus testing data by local government area (/coronavirus-testing-data-local-government-area)

Contact tracing data (/contact-tracing-data-covid-19)

Averages for easing restrictions (/averages-easing-restrictions-covid-19)

COVID-19 Infections Among Healthcare Workers (/victorian-healthcare-worker-covid-19-data)

Emerging from lockdown – model (/emerging-lockdown-model)

Tracking coronavirus in Victoria (/tracking-coronavirus-victoria)

Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)

Media hub - coronavirus (COVID-19) (/media-hub-coronavirus-disease-covid-19)

Promotional material (/promotional-material-coronavirus-covid-19)

Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

Business and industry (/business-sector-coronavirus-disease-covid-19)

Aboriginal and Torres Strait Islander communities (/coronavirus-information-aboriginal-and-torres-strait-islander-communities)

Was this page useful?

Yes No

Back to top

Updated on 19/06/2020

About the site

Copyright (/copyright)

Disclaimer (/disclaimer)

Privacy statement (/privacy-statement)

Accessibility (/accessibility)

Sitemap (/sitemap)

Our websites

Services (http://services.dhhs.vic.gov.au/)

Service providers (http://providers.dhhs.vic.gov.au/)

Health.vic (https://www2.health.vic.gov.au/)

HousingVic (http://housing.vic.gov.au/)

Better Health Channel (https://www.betterhealth.vic.gov.au/)

Seniors Online (https://www.seniorsonline.vic.gov.au/)

Funded Agency Channel (https://fac.dhhs.vic.gov.au/)

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Statement

The Hon Dan Andrews MP
Premier

VICTORIA State Government

Monday, 23 March 2020

STATEMENT FROM THE PREMIER

Victoria Police has established a coronavirus enforcement squad of five hundred officers to ensure containment measures that have been put in place to combat coronavirus are followed.

Coordinated through the Police Operations Centre, the officers will be out in the community doing spot checks on returning travellers who are in 14-day isolation, as well as enforcing the bans on indoor and outdoor gatherings.

This includes the decision of the National Cabinet to implement Stage 1 of a shutdown of non-essential activity across the country from midday today which is aimed at slowing the spread of coronavirus.

The businesses that will close due to the Stage 1 shutdown include pubs, clubs, nightclubs, Crown Casino, and licensed venues in hotels and pubs. It also includes gyms, indoor sporting venues, places of worship, cinemas and entertainment venues. Restaurants and cafes will only be allowed to provide home delivery or takeaway services.

This decision and other containment measures are meaningless if Victorians don't take them seriously or don't think they will be caught if they flout the rules.

Such thinking is wrong and the new coronavirus enforcement squad at Victoria Police will take action against anyone caught doing the wrong thing.

The Stage 1 shutdown will have a significant impact on the lives and livelihoods of many Victorians, but if we don't do this, more Victorians will contract coronavirus and more Victorians will die.

The decision will be reviewed regularly by the National Cabinet, and speaking as honestly as possible, it's likely that governments across Australia will need to go further in the days and weeks ahead.

The Government can also confirm that school holidays for government schools in Victoria will be brought forward, starting on Tuesday 24 March. Schools will use this time to support teachers and staff plan for flexible and remote learning in the event schools need to move to that method of teaching.

I have recently told Victorians that the Government will ask them to do things they have never experienced before – these are the types of measures that I was talking about.

I also call on every Victorian to undertake their civic duty and practice social distancing: don't be closer than 1.5 metres from another person, wash your hands and practice good hand hygiene.

Do that for yourself, your loved ones and for the loved ones of people you have never met. It will save lives.

Coronavirus update for Victoria - 24 March 2020

Media release
24 March 2020

Sixty-four new cases of coronavirus (COVID-19) were confirmed yesterday – bringing the total number of cases in Victoria to 411.

The new cases include 36 men and 27 women (and one being further investigated), with people aged from pre-school age to late eighties.

At the present time, there are six confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission. Currently 12 people are in hospital, including two patients in intensive care. One hundred and thirteen people have recovered. More than 25,000 Victorians have been tested to date.

Of the total 411 cases, there have been 350 in metropolitan Melbourne and 41 in regional Victoria. A number of cases remain under investigation.

Multiple cases have occurred in the regional local government areas of Greater Geelong (10), Ballarat (4), Baw Baw (2), Greater Shepparton (3), Surf Coast (2), Warrnambool (2), Macedon Ranges (2), Mitchell (3) and Mount Alexander (3). Bass Coast, Gannawarra, Hepburn, Latrobe, Mildura, Moira, Moorabool, South Gippsland, Wellington and Yarriambiack have all recorded one case.

A number of earlier cases have been removed following further investigation.

The Department of Health and Human Services follows up and monitors all close contacts of confirmed cases and provides them with information and support. All close contacts must self-isolate for 14-days.

All people arriving from any international destination must also self-isolate for 14 days as per Commonwealth Government direction.

While most Victorians are voluntarily complying with requests to isolate, Police have strong powers to enforce the direction if it's required. Under the State of Emergency people who don't comply with a directive could receive a fine of up to $20,000. Companies face fines of up to $100,000.

Victoria's Chief Health Officer Professor Brett Sutton said these are unprecedented times. The threat of coronavirus to public health is real and everyone must take social distancing seriously.

"Everyone who's unwell must isolate themselves and everyone who's been told they're in quarantine either as a returned traveller or close contact must do so," Professor Sutton said.

"Social distancing will save lives".

"Everyone needs to comply with restrictions in place to keep yourself, your loved ones and the whole community safe.

"We urge everyone to stay 1.5 metres away from everyone else, wash your hands often with soap and water and cough or sneeze into a tissue or your elbow."

The Victorian Department of Health and Human Services has a hotline for public information on COVID-19 which is 1800 675 398. Large numbers of calls will result in some delays and we ask Victorians for their patience as we work to manage the volume.

Further information is also available at https://www.dhhs.vic.gov.au/coronavirus (https://www.dhhs.vic.gov.au/coronavirus)

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CORONAVIRUS (/CORONAVIRUS)

Victoria's restriction levels (/victorias-restriction-levels-covid-19)

How to stay safe and well (/how-stay-safe-and-well-covid-19)

Getting tested (/getting-tested)

For health services and professionals (/health-services-and-professionals-coronavirus-covid-19)

Latest news and data (/latest-news-and-data-coronavirus-covid-19)

Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)

Case locations and outbreaks (/case-locations-and-outbreaks)

Coronavirus testing data by local government area (/coronavirus-testing-data-local-government-area)

Contact tracing data (/contact-tracing-data-covid-19)

Averages for easing restrictions (/averages-easing-restrictions-covid-19)

COVID-19 Infections Among Healthcare Workers (/victorian-healthcare-worker-covid-19-data)

Emerging from lockdown – model (/emerging-lockdown-model)

Tracking coronavirus in Victoria (/tracking-coronavirus-victoria)

Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)

Media hub - coronavirus (COVID-19) (/media-hub-coronavirus-disease-covid-19)

Promotional material (/promotional-material-coronavirus-covid-19)

Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

Business and industry (/business-sector-coronavirus-disease-covid-19)

Aboriginal and Torres Strait Islander communities (/coronavirus-information-aboriginal-and-torres-strait-islander-communities)

Was this page useful?

Yes No

Back to top

Updated on 19/06/2020

About the site

Copyright (/copyright)

Disclaimer (/disclaimer)

Privacy statement (/privacy-statement)

Accessibility (/accessibility)

Sitemap (/sitemap)

Our websites

Services (http://services.dhhs.vic.gov.au/)

Service providers (http://providers.dhhs.vic.gov.au/)

Health.vic (https://www2.health.vic.gov.au/)

HousingVic (http://housing.vic.gov.au/)

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Coronavirus update for Victoria - 25 March 2020

> Media release
> 25 March 2020

The total number of coronavirus (COVID-19) cases in Victoria is 466 – an increase of 55 from yesterday.

The total number of cases includes 271 men and 191 women (with four cases under investigation). People are aged from pre-school age to their late eighties.

At the present time, there are eight confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission. Currently 12 people are in hospital, including two patients in intensive care. One hundred and twenty eight people have recovered. More than 25,500 Victorians have been tested to date.

Of the total 466 cases, there have been 386 in metropolitan Melbourne and 47 in regional Victoria. A number of cases remain under investigation.

Multiple cases have occurred in the regional local government areas of Greater Geelong (11), Ballarat (5), Baw Baw (2), Greater Shepparton (2), Surf Coast (2), Warrnambool (2), Latrobe (2), Macedon Ranges (2), Mitchell (4) and Mount Alexander (3). Bass Coast, East Gippsland, Gannawarra, Hepburn, Mildura, Moira, Moyne, Moorabool, Northern Grampians, South Gippsland, Wellington and Yarriambiack have all recorded one case.

The Department of Health and Human Services follows up and monitors all close contacts of confirmed cases and provides them with information and support. All close contacts must self-isolate for 14 days.

All people arriving from any international destination must also self-isolate for 14 days as per Commonwealth Government direction.

While most Victorians are voluntarily complying with requests to isolate, Police have strong powers to enforce the direction if it's required. Under the State of Emergency people who don't comply with a directive could receive a fine of up to $20,000. Companies face fines of up to $100,000.

Victoria's Chief Health Officer Professor Brett Sutton said these are unprecedented times. The threat of coronavirus to public health is real and everyone must take social distancing seriously.

"Everyone who's unwell must isolate themselves and everyone who's been told they're in quarantine either as a returned traveller or close contact must do so," Professor Sutton said.

"Social distancing will save lives.

"Everyone needs to comply with restrictions in place to keep yourself, your loved ones and the whole community safe.

"We urge everyone to stay 1.5 metres away from everyone else, wash your hands often with soap and water and cough or sneeze into a tissue or your elbow."

The Victorian Department of Health and Human Services has a hotline for public information on COVID-19 which is 1800 675 398. Large numbers of calls will result in some delays and we ask Victorians for their patience as we work to manage the volume.

Further information is also available at https://www.dhhs.vic.gov.au/coronavirus (https://www.dhhs.vic.gov.au/coronavirus)

Media inquiries

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CORONAVIRUS (/CORONAVIRUS)

Victoria's restriction levels (/victorias-restriction-levels-covid-19)

How to stay safe and well (/how-stay-safe-and-well-covid-19)

Getting tested (/getting-tested)

For health services and professionals (/health-services-and-professionals-coronavirus-covid-19)

Latest news and data (/latest-news-and-data-coronavirus-covid-19)

Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)

Case locations and outbreaks (/case-locations-and-outbreaks)

Coronavirus testing data by local government area (/coronavirus-testing-data-local-government-area)

Contact tracing data (/contact-tracing-data-covid-19)

Averages for easing restrictions (/averages-easing-restrictions-covid-19)

COVID-19 Infections Among Healthcare Workers (/victorian-healthcare-worker-covid-19-data)

Emerging from lockdown – model (/emerging-lockdown-model)

Tracking coronavirus in Victoria (/tracking-coronavirus-victoria)

Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)

Media hub - coronavirus (COVID-19) (/media-hub-coronavirus-disease-covid-19)

Promotional material (/promotional-material-coronavirus-covid-19)

Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

Business and industry (/business-sector-coronavirus-disease-covid-19)

Aboriginal and Torres Strait Islander communities (/coronavirus-information-aboriginal-and-torres-strait-islander-communities)

Was this page useful?

Yes No

Back to top

Updated on 19/06/2020

About the site

Copyright (/copyright)

Disclaimer (/disclaimer)

Privacy statement (/privacy-statement)

Accessibility (/accessibility)

Sitemap (/sitemap)

Our websites

Services (http://services.dhhs.vic.gov.au/)

Service providers (http://providers.dhhs.vic.gov.au/)

Health.vic (https://www2.health.vic.gov.au/)

HousingVic (http://housing.vic.gov.au/)

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Seniors Online (https://www.seniorsonline.vic.gov.au/)

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Coronavirus update for Victoria - 26 March 2020

Media release
26 March 2020

Victoria has recorded its first three deaths related to coronavirus (COVID-19).

All were men aged in their seventies. All died in Melbourne hospitals.

The deaths came as the state's total number of cases increased to 520.

In Victoria, the total number of cases includes 300 men and 216 women. People are aged from pre-school age to their late eighties. Four cases are under investigation.

At the present time, there are nine confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission. Currently 14 people are in hospital, including three patients in intensive care. One hundred and forty-nine people have recovered. More than 26,900 Victorians have been tested to date.

Most cases have been in metropolitan Melbourne, with more that 50 cases in regional Victoria. Details can be found on the Media hub page (/media-hub-coronavirus-disease-covid-19) on this site.

Victoria's Chief Health Officer Professor Brett Sutton said these are unprecedented times. The threat of coronavirus to public health is real and everyone must take social distancing seriously.

'Sadly, Victoria has recorded the first three deaths in Victoria related to coronavirus. Our thoughts are with their loved ones at this difficult time,' Professor Sutton said.

'We're doing everything we can to save lives and slow the spread of this deadly virus, but we all have a role to play to protect those who are most vulnerable.

'I can't be clearer; if you can stay at home, you must stay at home.'

The Department of Health and Human Services follows up and monitors all close contacts of confirmed cases and provides them with information and support. All close contacts must self-isolate for 14 days.

All people arriving from any international destination must also self-isolate for 14 days as per Commonwealth Government direction.

While most Victorians are voluntarily complying with requests to isolate, Police have strong powers to enforce the direction if it's required. Under the State of Emergency people who don't comply with a directive could receive a fine of up to $20,000. Companies face fines of up to $100,000.

'Everyone who's unwell must isolate themselves and everyone who's been told they're in quarantine either as a returned traveller or close contact must do so,' Professor Sutton said.

'Social distancing will save lives.

'Everyone needs to comply with restrictions in place to keep yourself, your loved ones and the whole community safe. We urge everyone to stay 1.5 metres away from everyone else, wash your hands often with soap and water and cough or sneeze into a tissue or your elbow.'

The Victorian Department of Health and Human Services has a hotline for public information on COVID-19 which is 1800 675 398. Large numbers of calls will result in some delays and we ask Victorians for their patience as we work to manage the volume. Further information is also available at https://www.dhhs.vic.gov.au/coronavirus (https://www.dhhs.vic.gov.au/coronavirus)

Media inquiries

Department of Health & Human Services Media Unit (03) 9096 8860 or press@dhhs.vic.gov.au (mailto:press@dhhs.vic.gov.au)

CORONAVIRUS (/CORONAVIRUS)

Victoria's restriction levels (/victorias-restriction-levels-covid-19)

How to stay safe and well (/how-stay-safe-and-well-covid-19)

Getting tested (/getting-tested)

For health services and professionals (/health-services-and-professionals-coronavirus-covid-19)

Latest news and data (/latest-news-and-data-coronavirus-covid-19)

Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)

Case locations and outbreaks (/case-locations-and-outbreaks)

Coronavirus testing data by local government area (/coronavirus-testing-data-local-government-area)

Contact tracing data (/contact-tracing-data-covid-19)

Averages for easing restrictions (/averages-easing-restrictions-covid-19)

COVID-19 Infections Among Healthcare Workers (/victorian-healthcare-worker-covid-19-data)

Emerging from lockdown – model (/emerging-lockdown-model)

Tracking coronavirus in Victoria (/tracking-coronavirus-victoria)

Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)

Media hub - coronavirus (COVID-19) (/media-hub-coronavirus-disease-covid-19)

Promotional material (/promotional-material-coronavirus-covid-19)

Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

Business and industry (/business-sector-coronavirus-disease-covid-19)

Aboriginal and Torres Strait Islander communities (/coronavirus-information-aboriginal-and-torres-strait-islander-communities)

Was this page useful?

Yes No

Back to top

Updated on 19/06/2020

About the site

Copyright (/copyright)

Disclaimer (/disclaimer)

Privacy statement (/privacy-statement)

Accessibility (/accessibility)

Sitemap (/sitemap)

Our websites

Services (http://services.dhhs.vic.gov.au/)

Service providers (http://providers.dhhs.vic.gov.au/)

Health.vic (https://www2.health.vic.gov.au/)

HousingVic (http://housing.vic.gov.au/)

Better Health Channel (https://www.betterhealth.vic.gov.au/)

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Coronavirus update for Victoria - 27 March 2020

Media release
27 March 2020

The total number of coronavirus (COVID-19) cases in Victoria is 574 – an increase of 54 from yesterday. Victoria has recorded three deaths related to COVID-19. There have been no new deaths recorded overnight.

The total number of cases includes 332 men and 241 women, with people aged from eight to 88.

There are 16 confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission. Currently 22 people are in hospital, including three patients in intensive care. 172 people have recovered.

More than 27,800 Victorians have been tested to date.

Of the total 574 cases, there have been 475 in metropolitan Melbourne and 85 in regional Victoria. A number of cases remain under investigation.

Details can be found on the DHHS website on the Coronavirus media hub page (/media-hub-coronavirus-disease-covid-19).

The Department of Health and Human Services follows up and monitors all close contacts of confirmed cases and provides them with information and support. All close contacts must self-isolate for 14 days.

All people arriving from any international destination must also self-isolate for 14 days as per Commonwealth Government direction.

While most Victorians are voluntarily complying with requests to isolate, Police have strong powers to enforce the direction if it's required. Under the State of Emergency people who don't comply with a directive could receive a fine of up to $20,000. Companies face fines of up to $100,000.

Victoria's Chief Health Officer Professor Brett Sutton said these are unprecedented times. The threat of coronavirus to public health is real and everyone must take social distancing seriously.

"Everyone who's unwell must isolate themselves and everyone who's been told they're in quarantine either as a returned traveller or close contact must do so," Professor Sutton said.

"Social distancing will save lives.

"Everyone needs to comply with restrictions in place to keep yourself, your loved ones and the whole community safe.

"We urge everyone to stay 1.5 metres away from everyone else, wash your hands often with soap and water and cough or sneeze into a tissue or your elbow."

The Victorian Department of Health and Human Services has a hotline for public information on COVID-19 which is 1800 675 398. Large numbers of calls will result in some delays and we ask Victorians for their patience as we work to manage the volume. Further information is also available at https://www.dhhs.vic.gov.au/coronavirus (https://www.dhhs.vic.gov.au/coronavirus)

Media inquiries

Department of Health & Human Services Media Unit (03) 9096 8860 or press@dhhs.vic.gov.au (mailto:press@dhhs.vic.gov.au)

CORONAVIRUS (/CORONAVIRUS)

Victoria's restriction levels (/victorias-restriction-levels-covid-19)

How to stay safe and well (/how-stay-safe-and-well-covid-19)

Getting tested (/getting-tested)

For health services and professionals (/health-services-and-professionals-coronavirus-covid-19)

Latest news and data (/latest-news-and-data-coronavirus-covid-19)

- Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)
- Case locations and outbreaks (/case-locations-and-outbreaks)
- Coronavirus testing data by local government area (/coronavirus-testing-data-local-government-area)
- Contact tracing data (/contact-tracing-data-covid-19)
- Averages for easing restrictions (/averages-easing-restrictions-covid-19)
- COVID-19 Infections Among Healthcare Workers (/victorian-healthcare-worker-covid-19-data)
- Emerging from lockdown – model (/emerging-lockdown-model)
- Tracking coronavirus in Victoria (/tracking-coronavirus-victoria)
- Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)
- **Media hub - coronavirus (COVID-19) (/media-hub-coronavirus-disease-covid-19)**
- Promotional material (/promotional-material-coronavirus-covid-19)
- Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

Business and industry (/business-sector-coronavirus-disease-covid-19)

Aboriginal and Torres Strait Islander communities (/coronavirus-information-aboriginal-and-torres-strait-islander-communities)

Was this page useful?

Yes No

Back to top

Updated on 19/06/2020

About the site

Copyright (/copyright)

Disclaimer (/disclaimer)

Privacy statement (/privacy-statement)

Accessibility (/accessibility)

Sitemap (/sitemap)

Our websites

Services (http://services.dhhs.vic.gov.au/)

Service providers (http://providers.dhhs.vic.gov.au/)

Health.vic (https://www2.health.vic.gov.au/)

HousingVic (http://housing.vic.gov.au/)

Better Health Channel (https://www.betterhealth.vic.gov.au/)

Seniors Online (https://www.seniorsonline.vic.gov.au/)

Funded Agency Channel (https://fac.dhhs.vic.gov.au/)

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Coronavirus update for Victoria - 28 March 2020

> Media release
> 28 March 2020

The total number of coronavirus (COVID-19) cases in Victoria is 685 – an increase of 111 from yesterday. Victoria has recorded three deaths related to COVID-19. There have been no new deaths recorded overnight. The total number of cases includes 378 men and 300 women, with people aged from eight to 88.

There are 21 confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission. More than 30,100 Victorians have been tested to date.

Currently 21 people are in hospital, including three patients in intensive care. 191 people have recovered.

Of the total 685 cases, there have been 550 in metropolitan Melbourne and 117 in regional Victoria. A number of cases remain under investigation.

Details can be found on the Media hub page (/media-hub-coronavirus-disease-covid-19) on this site.

The Department of Health and Human Services follows up and monitors all close contacts of confirmed cases and provides them with information and support. All close contacts must self-isolate for 14 days.

All people arriving from any international destination today must also self-isolate for 14 days as per Commonwealth Government direction. From 11.59pm tonight, all travellers returning from overseas to Victoria will be placed in enforced quarantine for the self-isolation period of 14 days.

While most Victorians are voluntarily complying with requests to quarantine or self-isolate, Police have strong powers to enforce the direction if it's required. From today, police can issue on the spot fines for anyone who is not following the directions of the Chief Health Officer including up to $1,652 for individuals and up to $9,913 for businesses.

Under the State of Emergency people who don't comply could also be taken to court and receive a fine of up to $20,000. Companies face fines of up to $100,000.

Victoria's Chief Health Officer Professor Brett Sutton said these are unprecedented times. The threat of coronavirus to public health is real and everyone must take social distancing seriously.

"Everyone who's unwell must isolate themselves and everyone who's been told they're in quarantine either as a returned traveller or close contact must do so," Professor Sutton said.

"Social distancing will save lives.

"Everyone needs to comply with restrictions in place to keep yourself, your loved ones and the whole community safe.

"We urge everyone to stay 1.5 metres away from everyone else, wash your hands often with soap and water and cough or sneeze into a tissue or your elbow."

The Victorian Department of Health and Human Services has a hotline for public information on COVID-19 which is 1800 675 398. Large numbers of calls will result in some delays and we ask Victorians for their patience as we work to manage the volume. Further information is also available at https://www.dhhs.vic.gov.au/coronavirus (https://www.dhhs.vic.gov.au/coronavirus)

Media enquiries

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CORONAVIRUS (/CORONAVIRUS)

Victoria's restriction levels (/victorias-restriction-levels-covid-19)

How to stay safe and well (/how-stay-safe-and-well-covid-19)

Getting tested (/getting-tested)

For health services and professionals (/health-services-and-professionals-coronavirus-covid-19)

Latest news and data (/latest-news-and-data-coronavirus-covid-19)

Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)

Case locations and outbreaks (/case-locations-and-outbreaks)

Coronavirus testing data by local government area (/coronavirus-testing-data-local-government-area)

Contact tracing data (/contact-tracing-data-covid-19)

Averages for easing restrictions (/averages-easing-restrictions-covid-19)

COVID-19 Infections Among Healthcare Workers (/victorian-healthcare-worker-covid-19-data)

Emerging from lockdown – model (/emerging-lockdown-model)

Tracking coronavirus in Victoria (/tracking-coronavirus-victoria)

Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)

Media hub - coronavirus (COVID-19) (/media-hub-coronavirus-disease-covid-19)

Promotional material (/promotional-material-coronavirus-covid-19)

Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

Business and industry (/business-sector-coronavirus-disease-covid-19)

Aboriginal and Torres Strait Islander communities (/coronavirus-information-aboriginal-and-torres-strait-islander-communities)

Was this page useful?

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Back to top

Updated on 18/08/2020

About the site

Copyright (/copyright)

Disclaimer (/disclaimer)

Privacy statement (/privacy-statement)

Accessibility (/accessibility)

Sitemap (/sitemap)

Our websites

Services (http://services.dhhs.vic.gov.au/)

Service providers (http://providers.dhhs.vic.gov.au/)

Health.vic (https://www2.health.vic.gov.au/)

HousingVic (http://housing.vic.gov.au/)

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Coronavirus update for Victoria - 1 April 2020

Media release
1 April 2020

The total number of coronavirus (COVID-19) cases in Victoria is 968 – an increase of 51 from yesterday.

Four people have already died in Victoria, many more are in hospital or self-isolating at home.

The total number of cases includes 526 men and 438 women. Cases range in age from babies to their early nineties.

There are 39 confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission. More than 47,000 tests have been conducted to date.

Currently 32 people are in hospital – including six patients in intensive care – and 343 people have recovered.

Of the total 968 cases, there have been 771 in Melbourne and 183 in regional Victoria. A number of cases remain under investigation. Details can be found on the DHHS website at: https://www.dhhs.vic.gov.au/media-hub-coronavirus-disease-covid-19 (/media-hub-coronavirus-disease-covid-19)

The Department of Health and Human Services follows up and monitors all close contacts of confirmed cases and provides them with information and support. All close contacts must self-isolate for 14 days.

Under restrictions agreed by National Cabinet, gatherings of more than two people are now banned, except for members of your immediate household and for work or education purposes.

There are only four reasons for Victorians to leave their home: food and supplies, medical care and care giving, exercise, and work or education.

All people arriving from any international destination must also self-isolate for 14 days as per Commonwealth Government direction. All travelers returning from overseas to Victoria will be placed in enforced quarantine for the self-isolation period of 14 days.

Police have strong powers to enforce these directions and can issue on the spot fines, including up to $1,652 for individuals and up to $9,913 for businesses.

Under the State of Emergency people who don't comply could also be taken to court and receive a fine of up to $20,000. Companies face fines of up to $100,000.

Victoria's Chief Health Officer Professor Brett Sutton said these are unprecedented times. The threat of coronavirus to public health is real and everyone must take social distancing seriously.

"Everyone who's unwell must isolate themselves and everyone who's been told they're in quarantine either as a returned traveller or close contact must do so," Professor Sutton said.

"Social distancing will save lives. Everyone needs to comply with restrictions in place to keep yourself, your loved ones and the whole community safe.

"Our message is clear: if you can stay home, you must stay home."

The Victorian Department of Health and Human Services' has a hotline for public information on COVID-19 which is 1800 675 398. Large numbers of calls will result in some delays and we ask Victorians for their patience as we work to manage the volume.

Further information is also available at www.dhhs.vic.gov.au/coronavirus (https://www.dhhs.vic.gov.au/coronavirus)

Media inquiries

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CORONAVIRUS (/CORONAVIRUS)

Victoria's restriction levels (/victorias-restriction-levels-covid-19)

How to stay safe and well (/how-stay-safe-and-well-covid-19)

Getting tested (/getting-tested)

For health services and professionals (/health-services-and-professionals-coronavirus-covid-19)

Latest news and data (/latest-news-and-data-coronavirus-covid-19)

Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)

Case locations and outbreaks (/case-locations-and-outbreaks)

Coronavirus testing data by local government area (/coronavirus-testing-data-local-government-area)

Contact tracing data (/contact-tracing-data-covid-19)

Averages for easing restrictions (/averages-easing-restrictions-covid-19)

COVID-19 Infections Among Healthcare Workers (/victorian-healthcare-worker-covid-19-data)

Emerging from lockdown – model (/emerging-lockdown-model)

Tracking coronavirus in Victoria (/tracking-coronavirus-victoria)

Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)

Media hub - coronavirus (COVID-19) (/media-hub-coronavirus-disease-covid-19)

Promotional material (/promotional-material-coronavirus-covid-19)

Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

Business and industry (/business-sector-coronavirus-disease-covid-19)

Aboriginal and Torres Strait Islander communities (/coronavirus-information-aboriginal-and-torres-strait-islander-communities)

Was this page useful?

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Back to top

Updated on 19/06/2020

About the site

Copyright (/copyright)

Disclaimer (/disclaimer)

Privacy statement (/privacy-statement)

Accessibility (/accessibility)

Sitemap (/sitemap)

Our websites

Services (http://services.dhhs.vic.gov.au/)

Service providers (http://providers.dhhs.vic.gov.au/)

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Coronavirus update for Victoria - 2 April 2020

Media release
2 April 2020

The total number of coronavirus (COVID-19) cases in Victoria is 1036 – an increase of 68 from yesterday.

Yesterday a woman in her seventies died in hospital, taking the number of people who have died in Victoria from coronavirus to five.

The total number of cases includes 551 men and 480 women. Cases range in age from babies to their early nineties.

There are 57 confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission. More than 49,000 tests have been conducted to date.

Currently 36 people are in hospital – including six patients in intensive care – and 422 people have recovered.

Of the total 1036 cases, there have been 828 in Melbourne and 193 in regional Victoria. A number of cases remain under investigation. Details can be found on the DHHS website at: https://www.dhhs.vic.gov.au/media-hub-coronavirus-disease-covid-19 (/media-hub-coronavirus-disease-covid-19)

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There are only four reasons for Victorians to leave their home: food and supplies, medical care and care giving, exercise, and work or education.

All people arriving from any international destination must also self-isolate for 14 days as per Commonwealth Government direction. All travelers returning from overseas to Victoria will be placed in enforced quarantine for the self-isolation period of 14 days.

Police have strong powers to enforce these directions and can issue on the spot fines, including up to $1652 for individuals and up to $9913 for businesses.

Under the State of Emergency people who don't comply could also be taken to court and receive a fine of up to $20,000. Companies face fines of up to $100,000.

Victoria's Chief Health Officer Professor Brett Sutton said these are unprecedented times. The threat of coronavirus to public health is real and everyone must take social distancing seriously.

"Everyone who's unwell must isolate themselves and everyone who's been told they're in quarantine either as a returned traveller or close contact must do so," Professor Sutton said.

"Social distancing will save lives. Everyone needs to comply with restrictions in place to keep yourself, your loved ones and the whole community safe.

"Our message is clear: if you can stay home, you must stay home."

The Victorian Department of Health and Human Services' has a hotline for public information on COVID-19 which is 1800 675 398. Large numbers of calls will result in some delays and we ask Victorians for their patience as we work to manage the volume.

Further information is also available at www.dhhs.vic.gov.au/coronavirus (https://www.dhhs.vic.gov.au/coronavirus)

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CORONAVIRUS (/CORONAVIRUS)

Victoria's restriction levels (/victorias-restriction-levels-covid-19)

How to stay safe and well (/how-stay-safe-and-well-covid-19)

Getting tested (/getting-tested)

For health services and professionals (/health-services-and-professionals-coronavirus-covid-19)

Latest news and data (/latest-news-and-data-coronavirus-covid-19)

Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)

Case locations and outbreaks (/case-locations-and-outbreaks)

Coronavirus testing data by local government area (/coronavirus-testing-data-local-government-area)

Contact tracing data (/contact-tracing-data-covid-19)

Averages for easing restrictions (/averages-easing-restrictions-covid-19)

COVID-19 Infections Among Healthcare Workers (/victorian-healthcare-worker-covid-19-data)

Emerging from lockdown – model (/emerging-lockdown-model)

Tracking coronavirus in Victoria (/tracking-coronavirus-victoria)

Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)

Media hub - coronavirus (COVID-19) (/media-hub-coronavirus-disease-covid-19)

Promotional material (/promotional-material-coronavirus-covid-19)

Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

Business and industry (/business-sector-coronavirus-disease-covid-19)

Aboriginal and Torres Strait Islander communities (/coronavirus-information-aboriginal-and-torres-strait-islander-communities)

Was this page useful?

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Back to top

Updated on 19/06/2020

About the site

Copyright (/copyright)

Disclaimer (/disclaimer)

Privacy statement (/privacy-statement)

Accessibility (/accessibility)

Sitemap (/sitemap)

Our websites

Services (http://services.dhhs.vic.gov.au/)

Service providers (http://providers.dhhs.vic.gov.au/)

Health.vic (https://www2.health.vic.gov.au/)

HousingVic (http://housing.vic.gov.au/)

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Coronavirus update for Victoria - 3 April 2020

> Media release
> 3 April 2020

The total number of coronavirus (COVID-19) cases in Victoria is 1,085 – an increase of 49 from yesterday.

Yesterday a man in his eighties died in hospital, taking the number of people who have died in Victoria from coronavirus to seven.

The total number of cases includes 577 men and 504 women. Cases range in age from babies to their early nineties.

There are 62 confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission. More than 51,000 tests have been conducted to date.

Currently 37 people are in hospital – including seven patients in intensive care – and 476 people have recovered.

Of the total 1,085 cases, there have been 866 in Melbourne and 205 in regional Victoria. A number of cases remain under investigation.

The Department of Health and Human Services follows up and monitors all close contacts of confirmed cases and provides them with information and support. All close contacts must self-isolate for 14 days.

There are only four reasons for Victorians to leave their home: food and supplies, medical care and care giving, exercise, and work or education.

All people arriving from any international destination must also self-isolate for 14 days as per Commonwealth Government direction. All travelers returning from overseas to Victoria will be placed in enforced quarantine for the self-isolation period of 14 days.

Police have strong powers to enforce these directions and can issue on the spot fines, including up to $1652 for individuals and up to $9913 for businesses.

Under the State of Emergency people who don't comply could also be taken to court and receive a fine of up to $20,000. Companies face fines of up to $100,000.

Victoria's Chief Health Officer Professor Brett Sutton today stressed the importance for Victorians to get a flu vaccine ahead of the coming influenza season.

"Influenza is a serious illness that kills many Victorians each year. With COVID-19 now also circulating in the State, a widespread influenza outbreak would be a devastating double-whammy for our health services to cope with," he said.

"The best way to prevent flu is by getting vaccinated each year and I encourage everyone to get their annual flu shot from now."

"It is also important that workplaces that are still operating continue to offer their usual employee influenza immunisation programs."

The Victorian Department of Health and Human Services has a hotline for public information on COVID-19, which is 1800 675 398. Large numbers of calls can result in some delays and we ask Victorians for their patience as we work to manage the volume.

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CORONAVIRUS (/CORONAVIRUS)

Victoria's restriction levels (/victorias-restriction-levels-covid-19)

How to stay safe and well (/how-stay-safe-and-well-covid-19)

Getting tested (/getting-tested)

For health services and professionals (/health-services-and-professionals-coronavirus-covid-19)

Latest news and data (/latest-news-and-data-coronavirus-covid-19)

Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)

Case locations and outbreaks (/case-locations-and-outbreaks)

Coronavirus testing data by local government area (/coronavirus-testing-data-local-government-area)

Contact tracing data (/contact-tracing-data-covid-19)

Averages for easing restrictions (/averages-easing-restrictions-covid-19)

COVID-19 Infections Among Healthcare Workers (/victorian-healthcare-worker-covid-19-data)

Emerging from lockdown – model (/emerging-lockdown-model)

Tracking coronavirus in Victoria (/tracking-coronavirus-victoria)

Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)

Media hub - coronavirus (COVID-19) (/media-hub-coronavirus-disease-covid-19)

Promotional material (/promotional-material-coronavirus-covid-19)

Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

Business and industry (/business-sector-coronavirus-disease-covid-19)

Aboriginal and Torres Strait Islander communities (/coronavirus-information-aboriginal-and-torres-strait-islander-communities)

Was this page useful?

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Back to top

Updated on 19/06/2020

About the site

Our websites

Better Health Channel (https://www.betterhealth.vic.gov.au/)

Seniors Online (https://www.seniorsonline.vic.gov.au/)

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Coronavirus update for Victoria - 4 April 2020

> Media release
> 4 April 2020

The total number of coronavirus (COVID-19) cases in Victoria is 1115 – an increase of 30 from yesterday.

Last night a woman in her seventies died in hospital, taking the number of people who have died in Victoria from coronavirus to eight.

The total number of cases includes 587 men and 528 women. Cases range in age from babies to their early nineties.

There are 73 confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission. More than 54,000 tests have been conducted to date.

Currently 42 people are in hospital – including 10 patients in intensive care – and 527 people have recovered.

Of the 1115 cases, there have been 894 in Melbourne and 209 in regional Victoria. A number of cases remain under investigation.

The Department of Health and Human Services follows up and monitors all close contacts of confirmed cases and provides them with information and support. All close contacts must self-isolate for 14 days.

There are only four reasons for Victorians to leave their home: food and supplies, medical care and care giving, exercise, and work or education.

All people arriving from any international destination must also self-isolate for 14 days as per Commonwealth Government direction. All travelers returning from overseas to Victoria will be placed in enforced quarantine for the self-isolation period of 14 days.

Police have strong powers to enforce these directions and can issue on the spot fines, including up to $1652 for individuals and up to $9913 for businesses.

Under the State of Emergency people who don't comply could also be taken to court and receive a fine of up to $20,000. Companies face fines of up to $100,000.

Victoria's Chief Health Officer Professor Brett Sutton today urged Victorians to stay vigilant.

"Now is not the time for complacency. We still have a long way to go," Professor Sutton said.

"While we are starting to see some improvement in the rate of transmission, that rate is still far too high.

"We thank those Victorians who overwhelmingly are doing the right thing by staying at home, but we must keep at it to save lives.

"Everyone who's unwell must isolate themselves and everyone who's been told they're in quarantine either as a returned traveller or close contact must do so."

The Victorian Department of Health and Human Services has a hotline for public information on COVID-19, which is 1800 675 398. Large numbers of calls can result in some delays and we ask Victorians for their patience as we work to manage the volume.

Further information is also available from our Coronavirus page (/coronavirus).

Media inquiries

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Cases by Local Government Areas

Please find the latest COVID-19 notifications by local government areas. Note: Notifications are made according to place of residence, not where the infection was acquired.

Local Government Area	Cases
STONNINGTON	84
BANYULE	64
BOROONDARA	56
GREATER GEELONG	54
MORNINGTON PENINSULA	52
MELBOURNE	47
GLEN EIRA	45
MORELAND	45
MONASH	38
PORT PHILLIP	38
CASEY	37
FRANKSTON	33
HUME	31
MOONEE VALLEY	30
WYNDHAM	28
DAREBIN	27
BAYSIDE	26

BRIMBANK	26
YARRA	21
MANNINGHAM	20
WHITEHORSE	19
YARRA RANGES	19
MELTON	18
NILLUMBIK	18
KINGSTON	16
WHITTLESEA	15
HOBSONS BAY	13
KNOX	12
GREATER DANDENONG	11
BALLARAT	10
GREATER BENDIGO	10
MARIBYRNONG	10
MOIRA	10
CARDINIA	9
MAROONDAH	9
MITCHELL	9
SURF COAST	9
GREATER SHEPPARTON	8
MOUNT ALEXANDER	6
WELLINGTON	6
BAW BAW	5
LATROBE	5
MACEDON RANGES	5

WARRNAMBOOL	5
BENALLA	3
MILDURA	3
NORTHERN GRAMPIANS	3
SOUTH GIPPSLAND	3
SOUTHERN GRAMPIANS	3
BASS COAST	2
CAMPASPE	2
HEPBURN	2
HORSHAM	2
MANSFIELD	2
STRATHBOGIE	2
SWAN HILL	2
ARARAT	1
CENTRAL GOLDFIELDS	1
CORANGAMITE	1
EAST GIPPSLAND	1
GANNAWARRA	1
GLENELG	1
GOLDEN PLAINS	1
LODDON	1
MOORABOOL	1
MOYNE	1
MURRINDINDI	1
WANGARATTA	1
WEST WIMMERA	1

WODONGA	1
YARRIAMBIACK	1

CORONAVIRUS (/CORONAVIRUS)

Victoria's restriction levels (/victorias-restriction-levels-covid-19)

How to stay safe and well (/how-stay-safe-and-well-covid-19)

Getting tested (/getting-tested)

For health services and professionals (/health-services-and-professionals-coronavirus-covid-19)

Latest news and data (/latest-news-and-data-coronavirus-covid-19)

Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)

Case locations and outbreaks (/case-locations-and-outbreaks)

Coronavirus testing data by local government area (/coronavirus-testing-data-local-government-area)

Contact tracing data (/contact-tracing-data-covid-19)

Averages for easing restrictions (/averages-easing-restrictions-covid-19)

COVID-19 Infections Among Healthcare Workers (/victorian-healthcare-worker-covid-19-data)

Emerging from lockdown – model (/emerging-lockdown-model)

Tracking coronavirus in Victoria (/tracking-coronavirus-victoria)

Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)

Media hub - coronavirus (COVID-19) (/media-hub-coronavirus-disease-covid-19)

Promotional material (/promotional-material-coronavirus-covid-19)

Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

Business and industry (/business-sector-coronavirus-disease-covid-19)

Aboriginal and Torres Strait Islander communities (/coronavirus-information-aboriginal-and-torres-strait-islander-communities)

Was this page useful?

Yes No

Back to top

Updated on 19/06/2020

About the site

Copyright (/copyright)

Disclaimer (/disclaimer)

Privacy statement (/privacy-statement)

Accessibility (/accessibility)

Sitemap (/sitemap)

Our websites

Services (http://services.dhhs.vic.gov.au/)

Service providers (http://providers.dhhs.vic.gov.au/)

Health.vic (https://www2.health.vic.gov.au/)

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Coronavirus update for Victoria - 5 April 2020

> Media release
> 5 April 2020

The total number of coronavirus (COVID-19) cases in Victoria is 1135 – an increase of 20 from yesterday.

No additional deaths were recorded overnight.

The total number of cases includes 597 men and 538 women. Cases range in age from under one year to their early nineties.

There are 75 confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission. More than 56,000 tests have been conducted to date.

Currently 47 people are in hospital – including 11 patients in intensive care – and 573 people have recovered.

Of the total 1135 cases, there have been 911 in Melbourne and 212 in regional Victoria. A number of cases remain under investigation.

The Department of Health and Human Services follows up and monitors all close contacts of confirmed cases and provides them with information and support. All close contacts must self-isolate for 14 days.

There are only four reasons for Victorians to leave their home: food and supplies, medical care and care giving, exercise, and work or education.

All people arriving from any international destination must also self-isolate for 14 days as per Commonwealth Government direction. All travelers returning from overseas to Victoria will be placed in enforced quarantine for the self-isolation period of 14 days.

Police have strong powers to enforce these directions and can issue on the spot fines, including up to $1652 for individuals and up to $9913 for businesses.

Under the State of Emergency people who don't comply could also be taken to court and receive a fine of up to $20,000. Companies face fines of up to $100,000.

Victoria's Chief Health Officer Professor Brett Sutton today urged Victorians to stay vigilant.

"While we are starting to see some improvement in the rate of transmission, now is not the time for complacency. We still have a long way to go," Professor Sutton said.

"We thank those Victorians who overwhelmingly are doing the right thing by staying at home, but we must keep at it to save lives.

"Everyone who's unwell must isolate themselves and everyone who's been told they're in quarantine either as a returned traveller or close contact must do so."

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Cases by Local Government Areas

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Local Government Area	Cases
STONNINGTON	84
BANYULE	67
BOROONDARA	57
GREATER GEELONG	56
MORNINGTON PENINSULA	53
MELBOURNE	49
MORELAND	46
GLEN EIRA	45
MONASH	38
CASEY	37
PORT PHILLIP	37
FRANKSTON	34
HUME	31
MOONEE VALLEY	31
BRIMBANK	27
DAREBIN	27
WYNDHAM	27
BAYSIDE	26
MANNINGHAM	22

NILLUMBIK	21
YARRA	21
WHITEHORSE	20
YARRA RANGES	19
MELTON	18
KINGSTON	17
WHITTLESEA	16
HOBSONS BAY	13
KNOX	12
GREATER DANDENONG	11
BALLARAT	10
MARIBYRNONG	10
MOIRA	10
CARDINIA	9
GREATER BENDIGO	9
MAROONDAH	9
MITCHELL	9
SURF COAST	9
GREATER SHEPPARTON	8
MOUNT ALEXANDER	6
WELLINGTON	6
BAW BAW	5
LATROBE	5
MACEDON RANGES	5
WARRNAMBOOL	5
BENALLA	3

LODDON	3
MILDURA	3
NORTHERN GRAMPIANS	3
SOUTH GIPPSLAND	3
SOUTHERN GRAMPIANS	3
BASS COAST	2
CAMPASPE	2
HEPBURN	2
HORSHAM	2
MANSFIELD	2
STRATHBOGIE	2
SWAN HILL	2
ARARAT	1
CENTRAL GOLDFIELDS	1
CORANGAMITE	1
EAST GIPPSLAND	1
GANNAWARRA	1
GLENELG	1
GOLDEN PLAINS	1
MOORABOOL	1
MOYNE	1
MURRINDINDI	1
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CORONAVIRUS (/CORONAVIRUS)

Victoria's restriction levels (/victorias-restriction-levels-covid-19)

How to stay safe and well (/how-stay-safe-and-well-covid-19)

Getting tested (/getting-tested)

For health services and professionals (/health-services-and-professionals-coronavirus-covid-19)

Latest news and data (/latest-news-and-data-coronavirus-covid-19)

- Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)
- Case locations and outbreaks (/case-locations-and-outbreaks)
- Coronavirus testing data by local government area (/coronavirus-testing-data-local-government-area)
- Contact tracing data (/contact-tracing-data-covid-19)
- Averages for easing restrictions (/averages-easing-restrictions-covid-19)
- COVID-19 Infections Among Healthcare Workers (/victorian-healthcare-worker-covid-19-data)
- Emerging from lockdown – model (/emerging-lockdown-model)
- Tracking coronavirus in Victoria (/tracking-coronavirus-victoria)
- Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)
- **Media hub - coronavirus (COVID-19) (/media-hub-coronavirus-disease-covid-19)**
- Promotional material (/promotional-material-coronavirus-covid-19)
- Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

Business and industry (/business-sector-coronavirus-disease-covid-19)

Aboriginal and Torres Strait Islander communities (/coronavirus-information-aboriginal-and-torres-strait-islander-communities)

Was this page useful?

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Back to top

Updated on 19/06/2020

About the site

Copyright (/copyright)

Disclaimer (/disclaimer)

Privacy statement (/privacy-statement)

Accessibility (/accessibility)

Sitemap (/sitemap)

Our websites

Services (http://services.dhhs.vic.gov.au/)

Service providers (http://providers.dhhs.vic.gov.au/)

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Coronavirus update for Victoria - 6 April 2020

> Media release
> 6 April 2020

The total number of coronavirus (COVID-19) cases in Victoria is 1158 – an increase of 23 from yesterday, as testing for the virus expands.

Yesterday a man in his 50s died in hospital and a woman in her 80s died at home, taking the number of people who have died in Victoria from coronavirus to 10.

The total number of cases includes 608 men and 550 women. Cases range in age from babies to their early nineties.

There are 88 confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission. More than 57,000 tests have been conducted to date.

Currently 45 people are in hospital – including 11 patients in intensive care – and 620 people have recovered.

Of the total 1158 cases, there have been 940 in Melbourne and 212 in regional Victoria. A number of cases remain under investigation.

Victoria's testing criteria for COVID-19 have been broadened to include people whose employment and contact with the broader public may place them at higher risk of exposure to any virus which maybe circulating in the community.

If someone in the following categories displays clinical symptoms – a fever or acute respiratory infection – they will now be tested for COVID-19.

- Childcare and early childhood education
- Primary or secondary schools; and
- Firefighters who are emergency medical responders
- People aged 65 years and older.

The full testing criteria list is available at https://www2.health.vic.gov.au/about/news-and-events/healthalerts/2019-Coronavirus-disease--COVID-19 (https://www2.health.vic.gov.au/about/news-and-events/healthalerts/2019-Coronavirus-disease--COVID-19)

Victoria's Chief Health Officer Professor Brett Sutton said the changes are aimed at striking a balance between identifying cases that are not linked to known travel or other risks and maintaining current suppression efforts targeted at returned travellers and contacts of current cases.

'The number of community acquired cases contracted from an unknown source are continuing to rise – the expansion of the testing criteria will allow us to get a clearer picture of how much the virus is circulating,' Professor Sutton said.

'These new criteria do not mean our stage 3 restrictions should be relaxed. The reverse is true, we must continue these actions to flatten the curve.'

Our contact tracing of all known cases will continue so that anyone who has been exposed to a confirmed case completes the mandatory 14 days in self-isolation.

There are only four reasons for Victorians to leave their home: food and supplies, medical care and care giving, exercise, and work or education.

All people arriving from any international destination must also self-isolate for 14 days as per Commonwealth Government direction. All travelers returning from overseas to Victoria will be placed in enforced quarantine for the self-isolation period of 14 days.

Police have strong powers to enforce these directions and can issue on the spot fines, including up to $1652 for individuals and up to $9913 for businesses.

Under the State of Emergency people who don't comply could also be taken to court and receive a fine of up to $20,000. Companies face fines of up to $100,000.

'Social distancing will save lives. Everyone needs to comply with restrictions in place to keep yourself, your loved ones and the whole community safe,' Professor Sutton said.

'Our message is clear: if you can stay home, you must stay home.'

The Victorian Department of Health and Human Services has a hotline for public information on COVID-19, which is 1800 675 398. Large numbers of calls can result in some delays and we ask Victorians for their patience as we work to manage the volume.

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Cases by Local Government Areas

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STONNINGTON	86
BANYULE	72
BOROONDARA	58

GREATER GEELONG	56
MORNINGTON PENINSULA	53
MELBOURNE	50
MORELAND	46
GLEN EIRA	46
MONASH	39
CASEY	40
PORT PHILLIP	38
FRANKSTON	35
HUME	32
MOONEE VALLEY	33
BRIMBANK	28
DAREBIN	29
WYNDHAM	27
BAYSIDE	27
MANNINGHAM	24
NILLUMBIK	21
YARRA	21
WHITEHORSE	20
YARRA RANGES	20
MELTON	18
KINGSTON	17
WHITTLESEA	18
HOBSONS BAY	13
KNOX	12
GREATER DANDENONG	12

BALLARAT	10
MARIBYRNONG	10
MOIRA	10
CARDINIA	10
GREATER BENDIGO	9
MAROONDAH	9
MITCHELL	9
SURF COAST	9
GREATER SHEPPARTON	8
MOUNT ALEXANDER	6
WELLINGTON	7
BAW BAW	5
LATROBE	5
MACEDON RANGES	5
WARRNAMBOOL	5
BENALLA	3
LODDON	3
MILDURA	3
NORTHERN GRAMPIANS	3
SOUTH GIPPSLAND	3
SOUTHERN GRAMPIANS	3
BASS COAST	2
CAMPASPE	2
HEPBURN	2
HORSHAM	2
MANSFIELD	2

STRATHBOGIE	2
SWAN HILL	2
ARARAT	1
CENTRAL GOLDFIELDS	1
CORANGAMITE	1
EAST GIPPSLAND	1
GANNAWARRA	1
GLENELG	1
GOLDEN PLAINS	1
MOORABOOL	1
MOYNE	1
MURRINDINDI	1
WANGARATTA	1
WEST WIMMERA	1
WODONGA	1
YARRIAMBIACK	1

CORONAVIRUS (/CORONAVIRUS)

Victoria's restriction levels (/victorias-restriction-levels-covid-19)

How to stay safe and well (/how-stay-safe-and-well-covid-19)

Getting tested (/getting-tested)

For health services and professionals (/health-services-and-professionals-coronavirus-covid-19)

> **Latest news and data (/latest-news-and-data-coronavirus-covid-19)**

Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)

Case locations and outbreaks (/case-locations-and-outbreaks)

Coronavirus testing data by local government area (/coronavirus-testing-data-local-government-area)

Contact tracing data (/contact-tracing-data-covid-19)

Averages for easing restrictions (/averages-easing-restrictions-covid-19)

COVID-19 Infections Among Healthcare Workers (/victorian-healthcare-worker-covid-19-data)

Emerging from lockdown – model (/emerging-lockdown-model)

Tracking coronavirus in Victoria (/tracking-coronavirus-victoria)

Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)

Media hub - coronavirus (COVID-19) (/media-hub-coronavirus-disease-covid-19)

Promotional material (/promotional-material-coronavirus-covid-19)

Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

Business and industry (/business-sector-coronavirus-disease-covid-19)

Aboriginal and Torres Strait Islander communities (/coronavirus-information-aboriginal-and-torres-strait-islander-communities)

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Back to top

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Accessibility (/accessibility)

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Our websites

Services (http://services.dhhs.vic.gov.au/)

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The department is committed to safe and inclusive work places, policies and services for people of LGBTIQ communities and their families.

Coronavirus update for Victoria - 7 April 2020

Media release
7 April 2020

The total number of coronavirus (COVID-19) cases in Victoria is 1191 – an increase of 33 from yesterday.

Yesterday a woman in her 80s died in hospital, taking the number of people who have died in Victoria from coronavirus to 11, as new measures come into force from tonight to further slow the spread.

The total number of cases includes 623 men and 568 women. Cases range in age from babies to their early nineties.

There are 93 confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission. More than 58,000 tests have been conducted to date.

Currently 47 people are in hospital – including 13 patients in intensive care – and 686 people have recovered.

Of the total 1191 cases, there have been 966 in Melbourne and 217 in regional Victoria. A number of cases remain under investigation.

New measures come into force at midnight tonight to further slow the spread of coronavirus in Victoria.

These new directions have been authorised by the Chief Health Officer, Professor Brett Sutton, and are consistent with recent decisions made by National Cabinet.

Changes to the restricted activities include:

- Livestreaming of religious services is possible, however the services can only be attended by those people necessary to conduct and livestream the service.
- Introduction of a truck stop provision exclusively for long haul drivers who can dine in a dedicated section, as long as the physical distancing four square metre rule (/four-square-metre-rule-covid-19) is observed.

The Chief Health Officer has also amended current stay at home directions to provide further clarity about childcare arrangements.

To be clear, you can have another person come to your house to look after your child if you need to go out for one of the four listed reasons, or if you are working or studying at home.

You may also drop your child at another person's house to be looked after, while you are out – if it is for one of the four listed reasons.

There are only four reasons for Victorians to leave their home: food and supplies, medical care and care giving, exercise, and work or education.

Further details on the new directions can be found at https://www.dhhs.vic.gov.au/state-emergency (https://www.dhhs.vic.gov.au/state-emergency). Once again, the community is urged to consider whether an activity is truly necessary at this time.

Restrictions on visitors to hospitals have now also been expanded to cover residential care facilities for disability services, alcohol and drug services and secure welfare services.

You must not enter a care facility unless you are a resident, staff member or are visiting a resident of the facility, and even then, only in limited circumstances.

Visits will be limited to one per day, for a maximum of two hours and with no more than two people at one time.

"It's important that we have the right measures in place to slow the spread of this virus and protect the most vulnerable in our community," Professor Sutton said.

"We know these restrictions will be hard for some people, but everyone needs to comply with the measures to the best of their abilities to keep yourself and your loved ones safe."

"There is no doubt about it – physical distancing will save lives. I urge people not to look for loopholes, but to follow the advice and do the right thing."

"Our message is clear: if you can stay home, you must stay home."

The Department of Health and Human Services follows up and monitors all close contacts of confirmed cases and provides them with information and support. All close contacts must self-isolate for 14 days.

All people arriving from any international destination must also self-isolate for 14 days as per Commonwealth Government direction. All travellers returning from overseas to Victoria will be placed in enforced quarantine for the self-isolation period of 14 days.

Police have strong powers to enforce these directions and can issue on the spot fines, including up to $1652 for individuals and up to $9913 for businesses.

Under the State of Emergency people who don't comply could also be taken to court and receive a fine of up to $20,000. Companies face fines of up to $100,000.

The Victorian Department of Health and Human Services has a hotline for public information on COVID-19, which is 1800 675 398. Large numbers of calls can result in some delays and we ask Victorians for their patience as we work to manage the volume.

Further information is also available at www.dhhs.vic.gov.au/coronavirus (https://www.dhhs.vic.gov.au/coronavirus)

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Cases by Local Government Areas

Please find the latest COVID-19 notifications by local government areas below. Note:

- Residential location is the residential address provided when the case is notified.
- This is not where they were infected and may not be where the case currently resides.
- Numbers are correct as of 11.59pm last night, but are subject to change as cases are followed up and data is analysed.

Local Government Area	Cases
STONNINGTON	87
BANYULE	72
BOROONDARA	58
GREATER GEELONG	56
MORNINGTON PENINSULA	54
MELBOURNE	53
MORELAND	46
CASEY	45
GLEN EIRA	45
PORT PHILLIP	42
MONASH	40
MOONEE VALLEY	36
FRANKSTON	35
HUME	32
DAREBIN	29
BRIMBANK	28
BAYSIDE	27

WYNDHAM	27
MANNINGHAM	24
YARRA	23
NILLUMBIK	21
WHITEHORSE	21
YARRA RANGES	20
WHITTLESEA	19
KINGSTON	18
MELTON	18
GREATER DANDENONG	14
HOBSONS BAY	13
KNOX	12
CARDINIA	11
BALLARAT	10
MARIBYRNONG	10
MOIRA	10
GREATER BENDIGO	9
GREATER SHEPPARTON	9
MAROONDAH	9
MITCHELL	9
SURF COAST	9
WELLINGTON	8
LATROBE	6
MOUNT ALEXANDER	6
BAW BAW	5
MACEDON RANGES	5

WARRNAMBOOL	5
SOUTH GIPPSLAND	4
BENALLA	3
LODDON	3
MANSFIELD	3
MILDURA	3
NORTHERN GRAMPIANS	3
SWAN HILL	3
BASS COAST	2
CAMPASPE	2
HEPBURN	2
HORSHAM	2
SOUTHERN GRAMPIANS	2
STRATHBOGIE	2
ARARAT	1
CENTRAL GOLDFIELDS	1
CORANGAMITE	1
EAST GIPPSLAND	1
GANNAWARRA	1
GOLDEN PLAINS	1
MOORABOOL	1
MOYNE	1
MURRINDINDI	1
WANGARATTA	1
WEST WIMMERA	1
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CORONAVIRUS (/CORONAVIRUS)

Victoria's restriction levels (/victorias-restriction-levels-covid-19)

How to stay safe and well (/how-stay-safe-and-well-covid-19)

Getting tested (/getting-tested)

For health services and professionals (/health-services-and-professionals-coronavirus-covid-19)

Latest news and data (/latest-news-and-data-coronavirus-covid-19)

Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)

Case locations and outbreaks (/case-locations-and-outbreaks)

Coronavirus testing data by local government area (/coronavirus-testing-data-local-government-area)

Contact tracing data (/contact-tracing-data-covid-19)

Averages for easing restrictions (/averages-easing-restrictions-covid-19)

COVID-19 Infections Among Healthcare Workers (/victorian-healthcare-worker-covid-19-data)

Emerging from lockdown – model (/emerging-lockdown-model)

Tracking coronavirus in Victoria (/tracking-coronavirus-victoria)

Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)

Media hub - coronavirus (COVID-19) (/media-hub-coronavirus-disease-covid-19)

Promotional material (/promotional-material-coronavirus-covid-19)

Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

Business and industry (/business-sector-coronavirus-disease-covid-19)

Aboriginal and Torres Strait Islander communities (/coronavirus-information-aboriginal-and-torres-strait-islander-communities)

Was this page useful?

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Back to top

Updated on 18/08/2020

About the site

Copyright (/copyright)

Disclaimer (/disclaimer)

Privacy statement (/privacy-statement)

Accessibility (/accessibility)

Sitemap (/sitemap)

Our websites

Services (http://services.dhhs.vic.gov.au/)

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The department is committed to safe and inclusive work places, policies and services for people of LGBTIQ communities and their families.

Coronavirus update for Victoria - 8 April 2020

Media release
8 April 2020

The total number of coronavirus (COVID-19) cases in Victoria is 1212 – an increase of 21 from yesterday, as new measures came into force at midnight last night to further slow the spread.

Yesterday a woman in her 80s died in hospital, taking the number of people who have died in Victoria from coronavirus to 12.

The total number of cases includes 635 men and 577 women. Cases range in age from babies to their early nineties.

There are 101 confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission. More than 60,000 tests have been conducted to date.

Currently 45 people are in hospital – including 12 patients in intensive care – and 736 people have recovered.

Of the total 1212 cases, there have been 980 in Melbourne and 225 in regional Victoria. Several cases remain under investigation.

The Department of Health and Human Services follows up and monitors all close contacts of confirmed cases and provides them with information and support. All close contacts must self-isolate for 14 days.

In a move to ensure rapid access to essential medicines for all Victorians, a new emergency order has been enacted so that pharmacists can now receive digital images of Schedule 4 prescriptions from a prescriber without relying on the original or faxed copy. This means for patients that are self-isolating, their GP can email their pharmacist who may be able to arrange delivery to their home.

There are only four reasons for Victorians to leave their home: food and supplies, medical care and care giving, exercise, and work or education.

Police have strong powers to enforce these directions and can issue on the spot fines, including up to $1652 for individuals and up to $9913 for businesses.

Under the State of Emergency people who don't comply could also be taken to court and receive a fine of up to $20,000. Companies face fines of up to $100,000.

Victoria's Chief Health Officer Professor Brett Sutton today urged Victorians to stay vigilant, particularly as we approach the Easter holidays.

"The rules are clear - and they don't change over Easter: if you can stay at home, you must stay at home," Professor Sutton said.

"This is tough for many families, but no Easter holiday is worth a life. Stay at home, protect the health system, and save lives.

"There is no doubt about it – physical distancing will save lives. I urge people not to look for loopholes but to follow the advice and do the right thing."

The Victorian Department of Health and Human Services has a hotline for public information on COVID-19, which is 1800 675 398. Large numbers of calls can result in some delays and we ask Victorians for their patience as we work to manage the volume.

Further information is also available at www.dhhs.vic.gov.au/coronavirus (https://www.dhhs.vic.gov.au/coronavirus)

Media inquiries

Department of Health & Human Services Media Unit (03) 9096 8860 or press@dhhs.vic.gov.au (mailto:press@dhhs.vic.gov.au)

Cases by Local Government Areas

Please find the latest COVID-19 notifications by local government areas below.

Note:

- Residential location is the residential address provided when the case is notified.
- This is not where they were infected and may not be where the case currently resides.
- Numbers are correct as of 11.59pm last night but are subject to change as cases are followed up and data is analysed.

Local Government Area	Cases
ARARAT	1
BALLARAT	10
BANYULE	73
BASS COAST	4
BAW BAW	5
BAYSIDE	29
BENALLA	3
BOROONDARA	58
BRIMBANK	28
CAMPASPE	2
CARDINIA	11
CASEY	45
CENTRAL GOLDFIELDS	1
CORANGAMITE	1

Local Government Area	Cases
DAREBIN	32
EAST GIPPSLAND	1
FRANKSTON	36
GANNAWARRA	1
GLEN EIRA	45
GOLDEN PLAINS	1
GREATER BENDIGO	9
GREATER DANDENONG	15
GREATER GEELONG	57
GREATER SHEPPARTON	9
HEPBURN	2
HOBSONS BAY	13
HORSHAM	3
HUME	34
KINGSTON	19
KNOX	12
LATROBE	6
LODDON	3
MACEDON RANGES	5
MANNINGHAM	24
MANSFIELD	3
MARIBYRNONG	10
MAROONDAH	9
MELBOURNE	55
MELTON	18

Local Government Area	Cases
MILDURA	5
MITCHELL	9
MOIRA	10
MONASH	40
MOONEE VALLEY	36
MOORABOOL	1
MORELAND	47
MORNINGTON PENINSULA	54
MOUNT ALEXANDER	6
MOYNE	1
MURRINDINDI	1
NILLUMBIK	21
NORTHERN GRAMPIANS	3
PORT PHILLIP	41
SOUTH GIPPSLAND	4
SOUTHERN GRAMPIANS	2
STONNINGTON	87
STRATHBOGIE	2
SURF COAST	9
SWAN HILL	3
WANGARATTA	1
WARRNAMBOOL	5
WELLINGTON	8
WEST WIMMERA	1
WHITEHORSE	21

Local Government Area	Cases
WHITTLESEA	21
WODONGA	1
WYNDHAM	27
YARRA	23
YARRA RANGES	21
YARRIAMBIACK	1
UNKNOWN	2

CORONAVIRUS (/CORONAVIRUS)

Victoria's restriction levels (/victorias-restriction-levels-covid-19)

How to stay safe and well (/how-stay-safe-and-well-covid-19)

Getting tested (/getting-tested)

For health services and professionals (/health-services-and-professionals-coronavirus-covid-19)

Latest news and data (/latest-news-and-data-coronavirus-covid-19)

Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)

Case locations and outbreaks (/case-locations-and-outbreaks)

Coronavirus testing data by local government area (/coronavirus-testing-data-local-government-area)

Contact tracing data (/contact-tracing-data-covid-19)

Averages for easing restrictions (/averages-easing-restrictions-covid-19)

COVID-19 Infections Among Healthcare Workers (/victorian-healthcare-worker-covid-19-data)

Emerging from lockdown – model (/emerging-lockdown-model)

Tracking coronavirus in Victoria (/tracking-coronavirus-victoria)

Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)

Media hub - coronavirus (COVID-19) (/media-hub-coronavirus-disease-covid-19)

Promotional material (/promotional-material-coronavirus-covid-19)

Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

Business and industry (/business-sector-coronavirus-disease-covid-19)

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Back to top

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Our websites

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Coronavirus update for Victoria - 9 April 2020

> Media release
> 9 April 2020

The total number of coronavirus (COVID-19) cases in Victoria is 1228 – an increase of 16 from yesterday.

There were no new deaths overnight. The number of people who have died in Victoria from coronavirus is 12.

The total number of cases includes 642 men and 585 women. Cases range in age from babies to their early nineties.

There are 110 confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission. More than 62,000 tests have been conducted to date.

Currently 50 people are in hospital – including 13 patients in intensive care – and 806 people have recovered.

Of the total 1228 cases, there have been 992 in Melbourne and 225 in regional Victoria. Several cases remain under investigation.

The Department of Health and Human Services follows up and monitors all close contacts of confirmed cases and provides them with information and support. All close contacts must self-isolate for 14 days.

There are only four reasons for Victorians to leave their home: food and supplies, medical care and care giving, exercise, and work or education.

Police have strong powers to enforce these directions and can issue on the spot fines, including up to $1652 for individuals and up to $9913 for businesses.

Under the State of Emergency people who don't comply could also be taken to court and receive a fine of up to $20,000. Companies face fines of up to $100,000.

Police will be out in full force over the Easter long weekend issuing fines to anyone who disobeys these directions.

Victoria's Chief Health Officer Professor Brett Sutton today urged Victorians to stay vigilant, particularly as we approach the Easter holidays.

"The rules are clear - and they don't change over Easter: if you can stay at home, you must stay at home," Professor Sutton said.

"This is tough for many families, but no Easter holiday is worth a life. Stay at home, protect the health system, and save lives.

"This is not a normal Easter. Travelling, visiting friends, heading to the beach or staying in regional Victoria could see all our hard-won gains evaporate.

"There is no doubt about it – physical distancing will save lives. I urge people not to look for loopholes but to follow the advice and do the right thing."

The Victorian Department of Health and Human Services has a hotline for public information on COVID-19, which is 1800 675 398. Large numbers of calls can result in some delays and we ask Victorians for their patience as we work to manage the volume.

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Local Government Area Cases

STONNINGTON - 87
BANYULE - 75
BOROONDARA - 59
GREATER GEELONG - 58
MELBOURNE - 55
MORNINGTON PENINSULA - 54
CASEY - 47
MORELAND - 47
GLEN EIRA - 45
PORT PHILLIP - 44
MONASH - 40
FRANKSTON - 36
MOONEE VALLEY - 36
HUME - 33
DAREBIN - 32
BAYSIDE - 29
BRIMBANK - 28
WYNDHAM - 27
MANNINGHAM - 24
YARRA - 23
NILLUMBIK - 22

WHITTLESEA - 22
WHITEHORSE - 21
YARRA RANGES - 21
KINGSTON - 20
MELTON - 18
GREATER DANDENONG - 15
HOBSONS BAY - 13
KNOX - 12
CARDINIA - 11
BALLARAT - 10
MARIBYRNONG - 10
MOIRA - 10
GREATER BENDIGO - 9
GREATER SHEPPARTON - 9
MAROONDAH - 9
MITCHELL - 9
SURF COAST - 9
WELLINGTON - 8
LATROBE - 6
MOUNT ALEXANDER - 6
BAW BAW - 5
MACEDON RANGES - 5
MILDURA - 5
WARRNAMBOOL - 5
BASS COAST - 4
SOUTH GIPPSLAND - 4
BENALLA - 3
HORSHAM - 3
LODDON - 3
MANSFIELD - 3
NORTHERN GRAMPIANS - 3
SWAN HILL - 3
CAMPASPE - 2
HEPBURN - 2
SOUTHERN GRAMPIANS - 2
STRATHBOGIE - 2
ARARAT - 1
CENTRAL GOLDFIELDS - 1
CORANGAMITE - 1
EAST GIPPSLAND -1
GANNAWARRA - 1

GOLDEN PLAINS - 1
MOORABOOL - 1
MOYNE - 1
MURRINDINDI - 1
WANGARATTA - 1
WEST WIMMERA - 1
WODONGA - 1
YARRIAMBIACK - 1
Unknown - 4

CORONAVIRUS (/CORONAVIRUS)

Victoria's restriction levels (/victorias-restriction-levels-covid-19)

How to stay safe and well (/how-stay-safe-and-well-covid-19)

Getting tested (/getting-tested)

For health services and professionals (/health-services-and-professionals-coronavirus-covid-19)

Latest news and data (/latest-news-and-data-coronavirus-covid-19)

Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)

Case locations and outbreaks (/case-locations-and-outbreaks)

Coronavirus testing data by local government area (/coronavirus-testing-data-local-government-area)

Contact tracing data (/contact-tracing-data-covid-19)

Averages for easing restrictions (/averages-easing-restrictions-covid-19)

COVID-19 Infections Among Healthcare Workers (/victorian-healthcare-worker-covid-19-data)

Emerging from lockdown – model (/emerging-lockdown-model)

Tracking coronavirus in Victoria (/tracking-coronavirus-victoria)

Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)

Media hub - coronavirus (COVID-19) (/media-hub-coronavirus-disease-covid-19)

Promotional material (/promotional-material-coronavirus-covid-19)

Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

Business and industry (/business-sector-coronavirus-disease-covid-19)

Aboriginal and Torres Strait Islander communities (/coronavirus-information-aboriginal-and-torres-strait-islander-communities)

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Back to top

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About the site

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Accessibility (/accessibility)

Sitemap (/sitemap)

Our websites

Services (http://services.dhhs.vic.gov.au/)

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_(/)

Coronavirus update for Victoria - 10 April 2020

Media release
10 April 2020

The total number of coronavirus (COVID-19) cases in Victoria is 1241 – an increase of 13 from yesterday.

There was one new death yesterday, a man in his 80s who died in hospital, taking the number of people who have died in Victoria from coronavirus to 13.

The total number of cases includes 650 men and 591 women. Cases range in age from babies to their early nineties.

There are 116 confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission, six more than yesterday. Nearly 65,000 tests have been conducted to date.

Currently 43 people are in hospital – including 13 patients in intensive care – and 926 people have recovered.

Of the total 1241 cases, there have been 1001 in Melbourne and 229 in regional Victoria. Several cases remain under investigation.

The Department of Health and Human Services follows up and monitors all close contacts of confirmed cases and provides them with information and support. All close contacts must self-isolate for 14 days.

There are only four reasons for Victorians to leave their home: food and supplies, medical care and care giving, exercise, and work or education.

Police have strong powers to enforce these directions and can issue on the spot fines, including up to $1652 for individuals and up to $9913 for businesses.

Under the State of Emergency people who don't comply could also be taken to court and receive a fine of up to $20,000. Companies face fines of up to $100,000.

Police will be out in full force over the Easter long weekend issuing fines to anyone who disobeys these directions.

With the start of the Easter holidays, Victoria's Chief Health Officer Professor Brett Sutton today repeated his strong message that Victorians must continue to be vigilant in practicing physical distancing and staying at home for all but essential outings.

"The rules are clear - and they don't change over Easter: stay at home," Professor Sutton said.

"This is tough for many families, but no Easter holiday is worth a life. Stay at home, protect the health system, and save lives.

"This is not a normal Easter. Travelling, visiting friends, heading to the beach or staying in regional Victoria could see all our hard-won gains evaporate.

"Physical distancing will save lives. I urge people not to look for loopholes but to do the right thing."

The Victorian Department of Health and Human Services has a hotline for public information on COVID-19, which is 1800 675 398. Large numbers of calls can result in some delays and we ask Victorians for their patience as we work to manage the volume.

Further information is also available at www.dhhs.vic.gov.au/coronavirus (/coronavirus)

Media inquiries

Department of Health & Human Services Media Unit (03) 9096 8860 or press@dhhs.vic.gov.au (mailto:press@dhhs.vic.gov.au)

Cases by Local Government Areas

Please find the latest COVID-19 notifications by local government areas below.

Note:

- Residential location is the residential address provided when the case is notified.
- This is not where they were infected and may not be where the case currently resides.
- Numbers are correct as of 11.59pm last night but are subject to change as cases are followed up and data is analysed.

STONNINGTON - 87
BANYULE - 77
BOROONDARA - 59
GREATER GEELONG - 58
MELBOURNE - 55
MORNINGTON PENINSULA - 55
CASEY - 48
MORELAND - 48
GLEN EIRA - 45
PORT PHILLIP - 44
MONASH - 42
FRANKSTON - 36
MOONEE VALLEY - 35
HUME - 34
DAREBIN - 32
BAYSIDE - 29
BRIMBANK - 29
WYNDHAM - 27
MANNINGHAM - 24
KINGSTON - 23
YARRA - 23
WHITTLESEA - 22
NILLUMBIK - 21
WHITEHORSE - 21

YARRA RANGES - 21
MELTON - 18
GREATER DANDENONG - 15
HOBSONS BAY - 13
KNOX - 12
CARDINIA - 11
MOIRA - 11
BALLARAT - 10
MARIBYRNONG - 10
WELLINGTON - 10
GREATER BENDIGO - 9
GREATER SHEPPARTON - 9
MAROONDAH - 9
MITCHELL - 9
SURF COAST - 9
LATROBE - 6
MOUNT ALEXANDER - 6
BAW BAW - 5
MACEDON RANGES - 5
MILDURA - 5
WARRNAMBOOL - 5
BASS COAST - 4
SOUTH GIPPSLAND - 4
BENALLA - 3
HORSHAM - 3
LODDON - 3
MANSFIELD - 3
NORTHERN GRAMPIANS - 3
SWAN HILL - 3
CAMPASPE - 2
HEPBURN - 2
SOUTHERN GRAMPIANS - 2
STRATHBOGIE - 2
ARARAT - 1
CENTRAL GOLDFIELDS - 1
CORANGAMITE - 1
EAST GIPPSLAND - 1
GANNAWARRA - 1
GOLDEN PLAINS - 1
MOORABOOL - 1
MOYNE - 1

MURRINDINDI - 1
WANGARATTA - 1
WEST WIMMERA - 1
WODONGA - 1
YARRIAMBIACK - 1
Unknown - 2

CORONAVIRUS (/CORONAVIRUS)

Victoria's restriction levels (/victorias-restriction-levels-covid-19)

How to stay safe and well (/how-stay-safe-and-well-covid-19)

Getting tested (/getting-tested)

For health services and professionals (/health-services-and-professionals-coronavirus-covid-19)

Latest news and data (/latest-news-and-data-coronavirus-covid-19)

Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)

Case locations and outbreaks (/case-locations-and-outbreaks)

Coronavirus testing data by local government area (/coronavirus-testing-data-local-government-area)

Contact tracing data (/contact-tracing-data-covid-19)

Averages for easing restrictions (/averages-easing-restrictions-covid-19)

COVID-19 Infections Among Healthcare Workers (/victorian-healthcare-worker-covid-19-data)

Emerging from lockdown – model (/emerging-lockdown-model)

Tracking coronavirus in Victoria (/tracking-coronavirus-victoria)

Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)

Media hub - coronavirus (COVID-19) (/media-hub-coronavirus-disease-covid-19)

Promotional material (/promotional-material-coronavirus-covid-19)

Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

Business and industry (/business-sector-coronavirus-disease-covid-19)

Aboriginal and Torres Strait Islander communities (/coronavirus-information-aboriginal-and-torres-strait-islander-communities)

Was this page useful?

Yes No

Back to top

Updated on 13/08/2020

About the site

Copyright (/copyright)

Disclaimer (/disclaimer)

Privacy statement (/privacy-statement)

Accessibility (/accessibility)

Sitemap (/sitemap)

Our websites

Services (http://services.dhhs.vic.gov.au/)

Service providers (http://providers.dhhs.vic.gov.au/)

Health.vic (https://www2.health.vic.gov.au/)

HousingVic (http://housing.vic.gov.au/)

Better Health Channel (https://www.betterhealth.vic.gov.au/)

Seniors Online (https://www.seniorsonline.vic.gov.au/)

Funded Agency Channel (https://fac.dhhs.vic.gov.au/)

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Coronavirus update for Victoria - 11 April 2020

> Media release
> 11 April 2020

The total number of coronavirus (COVID-19) cases in Victoria is 1265 – an increase of 24 from yesterday.

There was one new death yesterday, a man in his eighties who died in hospital, taking the number of people who have died in Victoria from coronavirus to 14.

The total number of cases is made up of 661 men and 604 women, with people aged from babies to their early nineties.

At the present time, there are 118 confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission. Currently, 44 people are in hospital, including 15 patients in intensive care. 986 people have recovered. More than 67,000 Victorians have been tested to date.

Of the total 1265 cases, there have been 1012 in metropolitan Melbourne and 234 in regional Victoria. Several cases remain under investigation.

The Department of Health and Human Services follows up and monitors all close contacts of confirmed cases and provides them with information and support. All close contacts must self-isolate for 14-days.

There are only four reasons for Victorians to leave their home: food and supplies, medical care and care giving, exercise, and work or education.

Police have strong powers to enforce these directions and can issue on the spot fines, including up to $1,652 for individuals and up to $9,913 for businesses.

Under the State of Emergency people who don't comply could also be taken to court and receive a fine of up to $20,000. Companies face fines of up to $100,000.

Police will be out in full force over the Easter long weekend issuing fines to anyone who disobeys these directions.

With the Easter holidays in full swing, Victoria's Chief Health Officer Professor Brett Sutton today repeated his strong message that Victorians must continue to be vigilant in practicing physical distancing and staying at home for all but essential outings.

"The rules are clear and they don't change over Easter – stay at home," Professor Sutton said.

"This is tough for many families, but no Easter holiday is worth a life. Stay at home, protect the health system, and save lives.

"This is not a normal Easter. Travelling, visiting friends, heading to the beach or staying in regional Victoria could see all our hard-won gains evaporate.

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STONNINGTON - 88
BANYULE - 80
BOROONDARA - 60
GREATER GEELONG - 60
MELBOURNE - 56
MORNINGTON PENINSULA - 55
CASEY - 49
MORELAND - 49
GLEN EIRA - 46
PORT PHILLIP - 44
MONASH - 42
FRANKSTON - 36
MOONEE VALLEY - 35
HUME - 34
DAREBIN - 32
BRIMBANK - 30
BAYSIDE - 29
WYNDHAM - 27
MANNINGHAM - 25
YARRA - 23
KINGSTON - 22
WHITEHORSE - 22
WHITTLESEA - 22
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WELLINGTON - 10
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MAROONDAH - 9
MITCHELL - 9
LATROBE - 6
MOUNT ALEXANDER - 6
BAW BAW - 5
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MILDURA - 5
SOUTH GIPPSLAND - 5
WARRNAMBOOL - 5
BASS COAST - 4
BENALLA - 3
HORSHAM - 3
LODDON - 3
MANSFIELD - 3
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CAMPASPE - 2
HEPBURN - 2
SOUTHERN GRAMPIANS - 2
STRATHBOGIE - 2
WANGARATTA - 2
ARARAT - 1
CENTRAL GOLDFIELDS - 1
CORANGAMITE - 1
EAST GIPPSLAND - 1
GANNAWARRA - 1
GOLDEN PLAINS - 1
MOORABOOL - 1

MOYNE - 1
MURRINDINDI - 1
WEST WIMMERA - 1
WODONGA - 1
YARRIAMBIACK - 1
Unknown - 7

CORONAVIRUS (/CORONAVIRUS)

Victoria's restriction levels (/victorias-restriction-levels-covid-19)

How to stay safe and well (/how-stay-safe-and-well-covid-19)

Getting tested (/getting-tested)

For health services and professionals (/health-services-and-professionals-coronavirus-covid-19)

Latest news and data (/latest-news-and-data-coronavirus-covid-19)

Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)

Case locations and outbreaks (/case-locations-and-outbreaks)

Coronavirus testing data by local government area (/coronavirus-testing-data-local-government-area)

Contact tracing data (/contact-tracing-data-covid-19)

Averages for easing restrictions (/averages-easing-restrictions-covid-19)

COVID-19 Infections Among Healthcare Workers (/victorian-healthcare-worker-covid-19-data)

Emerging from lockdown – model (/emerging-lockdown-model)

Tracking coronavirus in Victoria (/tracking-coronavirus-victoria)

Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)

Media hub - coronavirus (COVID-19) (/media-hub-coronavirus-disease-covid-19)

Promotional material (/promotional-material-coronavirus-covid-19)

Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

Business and industry (/business-sector-coronavirus-disease-covid-19)

Aboriginal and Torres Strait Islander communities (/coronavirus-information-aboriginal-and-torres-strait-islander-communities)

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Back to top

Updated on 19/06/2020

About the site

Copyright (/copyright)

Disclaimer (/disclaimer)

Privacy statement (/privacy-statement)

Accessibility (/accessibility)

Sitemap (/sitemap)

Our websites

Services (http://services.dhhs.vic.gov.au/)

Service providers (http://providers.dhhs.vic.gov.au/)

Health.vic (https://www2.health.vic.gov.au/)

HousingVic (http://housing.vic.gov.au/)

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COVID-19 repatriation flights to land at Tullamarine airport

Media release
11 April 2020

The Victorian Government is working with the Commonwealth to ensure strict protocols are in place to keep passengers and staff safe on repatriation flights, and to protect the Victorian community once they disembark.

More than 1200 Australians are expected to land at Melbourne's Tullamarine airport over the course of the weekend after the Federal Government gave the green light for the flights to proceed.

The flights will carry Australian and New Zealander passengers and depart from Peru, Delhi and Uruguay. All passengers will be subject to strict quarantine protocols that require them to be medically screened before being transported to hotels for their 14 days isolation.

The repatriation flight from Uruguay is expected to contain a number of passengers who have tested positive to coronavirus, and the Victorian Government has sought assurances from the Commonwealth that they will be safe during their transit to Victoria. A majority of the passengers came from the cruise ship, Greg Mortimer.

Victoria's Deputy Chief Health Officer Dr Annaliese van Diemen said local health authorities have been working closely with the Federal Government, including Australian Border Force, to plan for the arrival of the Uruguay flight.

"Significant planning has been undertaken to ensure that the movement of the passengers and staff from the Uruguay flight is as safe as possible for them, and for the wider Victorian community." Dr van Diemen said.

"Our team has detailed safety arrangements in place and they will be followed to the letter – to protect Victorians and protect our hospital system."

"All passengers and staff will be screened when they arrive so we know exactly what we're dealing with and can ensure everyone on board is quarantined appropriately – whether that's in hospital or at a hotel."

When the flight arrives on Sunday, it will be met by a Field Emergency Medical Officer team to assess all passengers. Ambulance Victoria is on standby to transfer any passengers requiring hospitalisation to two of Melbourne's metropolitan hospitals.

Hospitals will also receive passengers who have not tested positive, but are displaying symptoms on arrival, for assessment and testing.

The remaining passengers from the Uruguay flight will all be transferred to the same hotel where they will be quarantined. During this time, onsite medical staff will provide ongoing support and assistance.

In the interests of patient confidentiality, no specific passenger details will be provided. The majority of passengers are Australians. A small number of passengers will board charter flights to return to New Zealand.

As agreed by the National Cabinet, all travellers returning from overseas to Victoria are now placed in mandatory quarantine for a self-isolation period of 14 days to slow the spread of coronavirus.

Media inquiries

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CORONAVIRUS (/CORONAVIRUS)

Victoria's restriction levels (/victorias-restriction-levels-covid-19)

How to stay safe and well (/how-stay-safe-and-well-covid-19)

Getting tested (/getting-tested)

For health services and professionals (/health-services-and-professionals-coronavirus-covid-19)

Latest news and data (/latest-news-and-data-coronavirus-covid-19)

Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)

Case locations and outbreaks (/case-locations-and-outbreaks)

Coronavirus testing data by local government area (/coronavirus-testing-data-local-government-area)

Contact tracing data (/contact-tracing-data-covid-19)

Averages for easing restrictions (/averages-easing-restrictions-covid-19)

COVID-19 Infections Among Healthcare Workers (/victorian-healthcare-worker-covid-19-data)

Emerging from lockdown – model (/emerging-lockdown-model)

Tracking coronavirus in Victoria (/tracking-coronavirus-victoria)

Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)

Media hub - coronavirus (COVID-19) (/media-hub-coronavirus-disease-covid-19)

Promotional material (/promotional-material-coronavirus-covid-19)

Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

Business and industry (/business-sector-coronavirus-disease-covid-19)

Aboriginal and Torres Strait Islander communities (/coronavirus-information-aboriginal-and-torres-strait-islander-communities)

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Back to top

Updated on 19/06/2020

About the site

Copyright (/copyright)

Disclaimer (/disclaimer)

Privacy statement (/privacy-statement)

Accessibility (/accessibility)

Sitemap (/sitemap)

Our websites

Services (http://services.dhhs.vic.gov.au/)

Service providers (http://providers.dhhs.vic.gov.au/)

Health.vic (https://www2.health.vic.gov.au/)

HousingVic (http://housing.vic.gov.au/)

Better Health Channel (https://www.betterhealth.vic.gov.au/)

Seniors Online (https://www.seniorsonline.vic.gov.au/)

Funded Agency Channel (https://fac.dhhs.vic.gov.au/)

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Coronavirus update for Victoria - 12 April 2020

Media release
12 April 2020

The total number of coronavirus (COVID-19) cases in Victoria is 1268 – an increase of three from yesterday.

There were no new deaths reported yesterday. To date, 14 people have died from coronavirus in Victoria.

The total number of cases is made up of 660 men and 608 women, with people aged from babies to their early nineties.

At the present time, there are 119 confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission. Currently 44 people are in hospital, including 16 patients in intensive care. 1015 people have recovered. More than 69,000 Victorians have been tested to date.

Of the total 1268 cases, there have been 1015 in metropolitan Melbourne and 234 in regional Victoria. Several cases remain under investigation.

The Department of Health and Human Services follows up and monitors all close contacts of confirmed cases and provides them with information and support. All close contacts must self-isolate for 14-days.

There are only four reasons for Victorians to leave their home: food and supplies, medical care and care giving, exercise, and work or education.

Police have strong powers to enforce these directions and can issue on the spot fines, including up to $1,652 for individuals and up to $9,913 for businesses.

Under the State of Emergency people who don't comply could also be taken to court and receive a fine of up to $20,000. Companies face fines of up to $100,000.

Police are out in full force over the Easter long weekend issuing fines to anyone who disobeys these directions.

With the Easter holidays continuing, Victoria's Chief Health Officer Professor Brett Sutton today repeated his strong message that Victorians must continue to be vigilant in practicing physical distancing and staying at home for all but essential outings.

"The rules are clear and they don't change over Easter – stay at home," Professor Sutton said.

"This is tough for many families, but no Easter holiday is worth a life. Stay at home, protect the health system, and save lives."

More than 450 people will leave their city hotel in a staged procedure today, following 14 days of mandatory quarantine as returned international travellers.

The exit from quarantine will be managed to maintain appropriate physical distancing across a large number of people. People are being supported to travel home or on to other states.

Everyone leaving will undergo health checks and must follow the rules in place for all Victorians; that is to go home and stay home.

The Victorian Department of Health and Human Services has a hotline for public information on COVID-19 which is 1800 675 398. Large numbers of calls will result in some delays and we ask Victorians for their patience as we work to manage the volume.

Further information is also available at www.dhhs.vic.gov.au/coronavirus (https://www.dhhs.vic.gov.au/coronavirus)

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CORONAVIRUS (/CORONAVIRUS)

Victoria's restriction levels (/victorias-restriction-levels-covid-19)

How to stay safe and well (/how-stay-safe-and-well-covid-19)

Getting tested (/getting-tested)

For health services and professionals (/health-services-and-professionals-coronavirus-covid-19)

Latest news and data (/latest-news-and-data-coronavirus-covid-19)

Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)

Case locations and outbreaks (/case-locations-and-outbreaks)

Coronavirus testing data by local government area (/coronavirus-testing-data-local-government-area)

Contact tracing data (/contact-tracing-data-covid-19)

Averages for easing restrictions (/averages-easing-restrictions-covid-19)

COVID-19 Infections Among Healthcare Workers (/victorian-healthcare-worker-covid-19-data)

Emerging from lockdown – model (/emerging-lockdown-model)

Tracking coronavirus in Victoria (/tracking-coronavirus-victoria)

Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)

Media hub - coronavirus (COVID-19) (/media-hub-coronavirus-disease-covid-19)

Promotional material (/promotional-material-coronavirus-covid-19)

Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

Business and industry (/business-sector-coronavirus-disease-covid-19)

Aboriginal and Torres Strait Islander communities (/coronavirus-information-aboriginal-and-torres-strait-islander-communities)

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Back to top

Updated on 19/06/2020

About the site

Copyright (/copyright)

Disclaimer (/disclaimer)

Privacy statement (/privacy-statement)

Accessibility (/accessibility)

Sitemap (/sitemap)

Our websites

Services (http://services.dhhs.vic.gov.au/)

Service providers (http://providers.dhhs.vic.gov.au/)

Health.vic (https://www2.health.vic.gov.au/)

HousingVic (http://housing.vic.gov.au/)

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Coronavirus update for Victoria - 13 April 2020

Media release
13 April 2020

The total number of coronavirus (COVID-19) cases in Victoria is 1281 – an increase of 13 from yesterday.

There were no new deaths reported yesterday. To date, 14 people have died from coronavirus in Victoria.

The total number of cases is made up of 669 men and 612 women, with people aged from babies to their early nineties.

At the present time, there are 122 confirmed cases of COVID-19 in Victoria that may have been acquired through community transmission. Currently 40 people are in hospital, including 14 patients in intensive care. 1075 people have recovered. More than 70,000 Victorians have been tested to date.

Of the total 1281 cases, there have been 1022 in metropolitan Melbourne and 235 in regional Victoria. Several cases remain under investigation.

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Under the State of Emergency people who don't comply could also be taken to court and receive a fine of up to $20,000. Companies face fines of up to $100,000.

Victoria's Chief Health Officer Professor Brett Sutton today urged Victorians to remain vigilant and not erode the gains made in preventing the spread of the virus over Easter.

"Now is not the time for complacency. We still have a long way to go," Professor Sutton said.

"While we are starting to see some improvement in the rate of transmission, that rate could climb quickly if we lose focus.

"We thank those Victorians who overwhelmingly are doing the right thing by staying at home, but we must keep at it to save lives.

"Everyone who's unwell must isolate themselves and everyone who's been told they're in quarantine either as a returned traveller or close contact must do so.

"Physical distancing will save lives. Everyone needs to comply with restrictions in place to keep yourself, your loved ones and the whole community safe.

"Our message is clear: if you can stay home, you must stay home. Stay at home, protect the health system, and save lives."

The Victorian Department of Health and Human Services has a hotline for public information on COVID-19 which is 1800 675 398. Large numbers of calls will result in some delays and we ask Victorians for their patience as we work to manage the volume.

Further information is also available at https://www.dhhs.vic.gov.au/coronavirus (https://www.dhhs.vic.gov.au/coronavirus)

Media inquiries

Department of Health & Human Services Media Unit (03) 9096 8860 or press@dhhs.vic.gov.au (mailto:press@dhhs.vic.gov.au)

Cases by Local Government Areas

Please find the latest COVID-19 notifications by local government areas below.

Note:

- Residential location is the residential address provided when the case is notified.
- This is not where they were infected and may not be where the case currently resides.
- Numbers are correct as of 11.59pm last night but are subject to change as cases are followed up and data is analysed.

Local Government Area - Number of Cases

STONNINGTON - 88

BANYULE - 80

GREATER GEELONG - 61

BOROONDARA - 60

MELBOURNE - 59

MORNINGTON PENINSULA - 55

CASEY - 50

MORELAND - 49

GLEN EIRA - 47

PORT PHILLIP - 46

MONASH - 42

FRANKSTON - 36

MOONEE VALLEY - 36

HUME - 34

DAREBIN - 32

BRIMBANK - 31

BAYSIDE - 29

MANNINGHAM - 27

WYNDHAM - 27

YARRA - 23

KINGSTON - 22

WHITEHORSE - 22

WHITTLESEA - 22

NILLUMBIK - 21

YARRA RANGES - 21

MELTON - 18

GREATER DANDENONG - 15

HOBSONS BAY - 13

KNOX - 12

UNKNOWN - 12

CARDINIA - 11

MOIRA - 11

BALLARAT - 10

MARIBYRNONG - 10

SURF COAST - 10

WELLINGTON - 10

GREATER BENDIGO - 9

GREATER SHEPPARTON - 9

MAROONDAH - 9

MITCHELL - 9

LATROBE - 6

MOUNT ALEXANDER - 6

BAW BAW - 5

MACEDON RANGES - 5

MILDURA - 5

SOUTH GIPPSLAND - 5

WARRNAMBOOL - 5

BASS COAST - 4

BENALLA - 3

HORSHAM - 3

LODDON - 3

MANSFIELD - 3

NORTHERN GRAMPIANS - 3

SWAN HILL - 3

CAMPASPE - 2

HEPBURN - 2

SOUTHERN GRAMPIANS - 2

STRATHBOGIE - 2

WANGARATTA - 2

ARARAT - 1

CENTRAL GOLDFIELDS - 1

CORANGAMITE - 1

EAST GIPPSLAND - 1

GANNAWARRA - 1

GOLDEN PLAINS - 1

MOORABOOL - 1

MOYNE - 1

MURRINDINDI - 1

WEST WIMMERA - 1

WODONGA - 1

YARRIAMBIACK - 1

CORONAVIRUS (/CORONAVIRUS)

Victoria's restriction levels (/victorias-restriction-levels-covid-19)

How to stay safe and well (/how-stay-safe-and-well-covid-19)

Getting tested (/getting-tested)

For health services and professionals (/health-services-and-professionals-coronavirus-covid-19)

Latest news and data (/latest-news-and-data-coronavirus-covid-19)

Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)

Case locations and outbreaks (/case-locations-and-outbreaks)

Coronavirus testing data by local government area (/coronavirus-testing-data-local-government-area)

Contact tracing data (/contact-tracing-data-covid-19)

Averages for easing restrictions (/averages-easing-restrictions-covid-19)

COVID-19 Infections Among Healthcare Workers (/victorian-healthcare-worker-covid-19-data)

Emerging from lockdown – model (/emerging-lockdown-model)

Tracking coronavirus in Victoria (/tracking-coronavirus-victoria)

Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)

Media hub - coronavirus (COVID-19) (/media-hub-coronavirus-disease-covid-19)

Promotional material (/promotional-material-coronavirus-covid-19)

Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

Business and industry (/business-sector-coronavirus-disease-covid-19)

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Back to top

Updated on 19/06/2020

About the site

Copyright (/copyright)

Disclaimer (/disclaimer)

Privacy statement (/privacy-statement)

Accessibility (/accessibility)

Sitemap (/sitemap)

Our websites

Services (http://services.dhhs.vic.gov.au/)

Service providers (http://providers.dhhs.vic.gov.au/)

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Coronavirus update for Victoria - 14 April 2020

Media release
14 April 2020

The total number of coronavirus (COVID-19) cases in Victoria is 1,291 – an increase of 10 from yesterday, as testing for the virus expands in Victoria.

There were no new deaths reported yesterday. To date, 14 people have died from coronavirus in Victoria.

The total number of cases is made up of 672 men and 619 women, with people aged from babies to their early nineties.

There are 122 confirmed cases of coronavirus in Victoria that may have been acquired through community transmission. Currently 40 people are in hospital, including 15 patients in intensive care. 1,118 people have recovered. More than 71,000 Victorians have been tested to date.

Of the total 1,291 cases, there have been 1029 in metropolitan Melbourne and 236 in regional Victoria. Several cases remain under investigation.

To better track the spread of the virus in the community, Victoria is once again expanding the testing for COVID-19.

Testing will now be based only on the clinical symptoms of COVID-19, regardless of age or occupation – making Victoria's testing criteria the widest in Australia.

These symptoms include any new fever, chills or breathing problems, specifically cough, sore throat or shortness of breath.

Only people in the general community with these symptoms will be eligible for testing.

As the testing expands, the public can be assured that it will also continue for people with compatible symptoms who are close contacts of confirmed COVID-19 cases, travellers from overseas, cruise ships passengers, as well as healthcare workers and people whose employment and contact with the broader public may place them at higher risk.

Healthcare workers and other frontline employees will be able to have their test results returned faster, allowing them to get back to their vital work in the community as soon as possible.

We are able to expand testing because the number of people returning from overseas has significantly reduced, and more labs have come online - allowing us to test more people. There are now 40 screening clinics open across Melbourne and regional Victoria.

The current testing criteria is available at Health services and general practice - coronavirus disease (COVID-19) page (https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19).

"Victoria is at a pivotal time in the response to COVID-19," Professor Sutton said.

"We have been successful in decreasing the number of cases coming from overseas due to reduced international travel and quarantine measures, however we now need to focus on finding cases that are being transmitted in our community to further slow the spread."

"The testing criteria have therefore been changed to include people with clinical symptoms of COVID-19, irrespective of where they have travelled or any other criteria such as age or occupation.

"We must remain vigilant and not erode the gains made in slowing the spread of the virus. Now is not the time for complacency. We still have a long way to go.

"While we are starting to see some improvement in the rate of transmission, that rate could climb quickly if we lose focus.

"Physical distancing will save lives. Everyone needs to comply with restrictions in place to keep yourself, your loved ones and the whole community safe. Our message is clear: if you can stay home, you must stay home."

The Department of Health and Human Services follows up and monitors all close contacts of confirmed cases and provides them with information and support. All close contacts must self-isolate for 14-days.

There are only four reasons for Victorians to leave their home: food and supplies, medical care and care giving, exercise, and work or education.

Police have strong powers to enforce these directions and can issue on the spot fines, including up to $1,652 for individuals and up to $9,913 for businesses.

Under the State of Emergency people who don't comply could also be taken to court and receive a fine of up to $20,000. Companies face fines of up to $100,000.

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MORELAND - 49

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PORT PHILLIP - 46

MONASH - 43

FRANKSTON - 36

MOONEE VALLEY - 36

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YARRA - 23

KINGSTON - 22

NILLUMBIK - 22

WHITEHORSE - 22

WHITTLESEA - 22

YARRA RANGES - 21

MELTON - 18

GREATER DANDENONG - 16

HOBSONS BAY - 13

KNOX - 12

UNKNOWN - 12

CARDINIA - 11

MOIRA - 11

BALLARAT - 10

MARIBYRNONG - 10

SURF COAST - 10

WELLINGTON - 10

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CORONAVIRUS (/CORONAVIRUS)

Victoria's restriction levels (/victorias-restriction-levels-covid-19)

How to stay safe and well (/how-stay-safe-and-well-covid-19)

Getting tested (/getting-tested)

For health services and professionals (/health-services-and-professionals-coronavirus-covid-19)

Latest news and data (/latest-news-and-data-coronavirus-covid-19)

Victorian coronavirus (COVID-19) data (/victorian-coronavirus-covid-19-data)

Case locations and outbreaks (/case-locations-and-outbreaks)

Coronavirus testing data by local government area (/coronavirus-testing-data-local-government-area)

Contact tracing data (/contact-tracing-data-covid-19)

Averages for easing restrictions (/averages-easing-restrictions-covid-19)

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Coronavirus (COVID-19) daily update (/coronavirus-covid-19-daily-update)

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Promotional material (/promotional-material-coronavirus-covid-19)

Updates (/coronavirus/updates)

For service providers (/service-providers-coronavirus-disease-covid-19)

Business and industry (/business-sector-coronavirus-disease-covid-19)

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Back to top

Updated on 19/06/2020

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Copyright (/copyright)

Disclaimer (/disclaimer)

Privacy statement (/privacy-statement)

Accessibility (/accessibility)

Sitemap (/sitemap)

Our websites

Services (http://services.dhhs.vic.gov.au/)

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

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

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

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

State situation report

Health Protection Branch

PLEASE NOTE:
All updates must be emailed to publichealth.intelligence@dhhs.vic.gov.au before midnight to be included in the following morning's situation report.

FOR OFFICIAL USE ONLY

Incident name	Coronavirus disease 2019 (COVID-19) Pandemic				
Situation report number	53	**Incident level**	Public Health Emergency	**Date**	28/03/2020 07:30am

Critical Activity within the Victorian Public Health Response

- As of 28 March 2020, a total of 685 (an increase of 111 since yesterday) confirmed cases have been reported in Victoria.
- Data reported include 3 deaths due to COVID-19.
- There are 21 cases acquired in Victoria with unknown source (an increase of 5 since yesterday).
- Clusters of confirmed cases initially identified and under investigation, include:
    - Tertiary hospital: the index case was a patient who had no known travel history or known risk factors for acquisition.
    - Hospital emergency department: three linked cases are doctors with known risk factors for acquisition.
    - There is a cluster of imported cases from Colorado, US, associated with a gathering of Australians at a ski resort. A returned traveller from this event created a cluster after attending a restaurant in Melbourne.
    - There is a cluster of cases associated with a wedding in NSW.
    - There is cluster associated with another wedding that had several attendees from overseas.
- A state of emergency was declared in Victoria, effective from midday on Monday 16 March.
- From 11:59 on 28 March 2020, all travellers arriving into Australia from overseas will be housed in hotels, motels, caravan parks, and student accommodation for their 14-day self-isolation period.
- Travellers returning from overseas will be housed in the state or territory they initially arrive in for 14 days. Interstate travellers may return to their home state only after completing their 14-day quarantine.
- On 27 March, a Chief Health Officer update was published to provide clinicians and public with this information.
- On 20 March, an updated health services and general practice guide was published and available here.
- Only confirmed cases should be notified.
- There is currently a significant shortage of swabs and reagents for testing.
- On 25 March the AHPPC recommended expanding minimum testing criteria to include people with fever or acute respiratory infection in: a) geographically localised areas with elevated risk of community transmission, b) high-risk settings such as aged facilities where there are two or more plausibly linked cases, even if there is no known community transmission.
- Victoria now publishes COVID-19 epidemiological data on the department's website at https://app.powerbi.com/view?r=eyJrIjoiODBmMmE3NWQtZWNlNC00OWRkLTk1NjYtMjM2YTY1MjI2NzdjIiwidCI6ImMwZTA2MDFmLTBmYWMtNDQ5Yy05Yzg4LWExMDRjNGViOWYyOCJ9

Victoria State Government | Health and Human Services

International and Interstate Update

International

- As at 07:00 AEDT on 28 March 2020, 585,040 confirmed cases and 26,819 deaths have been reported globally[1].
- Based on these numbers, the estimated global case fatality rate (CFR) is approximately 4.6%. Different case fatality rates can be calculated from data currently reported in other countries, but these estimates may be affected by different case definitions and detection rates[1].
- Details of the international situation can be found in WHO situation reports https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports

Interstate

Interstate confirmed cases (Source: National Incident Room Situation Report, 27 March 2020, Victorian data as of 28 March 2020)

	Cases (deaths) by jurisdiction								
Source of infection	**Australia**	**ACT**	**NSW**	**NT**	**QLD**	**SA**	**Tas**	**Vic**	**WA**
Overseas acquired	2184	51	877	12	394	176	44	418	212
Locally acquired- contact of a confirmed case	640	6	278	0	79	41	1	209	26
Locally acquired- no known link	187	0	145	0	15	4	0	21	2
Under investigation	266	5	105	0	67	36	1	37	15
Total	**3,277 (13)**	**62**	**1405 (6)**	**12**	**555 (2)**	**257**	**46**	**685 (3)**	**255 (2)**

Please note – the format of this table was changed on 22 March, to align with the reporting in the NIR Situation Report

Victoria Epidemiological update

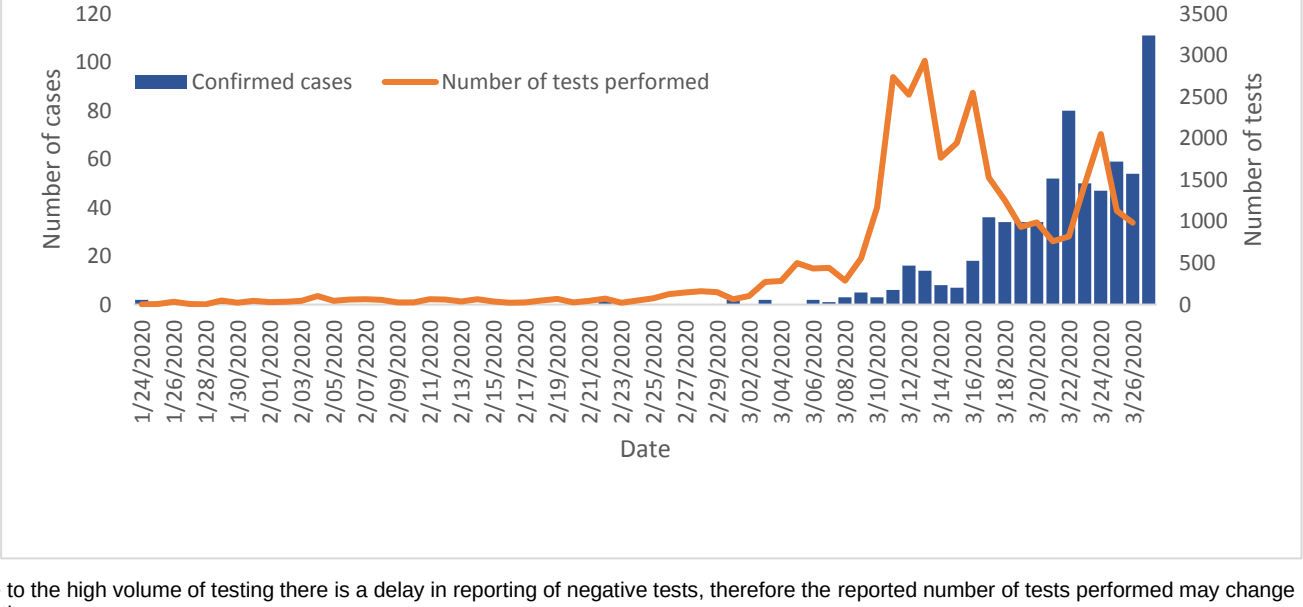
Victoria Confirmed case summary (00:01, 28 March 2020)		
Total		**685**
Status	Recovered	191
	Home isolation	258
	Admitted to hospital (not in ICU)	18
	Admitted to ICU	3
	Deceased	3
	Not stated	212
Hospitalised at any point during illness		57 (8%)
Sex; n(%)	Female	300 (44%)
	Male	378 (55%)
	Unknown	7 (1%)
Median age (range), years		47 (8 - 88)
Age group, years	0-4	0 (0%)
	5-14	4 (1%)
	15-44	308 (45%)

[1] Source: Johns Hopkins CSSE dashboard

	45-64	255 (37%)
	65-79	105 (15%)
	80+	8 (1%)
Indigenous status	Indigenous	2 (0%)
	Non-Indigenous	251 (37%)
	Missing/Not Stated	432 (63%)
Healthcare Workers	Not a healthcare worker	582 (85%)
	Medical practitioner	13 (2%)
	Nurse	20 (3%)
	Other healthcare worker	29 (14%)
	Unknown/not stated	41 (6%)
Residential location	Metro	550 (80%)
	Rural	117 (17%)
	Overseas	4 (1%)
	Unknown	12 (2%)
Acquired overseas		418 (61%)
	United States of America	102
	United Kingdom	84
	Not stated	67
	New Zealand	20
	Philippines	13
	Austria	11
	Other	121
Acquired in Australia - contact with a confirmed case		209 (31%)
Acquired in Australia - unknown source		21 (3%)
Place of acquisition - under investigation		37 (5%)

[a] This count includes one Victorian resident who is physically located in NSW. Cases reported in the last 24 hours are still under investigation. Information on these cases will be added to the total numbers as they become available.
* Countries with more than 10 cases are included in the table.

Epidemic curve showing number of confirmed cases and daily number of tests, Victoria*



*Due to the high volume of testing there is a delay in reporting of negative tests, therefore the reported number of tests performed may change over time.

State Response and Control Measures	
Overall public health response	**Governance and operations** • The Prime Minister has announced that travellers arriving into Australia from midnight Saturday 28 March 2020 will be quarantined in hotels for two weeks of quarantine. • Detailed modelling is being undertaken to inform planning for personal protective equipment (PPE) supplies, alternative models of care and care pathway planning. • Victoria's State Control Centre (SCC) remains activated (Tier 2) to support the coordination of Victoria's response to the spread of COVID-19). **Physical distancing measures** • On 25 March the Premier Daniel Andrews announced details of stage 2 restrictions on non-essential venues and activities. This is further to stage 1 restrictions implemented from midday 23 March • Businesses that will shutdown include: pubs, clubs, nightclubs, Crown Casino, and licensed venues in hotels and pubs. It also includes gyms, indoor sporting venues, places of worship, cinemas and entertainment venues. Restaurants and cafes will only be allowed to provide home delivery or takeaway services. A full list of restrictions is available at: coronavirus.vic.gov.au • As of 25 March businesses that will stay open include but are not limited to: supermarkets, petrol stations, banks, post offices and bottle shops. • On 25 March the Victorian Health Minister announced that public hospitals had been directed to wind back all non-urgent surgery, where safe to do so. This is in line with the current AHPPC advice. • On 24 March the Prime Minister announced further containment measures after a National Cabinet meeting, reinforcing the need to avoid large gatherings and redefining essential services and workers. Notably, guest numbers at weddings and funerals are to be limited and members of the public are encouraged to stay home and avoid congregating indoors or outdoors. These changes went into effect at 11:59pm on the 25th March. • Victorian school holidays commenced on Tuesday 24 March. Advice from the Chief Health Officer will determine whether schools reopen following school holidays.
Contact tracing	• There are 1,883 close contacts of confirmed cases being monitored. • Additional contact tracing is underway and further contacts are being added regularly.
Multi-site Capability	• The Department has worked with Services Australia to obtain locations at Moorabbin and Moreland (35 seats each), where teams are likely to start to be deployed soon. 50 Lonsdale Street will continue to be the primary site.
Health service reports	• Health services are now reporting daily emergency data to DHHS. Modifications to the dataset are being made to enable reporting of specific COVID-related presentations (pending implementation).
Pathology Sector	• 11 laboratories are currently testing for COVID-19; the Victorian Infectious Diseases Reference Laboratory (VIDRL), the Microbiological Diagnostic Unit Public Health Laboratory (MDU PHL), Alfred Pathology, Austin Pathology, Monash Pathology, Royal Children's Hospital Services, Royal Melbourne Hospital Pathology Service, St. Vincent's Pathology, Dorevitch Pathology, Australian Clinical Laboratories and the Australian Rickettsial Reference Laboratory. • 4 other laboratories are working towards testing and are currently referring their samples to either VIDRL or MDU PHL for testing. 1 of these laboratories, Clinical Laboratories and Melbourne Pathology are currently validating their tests and are aiming to be testing by the end of next week. The other three, Eastern Pathology, Northern Pathology and Goulburn Valley Health should be testing by the second week of April. • The laboratories have indicated that at their highest surge capacity with caveats including receiving new machines, consumables and staffing 18 hour shifts, the largest number for daily testing will be approx.11,000. The number of tests completed 26 March was 4,399 (4,049 on 25 March). The cumulative number of tests from 1 Jan 2020 is more than 35,000.

Phone line usage

DHHS CD Covid-19 Helpline (1300 651 160)

- The DHHS is managing a communicable diseases hotline for notifications and advice for physicians (1300 651 160)

DHHS CD Covid-19 Helpline (1300 651 160) Call Volumes			
Date	**Calls Answered**	**Calls Abandoned**	**Outbound Calls**
23/3/2020	1,399	984	46
24/3/2020	1,171	490	42
25/3/2020	870	573	35
26/3/2020	916	411	37

VIC Government Coronavirus Hotline (1800 675 398)

VIC Government Coronavirus Hotline (1800 675 398) Call Volumes		
Date	**Calls Answered**	**Calls Abandoned**
24/3/2020	10,966	249
25/3/2020	9,196	112
26/3/2020	8,158	86

VIC Government Coronavirus Hotline (1800 675 398) IVR Option Choices		
25/03/2020	1. Divert to national line - Health information	5,048
	2. Social distancing measures	973
	3. Relief services	1,212
	4. report breaches of directions	252
26/03/2020	1. Divert to national line - Health information	4,647
	2. Social distancing measures	874
	3. Relief services	1,074
	4. Report breaches of directions	294

- There is also a Victorian Government Coronavirus Hotline (1800 675 398). Ambulance Victoria originally established the Victorian Coronavirus hotline on 25 January. From 16 March callers seeking health information or symptoms assessment are being connected with the National Coronavirus information service as a result of additional coordination with other state governments and the Commonwealth government.

Ports of entry report

Melbourne Airport and Avalon Airport

- As of 26 March 2020, no further international flights are scheduled to arrive at Avalon airport until further notice.
- From 2100 20 March 2020, airport COVID-19 screening processes have changed. Specific screening will no longer occur for all arrivals from the four previous countries of concern (China, Iran, Italy and Korea). Screenings will now be conducted on a percentage of passengers from all overseas flights. This does not change DHHS nurse commitment at the airports.
- To date, screening at Victorian ports of entry has not detected any confirmed cases.

Maritime ports

- As of 26 March 2020, no further cruise ships are expected to arrive in Melbourne, though cargo ships will continue to arrive.
- To date, screening at the ports of entry has not detected any confirmed cases.

Emergency relief

- The Prime Minister has announced that travellers arriving into Australia from midnight Saturday 28 March 2020 will be quarantined in hotels for two weeks. DHHS is undertaking preparedness activity with other departments and agencies, and will ensure arrangements are in place to meet any health and relief needs of these travellers during their self-isolation period.
- As of 23 March 2020, Victorians self-isolating due to COVID-19 with no access to food and essential supplies have been able to receive emergency relief packages under a program introduced by the Victorian Government. This program supports people in mandatory self-isolation, who have little or no food, and no network of family and friends to support them.

	Each eligible household receives a two-week supply of essential goods. These arrangements are being coordinated by the State Relief Coordinator through the Victorian COVID hotline 1800 675 398. In response to requests received through the COVID hotline, a total of 707 urgent food relief packages have been delivered and 153 telephone outreach calls have been made (through VCC & Red Cross) between 24 March and 27 March 2020. • Victorians are also supported with relief needs which are identified through DHHS case contact tracing and other referrals. Twenty-eight households have been provided with support by DHHS to meet their immediate needs.
Media and Communications	**Media** • The March 26 CHO media release focussed on the first three confirmed deaths related to COVID-19. Messaging focussed on distancing, hygiene and police powers to enforce directions under the current state of emergency. • On March 25 the Premier and Health Minister did a press conference, reinforcing the messaging that people should stay home and introduced the idea that there will be further stages of restrictions. See press release: https://www.premier.vic.gov.au/statement-from-the-premier-34/ • The Health Minister and the Chief Health Officer held a press conference to discuss cases and how we will be contacting confirmed cases through the Whispir system. Audio is available on our page: https://www.dhhs.vic.gov.au/media-hub-coronavirus-disease-covid-19 • The Department issued our daily media release with updated information on case numbers. **Communications updates** • The daily Chief Health Officer COVID-19 update was published and is being distributed via the Chief Health Officer alert system: https://www.dhhs.vic.gov.au/coronavirus-covid-19-daily-update • Changes were made to our website and a new page was added to detail the new Stage 2 restrictions: https://www.dhhs.vic.gov.au/coronavirus-covid-19-new-restrictions-and-closures **VicEmergency** • Updated 27 March 2020 advice is focussed on restricted activities, physical distancing, self-isolation, reducing exposure and proper hygiene. **Social media insights** • There is increasing anger and frustration towards people who “break” quarantine advice. Some are concerned that the “stay at home” message is not cutting through. Others argue that they do not “trust” other people to self-isolate. • Be wary of communications that encourage a culture of public shame, particularly as many feel they do not have enough information to comfortably make decisions. Promoting unity and community through communications could ease negativity online • Social media on 27 March included short videos on social distancing and quarantining (twitter; facebook) • People are increasingly interested in the details of cases, as the number of confirmed cases rise. There are requests to see this data on a map, so that people can identify "clusters" and "affected areas". The Chief Health Officer shared a dashboard about Victorian cases via Twitter. Consider incorporating this dashboard into future communications. • As of 26 March 2020, short videos on coronavirus, recent travellers and protecting children. • There is overwhelming positivity towards frontline health workers. Reinforcing the “stay home for them” message may drive behaviour change.
National and International Response Overview	
National Response measures	**Communicable Disease Network of Australia (CDNA)** • The Public Health Commander is a member of the CDNA working group that meets daily or more frequently as needed. **Australian Health Protection Principal Committee (AHPPC)** • National committees debating whether and how to pause national screening programmes like cervical screening. • AHPPC will convene a working group and held a joint AHPPC and CDNA teleconference on 22 March.

	Border measures • On 27 March the Prime Minister announced that all travellers arriving in Australia will be required undertake their mandatory 14 day quarantine at designated facilities (e.g. hotels). The ADF will begin assisting state and territory governments to undertake quarantine compliance checks of those in mandatory isolation after arriving from overseas. • As of 24 March 2020, there is a ban placed on all overseas travel, with limited exemptions. • As of 21:00 20 March 2020, a travel ban has been placed on all non-residents, not Australian citizens, coming to Australia. • On 17 March 2020, the Department of Foreign Affairs and Trade (DFAT) advised Australians overseas who wish to return to Australia should do so as soon as possible. • As of 18 March 2020, the travel advice for the entire world was raised to "do not travel". **Other** • On 27 March 2020, the Prime Minister asked that only children of workers for whom no suitable care arrangements are available at home continue to physically attend school. • The National Cabinet has stated that from 26 March 2020 all non-urgent elective surgery is temporarily suspended. • On 25 March 2020 the National Cabinet agreed to expand current coronavirus testing criteria, following advice from AHPPC. • On 25 March 2020 the Prime Minister announced the creation of a National COVID-19 Coordination Commission (NCCC). • On 22 March 2020 the Commonwealth Government released the second stage of its economic response to coronavirus. • On 18 March 2020 the Governor-General has accepted the Commonwealth Government's recommendation that the Prime Minister declare a "human biosecurity emergency" under the Biosecurity Act 2015, • On 27 February 2020, the Prime Minister announced the activation of the 'Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)'.
International Response	**WHO** • The United Nations launched a US $2 billion COVID-19 global humanitarian response plan to support vulnerable countries. • On 22 March 2020 WHO released interim laboratory testing guidelines to guide countries' testing strategies in the face of global shortages of supplies and capacity. • On 21 March 2020, to increase access to reliable information, WHO has partnered with WhatsApp and Facebook to launch a WHO Health Alert messaging service. To access it, send the word "hi" to the following number on WhatsApp: +41 798 931 892. • WHO notes that the first vaccine trial has begun just 60 days after the genetic sequence of the virus was shared by China. • On 21 March 2020, to ensure clear evidence of which treatments are most effective, WHO and its partners are organizing a large international study, called the Solidarity Trial, in many countries to compare different treatments. • On 13 March 2020, urged countries to break chains of transmission through testing, contact tracing and isolation of cases. • On 11 March 2020, the WHO Director-General stated that COVID-19 can be characterized as a pandemic. He stated they are deeply concerned by alarming levels of spread and severity, and by the alarming levels of inaction.

The next situation report will be issued on: 29 March 2020

Authorised by: REDACTED **Intelligence Lead**

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REDACTED Principal Policy Officer, Health and Wellbeing

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

Isolation (Diagnosis) Direction

Public Health and Wellbeing Act 2008 (Vic)
Section 200

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

1 Preamble

The purpose of this direction is to require persons diagnosed with Novel Coronavirus 2019 **(2019-nCoV**) to isolate (self-isolate) in order to limit the spread of 2019-nCoV.

2 Citation

This direction may be referred to as the **Isolation (Diagnosis) Direction.**

3 Direction

(1) A person who is diagnosed with 2019-nCoV in the State of Victoria between midnight on 25 March 2020 and midnight on 13 April 2020:

(a) if the diagnosis is communicated to the person in a place other than where the person resides, must:

(i) travel directly from that place to a premises that is suitable for the person to reside in and reside in that premises until **clearance from isolation (self-isolation)** is given under subclause (2); or

(ii) travel directly to a hospital for medical treatment, and following treatment and discharge from the hospital, travel directly to a premises that is suitable for the person to reside in until clearance from isolation (self-isolation) is given under subclause (2); and

(b) if the diagnosis is communicated to the person in suitable premises where the person resides, must reside in that premises beginning on the day of the diagnosis and ending when clearance from isolation (self-isolation) is given under subclause (2); and

(c) must not leave the premises, except:

(i) for the purposes of obtaining medical care or medical supplies; or

(ii) in any other emergency situation; or

(iii) in limited outdoor circumstances when it is possible to avoid close contact with other persons and not to enter any other building; and

(d) must not permit any other person to enter the premises unless that other person usually lives at the premises or is living at the premises for the purposes of isolation (self-isolation), or for medical or emergency purposes.

(2) A person subject to the requirements in subclause (1) is given **clearance from isolation (self-isolation)** when an officer of the Department of Health and Human Services certifies that the person meets the criteria for discharge from isolation (self-isolation) under existing Departmental requirements.

(3) Certification under subclause (2) must be in writing but is not required to be in a particular form.

4 Penalties

Section 203 of the PHW Act provides:

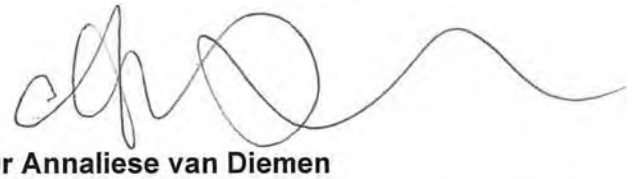
Compliance with direction or other requirement

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

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

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

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



Dr Annaliese van Diemen

Deputy Chief Health Officer (Communicable Disease), as authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the PHW Act.

25 March 2020

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

Isolation (Diagnosis) Direction (No 2)

Public Health and Wellbeing Act 2008 (Vic)
Section 200

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

1 Preamble

(1) The purpose of this direction is to require persons diagnosed with Novel Coronavirus 2019 (**2019-nCoV**) to isolate (self-isolate) in order to limit the spread of 2019-nCoV.

(2) This direction replaces the **Isolation (Diagnosis) Direction** given on 25 March 2020.

2 Citation

This direction may be referred to as the **Isolation (Diagnosis) Direction (No 2)**.

3 Revocation

The **Isolation (Diagnosis) Direction** is revoked with effect from midnight on 13 April 2020.

4 Direction

(1) A person who is diagnosed with 2019-nCoV in Victoria between midnight on 13 April 2020 and midnight on 11 May 2020:

(a) if the diagnosis is communicated to the person in a place other than where the person resides, must:

(i) travel directly from that place to a **premises** that is suitable for the person to reside in and reside in that premises until **clearance from isolation (self-isolation)** is given under subclause (2); or

(ii) travel directly to a hospital for medical treatment, and following treatment and discharge from the hospital, travel directly to a premises that is suitable for the person to reside in until clearance from isolation (self-isolation) is given under subclause (2); and

(b) if the diagnosis is communicated to the person in suitable premises where the person resides, must reside in that premises beginning on the day of the diagnosis and ending when clearance from isolation (self-isolation) is given under subclause (2); and

(c) must not leave the premises, except:

(i) for the purposes of obtaining medical care or medical supplies; or

(ii) in any other emergency situation; or

(iii) for the purposes of exercise, but only if it is possible for the person:

(A) to avoid close contact with any other person; and

(B) not to enter any other building; or

(iv) if required to do so by law; and

(d) must not permit any other person to enter the premises unless that other person usually lives at the premises or is living at the premises for the purposes of isolation (self-isolation), or for medical or emergency purposes.

(2) A person subject to the requirements in subclause (1) is given **clearance from isolation (self-isolation)** when an officer of the Department of Health and Human Services certifies that the person meets the criteria for discharge from isolation (self-isolation) under existing Departmental requirements.

(3) Certification under subclause (2) must be in writing but is not required to be in a particular form.

5 Definition of premises

In this direction, **premises** means:

(1) a building, or part of a building; and

(2) any land on which the building is located, other than land that is available for communal use.

6 Penalties

Section 203 of the PHW Act provides:

Compliance with direction or other requirement

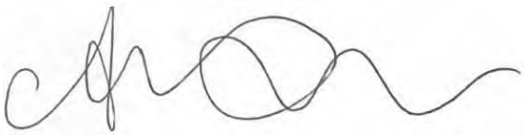
(1) A person must not refuse or fail to comply with a direction given to the person, or a requirement made of the person, in the exercise of a power under an authorisation given under section 199.

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

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

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

requirement



Dr Annaliese van Diemen

Deputy Chief Health Officer (Communicable Disease), as authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the PHW Act.

13 April 2020

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

Diagnosed Persons and Close Contacts Directions

Public Health and Wellbeing Act 2008 (Vic)
Section 200

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

1 Preamble

(1) The purpose of these directions is to require persons:

(a) diagnosed with Novel Coronavirus 2019 (**2019-nCoV**) to self-isolate;

(b) who are living with a diagnosed person, or who have been in close contact with a diagnosed person, to self-quarantine;

in order to limit the spread of 2019-nCoV.

(2) These directions replace the **Isolation (Diagnosis) Direction (No 2)** given on 13 April 2020, and add the requirement that persons living at the same premises as a diagnosed person, and close contacts of a diagnosed person, must self-quarantine.

2 Citation

These directions may be referred to as the **Diagnosed Persons and Close Contacts Directions**.

3 Commencement

These directions commence at midnight on 11 May 2020.

4 Self-isolation for diagnosed persons

Who is a diagnosed person?

(1) A person is a **diagnosed person** if the person:

(a) at any time between midnight on 25 March 2020 and 11:59:00pm on 31 May 2020 has been informed that they have been diagnosed with 2019-nCoV; and

(b) has not been given **clearance from self-isolation** under clause 5.

Requirement to self-isolate

(2) A diagnosed person must **self-isolate** under these directions:

(a) if the diagnosis is communicated to the person after the commencement of these directions; or

(b) if the diagnosis was communicated to the person before the commencement of these directions.

Note: The requirements of self-isolation are specified in clause 9. A diagnosed person can still leave the premises at which they are self-isolating to obtain medical care.

Location of self-isolation

(3) A diagnosed person must self-isolate:

(a) if subclause (2)(a) applies, at the **premises** chosen by the person under subclause (4); or

(b) if subclause (2)(b) applies, at the premises at which the person was required to reside under clause 4(1) of a **Revoked Isolation Direction**

(4) For the purposes of subclause (3)(a), the diagnosed person may choose to self-isolate at:

(a) a premises at which they ordinarily reside; or

(b) another premises that is suitable for the person to reside in for the purpose of self-isolation.

Note: a person can decide to self-isolate at a hotel or other suitable location, instead of self-isolating at their ordinary place of residence.

Self-isolation period

(5) The period of self-isolation begins:

(a) if subclause (2)(a) applies, when the diagnosis is communicated to the person; or

(b) if subclause (2)(b) applies, upon the commencement of these directions.

(6) For the purposes of subclause (2), the period of self-isolation ends when the person is given **clearance from self-isolation** under clause 5.

Notifications by the diagnosed person

(7) Immediately after choosing a premises under subclause (4), the diagnosed person must:

(a) if any other person is residing at the premises chosen by the diagnosed person, notify the other person that:

(i) the diagnosed person has been diagnosed with 2019-nCoV; and

(ii) the diagnosed person has chosen to self-isolate at the premises; and

(b) notify the **Department** of:

(i) the address of the premises chosen by the diagnosed person; and

(ii) the name of any other person who is residing at the premises chosen by the diagnosed person.

(8) If, during the period that a diagnosed person is self-isolating at a premises for the purposes of clause 4, another person informs the diagnosed person that they intend to commence residing at the premises chosen by the diagnosed person, the diagnosed person must inform the other person of their diagnosis.

5 Clearance from self-isolation

(1) A diagnosed person is given **clearance from self-isolation** if:

(a) an officer of the Department makes a determination under subclause (2) in relation to the person; and

(b) the person is given notice of the determination in accordance with subclause (3).

(2) For the purposes of subclause (1)(a), an officer of the Department may make a determination in relation to a person if the officer is satisfied that the person meets the criteria for discharge from self-isolation under the **National Guidelines**.

(3) For the purposes of subclause (1)(b), the notice must be in writing but is not required to be in a particular form.

(4) A person who has been given clearance from isolation (self-isolation) under clause 4(2) of a **Revoked Isolation Direction** is taken to have been given clearance from self-isolation under this clause.

6 Self-quarantine for persons residing with diagnosed person

Existing residents

(1) If:

(a) at the time these directions commence; or

(b) following the commencement of these directions and before 11:59:00pm on 31 May 2020;

a diagnosed person begins self-isolating at a premises for the purposes of clause 4, any other person residing at the premises at that time must **self-quarantine** at that premises.

Note 1: The requirements of self-quarantine are specified in clause 9.

Note 2: If a diagnosed person was diagnosed before the commencement of these directions, they begin self-isolating for the purpose of clause 4 of these directions at the time these directions commence: clause 4(2)(b) and (5)(b). A person residing with that diagnosed person at the time these directions commence must begin to self-quarantine at that time: clause 6(1)(a).

New place of residence

(2) If, between the commencement of these directions and 11:59:00pm on 31 May 2020, a person begins to reside at a premises at which a diagnosed person is self-isolating for the purpose of clause 4, the person must **self-quarantine** at that premises.

Example: a person may begin to reside at a new premises because they move to a new ordinary place of residence, including for the purpose of providing care and support to a diagnosed person.

Self-quarantine period

(3) The period of self-quarantine begins:

(a) for the purposes of subclause (1), when the diagnosed person commences self-isolating at the premises for the purposes of clause 4; or

(b) for the purposes of subclause (2), when the person commences residing at the premises at which the diagnosed person is self-isolating for the purposes of clause 4.

(4) For the purposes of this clause, the period of self-quarantine ends:

(a) if one diagnosed person is self-isolating at the premises—14 days after clearance from self-isolation is given to the diagnosed person under clause 5; or

(b) if more than one diagnosed person is self-isolating at the premises—14 days after clearance from self-isolation is given to the last remaining diagnosed person at the premises under clause 5; or

(c) if a diagnosed person who is self-isolating at the premises is admitted to **hospital** or other facility for the purposes of receiving medical care—14 days from the admission, except if during that 14 day period:

(i) the diagnosed person returns to the premises; or

(ii) there is another diagnosed person residing at the premises; or

(d) if the person becomes a diagnosed person following a test for 2019-nCoV—when the diagnosis is communicated to the person.

Note: A person who becomes a diagnosed person will then be required to self-isolate under clause 4, for a period ending when the person is given clearance from self-isolation under clause 5.

Exception — previous clearance

(5) A person is not required to self-quarantine under this clause if, before the time specified in subclause (3), the person has been given clearance from self-isolation under clause 5.

7 Self-quarantine for close contacts

Who is a close contact?

(1) For the purposes of this clause, a person is a **close contact** if:

(a) an officer of the Department has made a determination under subclause (2) in relation to the person; and

(b) between the commencement of these directions and 11:59:00pm on 31 May 2020, the person has been given notice of the determination in accordance with subclause (3).

(2) For the purposes of subclause (1)(a), an officer of the Department may make a determination in relation to a person if the officer is satisfied, having regard to the **National Guidelines**, that the person has had close contact with another person who:

(a) since the time of last contact, has become a diagnosed person; or

(b) at the time of last contact, was a diagnosed person.

Note: under the National Guidelines, a person is generally considered to have had close contact if, in the period extending from 48 hours before onset of symptoms in the diagnosed person:

- *they have had face-to-face contact in any setting with the diagnosed person for more than a total of 15 minutes over the course of a week; or*
- *they have shared of a closed space with a diagnosed person for a prolonged period (eg, more than 2 hours).*

(3) For the purposes of subclause (1)(b), the notice:

(a) must specify the time at which the person will no longer be required to self-quarantine, having regard to the National Guidelines;

(b) may be given orally or in writing, and, if given orally, must be confirmed in writing as soon as reasonably practicable; and

(c) is not required to be in a particular form.

Requirement to self-quarantine

(4) A **close contact** must **self-quarantine** at the premises at which they ordinarily reside.

Note: The requirements of self-quarantine are specified in clause 9.

Self-quarantine period

(5) For the purposes of this clause, the period of self-quarantine:

(a) begins when the person is given notice under subclause (1)(b); and

(b) ends:

(i) subject to paragraph (ii), at the time specified in the notice given under subclause (1)(b); or

(ii) if the person becomes a diagnosed person following a test for 2019-nCoV—when the diagnosis is communicated to the person.

Note: A close contact who becomes a diagnosed person will then be required to self-isolate under clause 4, for a period ending when the person is given clearance from self-isolation under clause 5.

Exception — persons residing with diagnosed person

(6) A person is not required to self-quarantine under this clause if the person is required to self-quarantine under clause 6.

Exception — previous clearance

(7) A person is not required to self-quarantine under this clause if, before the time that notice is given under subclause (1)(b), the person has been given clearance from self-isolation under clause 5.

8 Testing of persons in self-quarantine

(1) If a person is required to self-quarantine under clause 6 or 7 and, during the period of self-quarantine, the person:

(a) is tested for 2019-nCoV; and

(b) the period for which the person is required to self-quarantine under clause 6 or 7, as the case requires, expires during the period in which the person is awaiting the result of that test;

the period of self-quarantine is extended until the result of the test is communicated to the person.

Note: persons who are in self-quarantine and experience a temperature higher than 37.5 degrees or symptoms of acute respiratory infection are encouraged to get tested. In certain circumstances, a person may be required to comply with an order that they undergo a medical test: PHW Act, s 113(3).

(2) If a person is required to self-quarantine under clause 6 or 7 and, during the period of self-quarantine, the person receives a communication that they have been diagnosed with 2019-nCoV, the person becomes a diagnosed person and must self-isolate under clause 4.

(3) If a person is required to self-quarantine under clause 6 or 7 and, during the period of self-quarantine, the person receives a communication that they have not been diagnosed with 2019-nCoV:

(a) if the period for which the person is required to self-quarantine under clause 6 or 7, as the case requires, has not expired—must continue to self-quarantine under that clause for the remainder of that period; or

(b) if the period of self-quarantine was extended under subclause (1)—may cease self-quarantining.

9 Requirements of self-isolation and self-quarantine

(1) This clause applies to a person who is required to:

(a) **self-isolate** at a premises under clause 4; or

(b) **self-quarantine** at a premises under clause 6 or 7.

(2) The person identified in subclause (1):

(a) if the period of self-isolation or self-quarantine, as the case requires, begins at a time when the person is not at the premises, must immediately and directly travel to that premises, unless the person is admitted to a hospital or other facility for the purposes of receiving medical care; and

(b) must reside at that premises for the entirety of the period of self-isolation or self-quarantine, as the case requires, except for any period that the person is admitted to a hospital or other facility for the purposes of receiving medical care; and

(c) must not leave the premises, except:

(i) for the purposes of obtaining medical care or medical supplies; or

(ii) in any emergency situation; or

(iii) for the purposes of exercise, but only if the person:

(A) takes reasonable steps to maintain a distance of 1.5 metres from any other person, unless the other person is required to self-isolate or self-quarantine at the same premises; and

(B) does not enter any other building; or

(iv) if required to do so by law; and

(d) must not permit any other person to enter the premises unless:

(i) that other person:

(A) ordinarily resides at the premises; or

(B) is required to self-isolate or self-quarantine at the premises under these directions; or

(ii) it is necessary for the other person to enter for medical or emergency purposes; or

(iii) the other person is a **disability worker**, and it is necessary for the disability worker to enter for the purpose of providing a **disability service** to a person with a **disability**; or

Example: a disability worker may enter to support a person with a disability to manage the person's limitations in undertaking self-care (such as assistance with eating, showering, toileting, etc).

(iv) the entry is otherwise required or authorised by law.

10 Definitions

In these directions:

(1) **Department** means the Victorian Department of Health and Human Services;

(2) **hospital** has the same meaning as in the **Hospital Visitors Directions (No 3)**;

(3) **National Guidelines** means the document titled "Coronavirus Disease 2019 (COVID-19) — CDNA National Guidelines for Public Health Units", as amended from time to time;

Note: The National Guidelines are available at: https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm.

(4) **premises** means:

(a) a building, or part of a building; and

(b) any land on which the building is located, other than land that is available for communal use;

(5) **Revoked Isolation Direction** means the:

(a) **Isolation (Diagnosis) Direction**, given on 25 March 2020; or

(b) **Isolation (Diagnosis) Direction (No 2)**, given on 13 April 2020;

(6) The following expressions have the same meaning that they have in the **Disability Service Safeguards Act 2018**:

(a) disability;

(b) disability service;

(c) disability worker.

11 Penalties

Section 203 of the PHW Act provides:

Compliance with direction or other requirement

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

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

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

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

Dr Annaliese van Diemen

Deputy Chief Health Officer (Communicable Disease), as authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the PHW Act.

11 May 2020

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

Diagnosed Persons and Close Contacts Directions (No 2)

Public Health and Wellbeing Act 2008 (Vic)
Section 200

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

1 Preamble

(1) The purpose of these directions is to require persons:

(a) diagnosed with Novel Coronavirus 2019 (**2019-nCoV**) to self-isolate;

(b) who are living with a diagnosed person, or who have been in close contact with a diagnosed person, to self-quarantine;

in order to limit the spread of 2019-nCoV.

(2) These directions replace the **Diagnosed Persons and Close Contacts Directions** given on 11 May 2020, and amend the requirements of self-isolation and self-quarantine to:

(a) allow a person who is required to self-quarantine to visit a patient in a hospital if permitted to do so under the **Hospital Visitor Directions (No 4)**; and

(b) allow a person who is required to self-isolate or self-quarantine to receive assistance with personal care or household assistance if needed by reason of the person's age, disability or chronic health condition.

2 Citation

(1) These directions may be referred to as the **Diagnosed Persons and Close Contacts Directions (No 2)**.

(2) A reference in any other direction to the **Diagnosed Persons and Close Contacts Directions** is taken to be a reference to these directions.

3 Commencement and revocation

(1) These directions commence at 11:59:00pm on 31 May 2020.

(2) The **Diagnosed Persons and Close Contacts Directions** are revoked at 11:59:00pm on 31 May 2020.

4 Self-isolation for diagnosed persons

Who is a diagnosed person?

(1) A person is a **diagnosed person** if the person:

(a) at any time between midnight on 25 March 2020 and 11:59:00pm on 21 June 2020 has been informed that they have been diagnosed with 2019-nCoV; and

(b) has not been given, or is not taken to have been given, **clearance from self-isolation** under clause 5.

Requirement to self-isolate

(2) A diagnosed person must **self-isolate** under these directions:

(a) if the diagnosis is communicated to the person on or after the commencement of these directions; or

(b) if the diagnosis was communicated to the person before the commencement of these directions.

Note: the requirements of self-isolation are specified in clause 9. A diagnosed person can still leave the premises at which they are self-isolating to obtain medical care.

Location of self-isolation

(3) A diagnosed person must self-isolate:

(a) if subclause (2)(a) applies, at the **premises** chosen by the person under subclause (4); or

(b) if subclause (2)(b) applies, at the premises at which the person was required to reside under a **Revoked Isolation Direction**.

(4) For the purposes of subclause (3)(a), the diagnosed person may choose to self-isolate at:

(a) a premises at which they ordinarily reside; or

(b) another premises that is suitable for the person to reside in for the purpose of self-isolation.

Note 1: a person can decide to self-isolate at a hotel or other suitable location, instead of self-isolating at their ordinary place of residence.

Note 2: once a person has chosen the premises at which to self-isolate, the person must reside at that premises for the entirety of the period of self-isolation: see clause 9(2)(a).

(5) If a diagnosed person who has chosen a premises under subclause (4) is not at the premises at the time when the choice is made, the person must immediately and directly travel to that premises, unless the person is

admitted to a **hospital** or other facility for the purposes of receiving medical care.

Self-isolation period

(6) The period of self-isolation begins:

(a) if subclause (2)(a) applies, when the diagnosis is communicated to the person; or

(b) if subclause (2)(b) applies, upon the commencement of these directions.

(7) For the purposes of subclause (2), the period of self-isolation ends when the person is given **clearance from self-isolation** under clause 5.

Notifications by the diagnosed person

(8) Immediately after choosing a premises under subclause (4), the diagnosed person must:

(a) if any other person is residing at the premises chosen by the diagnosed person, notify the other person that:

(i) the diagnosed person has been diagnosed with 2019-nCoV; and

(ii) the diagnosed person has chosen to self-isolate at the premises; and

(b) notify the **Department** of:

(i) the address of the premises chosen by the diagnosed person; and

(ii) the name of any other person who is residing at the premises chosen by the diagnosed person.

(9) If, during the period that a diagnosed person is self-isolating at a premises for the purposes of clause 4, another person informs the diagnosed person that they intend to commence residing at the premises chosen by the diagnosed person, the diagnosed person must inform the other person of their diagnosis.

5 Clearance from self-isolation

(1) A diagnosed person is given **clearance from self-isolation** if:

(a) an officer of the Department makes a determination under subclause (2) in relation to the person; and

(b) the person is given notice of the determination in accordance with subclause (3).

(2) For the purposes of subclause (1)(a), an officer of the Department may make a determination in relation to a person if the officer is satisfied that the person meets the criteria for discharge from self-isolation under existing **Departmental Requirements**.

(3) For the purposes of subclause (1)(b), the notice must be in writing but is not required to be in a particular form.

(4) A person who has been given clearance from self-isolation, however expressed, under a Revoked Isolation Direction is taken to have been given clearance from self-isolation under this clause.

6 Self-quarantine for persons residing with diagnosed person

Requirement to self-quarantine

(1) A person must **self-quarantine** at a premises if between the commencement of these directions and 11:59:00pm on 21 June 2020:

(a) a diagnosed person begins self-isolating under clause 4 at the premises at which the person is residing; or

(b) the person begins to reside at a premises at which a diagnosed person is self-isolating for the purpose of clause 4.

Example: a person may begin to reside at a new premises because they move to a new ordinary place of residence, including for the purpose of providing care and support to a diagnosed person.

Note: the requirements of self-quarantine are specified in clause 9.

(2) For the purposes of subclause (1)(a), if the person is not at the premises at the time the diagnosed person begins self-isolating there, the person must immediately and directly travel to that premises.

Continued self-quarantine - persons subject to a Revoked Isolation Direction

(3) A person must **self-quarantine** at a premises under these directions if:

(a) the person was required to self-quarantine at that premises under clause 6 of a Revoked Isolation Direction; and

(b) the person's period of self-quarantine under the Revoked Isolation Direction had not ended before the commencement of these directions.

Note 1: the requirements of self-quarantine are specified in clause 9.

Note 2: if a person was required to self-quarantine under a Revoked Isolation Direction because they were residing with a diagnosed person, they will have to continue to self-quarantine under these directions, unless their period of self-quarantine had ended before the commencement of these directions. Their continued period of self-quarantine is provided for in subclauses (4) and (5).

End of self-quarantine period

(4) For the purposes of this clause, the period of self-quarantine ends:

(a) if one diagnosed person is self-isolating at the premises—14 days after clearance from self-isolation is given to the diagnosed person under clause 5; or

(b) if more than one diagnosed person is self-isolating at the premises—14 days after clearance from self-isolation is given to the last remaining diagnosed person at the premises under clause 5; or

(c) if a diagnosed person who is self-isolating at the premises is admitted to hospital or other facility for the purposes of receiving medical care—14 days from the admission, except if during that 14 day period:

(i) the diagnosed person returns to the premises without having received clearance from self-isolation under clause 5; or

(ii) there is another diagnosed person residing at the premises; or

(d) if the person becomes a diagnosed person following a test for 2019-nCoV—when the diagnosis is communicated to the person.

Note: a person who becomes a diagnosed person will then be required to self-isolate under clause 4, for a period ending when the person is given clearance from self-isolation under clause 5.

(5) In the case of a person who is required to self-quarantine under subclause (3), a reference in subclause (4) to:

(a) a diagnosed person includes a person who was a diagnosed person under a Revoked Isolation Direction but had been given clearance from self-isolation before the commencement of these directions; and

(b) the present tense is taken to include a reference to the past tense.

Note: by operation of this paragraph, the word 'is' in subclause (4) can be read as 'was'.

Example: if a person had been a diagnosed person under a Revoked Isolation Direction and had been given clearance from self-isolation 8 days before these directions commenced, a person residing with them will be required to continue to self-quarantine under these directions for a further 6 days: see subclauses (3), (4) and (5).

Exception — previous clearance

(6) A person is not required to self-quarantine under this clause if, before the time specified in subclause (4), the person has been given, or is taken to have been given, clearance from self-isolation under clause 5.

7 Self-quarantine for close contacts

Who is a close contact?

(1) For the purposes of this clause, a person is a **close contact** if:

(a) an officer of the Department has made a determination under subclause (2) in relation to the person; and

(b) between midnight on 11 May 2020 and 11:59:00pm on 21 June 2020, the person has been given notice of the determination in accordance with subclause (3).

(2) For the purposes of subclause (1)(a), an officer of the Department may make a determination in relation to a person if the officer is satisfied, having regard to Departmental Requirements, that the person has had close contact with another person who:

(a) since the time of last contact, has become a diagnosed person; or

(b) at the time of last contact, was a diagnosed person.

Note: under the Departmental Requirements, a person is generally considered to have had close contact if, in the period extending from 48 hours before onset of symptoms in the diagnosed person:

- *they have had face-to-face contact in any setting with the diagnosed person for more than a total of 15 minutes over the course of a week; or*
- *they have shared of a closed space with a diagnosed person for a prolonged period (for example, more than 2 hours).*

(3) For the purposes of subclause (1)(b), the notice:

(a) must specify the time at which the person will no longer be required to self-quarantine, having regard to Departmental Requirements; and

(b) may be given orally or in writing, and, if given orally, must be confirmed in writing as soon as reasonably practicable; and

(c) is not required to be in a particular form.

(4) If a person was a close contact under clause 7 of a Revoked Isolation Direction:

(a) a determination in relation to the person made under clause 7(2) of the Revoked Isolation Direction is taken to be a determination made under subclause (2); and

(b) a notice given to the person under clause 7(1)(b) of the Revoked Isolation Direction is taken to be a notice given under subclause (1)(b).

Requirement to self-quarantine

(5) A **close contact** must **self-quarantine** at the premises at which they ordinarily reside.

Note: the requirements of self-quarantine are specified in clause 9.

(6) If, at the time a person is given a notice under subclause (1)(b), the person is not at the premises at which they ordinarily reside, the person must immediately and directly travel to that premises.

End of self-quarantine period

(7) For the purposes of this clause, the period of self-quarantine ends:

(a) subject to paragraph (b), at the time specified in the notice given under subclause (1)(b); or

(b) if the person becomes a diagnosed person following a test for 2019-nCoV—when the diagnosis is communicated to the person.

Note: a close contact who becomes a diagnosed person will then be required to self-isolate under clause 4, for a period ending when the person is given clearance from self-isolation under clause 5.

Exception — persons residing with diagnosed person

(8) A person is not required to self-quarantine under this clause if the person is required to self-quarantine under clause 6.

Exception — previous clearance

(9) A person is not required to self-quarantine under this clause if, before the time that notice is given under subclause (1)(b), the person has been given, or is taken to have been given, clearance from self-isolation under clause 5.

8 Testing of persons in self-quarantine

(1) If a person is required to self-quarantine under clause 6 or 7 and, during the period of self-quarantine, the person:

(a) is tested for 2019-nCoV; and

(b) the period for which the person is required to self-quarantine under clause 6 or 7, as the case requires, expires during the period in which the person is awaiting the result of that test;

the period of self-quarantine is extended until the person receives the result of the test.

Note: persons who are in self-quarantine and experience a temperature higher than 37.5 degrees or symptoms of acute respiratory infection are encouraged to get tested. In certain circumstances, a person may be required to comply with an order that they undergo a medical test: PHW Act, section 113(3).

(2) If a person is required to self-quarantine under clause 6 or 7 and, during the period of self-quarantine, the person receives a test result stating that they have been diagnosed with 2019-nCoV, the person becomes a diagnosed person and must self-isolate under clause 4.

(3) If a person is required to self-quarantine under clause 6 or 7 and, during the period of self-quarantine, the person receives a test result stating that they have not been diagnosed with 2019-nCoV:

(a) if the period for which the person is required to self-quarantine under clause 6 or 7, as the case requires, has not expired—must continue to self-quarantine under that clause for the remainder of that period; or

(b) if the period of self-quarantine was extended under subclause (1)—may cease self-quarantining.

9 Requirements of self-isolation and self-quarantine

(1) This clause applies to a person who is required to:

(a) **self-isolate** at a premises under clause 4; or

(b) **self-quarantine** at a premises under clause 6 or 7.

(2) The person identified in subclause (1):

(a) must reside at that premises for the entirety of the period of self-isolation or self-quarantine, as the case requires, except for any period that the person is admitted to a hospital or other facility for the purposes of receiving medical care; and

(b) must not leave the premises, except:

(i) for the purposes of obtaining medical care or medical supplies; or

(ii) in any emergency situation; or

(iii) for the purposes of exercise, but only if the person:

(A) takes reasonable steps to maintain a distance of 1.5 metres from any other person, unless the other person is required to self-isolate or self-quarantine at the same premises; and

(B) does not enter any other building; or

(iv) if required to do so by law; or

(v) for the purposes of visiting a patient in hospital if permitted to do so under the **Hospital Visitor Directions (No 4)**; and

(c) must not permit any other person to enter the premises unless:

(i) that other person:

(A) ordinarily resides at the premises; or

(B) is required to self-isolate or self-quarantine at the premises under these directions; or

(ii) it is necessary for the other person to enter for medical or emergency purposes; or

(iii) the other person is a **disability worker**, and it is necessary for the disability worker to enter for the purpose of providing a **disability service** to a person with a **disability**;

(iv) it is necessary for the other person to enter for the purpose of providing personal care or household assistance to the person as a result of that person's age, disability or chronic health condition; or

Example: personal care includes assistance with showering, toileting, eating; household assistance includes help with cooking, house cleaning, laundry and gardening.

(v) the entry is otherwise required or authorised by law.

(3) Subclause (2)(c) does not apply to a person who is a **resident** of a **care facility**.

*Note: the **Care Facilities Directions (No 4)** govern who can enter a care facility.*

10 Definitions

In these directions:

(1) **care facility** has the same meaning as in the **Care Facilities Directions (No 4)**;

(2) **Department** means the Victorian Department of Health and Human Services;

(3) **hospital** has the same meaning as in the **Hospital Visitors Directions (No 4)**;

(4) **Departmental Requirements** means the document titled "COVID-19 Pandemic Plan for the Victorian Health Sector", as amended from time to time;

Note: the Departmental Requirements are available at:

https://www2.health.vic.gov.au/about/publications/ResearchAndReports/covid-19-pandemic-plan-for-vic

(5) **premises** means:

(a) a building, or part of a building; and

(b) any land on which the building is located, other than land that is available for communal use;

(6) **resident** of a care facility has the same meaning as in the **Care Facilities Directions (No 4)**;

(7) **Revoked Isolation Direction** means the following directions:

(a) **Isolation (Diagnosis) Direction**, given on 25 March 2020;

(b) **Isolation (Diagnosis) Direction (No 2)**, given on 13 April 2020;

(c) **Diagnosed Persons and Close Contacts Directions**, given on 11 May 2020;

(8) the following expressions have the same meaning that they have in the **Disability Service Safeguards Act 2018**:

(a) disability;

(b) disability service;

(c) disability worker.

11 Penalties

Section 203 of the PHW Act provides:

Compliance with direction or other requirement

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

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

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

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

Dr Annaliese van Diemen

Deputy Chief Health Officer (Communicable Disease), as authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the PHW Act.

31 May 2020

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

Diagnosed Persons and Close Contacts Directions (No 3)

Public Health and Wellbeing Act 2008 (Vic)
Section 200

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

1 Preamble

(1) The purpose of these directions is to require persons:

(a) diagnosed with Novel Coronavirus 2019 (**2019-nCoV**) to self-isolate;

(b) who are living with a diagnosed person, or who have been in close contact with a diagnosed person, to self-quarantine;

in order to limit the spread of 2019-nCoV.

(2) These directions replace the **Diagnosed Persons and Close Contacts Directions (No 2)** given on 31 May 2020, and:

(a) require diagnosed persons to notify the **Department** if a person begins residing with them while they are self-isolating;

(b) consolidate self-quarantine requirements so that persons residing with a diagnosed person are treated as close contacts;

(c) permit a close contact to choose the location at which they are required to self-quarantine;

(d) permit an officer of the Department to vary or revoke a notice given to a person of a determination that the person is a close contact, where appropriate on a review of the determination and relevant circumstances;

(e) provide continuity for persons required to self-quarantine under the **Diagnosed Persons and Close Contacts Directions (No 2)** because they reside with a diagnosed person, by providing that the requirements in relation to self-quarantine under those directions continue to apply to them; and

(f) permit the Chief Health Officer or Deputy Chief Health Officer to grant exemptions to the requirements of these directions, where appropriate on a review of the relevant circumstances.

2 Citation

These directions may be referred to as the **Diagnosed Persons and Close Contacts Directions (No 3)**.

3 Commencement and revocation

(1) These directions commence at 11:59:00pm on 21 June 2020.

(2) The **Diagnosed Persons and Close Contacts Directions (No 2)** are revoked at 11:59:00pm on 21 June 2020.

4 Self-isolation for diagnosed persons

Who is a diagnosed person?

(1) A person is a **diagnosed person** if the person:

(a) at any time between midnight on 25 March 2020 and 11:59:00pm on 12 July 2020 has been informed that they have been diagnosed with 2019-nCoV; and

(b) has not been given, or is not taken to have been given, **clearance from self-isolation** under clause 5.

Requirement to self-isolate

(2) A diagnosed person must **self-isolate** under these directions:

(a) if the diagnosis is communicated to the person on or after the commencement of these directions; or

(b) if the diagnosis was communicated to the person before the commencement of these directions.

Note: the requirements of self-isolation are specified in clause 8. A diagnosed person can still leave the premises at which they are self-isolating to obtain medical care.

Location of self-isolation

(3) A diagnosed person must self-isolate:

(a) if subclause (2)(a) applies, at the **premises** chosen by the person under subclause (4); or

(b) if subclause (2)(b) applies, at the premises at which the person was required to reside under a **Revoked Isolation Direction**.

(4) For the purposes of subclause (3)(a), the diagnosed person may choose to self-isolate at:

(a) a premises at which they ordinarily reside; or

(b) another premises that is suitable for the person to reside in for the purpose of self-isolation.

Note 1: a person can decide to self-isolate at a hotel or other suitable location, instead of self-isolating at their ordinary place of residence.

Note 2: once a person has chosen the premises at which to self-isolate, the person must reside at that premises for the entirety of the period of self-isolation: see clause 8(2)(a).

(5) If a diagnosed person who has chosen a premises under subclause (4) is not at the premises at the time when the choice is made, the person must immediately and directly travel to that premises, unless the person is admitted to a **hospital** or other facility for the purposes of receiving medical care.

Self-isolation period

(6) For the purposes of subclause (2), the period of self-isolation begins:

(a) if subclause (2)(a) applies, when the diagnosis is communicated to the person; or

(b) if subclause (2)(b) applies, upon the commencement of these directions.

(7) For the purposes of subclause (2), the period of self-isolation ends when the person is given **clearance from self-isolation** under clause 5.

Notifications by the diagnosed person

(8) Immediately after choosing a premises under subclause (4), the diagnosed person must:

(a) if any other person is residing at the premises chosen by the diagnosed person, notify the other person that:

(i) the diagnosed person has been diagnosed with 2019-nCoV; and

(ii) the diagnosed person has chosen to self-isolate at the premises; and

(b) notify the Department of:

(i) the address of the premises chosen by the diagnosed person; and

(ii) the name of any other person who is residing at the premises chosen by the diagnosed person.

(9) If, during the period that a diagnosed person is self-isolating at a premises for the purposes of clause 4, another person informs the diagnosed person that they intend to commence residing at the premises chosen by the diagnosed person:

(a) the diagnosed person must inform the other person of their diagnosis; and

(b) if the other person commences residing at the premises, the diagnosed person must notify the Department that a person has commenced residing with the diagnosed person and of the name of that person.

5 Clearance from self-isolation

(1) A diagnosed person is given **clearance from self-isolation** if:

(a) an officer of the Department makes a determination under subclause (2) in relation to the person; and

(b) the person is given notice of the determination in accordance with subclause (3).

(2) For the purposes of subclause (1)(a), an officer of the Department may make a determination in relation to a person if the officer is satisfied that the person meets the criteria for discharge from self-isolation under existing **Departmental Requirements**.

(3) For the purposes of subclause (1)(b), the notice must be in writing but is not required to be in a particular form.

(4) A person who has been given clearance from self-isolation, however expressed, under a Revoked Isolation Direction is taken to have been given clearance from self-isolation under this clause.

6 Self-quarantine for close contacts

Who is a close contact?

(1) For the purposes of this clause, a person is a **close contact** if:

(a) an officer of the Department has made a determination under subclause (2) in relation to the person; and

(b) between midnight on 11 May 2020 and 11:59:00pm on 12 July 2020, the person has been given notice of the determination in accordance with subclause (3).

(2) For the purposes of subclause (1)(a), an officer of the Department may make a determination in relation to a person if the officer is satisfied, having regard to Departmental Requirements, that the person has had close contact with another person who:

(a) since the time of last contact, has become a diagnosed person; or

(b) at the time of last contact, was a diagnosed person.

Note: under the Departmental Requirements, a person is generally considered to have had close contact if, in the period extending from 48 hours before onset of symptoms in the diagnosed person:

- *they have had face-to-face contact in any setting with the diagnosed person for more than a total of 15 minutes over the course of a week; or*
- *they have shared a closed space with a diagnosed person for a prolonged period (for example, more than 2 hours).*

(3) For the purposes of subclause (1)(b), the notice:

(a) must specify the time (including by reference to an event) at which the person will no longer be required to self-quarantine, having regard to Departmental Requirements; and

Example: the notice could specify that a person is no longer required to self-quarantine from 14 days after a diagnosed person who the person is living with receives clearance from self-isolation.

(b) may be given orally or in writing, and, if given orally, must be confirmed in writing as soon as reasonably practicable; and

(c) is not required to be in a particular form.

Requirement to self-quarantine

(4) A **close contact** must **self-quarantine** under these directions.

Note: the requirements of self-quarantine are specified in clause 8.

Location of self-quarantine

(5) A close contact may choose to self-quarantine at:

(a) a premises at which they ordinarily reside; or

(b) another premises that is suitable for the person to reside in for the purpose of self-quarantine.

Note 1: a person can decide to self-quarantine at a hotel or other suitable location, instead of self-quarantining at their ordinary place of residence.

Note 2: once a person has chosen the premises at which to self-quarantine, the person must reside at that premises for the entirety of the period of self-quarantine: see clause 8(2)(a).

(6) If, at the time a person is given a notice under subclause (1)(b), the person is not at the premises chosen by the person under subclause (5), the person must immediately and directly travel to that premises.

End of self-quarantine period

(7) For the purposes of this clause, the period of self-quarantine ends:

(a) subject to paragraph (c), at the time specified in the notice given under subclause (1)(b) as given or as varied under subclause (9); or

(b) if the notice given to the person under subclause (1)(b) is revoked under subclause (9), at the time that revocation takes effect; or

(c) if the person becomes a diagnosed person following a test for 2019-nCoV—when the diagnosis is communicated to the person.

Note: a close contact who becomes a diagnosed person will then be required to self-isolate under clause 4, for a period ending when the person is given clearance from self-isolation under clause 5.

Exception — previous clearance

(8) A person is not required to self-quarantine under this clause if, before the time that notice is given under subclause (1)(b), the person has been given, or is taken to have been given, clearance from self-isolation under clause 5.

Review of determination and notice

(9) An **authorised officer**, who is authorised to exercise **emergency powers** by the Chief Health Officer under section 199(2)(a) of the PHW Act, may review a determination made under subclause (2) and, if satisfied that it is appropriate, having regard to Departmental Requirements, may vary or revoke the notice given to the person under subclause (1)(b), and must give the person notice of the authorised officer's decision.

Transitional provision — close contacts under Revoked Isolation Directions

(10) If a person was a close contact under clause 7 of a Revoked Isolation Direction:

(a) a determination in relation to the person made under clause 7(2) of the Revoked Isolation Direction is taken to be a determination made under subclause (2); and

(b) a notice given to the person under clause 7(1)(b) of the Revoked Isolation Direction is taken to be a notice given under subclause (1)(b); and

(c) for the purposes of subclause (5), the person is taken to have chosen to self-quarantine at the premises at which the person was required to self-quarantine under the Revoked Isolation Direction.

Transitional provision — persons residing with diagnosed person

(11) If immediately prior to the commencement of these Directions, a person was required to self-quarantine under clause 6 of the **Diagnosed Persons and Close Contacts Directions (No 2)** (the **previous directions**):

(a) the person is taken to have been determined to be a close contact for the purposes of this clause; and

(b) for the purposes of subclause (5), the person is taken to have chosen to self-quarantine at the premises at which the person was required to self-quarantine under the previous directions; and

(c) the person is taken to have been given a notice under subclause (1)(b) specifying that the time at which the person will no longer be required to self-quarantine is the time provided for in clause 6(4) of the previous directions.

Note: a person who was required to self-quarantine under the previous directions because they reside with a person who is, or was, a diagnosed person, will continue to be required to self-quarantine for the period determined by the previous directions, unless that period is altered pursuant to subclause (9).

7 Testing of persons in self-quarantine

(1) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person:

(a) is tested for 2019-nCoV; and

(b) the period for which the person is required to self-quarantine under clause 6 expires during the period in which the person is awaiting the result of that test;

the period of self-quarantine is extended until the person receives the result of the test.

Note: persons who are in self-quarantine and experience a temperature higher than 37.5 degrees or symptoms of acute respiratory infection are encouraged to get tested. In certain circumstances, a person may be required to comply with an order that they undergo a medical test: PHW Act, section 113(3).

(2) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person receives a test result stating that they have been diagnosed with 2019-nCoV, the person becomes a diagnosed person and must self-isolate under clause 4.

(3) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person receives a test result stating that they have not been diagnosed with 2019-nCoV:

(a) if the period for which the person is required to self-quarantine under clause 6 has not expired—must continue to self-quarantine under that clause for the remainder of that period; or

(b) if the period of self-quarantine was extended under subclause (1)—may cease self-quarantining.

8 Requirements of self-isolation and self-quarantine

(1) This clause applies to a person who is required to:

(a) **self-isolate** at a premises under clause 4; or

(b) **self-quarantine** at a premises under clause 6.

(2) The person identified in subclause (1):

(a) must reside at that premises for the entirety of the period of self-isolation or self-quarantine, as the case requires, except for any period that the person is admitted to a hospital or other facility for the purposes of receiving medical care; and

(b) must not leave the premises, except:

(i) for the purposes of obtaining medical care or medical supplies; or

(ii) in any emergency situation; or

(iii) for the purposes of exercise, but only if the person:

(A) takes reasonable steps to maintain a distance of 1.5 metres from any other person, unless the other person is required to self-isolate or self-quarantine at the same premises; and

(B) does not enter any other building; or

(iv) if required to do so by law; or

(v) for the purposes of visiting a patient in hospital if permitted to do so under the **Hospital Visitor Directions (No 6)**; and

(c) must not permit any other person to enter the premises unless:

(i) that other person:

(A) ordinarily resides at the premises; or

(B) is required to self-isolate or self-quarantine at the premises under these directions; or

(ii) it is necessary for the other person to enter for medical or emergency purposes; or

(iii) the other person is a **disability worker**, and it is necessary for the disability worker to enter for the purpose of providing a **disability service** to a person with a **disability**;

(iv) it is necessary for the other person to enter for the purpose of providing personal care or household assistance to the person as a result of that person's age, disability or chronic health condition; or

Example: personal care includes assistance with showering, toileting, eating; household assistance includes help with cooking, house cleaning, laundry and gardening.

(v) the entry is otherwise required or authorised by law.

(3) Subclause (2)(c) does not apply to a person who is a **resident** of a **care facility**.

Note: the Care Facilities Directions (No 5) govern who can enter a care facility.

9 Exemption power

(1) A person is not required to comply with a requirement of these directions if the person is granted an exemption from that requirement under subclause (2).

(2) The Chief Health Officer or Deputy Chief Health Officer may exempt a person from any or all requirements contained in these directions, if satisfied that an exemption is appropriate, having regard to the:

(a) need to protect public health; and

(b) principles in sections 5 to 10 of the PHW Act, as appropriate.

(3) An exemption under subclause (2) must:

(a) be given, in writing, to the person the subject of the exemption; and

(b) specify the requirement or requirements that the person need not comply with.

(4) An exemption granted to a person under this clause does not prevent an authorised officer from exercising an emergency power to give the person a different direction or impose a different requirement on the person.

10 Definitions

In these directions:

(1) **authorised officer** has the same meaning as in the PHW Act;

(2) **care facility** has the same meaning as in the **Care Facilities Directions (No 5)**;

(3) **Department** means the Victorian Department of Health and Human Services;

(4) **Departmental Requirements** means the document titled "COVID-19 Pandemic Plan for the Victorian Health Sector", as amended from time to time;

Note: the Departmental Requirements are available at:

https://www2.health.vic.gov.au/about/publications/ResearchAndReports/covid-19-pandemic-plan-for-vic

(5) **emergency powers** has the same meaning as in the PHW Act;

(6) **hospital** has the same meaning as in the **Hospital Visitors Directions (No 6)**;

(7) **premises** means:

(a) a building, or part of a building; and

(b) any land on which the building is located, other than land that is available for communal use;

(8) **resident** of a care facility has the same meaning as in the **Care Facilities Directions (No 5)**;

(9) **Revoked Isolation Direction** means the following directions:

(a) **Isolation (Diagnosis) Direction**, given on 25 March 2020;

(b) **Isolation (Diagnosis) Direction (No 2)**, given on 13 April 2020;

(c) **Diagnosed Persons and Close Contacts Directions**, given on 11 May 2020;

(d) **Diagnosed Persons and Close Contacts Directions (No 2)**, given on 31 May 2020;

(10) the following expressions have the same meaning that they have in the **Disability Service Safeguards Act 2018**:

(a) disability;

(b) disability service;

(c) disability worker.

11 Penalties

Section 203 of the PHW Act provides:

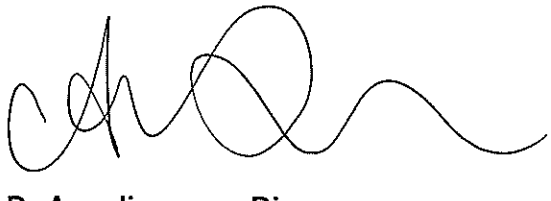
Compliance with direction or other requirement

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

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

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

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



Dr Annaliese van Diemen

Deputy Chief Health Officer (Communicable Disease), as authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the PHW Act.

21 June 2020

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

Diagnosed Persons and Close Contacts Directions (No 4)

Public Health and Wellbeing Act 2008 (Vic)
Section 200

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

1 Preamble

(1) The purpose of these directions is to require persons:

(a) diagnosed with Novel Coronavirus 2019 (**2019-nCoV**) to self-isolate;

(b) who are living with a diagnosed person, or who have been in close contact with a diagnosed person, to self-quarantine;

in order to limit the spread of 2019-nCoV.

(2) These directions replace the **Diagnosed Persons and Close Contacts Directions (No 3)** given on 21 June 2020.

2 Citation

These directions may be referred to as the **Diagnosed Persons and Close Contacts Directions (No 4)**.

3 Commencement and revocation

(1) These directions commence at 11:59:00pm on 1 July 2020.

(2) The **Diagnosed Persons and Close Contacts Directions (No 3)** are revoked at 11:59:00pm on 1 July 2020.

4 Self-isolation for diagnosed persons

Who is a diagnosed person?

(1) A person is a **diagnosed person** if the person:

(a) at any time between midnight on 25 March 2020 and 11:59:00pm on 19 July 2020 has been informed that they have been diagnosed with 2019-nCoV; and

(b) has not been given, or is not taken to have been given, **clearance from self-isolation** under clause 5.

Requirement to self-isolate

(2) A diagnosed person must **self-isolate** under these directions:

(a) if the diagnosis is communicated to the person on or after the commencement of these directions; or

(b) if the diagnosis was communicated to the person before the commencement of these directions.

Note: the requirements of self-isolation are specified in clause 8. A diagnosed person can still leave the premises at which they are self-isolating to obtain medical care.

Location of self-isolation

(3) A diagnosed person must self-isolate:

(a) if subclause (2)(a) applies, at the **premises** chosen by the person under subclause (4); or

(b) if subclause (2)(b) applies, at the premises at which the person was required to reside under a **Revoked Isolation Direction**.

(4) For the purposes of subclause (3)(a), the diagnosed person may choose to self-isolate at:

(a) a premises at which they ordinarily reside; or

(b) another premises that is suitable for the person to reside in for the purpose of self-isolation.

Note 1: a person can decide to self-isolate at a hotel or other suitable location, instead of self-isolating at their ordinary place of residence.

Note 2: once a person has chosen the premises at which to self-isolate, the person must reside at that premises for the entirety of the period of self-isolation: see clause 8(2)(a).

(5) If a diagnosed person who has chosen a premises under subclause (4) is not at the premises at the time when the choice is made, the person must immediately and directly travel to that premises, unless the person is admitted to a **hospital** or other facility for the purposes of receiving medical care.

Self-isolation period

(6) For the purposes of subclause (2), the period of self-isolation begins:

(a) if subclause (2)(a) applies, when the diagnosis is communicated to the person; or

(b) if subclause (2)(b) applies, upon the commencement of these directions.

(7) For the purposes of subclause (2), the period of self-isolation ends when the person is given **clearance from self-isolation** under clause 5.

Notifications by the diagnosed person

(8) Immediately after choosing a premises under subclause (4), the diagnosed person must:

(a) if any other person is residing at the premises chosen by the diagnosed person, notify the other person that:

(i) the diagnosed person has been diagnosed with 2019-nCoV; and

(ii) the diagnosed person has chosen to self-isolate at the premises; and

(b) notify the Department of:

(i) the address of the premises chosen by the diagnosed person; and

(ii) the name of any other person who is residing at the premises chosen by the diagnosed person.

(9) If, during the period that a diagnosed person is self-isolating at a premises for the purposes of clause 4, another person informs the diagnosed person that they intend to commence residing at the premises chosen by the diagnosed person:

(a) the diagnosed person must inform the other person of their diagnosis; and

(b) if the other person commences residing at the premises, the diagnosed person must notify the Department that a person has commenced residing with the diagnosed person and of the name of that person.

5 Clearance from self-isolation

(1) A diagnosed person is given **clearance from self-isolation** if:

(a) an officer of the Department makes a determination under subclause (2) in relation to the person; and

(b) the person is given notice of the determination in accordance with subclause (3).

(2) For the purposes of subclause (1)(a), an officer of the Department may make a determination in relation to a person if the officer is satisfied that the person meets the criteria for discharge from self-isolation under existing **Departmental Requirements**.

(3) For the purposes of subclause (1)(b), the notice must be in writing but is not required to be in a particular form.

(4) A person who has been given clearance from self-isolation, however expressed, under a Revoked Isolation Direction is taken to have been given clearance from self-isolation under this clause.

6 Self-quarantine for close contacts

Who is a close contact?

(1) For the purposes of this clause, a person is a **close contact** if:

(a) an officer of the Department has made a determination under subclause (2) in relation to the person; and

(b) between midnight on 11 May 2020 and 11:59:00pm on 19 July 2020, the person has been given notice of the determination in accordance with subclause (3).

(2) For the purposes of subclause (1)(a), an officer of the Department may make a determination in relation to a person if the officer is satisfied, having regard to Departmental Requirements, that the person has had close contact with another person who:

(a) since the time of last contact, has become a diagnosed person; or

(b) at the time of last contact, was a diagnosed person.

Note: under the Departmental Requirements, a person is generally considered to have had close contact if, in the period extending from 48 hours before onset of symptoms in the diagnosed person:

- *they have had face-to-face contact in any setting with the diagnosed person for more than a total of 15 minutes over the course of a week; or*
- *they have shared a closed space with a diagnosed person for a prolonged period (for example, more than 2 hours).*

(3) For the purposes of subclause (1)(b), the notice:

(a) must specify the time (including by reference to an event) at which the person will no longer be required to self-quarantine, having regard to Departmental Requirements; and

Example: the notice could specify that a person is no longer required to self-quarantine from 14 days after a diagnosed person who the person is living with receives clearance from self-isolation.

(b) may be given orally or in writing, and, if given orally, must be confirmed in writing as soon as reasonably practicable; and

(c) is not required to be in a particular form.

Requirement to self-quarantine

(4) A **close contact** must **self-quarantine** under these directions.

Note: the requirements of self-quarantine are specified in clause 8.

Location of self-quarantine

(5) A close contact may choose to self-quarantine at:

(a) a premises at which they ordinarily reside; or

(b) another premises that is suitable for the person to reside in for the purpose of self-quarantine.

Note 1: a person can decide to self-quarantine at a hotel or other suitable location, instead of self-quarantining at their ordinary place of residence.

Note 2: once a person has chosen the premises at which to self-quarantine, the person must reside at that premises for the entirety of the period of self-quarantine: see clause 8(2)(a).

(6) If, at the time a person is given a notice under subclause (1)(b), the person is not at the premises chosen by the person under subclause (5), the person must immediately and directly travel to that premises.

End of self-quarantine period

(7) For the purposes of this clause, the period of self-quarantine ends:

(a) subject to paragraph (c), at the time specified in the notice given under subclause (1)(b) as given or as varied under subclause (9); or

(b) if the notice given to the person under subclause (1)(b) is revoked under subclause (9), at the time that revocation takes effect; or

(c) if the person becomes a diagnosed person following a test for 2019-nCoV—when the diagnosis is communicated to the person.

Note: a close contact who becomes a diagnosed person will then be required to self-isolate under clause 4, for a period ending when the person is given clearance from self-isolation under clause 5.

Exception — previous clearance

(8) A person is not required to self-quarantine under this clause if, before the time that notice is given under subclause (1)(b), the person has been given, or is taken to have been given, clearance from self-isolation under clause 5.

Review of determination and notice

(9) An **authorised officer**, who is authorised to exercise **emergency powers** by the Chief Health Officer under section 199(2)(a) of the PHW Act, may review a determination made under subclause (2) and, if satisfied that it is appropriate, having regard to Departmental Requirements, may vary or revoke the notice given to the person under subclause (1)(b), and must give the person notice of the authorised officer's decision.

Transitional provision — close contacts under Revoked Isolation Directions

(10) If a person was a close contact under a Revoked Isolation Direction:

(a) a determination made, or taken to have been made, under the Revoked Isolation Direction in relation to the person's status as a close contact is taken to be a determination made under subclause (2); and

(b) a notice given, or taken to have been given, to the person under the Revoked Isolation Direction in relation to the determination referred to in paragraph (a) is taken to be a notice given under subclause (1)(b); and

(c) for the purposes of subclause (5), the person is taken to have chosen to self-quarantine at the premises at which the person was required to self-quarantine under the Revoked Isolation Direction.

Note: a person who was required to self-quarantine under previous directions because they reside with a person who is, or was, a diagnosed person, are now treated as close contacts, and also continue to be required to self-quarantine for the period determined by the previous directions, unless that period is altered pursuant to subclause (9).

7 Testing of persons in self-quarantine

(1) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person:

(a) is tested for 2019-nCoV; and

(b) the period for which the person is required to self-quarantine under clause 6 expires during the period in which the person is awaiting the result of that test;

the period of self-quarantine is extended until the person receives the result of the test.

Note: persons who are in self-quarantine and experience a temperature higher than 37.5 degrees or symptoms of acute respiratory infection are encouraged to get tested. In certain circumstances, a person may be required to comply with an order that they undergo a medical test: PHW Act, section 113(3).

(2) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person receives a test result stating that they have been diagnosed with 2019-nCoV, the person becomes a diagnosed person and must self-isolate under clause 4.

(3) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person receives a test result stating that they have not been diagnosed with 2019-nCoV:

(a) if the period for which the person is required to self-quarantine under clause 6 has not expired—must continue to self-quarantine under that clause for the remainder of that period; or

(b) if the period of self-quarantine was extended under subclause (1)—may cease self-quarantining.

8 Requirements of self-isolation and self-quarantine

(1) This clause applies to a person who is required to:

(a) **self-isolate** at a premises under clause 4; or

(b) **self-quarantine** at a premises under clause 6.

(2) The person identified in subclause (1):

(a) must reside at that premises for the entirety of the period of self-isolation or self-quarantine, as the case requires, except for any period

that the person is admitted to a hospital or other facility for the purposes of receiving medical care; and

(b) must not leave the premises, except:

(i) for the purposes of obtaining medical care or medical supplies; or

(ii) in any emergency situation; or

(iii) for the purposes of exercise, but only if the person:

(A) takes reasonable steps to maintain a distance of 1.5 metres from any other person, unless the other person is required to self-isolate or self-quarantine at the same premises; and

(B) does not enter any other building; or

(iv) if required to do so by law; or

(v) for the purposes of visiting a patient in hospital if permitted to do so under the **Hospital Visitor Directions (No 7)**; and

(c) must not permit any other person to enter the premises unless:

(i) that other person:

(A) ordinarily resides at the premises; or

(B) is required to self-isolate or self-quarantine at the premises under these directions; or

(ii) it is necessary for the other person to enter for medical or emergency purposes; or

(iii) the other person is a **disability worker**, and it is necessary for the disability worker to enter for the purpose of providing a **disability service** to a person with a **disability**;

(iv) it is necessary for the other person to enter for the purpose of providing personal care or household assistance to the person as a result of that person's age, disability or chronic health condition; or

Example: personal care includes assistance with showering, toileting, eating; household assistance includes help with cooking, house cleaning, laundry and gardening.

(v) the entry is otherwise required or authorised by law.

(3) Subclause (2)(c) does not apply to a person who is a **resident** of a **care facility**.

Note: the Care Facilities Directions (No 6) govern who can enter a care facility.

9 Exemption power

(1) A person is not required to comply with a requirement of these directions if the person is granted an exemption from that requirement under subclause (2).

(2) The Chief Health Officer or Deputy Chief Health Officer may exempt a person from any or all requirements contained in these directions, if satisfied that an exemption is appropriate, having regard to the:

(a) need to protect public health; and

(b) principles in sections 5 to 10 of the PHW Act, as appropriate.

(3) An exemption under subclause (2) must:

(a) be given, in writing, to the person the subject of the exemption; and

(b) specify the requirement or requirements that the person need not comply with.

(4) An exemption granted to a person under this clause does not prevent an authorised officer from exercising an emergency power to give the person a different direction or impose a different requirement on the person.

10 Definitions

In these directions:

(1) **authorised officer** has the same meaning as in the PHW Act;

(2) **care facility** has the same meaning as in the **Care Facilities Directions (No 6)**;

(3) **Department** means the Victorian Department of Health and Human Services;

(4) **Departmental Requirements** means the document titled "COVID-19 Pandemic Plan for the Victorian Health Sector", as amended from time to time;

Note: the Departmental Requirements are available at:

https://www2.health.vic.gov.au/about/publications/ResearchAndReports/covid-19-pandemic-plan-for-vic

(5) **emergency powers** has the same meaning as in the PHW Act;

(6) **hospital** has the same meaning as in the **Hospital Visitors Directions (No 7)**;

(7) **premises** means:

(a) a building, or part of a building; and

(b) any land on which the building is located, other than land that is available for communal use;

(8) **resident** of a care facility has the same meaning as in the **Care Facilities Directions (No 6)**;

(9) **Revoked Isolation Direction** means the following directions:

(a) **Isolation (Diagnosis) Direction**, given on 25 March 2020;

(b) **Isolation (Diagnosis) Direction (No 2)**, given on 13 April 2020;

(c) **Diagnosed Persons and Close Contacts Directions**, given on 11 May 2020;

(d) **Diagnosed Persons and Close Contacts Directions (No 2)**, given on 31 May 2020;

(e) **Diagnosed Persons and Close Contacts Directions (No 3)**, given on 21 June 2020;

(10) the following expressions have the same meaning that they have in the **Disability Service Safeguards Act 2018**:

(a) disability;

(b) disability service;

(c) disability worker.

11 Penalties

Section 203 of the PHW Act provides:

Compliance with direction or other requirement

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

Penalty: In the case of a natural person, 120 penalty units;
In the case of a body corporate, 600 penalty units.

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

Dr Annaliese van Diemen

Deputy Chief Health Officer (Communicable Disease), as authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the PHW Act.

1 July 2020

Direction from Deputy Public Health Commander in accordance with emergency powers arising from declared state of emergency

Diagnosed Persons and Close Contacts Directions (No 5)

Public Health and Wellbeing Act 2008 (Vic)
Section 200

I, Dr Finn Romanes, Deputy Public Health Commander, consider it reasonably necessary to protect public health to give the following directions pursuant to section 200(1)(b) and (d) of the **Public Health and Wellbeing Act 2008** (Vic) (**PHW Act**):

1 Preamble

(1) The purpose of these directions is to require persons:

(a) diagnosed with Novel Coronavirus 2019 (**2019-nCoV**) to self-isolate;

(b) who are living with a diagnosed person, or who have been in close contact with a diagnosed person, to self-quarantine;

in order to limit the spread of 2019-nCoV.

(2) These directions replace the **Diagnosed Persons and Close Contacts Directions (No 4)** given on 11 July 2020.

2 Citation

(1) These directions may be referred to as the **Diagnosed Persons and Close Contacts Directions (No 5).**

(2) A reference in any other direction to the **Diagnosed Persons and Close Contacts Directions (No 4)** is taken to be a reference to these directions.

3 Commencement and revocation

(1) These directions commence at 11:59:00pm on 15 July 2020.

(2) The **Diagnosed Persons and Close Contacts Directions (No 4)** are revoked at 11:59:00pm on 15 July 2020.

4 Self-isolation for diagnosed persons

Who is a diagnosed person?

(1) A person is a **diagnosed person** if the person:

(a) at any time between midnight on 25 March 2020 and 11:59:00pm on 19 July 2020 has been informed that they have been diagnosed with 2019-nCoV; and

(b) has not been given, or is not taken to have been given, **clearance from self-isolation** under clause 5.

Requirement to self-isolate

(2) A diagnosed person must **self-isolate** under these directions:

(a) if the diagnosis is communicated to the person on or after the commencement of these directions; or

(b) if the diagnosis was communicated to the person before the commencement of these directions.

Note: the requirements of self-isolation are specified in clause 8. A diagnosed person can still leave the premises at which they are self-isolating to obtain medical care.

Location of self-isolation

(3) A diagnosed person must self-isolate:

(a) if subclause (2)(a) applies, at the **premises** chosen by the person under subclause (4); or

(b) if subclause (2)(b) applies, at the premises at which the person was required to reside under a **Revoked Isolation Direction**.

(4) For the purposes of subclause (3)(a), the diagnosed person may choose to self-isolate at:

(a) a premises at which they ordinarily reside; or

(b) another premises that is suitable for the person to reside in for the purpose of self-isolation.

Note 1: a person can decide to self-isolate at a hotel or other suitable location, instead of self-isolating at their ordinary place of residence.

Note 2: once a person has chosen the premises at which to self-isolate, the person must reside at that premises for the entirety of the period of self-isolation: see clause 8(2)(a).

(5) If a diagnosed person who has chosen a premises under subclause (4) is not at the premises at the time when the choice is made, the person must immediately and directly travel to that premises, unless the person is admitted to a **hospital** or other facility for the purposes of receiving medical care.

Self-isolation period

(6) For the purposes of subclause (2), the period of self-isolation begins:

(a) if subclause (2)(a) applies, when the diagnosis is communicated to the person; or

(b) if subclause (2)(b) applies, upon the commencement of these directions.

(7) For the purposes of subclause (2), the period of self-isolation ends when the person is given **clearance from self-isolation** under clause 5.

Notifications by the diagnosed person

(8) Immediately after choosing a premises under subclause (4), the diagnosed person must:

(a) if any other person is residing at the premises chosen by the diagnosed person, notify the other person that:

(i) the diagnosed person has been diagnosed with 2019-nCoV; and

(ii) the diagnosed person has chosen to self-isolate at the premises; and

(b) notify the Department of:

(i) the address of the premises chosen by the diagnosed person; and

(ii) the name of any other person who is residing at the premises chosen by the diagnosed person.

(9) If, during the period that a diagnosed person is self-isolating at a premises for the purposes of clause 4, another person informs the diagnosed person that they intend to commence residing at the premises chosen by the diagnosed person:

(a) the diagnosed person must inform the other person of their diagnosis; and

(b) if the other person commences residing at the premises, the diagnosed person must notify the Department that a person has commenced residing with the diagnosed person and of the name of that person.

5 Clearance from self-isolation

(1) A diagnosed person is given **clearance from self-isolation** if:

(a) an officer of the Department makes a determination under subclause (2) in relation to the person; and

(b) the person is given notice of the determination in accordance with subclause (3).

(2) For the purposes of subclause (1)(a), an officer of the Department may make a determination in relation to a person if the officer is satisfied that the person meets the criteria for discharge from self-isolation under existing **Departmental Requirements**.

(3) For the purposes of subclause (1)(b), the notice must be in writing but is not required to be in a particular form.

(4) A person who has been given clearance from self-isolation, however expressed, under a Revoked Isolation Direction is taken to have been given clearance from self-isolation under this clause.

6 Self-quarantine for close contacts

Who is a close contact?

(1) For the purposes of this clause, a person is a **close contact** if:

(a) an officer of the Department has made a determination under subclause (2) in relation to the person; and

(b) between midnight on 11 May 2020 and 11:59:00pm on 19 July 2020, the person has been given notice of the determination in accordance with subclause (3).

(2) For the purposes of subclause (1)(a), an officer of the Department may make a determination in relation to a person if the officer is satisfied, having regard to Departmental Requirements, that the person has had close contact with another person who:

(a) since the time of last contact, has become a diagnosed person; or

(b) at the time of last contact, was a diagnosed person.

Note: under the Departmental Requirements, a person is generally considered to have had close contact if, in the period extending from 48 hours before onset of symptoms in the diagnosed person:

- *they have had face-to-face contact in any setting with the diagnosed person for more than a total of 15 minutes over the course of a week; or*
- *they have shared a closed space with a diagnosed person for a prolonged period (for example, more than 2 hours).*

(3) For the purposes of subclause (1)(b), the notice:

(a) must specify the time (including by reference to an event) at which the person will no longer be required to self-quarantine, having regard to Departmental Requirements; and

Example: the notice could specify that a person is no longer required to self-quarantine from 14 days after a diagnosed person who the person is living with receives clearance from self-isolation.

(b) may be given orally or in writing, and, if given orally, must be confirmed in writing as soon as reasonably practicable; and

(c) is not required to be in a particular form.

Requirement to self-quarantine

(4) A **close contact** must **self-quarantine** under these directions.

Note: the requirements of self-quarantine are specified in clause 8.

Location of self-quarantine

(5) A close contact may choose to self-quarantine at:

(a) a premises at which they ordinarily reside; or

(b) another premises that is suitable for the person to reside in for the purpose of self-quarantine.

Note 1: a person can decide to self-quarantine at a hotel or other suitable location, instead of self-quarantining at their ordinary place of residence.

Note 2: once a person has chosen the premises at which to self-quarantine, the person must reside at that premises for the entirety of the period of self-quarantine: see clause 8(2)(a).

(6) If, at the time a person is given a notice under subclause (1)(b), the person is not at the premises chosen by the person under subclause (5), the person must immediately and directly travel to that premises.

End of self-quarantine period

(7) For the purposes of this clause, the period of self-quarantine ends:

(a) subject to paragraph (c), at the time specified in the notice given under subclause (1)(b) as given or as varied under subclause (9); or

(b) if the notice given to the person under subclause (1)(b) is revoked under subclause (9), at the time that revocation takes effect; or

(c) if the person becomes a diagnosed person following a test for 2019-nCoV—when the diagnosis is communicated to the person.

Note: a close contact who becomes a diagnosed person will then be required to self-isolate under clause 4, for a period ending when the person is given clearance from self-isolation under clause 5.

Exception — previous clearance

(8) A person is not required to self-quarantine under this clause if, before the time that notice is given under subclause (1)(b), the person has been given, or is taken to have been given, clearance from self-isolation under clause 5.

Review of determination and notice

(9) An **authorised officer**, who is authorised to exercise **emergency powers** by the Chief Health Officer under section 199(2)(a) of the PHW Act, may review a determination made under subclause (2) and, if satisfied that it is appropriate, having regard to Departmental Requirements, may vary or revoke the notice given to the person under subclause (1)(b), and must give the person notice of the authorised officer's decision.

Transitional provision — close contacts under Revoked Isolation Directions

(10) If a person was a close contact under a Revoked Isolation Direction:

(a) a determination made, or taken to have been made, under the Revoked Isolation Direction in relation to the person's status as a close contact is taken to be a determination made under subclause (2); and

(b) a notice given, or taken to have been given, to the person under the Revoked Isolation Direction in relation to the determination referred to in paragraph (a) is taken to be a notice given under subclause (1)(b); and

(c) for the purposes of subclause (5), the person is taken to have chosen to self-quarantine at the premises at which the person was required to self-quarantine under the Revoked Isolation Direction.

Note: a person who was required to self-quarantine under previous directions because they reside with a person who is, or was, a diagnosed person, are now treated as close contacts, and also continue to be required to self-quarantine for the period determined by the previous directions, unless that period is altered pursuant to subclause (9).

7 Testing of persons in self-quarantine

(1) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person:

(a) is tested for 2019-nCoV; and

(b) the period for which the person is required to self-quarantine under clause 6 expires during the period in which the person is awaiting the result of that test;

the period of self-quarantine is extended until the person receives the result of the test.

Note: persons who are in self-quarantine and experience a temperature higher than 37.5 degrees or symptoms of acute respiratory infection are encouraged to get tested. In certain circumstances, a person may be required to comply with an order that they undergo a medical test: PHW Act, section 113(3).

(2) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person receives a test result stating that they have been diagnosed with 2019-nCoV, the person becomes a diagnosed person and must self-isolate under clause 4.

(3) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person receives a test result stating that they have not been diagnosed with 2019-nCoV:

(a) if the period for which the person is required to self-quarantine under clause 6 has not expired—must continue to self-quarantine under that clause for the remainder of that period; or

(b) if the period of self-quarantine was extended under subclause (1)—may cease self-quarantining.

8 Requirements of self-isolation and self-quarantine

(1) This clause applies to a person who is required to:

(a) **self-isolate** at a premises under clause 4; or

(b) **self-quarantine** at a premises under clause 6.

(2) The person identified in subclause (1):

(a) must reside at that premises for the entirety of the period of self-isolation or self-quarantine, as the case requires, except for any period

that the person is admitted to a hospital or other facility for the purposes of receiving medical care; and

(b) must not leave the premises, except:

(i) for the purposes of obtaining medical care or medical supplies; or

(ii) in any emergency situation; or

(iii) for the purposes of exercise, but only if the person:

(A) takes reasonable steps to maintain a distance of 1.5 metres from any other person, unless the other person is required to self-isolate or self-quarantine at the same premises; and

(B) does not enter any other building; or

Note: Where a person is unable to take reasonable steps to maintain a distance of 1.5 metres from any other person when exercising, an authorised officer may direct that person to comply with another exercise program in order to mitigate a risk to public health, if that person wishes to exercise during their period of self-isolation or self-quarantine, as the case may be.

(iv) if required to do so by law; or

(v) for the purposes of visiting a patient in hospital if permitted to do so under the **Hospital Visitor Directions (No 7)**; and

(c) must not permit any other person to enter the premises unless:

(i) that other person:

(A) ordinarily resides at the premises; or

(B) is required to self-isolate or self-quarantine at the premises under these directions; or

(ii) it is necessary for the other person to enter for medical or emergency purposes; or

(iii) the other person is a **disability worker**, and it is necessary for the disability worker to enter for the purpose of providing a **disability service** to a person with a **disability**;

(iv) it is necessary for the other person to enter for the purpose of providing personal care or household assistance to the person as a result of that person's age, disability or chronic health condition; or

Example: personal care includes assistance with showering, toileting, eating; household assistance includes help with cooking, house cleaning, laundry and gardening.

(v) the entry is otherwise required or authorised by law.

(3) Subclause (2)(c) does not apply to a person who is a **resident** of a **care facility**.

Note: the Care Facilities Directions (No 6) govern who can enter a care facility.

9 Exemption power

(1) A person is not required to comply with a requirement of these directions if the person is granted an exemption from that requirement under subclause (2).

(2) The Chief Health Officer or Deputy Chief Health Officer may exempt a person or a group of persons, from any or all requirements contained in these directions, if satisfied that an exemption is appropriate, having regard to the:

(a) need to protect public health; and

(b) principles in sections 5 to 10 of the PHW Act, as appropriate.

(3) An exemption under subclause (2) must:

(a) be given, in writing, to the person the subject of the exemption; and

(b) specify the requirement or requirements that the person need not comply with.

(4) An exemption granted to a person under this clause does not prevent an authorised officer from exercising an emergency power to give the person a different direction or impose a different requirement on the person.

10 Definitions

In these directions:

(1) **authorised officer** has the same meaning as in the PHW Act;

(2) **care facility** has the same meaning as in the **Care Facilities Directions (No 6)**;

(3) **Department** means the Victorian Department of Health and Human Services;

(4) **Departmental Requirements** means the document titled "COVID-19 Pandemic Plan for the Victorian Health Sector", as amended from time to time;

Note: the Departmental Requirements are available at:

https://www2.health.vic.gov.au/about/publications/ResearchAndReports/covid-19-pandemic-plan-for-vic

(5) **emergency powers** has the same meaning as in the PHW Act;

(6) **hospital** has the same meaning as in the **Hospital Visitors Directions (No 7)**;

(7) **premises** means:

(a) a building, or part of a building; and

(b) any land on which the building is located, other than land that is available for communal use;

(8) **resident** of a care facility has the same meaning as in the **Care Facilities Directions (No 6)**;

(9) **Revoked Isolation Direction** means the following directions:

(a) **Isolation (Diagnosis) Direction**, given on 25 March 2020;

(b) **Isolation (Diagnosis) Direction (No 2)**, given on 13 April 2020;

(c) **Diagnosed Persons and Close Contacts Directions**, given on 11 May 2020;

(d) **Diagnosed Persons and Close Contacts Directions (No 2)**, given on 31 May 2020;

(e) **Diagnosed Persons and Close Contacts Directions (No 3)**, given on 21 June 2020;

(f) **Diagnosed Persons and Close Contacts Directions (No 4)**, given on 1 July 2020;

(10) the following expressions have the same meaning that they have in the **Disability Service Safeguards Act 2018**:

(a) disability;

(b) disability service;

(c) disability worker.

11 Penalties

Section 203 of the PHW Act provides:

Compliance with direction or other requirement

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

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

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

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

Dr Finn Romanes

Deputy Public Health Commander, as authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the PHW Act.

15 July 2020

Direction from Deputy Public Health Commander in accordance with emergency powers arising from declared state of emergency

Diagnosed Persons and Close Contacts Directions (No 6)

Public Health and Wellbeing Act 2008 (Vic)
Section 200

I, Dr Finn Romanes, Deputy Public Health Commander, consider it reasonably necessary to protect public health to give the following directions pursuant to section 200(1)(b) and (d) of the **Public Health and Wellbeing Act 2008** (Vic) (**PHW Act**):

1 Preamble

(1) The purpose of these directions is to require persons:

(a) diagnosed with Novel Coronavirus 2019 (**2019-nCoV**) to self-isolate;

(b) who are living with a diagnosed person, or who have been in close contact with a diagnosed person, to self-quarantine;

in order to limit the spread of 2019-nCoV.

(2) These directions replace the **Diagnosed Persons and Close Contacts Directions (No 5)** given on 15 July 2020.

2 Citation

These directions may be referred to as the **Diagnosed Persons and Close Contacts Directions (No 6).**

3 Commencement and revocation

(1) These directions commence at 11:59:00pm on 19 July 2020.

(2) The **Diagnosed Persons and Close Contacts Directions (No 5)** are revoked at 11:59:00pm on 16 August 2020.

4 Self-isolation for diagnosed persons

Who is a diagnosed person?

(1) A person is a **diagnosed person** if the person:

(a) at any time between midnight on 25 March 2020 and 11:59:00pm on 16 August 2020 has been informed that they have been diagnosed with 2019-nCoV; and

(b) has not been given, or is not taken to have been given, **clearance from self-isolation** under clause 5.

Requirement to self-isolate

(2) A diagnosed person must **self-isolate** under these directions:

(a) if the diagnosis is communicated to the person on or after the commencement of these directions; or

(b) if the diagnosis was communicated to the person before the commencement of these directions.

Note: the requirements of self-isolation are specified in clause 8. A diagnosed person can still leave the premises at which they are self-isolating to obtain medical care.

Location of self-isolation

(3) A diagnosed person must self-isolate:

(a) if subclause (2)(a) applies, at the **premises** chosen by the person under subclause (4); or

(b) if subclause (2)(b) applies, at the premises at which the person was required to reside under a **Revoked Isolation Direction**.

(4) For the purposes of subclause (3)(a), the diagnosed person may choose to self-isolate at:

(a) a premises at which they ordinarily reside; or

(b) another premises that is suitable for the person to reside in for the purpose of self-isolation.

Note 1: a person can decide to self-isolate at a hotel or other suitable location, instead of self-isolating at their ordinary place of residence.

Note 2: once a person has chosen the premises at which to self-isolate, the person must reside at that premises for the entirety of the period of self-isolation: see clause 8(2)(a).

(5) If a diagnosed person who has chosen a premises under subclause (4) is not at the premises at the time when the choice is made, the person must immediately and directly travel to that premises, unless the person is admitted to a **hospital** or other facility for the purposes of receiving medical care.

Self-isolation period

(6) For the purposes of subclause (2), the period of self-isolation begins:

(a) if subclause (2)(a) applies, when the diagnosis is communicated to the person; or

(b) if subclause (2)(b) applies, upon the commencement of these directions.

(7) For the purposes of subclause (2), the period of self-isolation ends when the person is given **clearance from self-isolation** under clause 5.

Notifications by the diagnosed person

(8) Immediately after choosing a premises under subclause (4), the diagnosed person must:

(a) if any other person is residing at the premises chosen by the diagnosed person, notify the other person that:

(i) the diagnosed person has been diagnosed with 2019-nCoV; and

(ii) the diagnosed person has chosen to self-isolate at the premises; and

(b) notify the Department of:

(i) the address of the premises chosen by the diagnosed person; and

(ii) the name of any other person who is residing at the premises chosen by the diagnosed person.

(9) If, during the period that a diagnosed person is self-isolating at a premises for the purposes of clause 4, another person informs the diagnosed person that they intend to commence residing at the premises chosen by the diagnosed person:

(a) the diagnosed person must inform the other person of their diagnosis; and

(b) if the other person commences residing at the premises, the diagnosed person must notify the Department that a person has commenced residing with the diagnosed person and of the name of that person.

5 Clearance from self-isolation

(1) A diagnosed person is given **clearance from self-isolation** if:

(a) an officer of the Department makes a determination under subclause (2) in relation to the person; and

(b) the person is given notice of the determination in accordance with subclause (3).

(2) For the purposes of subclause (1)(a), an officer of the Department may make a determination in relation to a person if the officer is satisfied that the person meets the criteria for discharge from self-isolation under existing **Departmental Requirements**.

(3) For the purposes of subclause (1)(b), the notice must be in writing but is not required to be in a particular form.

(4) A person who has been given clearance from self-isolation, however expressed, under a Revoked Isolation Direction is taken to have been given clearance from self-isolation under this clause.

6 Self-quarantine for close contacts

Who is a close contact?

(1) For the purposes of this clause, a person is a **close contact** if:

(a) an officer or nominated representative of the Department has made a determination under subclause (2) in relation to the person; and

(b) between midnight on 11 May 2020 and 11:59:00pm on 16 August 2020, the person has been given notice of the determination in accordance with subclause (3).

(2) For the purposes of subclause (1)(a), an officer or nominated representative of the Department may make a determination in relation to a person if the officer or nominated representative is satisfied, having regard to Departmental Requirements, that the person has had close contact with another person who:

(a) since the time of last contact, has become a diagnosed person; or

(b) at the time of last contact, was a diagnosed person.

Note: under the Departmental Requirements, a person is generally considered to have had close contact if, in the period extending from 48 hours before onset of symptoms in the diagnosed person:

- *they have had face-to-face contact in any setting with the diagnosed person for more than a total of 15 minutes over the course of a week; or*
- *they have shared a closed space with a diagnosed person for a prolonged period (for example, more than 2 hours).*

(3) For the purposes of subclause (1)(b), the notice:

(a) must specify the time (including by reference to an event) at which the person will no longer be required to self-quarantine, having regard to Departmental Requirements; and

Example: the notice could specify that a person is no longer required to self-quarantine from 14 days after a diagnosed person who the person is living with receives clearance from self-isolation.

(b) may be given orally or in writing, and, if given orally, must be confirmed in writing as soon as reasonably practicable; and

(c) is not required to be in a particular form.

Requirement to self-quarantine

(4) A **close contact** must **self-quarantine** under these directions.

Note: the requirements of self-quarantine are specified in clause 8.

Location of self-quarantine

(5) A close contact may choose to self-quarantine at:

(a) a premises at which they ordinarily reside; or

(b) another premises that is suitable for the person to reside in for the purpose of self-quarantine.

Note 1: a person can decide to self-quarantine at a hotel or other suitable location, instead of self-quarantining at their ordinary place of residence.

Note 2: once a person has chosen the premises at which to self-quarantine, the person must reside at that premises for the entirety of the period of self-quarantine: see clause 8(2)(a).

(6) If, at the time a person is given a notice under subclause (1)(b), the person is not at the premises chosen by the person under subclause (5), the person must immediately and directly travel to that premises.

End of self-quarantine period

(7) For the purposes of this clause, the period of self-quarantine ends:

(a) subject to paragraph (c), at the time specified in the notice given under subclause (1)(b) as given or as varied under subclause (9); or

(b) if the notice given to the person under subclause (1)(b) is revoked under subclause (9), at the time that revocation takes effect; or

(c) if the person becomes a diagnosed person following a test for 2019-nCoV—when the diagnosis is communicated to the person.

Note: a close contact who becomes a diagnosed person will then be required to self-isolate under clause 4, for a period ending when the person is given clearance from self-isolation under clause 5.

Exception — previous clearance

(8) A person is not required to self-quarantine under this clause if, before the time that notice is given under subclause (1)(b), the person has been given, or is taken to have been given, clearance from self-isolation under clause 5.

Review of determination and notice

(9) An **authorised officer**, who is authorised to exercise **emergency powers** by the Chief Health Officer under section 199(2)(a) of the PHW Act, may review a determination made under subclause (2) and, if satisfied that it is appropriate, having regard to Departmental Requirements, may vary or revoke the notice given to the person under subclause (1)(b), and must give the person notice of the authorised officer's decision.

Transitional provision — close contacts under Revoked Isolation Directions

(10) If a person was a close contact under a Revoked Isolation Direction:

(a) a determination made, or taken to have been made, under the Revoked Isolation Direction in relation to the person's status as a close contact is taken to be a determination made under subclause (2); and

(b) a notice given, or taken to have been given, to the person under the Revoked Isolation Direction in relation to the determination referred to in paragraph (a) is taken to be a notice given under subclause (1)(b); and

(c) for the purposes of subclause (5), the person is taken to have chosen to self-quarantine at the premises at which the person was required to self-quarantine under the Revoked Isolation Direction.

Note: a person who was required to self-quarantine under previous directions because they reside with a person who is, or was, a diagnosed person, are now treated as close contacts, and also continue to be required to self-quarantine for the period determined by the previous directions, unless that period is altered pursuant to subclause (9).

7 Testing of persons in self-quarantine

(1) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person:

(a) is tested for 2019-nCoV; and

(b) the period for which the person is required to self-quarantine under clause 6 expires during the period in which the person is awaiting the result of that test;

the period of self-quarantine is extended until the person receives the result of the test.

Note: persons who are in self-quarantine and experience a temperature higher than 37.5 degrees or symptoms of acute respiratory infection are encouraged to get tested. In certain circumstances, a person may be required to comply with an order that they undergo a medical test: PHW Act, section 113(3).

(2) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person receives a test result stating that they have been diagnosed with 2019-nCoV, the person becomes a diagnosed person and must self-isolate under clause 4.

(3) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person receives a test result stating that they have not been diagnosed with 2019-nCoV:

(a) if the period for which the person is required to self-quarantine under clause 6 has not expired—must continue to self-quarantine under that clause for the remainder of that period; or

(b) if the period of self-quarantine was extended under subclause (1)—may cease self-quarantining.

8 Requirements of self-isolation and self-quarantine

(1) This clause applies to a person who is required to:

(a) **self-isolate** at a premises under clause 4; or

(b) **self-quarantine** at a premises under clause 6.

(2) The person identified in subclause (1):

(a) must reside at that premises for the entirety of the period of self-isolation or self-quarantine, as the case requires, except for any period

that the person is admitted to a hospital or other facility for the purposes of receiving medical care; and

(b) must not leave the premises, except:

(i) for the purposes of obtaining medical care or medical supplies; or

(ii) in any emergency situation; or

(iii) for the purposes of exercise, but only if the person:

(A) takes reasonable steps to maintain a distance of 1.5 metres from any other person, unless the other person is required to self-isolate or self-quarantine at the same premises; and

(B) does not enter any other building; or

Note: Where a person is unable to take reasonable steps to maintain a distance of 1.5 metres from any other person when exercising, an authorised officer may direct that person to comply with another exercise program in order to mitigate a risk to public health, if that person wishes to exercise during their period of self-isolation or self-quarantine, as the case may be.

(iv) if required to do so by law; or

(v) for the purposes of visiting a patient in hospital if permitted to do so under the **Hospital Visitor Directions (No 8)**; and

(c) must not permit any other person to enter the premises unless:

(i) that other person:

(A) ordinarily resides at the premises; or

(B) is required to self-isolate or self-quarantine at the premises under these directions; or

(ii) it is necessary for the other person to enter for medical or emergency purposes; or

(iii) the other person is a **disability worker**, and it is necessary for the disability worker to enter for the purpose of providing a **disability service** to a person with a **disability**;

(iv) it is necessary for the other person to enter for the purpose of providing personal care or household assistance to the person as a result of that person's age, disability or chronic health condition; or

Example: personal care includes assistance with showering, toileting, eating; household assistance includes help with cooking, house cleaning, laundry and gardening.

(v) the entry is otherwise required or authorised by law.

(3) Subclause (2)(c) does not apply to a person who is a **resident** of a **care facility**.

Note: the Care Facilities Directions (No 7) govern who can enter a care facility.

9 Exemption power

(1) A person is not required to comply with a requirement of these directions if the person is granted an exemption from that requirement under subclause (2).

(2) The Chief Health Officer or Deputy Chief Health Officer may exempt a person or a group of persons, from any or all requirements contained in these directions, if satisfied that an exemption is appropriate, having regard to the:

(a) need to protect public health; and

(b) principles in sections 5 to 10 of the PHW Act, as appropriate.

(3) An exemption under subclause (2) must:

(a) be given, in writing, to the person the subject of the exemption; and

(b) specify the requirement or requirements that the person need not comply with.

(4) An exemption granted to a person under this clause does not prevent an authorised officer from exercising an emergency power to give the person a different direction or impose a different requirement on the person.

10 Definitions

In these directions:

(1) **authorised officer** has the same meaning as in the PHW Act;

(2) **care facility** has the same meaning as in the **Care Facilities Directions (No 7)**;

(3) **Department** means the Victorian Department of Health and Human Services;

(4) **Departmental Requirements** means the document titled "COVID-19 Pandemic Plan for the Victorian Health Sector", as amended from time to time;

Note: the Departmental Requirements are available at:

https://www2.health.vic.gov.au/about/publications/ResearchAndReports/covid-19-pandemic-plan-for-vic

(5) **emergency powers** has the same meaning as in the PHW Act;

(6) **hospital** has the same meaning as in the **Hospital Visitors Directions (No 8)**;

(7) **premises** means:

(a) a building, or part of a building; and

(b) any land on which the building is located, other than land that is available for communal use;

(8) **resident** of a care facility has the same meaning as in the **Care Facilities Directions (No 7)**;

(9) **Revoked Isolation Direction** means the following directions:

(a) **Isolation (Diagnosis) Direction**, given on 25 March 2020;

(b) **Isolation (Diagnosis) Direction (No 2)**, given on 13 April 2020;

(c) **Diagnosed Persons and Close Contacts Directions**, given on 11 May 2020;

(d) **Diagnosed Persons and Close Contacts Directions (No 2)**, given on 31 May 2020;

(e) **Diagnosed Persons and Close Contacts Directions (No 3)**, given on 21 June 2020;

(f) **Diagnosed Persons and Close Contacts Directions (No 4)**, given on 1 July 2020;

(g) **Diagnosed Persons and Close Contacts Directions (No 5)**, given on 15 July 2020;

(10) the following expressions have the same meaning that they have in the **Disability Service Safeguards Act 2018**:

(a) disability;

(b) disability service;

(c) disability worker.

11 Penalties

Section 203 of the PHW Act provides:

Compliance with direction or other requirement

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

Penalty: In the case of a natural person, 120 penalty units;
In the case of a body corporate, 600 penalty units.

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

Dr Finn Romanes

Deputy Public Health Commander, as authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the PHW Act.

19 July 2020

Direction from Deputy Public Health Commander in accordance with emergency powers arising from declared state of emergency

Diagnosed Persons and Close Contacts Directions (No 7)

Public Health and Wellbeing Act 2008 (Vic)
Section 200

I, Dr Finn Romanes, Deputy Public Health Commander, consider it reasonably necessary to protect public health to give the following directions pursuant to section 200(1)(b) and (d) of the **Public Health and Wellbeing Act 2008** (Vic) (**PHW Act**):

1 Preamble

(1) The purpose of these directions is to require persons:

(a) diagnosed with Novel Coronavirus 2019 (**2019-nCoV**) to self-isolate;

(b) who are living with a diagnosed person, or who have been in close contact with a diagnosed person, to self-quarantine;

in order to limit the spread of 2019-nCoV.

(2) These directions replace the **Diagnosed Persons and Close Contacts Directions (No 6)**.

2 Citation

(1) These directions may be referred to as the **Diagnosed Persons and Close Contacts Directions (No 7)**.

(2) A reference in any other direction to the **Diagnosed Persons and Close Contacts Directions (No 6)** is taken to be a reference to these directions.

3 Commencement and revocation

(1) These directions commence at 11:59:00pm on 22 July 2020.

(2) The **Diagnosed Persons and Close Contacts Directions (No 5)** are revoked at 11:59:00pm on 22 July 2020.

(3) The **Diagnosed Persons and Close Contacts Directions (No 6)** are revoked at 11:59:00pm on 22 July 2020.

4 Self-isolation for diagnosed persons

Who is a diagnosed person?

(1) A person is a **diagnosed person** if the person:

(a) at any time between midnight on 25 March 2020 and 11:59:00pm on 16 August 2020 has been informed that they have been diagnosed with 2019-nCoV; and

(b) has not been given, or is not taken to have been given, **clearance from self-isolation** under clause 5.

Requirement to self-isolate

(2) A diagnosed person must **self-isolate** under these directions:

(a) if the diagnosis is communicated to the person on or after the commencement of these directions; or

(b) if the diagnosis was communicated to the person before the commencement of these directions.

Note: the requirements of self-isolation are specified in clause 8. A diagnosed person can still leave the premises at which they are self-isolating to obtain medical care.

Location of self-isolation

(3) A diagnosed person must self-isolate:

(a) if subclause (2)(a) applies, at the **premises** chosen by the person under subclause (4); or

(b) if subclause (2)(b) applies, at the premises at which the person was required to reside under a **Revoked Isolation Direction**.

(4) For the purposes of subclause (3)(a), the diagnosed person may choose to self-isolate at:

(a) a premises at which they ordinarily reside; or

(b) another premises that is suitable for the person to reside in for the purpose of self-isolation.

Note 1: a person can decide to self-isolate at a hotel or other suitable location, instead of self-isolating at their ordinary place of residence.

Note 2: once a person has chosen the premises at which to self-isolate, the person must reside at that premises for the entirety of the period of self-isolation: see clause 8(2)(a).

(5) If a diagnosed person who has chosen a premises under subclause (4) is not at the premises at the time when the choice is made, the person must immediately and directly travel to that premises, unless the person is admitted to a **hospital** or other facility for the purposes of receiving medical care.

Self-isolation period

(6) For the purposes of subclause (2), the period of self-isolation begins:

(a) if subclause (2)(a) applies, when the diagnosis is communicated to the person; or

(b) if subclause (2)(b) applies, upon the commencement of these directions.

(7) For the purposes of subclause (2), the period of self-isolation ends when the person is given **clearance from self-isolation** under clause 5.

Notifications by the diagnosed person

(8) Immediately after choosing a premises under subclause (4), the diagnosed person must:

(a) if any other person is residing at the premises chosen by the diagnosed person, notify the other person that:

(i) the diagnosed person has been diagnosed with 2019-nCoV; and

(ii) the diagnosed person has chosen to self-isolate at the premises; and

(b) notify the Department of:

(i) the address of the premises chosen by the diagnosed person; and

(ii) the name of any other person who is residing at the premises chosen by the diagnosed person.

(9) If, during the period that a diagnosed person is self-isolating at a premises for the purposes of clause 4, another person informs the diagnosed person that they intend to commence residing at the premises chosen by the diagnosed person:

(a) the diagnosed person must inform the other person of their diagnosis; and

(b) if the other person commences residing at the premises, the diagnosed person must notify the Department that a person has commenced residing with the diagnosed person and of the name of that person.

5 Clearance from self-isolation

(1) A diagnosed person is given **clearance from self-isolation** if:

(a) an officer of the Department makes a determination under subclause (2) in relation to the person; and

(b) the person is given notice of the determination in accordance with subclause (3).

(2) For the purposes of subclause (1)(a), an officer of the Department may make a determination in relation to a person if the officer is satisfied that the person meets the criteria for discharge from self-isolation under existing **Departmental Requirements**.

(3) For the purposes of subclause (1)(b), the notice must be in writing but is not required to be in a particular form.

(4) A person who has been given clearance from self-isolation, however expressed, under a Revoked Isolation Direction is taken to have been given clearance from self-isolation under this clause.

6 Self-quarantine for close contacts

Who is a close contact?

(1) For the purposes of this clause, a person is a **close contact** if:

(a) an officer or nominated representative of the Department has made a determination under subclause (2) in relation to the person; and

(b) between midnight on 11 May 2020 and 11:59:00pm on 16 August 2020, the person has been given notice of the determination in accordance with subclause (3).

(2) For the purposes of subclause (1)(a), an officer or nominated representative of the Department may make a determination in relation to a person if the officer or nominated representative is satisfied, having regard to Departmental Requirements, that the person has had close contact with another person who:

(a) since the time of last contact, has become a diagnosed person; or

(b) at the time of last contact, was a diagnosed person.

Note: under the Departmental Requirements, a person is generally considered to have had close contact if, in the period extending from 48 hours before onset of symptoms in the diagnosed person:

- *they have had face-to-face contact in any setting with the diagnosed person for more than a total of 15 minutes over the course of a week; or*
- *they have shared a closed space with a diagnosed person for a prolonged period (for example, more than 2 hours).*

(3) For the purposes of subclause (1)(b), the notice:

(a) must specify the time (including by reference to an event) at which the person will no longer be required to self-quarantine, having regard to Departmental Requirements; and

Example: the notice could specify that a person is no longer required to self-quarantine from 14 days after a diagnosed person who the person is living with receives clearance from self-isolation.

(b) may be given orally or in writing, and, if given orally, must be confirmed in writing as soon as reasonably practicable; and

(c) is not required to be in a particular form.

Requirement to self-quarantine

(4) A **close contact** must **self-quarantine** under these directions.

Note: the requirements of self-quarantine are specified in clause 8.

Location of self-quarantine

(5) A close contact may choose to self-quarantine at:

(a) a premises at which they ordinarily reside; or

(b) another premises that is suitable for the person to reside in for the purpose of self-quarantine.

Note 1: a person can decide to self-quarantine at a hotel or other suitable location, instead of self-quarantining at their ordinary place of residence.

Note 2: once a person has chosen the premises at which to self-quarantine, the person must reside at that premises for the entirety of the period of self-quarantine: see clause 8(2)(a).

(6) If, at the time a person is given a notice under subclause (1)(b), the person is not at the premises chosen by the person under subclause (5), the person must immediately and directly travel to that premises.

End of self-quarantine period

(7) For the purposes of this clause, the period of self-quarantine ends:

(a) subject to paragraph (c), at the time specified in the notice given under subclause (1)(b) as given or as varied under subclause (9); or

(b) if the notice given to the person under subclause (1)(b) is revoked under subclause (9), at the time that revocation takes effect; or

(c) if the person becomes a diagnosed person following a test for 2019-nCoV—when the diagnosis is communicated to the person.

Note: a close contact who becomes a diagnosed person will then be required to self-isolate under clause 4, for a period ending when the person is given clearance from self-isolation under clause 5.

Exception — previous clearance

(8) A person is not required to self-quarantine under this clause if, before the time that notice is given under subclause (1)(b), the person has been given, or is taken to have been given, clearance from self-isolation under clause 5.

Review of determination and notice

(9) An **authorised officer**, who is authorised to exercise **emergency powers** by the Chief Health Officer under section 199(2)(a) of the PHW Act, may review a determination made under subclause (2) and, if satisfied that it is appropriate, having regard to Departmental Requirements, may vary or revoke the notice given to the person under subclause (1)(b), and must give the person notice of the authorised officer's decision.

Transitional provision — close contacts under Revoked Isolation Directions

(10) If a person was a close contact under a Revoked Isolation Direction:

(a) a determination made, or taken to have been made, under the Revoked Isolation Direction in relation to the person's status as a close contact is taken to be a determination made under subclause (2); and

(b) a notice given, or taken to have been given, to the person under the Revoked Isolation Direction in relation to the determination referred to in paragraph (a) is taken to be a notice given under subclause (1)(b); and

(c) for the purposes of subclause (5), the person is taken to have chosen to self-quarantine at the premises at which the person was required to self-quarantine under the Revoked Isolation Direction.

Note: a person who was required to self-quarantine under previous directions because they reside with a person who is, or was, a diagnosed person, are now treated as close contacts, and also continue to be required to self-quarantine for the period determined by the previous directions, unless that period is altered pursuant to subclause (9).

7 Testing of persons in self-quarantine

(1) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person:

(a) is tested for 2019-nCoV; and

(b) the period for which the person is required to self-quarantine under clause 6 expires during the period in which the person is awaiting the result of that test,

the period of self-quarantine is extended until the person receives the result of the test.

Note: persons who are in self-quarantine and experience a temperature higher than 37.5 degrees or symptoms of acute respiratory infection are encouraged to get tested. In certain circumstances, a person may be required to comply with an order that they undergo a medical test: PHW Act, section 113(3).

(2) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person receives a test result stating that they have been diagnosed with 2019-nCoV, the person becomes a diagnosed person and must self-isolate under clause 4.

(3) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person receives a test result stating that they have not been diagnosed with 2019-nCoV:

(a) if the period for which the person is required to self-quarantine under clause 6 has not expired—must continue to self-quarantine under that clause for the remainder of that period; or

(b) if the period of self-quarantine was extended under subclause (1)—may cease self-quarantining.

8 Requirements of self-isolation and self-quarantine

(1) This clause applies to a person who is required to:

(a) **self-isolate** at a premises under clause 4; or

(b) **self-quarantine** at a premises under clause 6.

(2) The person identified in subclause (1):

(a) must reside at that premises for the entirety of the period of self-isolation or self-quarantine, as the case requires, except for any period that the person is admitted to a hospital or other facility for the purposes of receiving medical care; and

(b) must not leave the premises, except:

(i) for the purposes of obtaining medical care or medical supplies; or

(ii) in any emergency situation; or

(iii) for the purposes of exercise, but only if the person:

(A) takes reasonable steps to maintain a distance of 1.5 metres from any other person, unless the other person is required to self-isolate or self-quarantine at the same premises; and

(B) does not enter any other building; or

Note: Where a person is unable to take reasonable steps to maintain a distance of 1.5 metres from any other person when exercising, an authorised officer may direct that person to comply with another exercise program in order to mitigate a risk to public health, if that person wishes to exercise during their period of self-isolation or self-quarantine, as the case may be.

(iv) if required to do so by law; or

(v) for the purposes of visiting a patient in hospital if permitted to do so under the **Hospital Visitor Directions (No 9)**; and

(c) must not permit any other person to enter the premises unless:

(i) that other person:

(A) ordinarily resides at the premises; or

(B) is required to self-isolate or self-quarantine at the premises under these directions; or

(ii) it is necessary for the other person to enter for medical or emergency purposes; or

(iii) the other person is a **disability worker**, and it is necessary for the disability worker to enter for the purpose of providing a **disability service** to a person with a **disability**;

(iv) it is necessary for the other person to enter for the purpose of providing personal care or household assistance to the person as a result of that person's age, disability or chronic health condition; or

Example: personal care includes assistance with showering, toileting, eating; household assistance includes help with cooking, house cleaning, laundry and gardening.

(v) the entry is otherwise required or authorised by law.

(3) Subclause (2)(c) does not apply to a person who is a **resident** of a **care facility**.

Note: the Care Facilities Directions (No 8) govern who can enter a care facility.

9 Exemption power

(1) A person is not required to comply with a requirement of these directions if the person is granted an exemption from that requirement under subclause (2).

(2) The Chief Health Officer or Deputy Chief Health Officer may exempt a person or a group of persons, from any or all requirements contained in these directions, if satisfied that an exemption is appropriate, having regard to the:

(a) need to protect public health; and

(b) principles in sections 5 to 10 of the PHW Act, as appropriate.

(3) An exemption under subclause (2) must:

(a) be given, in writing, to the person the subject of the exemption; and

(b) specify the requirement or requirements that the person need not comply with.

(4) An exemption granted to a person under this clause does not prevent an authorised officer from exercising an emergency power to give the person a different direction or impose a different requirement on the person.

10 Definitions

In these directions:

(1) **authorised officer** has the same meaning as in the PHW Act;

(2) **care facility** has the same meaning as in the **Care Facilities Directions (No 8)**;

(3) **Department** means the Victorian Department of Health and Human Services;

(4) **Departmental Requirements** means the document titled "COVID-19 Pandemic Plan for the Victorian Health Sector", as amended from time to time;

Note: the Departmental Requirements are available at:

https://www2.health.vic.gov.au/about/publications/ResearchAndReports/covid-19-pandemic-plan-for-vic

(5) **emergency powers** has the same meaning as in the PHW Act;

(6) **hospital** has the same meaning as in the **Hospital Visitor Directions (No 9)**;

(7) **premises** means:

(a) a building, or part of a building; and

(b) any land on which the building is located, other than land that is available for communal use;

(8) **resident** of a care facility has the same meaning as in the **Care Facilities Directions (No 8)**;

(9) **Revoked Isolation Direction** means the following directions:

(a) **Isolation (Diagnosis) Direction**, given on 25 March 2020;

(b) **Isolation (Diagnosis) Direction (No 2)**, given on 13 April 2020;

(c) **Diagnosed Persons and Close Contacts Directions**, given on 11 May 2020;

(d) **Diagnosed Persons and Close Contacts Directions (No 2)**, given on 31 May 2020;

(e) **Diagnosed Persons and Close Contacts Directions (No 3)**, given on 21 June 2020;

(f) **Diagnosed Persons and Close Contacts Directions (No 4)**, given on 1 July 2020;

(g) **Diagnosed Persons and Close Contacts Directions (No 5)**, given on 15 July 2020;

(h) **Diagnosed Persons and Close Contacts Direction (No 6)**, given on 19 July 2020;

(10) the following expressions have the same meaning that they have in the **Disability Service Safeguards Act 2018**:

(a) disability;

(b) disability service;

(c) disability worker.

11 Penalties

Section 203 of the PHW Act provides:

Compliance with direction or other requirement

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

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

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

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

Dr Finn Romanes

Deputy Public Health Commander, as authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the PHW Act.

21 July 2020

Direction from Public Health Commander in accordance with emergency powers arising from declared state of emergency

Diagnosed Persons and Close Contacts Directions (No 8)

Public Health and Wellbeing Act 2008 (Vic)
Section 200

I, Dr Finn Romanes, Public Health Commander, consider it reasonably necessary to protect public health to give the following directions pursuant to section 200(1)(b) and (d) of the **Public Health and Wellbeing Act 2008** (Vic) (**PHW Act**):

1 Preamble

(1) The purpose of these directions is to require persons:

(a) diagnosed with Novel Coronavirus 2019 (**2019-nCoV**) to self-isolate;

(b) who are living with a diagnosed person, or who have been in close contact with a diagnosed person, to self-quarantine;

in order to limit the spread of 2019-nCoV.

(2) These directions replace the **Diagnosed Persons and Close Contacts Directions (No 7)**, and alter the circumstances in which a person required to self-isolate or self-quarantine under these directions may leave the premises at which they are required to self-isolate or self-quarantine.

2 Citation

(1) These directions may be referred to as the **Diagnosed Persons and Close Contacts Directions (No 8)**.

(2) A reference in any other direction to the **Diagnosed Persons and Close Contacts Directions (No 7)** is taken to be a reference to these directions.

3 Commencement and revocation

(1) These directions commence at 11:59:00pm on 3 August 2020.

(2) The **Diagnosed Persons and Close Contacts Directions (No 7)** are revoked at 11:59:00pm on 3 August 2020.

4 Self-isolation for diagnosed persons

Who is a diagnosed person?

(1) A person is a **diagnosed person** if the person:

(a) at any time between midnight on 25 March 2020 and 11:59:00pm on 16 August 2020 has been informed that they have been diagnosed with 2019-nCoV; and

(b) has not been given, or is not taken to have been given, **clearance from self-isolation** under clause 5.

Requirement to self-isolate

(2) A diagnosed person must **self-isolate** under these directions:

(a) if the diagnosis is communicated to the person on or after the commencement of these directions; or

(b) if the diagnosis was communicated to the person before the commencement of these directions.

Note: the requirements of self-isolation are specified in clause 8. A diagnosed person can still leave the premises at which they are self-isolating to obtain medical care.

Location of self-isolation

(3) A diagnosed person must self-isolate:

(a) if subclause (2)(a) applies, at the **premises** chosen by the person under subclause (4); or

(b) if subclause (2)(b) applies, at the premises at which the person was required to reside under a **Revoked Isolation Direction**.

(4) For the purposes of subclause (3)(a), the diagnosed person may choose to self-isolate at:

(a) a premises at which they ordinarily reside; or

(b) another premises that is suitable for the person to reside in for the purpose of self-isolation.

Note 1: a person can decide to self-isolate at a hotel or other suitable location, instead of self-isolating at their ordinary place of residence.

Note 2: once a person has chosen the premises at which to self-isolate, the person must reside at that premises for the entirety of the period of self-isolation: see clause 8(2)(a).

(5) If a diagnosed person who has chosen a premises under subclause (4) is not at the premises at the time when the choice is made, the person must immediately and directly travel to that premises, unless the person is admitted to a **hospital** or other facility for the purposes of receiving medical care.

Self-isolation period

(6) For the purposes of subclause (2), the period of self-isolation begins:

(a) if subclause (2)(a) applies, when the diagnosis is communicated to the person; or

(b) if subclause (2)(b) applies, upon the commencement of these directions.

(7) For the purposes of subclause (2), the period of self-isolation ends when the person is given **clearance from self-isolation** under clause 5.

Notifications by the diagnosed person

(8) Immediately after choosing a premises under subclause (4), the diagnosed person must:

(a) if any other person is residing at the premises chosen by the diagnosed person, notify the other person that:

(i) the diagnosed person has been diagnosed with 2019-nCoV; and

(ii) the diagnosed person has chosen to self-isolate at the premises; and

(b) notify the Department of:

(i) the address of the premises chosen by the diagnosed person; and

(ii) the name of any other person who is residing at the premises chosen by the diagnosed person.

(9) If, during the period that a diagnosed person is self-isolating at a premises for the purposes of clause 4, another person informs the diagnosed person that they intend to commence residing at the premises chosen by the diagnosed person:

(a) the diagnosed person must inform the other person of their diagnosis; and

(b) if the other person commences residing at the premises, the diagnosed person must notify the Department that a person has commenced residing with the diagnosed person and of the name of that person.

5 Clearance from self-isolation

(1) A diagnosed person is given **clearance from self-isolation** if:

(a) an officer of the Department makes a determination under subclause (2) in relation to the person; and

(b) the person is given notice of the determination in accordance with subclause (3).

(2) For the purposes of subclause (1)(a), an officer of the Department may make a determination in relation to a person if the officer is satisfied that the person meets the criteria for discharge from self-isolation under existing **Departmental Requirements**.

(3) For the purposes of subclause (1)(b), the notice must be in writing but is not required to be in a particular form.

(4) A person who has been given clearance from self-isolation, however expressed, under a Revoked Isolation Direction is taken to have been given clearance from self-isolation under this clause.

6 Self-quarantine for close contacts

Who is a close contact?

(1) For the purposes of this clause, a person is a **close contact** if:

(a) an officer or nominated representative of the Department has made a determination under subclause (2) in relation to the person; and

(b) between midnight on 11 May 2020 and 11:59:00pm on 16 August 2020, the person has been given notice of the determination in accordance with subclause (3).

(2) For the purposes of subclause (1)(a), an officer or nominated representative of the Department may make a determination in relation to a person if the officer or nominated representative is satisfied, having regard to Departmental Requirements, that the person has had close contact with another person who:

(a) since the time of last contact, has become a diagnosed person; or

(b) at the time of last contact, was a diagnosed person.

Note: under the Departmental Requirements, a person is generally considered to have had close contact if, in the period extending from 48 hours before onset of symptoms in the diagnosed person:

- *they have had face-to-face contact in any setting with the diagnosed person for more than a total of 15 minutes over the course of a week; or*
- *they have shared a closed space with a diagnosed person for a prolonged period (for example, more than 2 hours).*

(3) For the purposes of subclause (1)(b), the notice:

(a) must specify the time (including by reference to an event) at which the person will no longer be required to self-quarantine, having regard to Departmental Requirements; and

Example: the notice could specify that a person is no longer required to self-quarantine from 14 days after a diagnosed person who the person is living with receives clearance from self-isolation.

(b) may be given orally or in writing, and, if given orally, must be confirmed in writing as soon as reasonably practicable; and

(c) is not required to be in a particular form.

Requirement to self-quarantine

(4) A **close contact** must **self-quarantine** under these directions.

Note: the requirements of self-quarantine are specified in clause 8.

Location of self-quarantine

(5) A close contact may choose to self-quarantine at:

(a) a premises at which they ordinarily reside; or

(b) another premises that is suitable for the person to reside in for the purpose of self-quarantine.

Note 1: a person can decide to self-quarantine at a hotel or other suitable location, instead of self-quarantining at their ordinary place of residence.

Note 2: once a person has chosen the premises at which to self-quarantine, the person must reside at that premises for the entirety of the period of self-quarantine: see clause 8(2)(a).

(6) If, at the time a person is given a notice under subclause (1)(b), the person is not at the premises chosen by the person under subclause (5), the person must immediately and directly travel to that premises.

End of self-quarantine period

(7) For the purposes of this clause, the period of self-quarantine ends:

(a) subject to paragraph (c), at the time specified in the notice given under subclause (1)(b) as given or as varied under subclause (9); or

(b) if the notice given to the person under subclause (1)(b) is revoked under subclause (9), at the time that revocation takes effect; or

(c) if the person becomes a diagnosed person following a test for 2019-nCoV—when the diagnosis is communicated to the person.

Note: a close contact who becomes a diagnosed person will then be required to self-isolate under clause 4, for a period ending when the person is given clearance from self-isolation under clause 5.

Exception — previous clearance

(8) A person is not required to self-quarantine under this clause if, before the time that notice is given under subclause (1)(b), the person has been given, or is taken to have been given, clearance from self-isolation under clause 5.

Review of determination and notice

(9) An **authorised officer**, who is authorised to exercise **emergency powers** by the Chief Health Officer under section 199(2)(a) of the PHW Act, may review a determination made under subclause (2) and, if satisfied that it is appropriate, having regard to Departmental Requirements, may vary or revoke the notice given to the person under subclause (1)(b), and must give the person notice of the authorised officer's decision.

Transitional provision — close contacts under Revoked Isolation Directions

(10) If a person was a close contact under a Revoked Isolation Direction:

(a) a determination made, or taken to have been made, under the Revoked Isolation Direction in relation to the person's status as a close contact is taken to be a determination made under subclause (2); and

(b) a notice given, or taken to have been given, to the person under the Revoked Isolation Direction in relation to the determination referred to in paragraph (a) is taken to be a notice given under subclause (1)(b); and

(c) for the purposes of subclause (5), the person is taken to have chosen to self-quarantine at the premises at which the person was required to self-quarantine under the Revoked Isolation Direction.

Note: a person who was required to self-quarantine under previous directions because they reside with a person who is, or was, a diagnosed person, are now treated as close contacts, and also continue to be required to self-quarantine for the period determined by the previous directions, unless that period is altered pursuant to subclause (9).

7 Testing of persons in self-quarantine

(1) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person:

(a) is tested for 2019-nCoV; and

(b) the period for which the person is required to self-quarantine under clause 6 expires during the period in which the person is awaiting the result of that test,

the period of self-quarantine is extended until the person receives the result of the test.

Note: persons who are in self-quarantine and experience a temperature higher than 37.5 degrees or symptoms of acute respiratory infection are encouraged to get tested. In certain circumstances, a person may be required to comply with an order that they undergo a medical test: PHW Act, section 113(3).

(2) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person receives a test result stating that they have been diagnosed with 2019-nCoV, the person becomes a diagnosed person and must self-isolate under clause 4.

(3) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person receives a test result stating that they have not been diagnosed with 2019-nCoV:

(a) if the period for which the person is required to self-quarantine under clause 6 has not expired—must continue to self-quarantine under that clause for the remainder of that period; or

(b) if the period of self-quarantine was extended under subclause (1)—may cease self-quarantining.

8 Requirements of self-isolation and self-quarantine

(1) This clause applies to a person who is required to:

(a) **self-isolate** at a premises under clause 4; or

(b) **self-quarantine** at a premises under clause 6.

(2) The person identified in subclause (1):

(a) must reside at that premises for the entirety of the period of self-isolation or self-quarantine, as the case requires, except for any period that the person is admitted to a hospital or other facility for the purposes of receiving medical care; and

(b) must not leave the premises, except:

(i) for the purposes of obtaining medical care or medical supplies; or

(ii) in any emergency situation; or

(iii) if required to do so by law; or

(iv) for the purposes of visiting a patient in hospital if permitted to do so under the **Hospital Visitor Directions (No 9)**; or

(v) for the purposes of working in a care facility if permitted to do so under the **Care Facilities Directions (No 9)**; and

(c) must not permit any other person to enter the premises unless:

(i) that other person:

(A) ordinarily resides at the premises; or

(B) is required to self-isolate or self-quarantine at the premises under these directions; or

(ii) it is necessary for the other person to enter for medical or emergency purposes; or

(iii) the other person is a **disability worker**, and it is necessary for the disability worker to enter for the purpose of providing a **disability service** to a person with a **disability**; or

(iv) it is necessary for the other person to enter for the purpose of providing personal care or household assistance to the person as a result of that person's age, disability or chronic health condition; or

Example: personal care includes assistance with showering, toileting, eating; household assistance includes help with cooking, house cleaning, laundry and gardening.

(v) the entry is otherwise required or authorised by law.

(3) Subclause (2)(c) does not apply to a person who is a **resident** of a **care facility**.

Note: the Care Facilities Directions (No 9) govern who can enter a care facility.

9 Exemption power

(1) A person is not required to comply with a requirement of these directions if the person is granted an exemption from that requirement under subclause (2).

(2) The Chief Health Officer or Deputy Chief Health Officer may exempt a person or a group of persons, from any or all requirements contained in these directions, if satisfied that an exemption is appropriate, having regard to the:

(a) need to protect public health; and

(b) principles in sections 5 to 10 of the PHW Act, as appropriate.

(3) An exemption under subclause (2) must:

(a) be given, in writing, to the person the subject of the exemption; and

(b) specify the requirement or requirements that the person need not comply with.

(4) An exemption granted to a person under this clause does not prevent an authorised officer from exercising an emergency power to give the person a different direction or impose a different requirement on the person.

10 Definitions

In these directions:

(1) **authorised officer** has the same meaning as in the PHW Act;

(2) **care facility** has the same meaning as in the **Care Facilities Directions (No 9)**;

(3) **Department** means the Victorian Department of Health and Human Services;

(4) **Departmental Requirements** means the document titled "COVID-19 Pandemic Plan for the Victorian Health Sector", as amended from time to time;

Note: the Departmental Requirements are available at:

https://www2.health.vic.gov.au/about/publications/ResearchAndReports/covid-19-pandemic-plan-for-vic

(5) **emergency powers** has the same meaning as in the PHW Act;

(6) **hospital** has the same meaning as in the **Hospital Visitor Directions (No 9)**;

(7) **premises** means:

(a) a building, or part of a building; and

(b) any land on which the building is located, other than land that is available for communal use;

(8) **resident** of a care facility has the same meaning as in the **Care Facilities Directions (No 9)**;

(9) **Revoked Isolation Direction** means the following directions:

(a) **Isolation (Diagnosis) Direction**, given on 25 March 2020;

(b) **Isolation (Diagnosis) Direction (No 2)**, given on 13 April 2020;

(c) **Diagnosed Persons and Close Contacts Directions**, given on 11 May 2020;

(d) **Diagnosed Persons and Close Contacts Directions (No 2)**, given on 31 May 2020;

(e) **Diagnosed Persons and Close Contacts Directions (No 3)**, given on 21 June 2020;

(f) **Diagnosed Persons and Close Contacts Directions (No 4)**, given on 1 July 2020;

(g) **Diagnosed Persons and Close Contacts Directions (No 5)**, given on 15 July 2020;

(h) **Diagnosed Persons and Close Contacts Direction (No 6)**, given on 19 July 2020;

(i) **Diagnosed Persons and Close Contacts Direction (No 7)**, given on 22 July 2020;

(10) the following expressions have the same meaning that they have in the **Disability Service Safeguards Act 2018**:

(a) disability;

(b) disability service;

(c) disability worker.

11 Penalties

Section 203 of the PHW Act provides:

Compliance with direction or other requirement

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

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

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

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

Dr Finn Romanes

Public Health Commander, as authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the PHW Act.

3 August 2020

Direction from Public Health Commander in accordance with emergency powers arising from declared state of emergency

Diagnosed Persons and Close Contacts Directions (No 9)

Public Health and Wellbeing Act 2008 (Vic)

Section 200

I, Dr Finn Romanes, Public Health Commander, consider it reasonably necessary to protect public health to give the following directions pursuant to section 200(1)(b) and (d) of the **Public Health and Wellbeing Act 2008** (Vic) (**PHW Act**):

1 Preamble

(1) The purpose of these directions is to require persons:

(a) diagnosed with Novel Coronavirus 2019 (**2019-nCoV**) to self-isolate;

(b) who are living with a diagnosed person, or who have been in close contact with a diagnosed person, to self-quarantine;

in order to limit the spread of 2019-nCoV.

(2) These directions replace the **Diagnosed Persons and Close Contacts Directions (No 8)**, and:

(a) allow nominated representatives, in addition to officers, of the Department to make determinations in relation to clearance of a person from self-isolation; and

(b) clarify that a person required to self-isolate or self-quarantine under these directions may leave the premises at which they are required to self-isolate or self-quarantine to get tested for 2019-nCoV.

2 Citation

(1) These directions may be referred to as the **Diagnosed Persons and Close Contacts Directions (No 9)**.

(2) A reference in any other direction to the **Diagnosed Persons and Close Contacts Directions (No 8)** is taken to be a reference to these directions.

3 Commencement and revocation

(1) These directions commence at 2:59:00pm on 13 August 2020.

(2) The **Diagnosed Persons and Close Contacts Directions (No 8)** are revoked at 2:59:00pm on 13 August 2020.

4 Self-isolation for diagnosed persons

Who is a diagnosed person?

(1) A person is a **diagnosed person** if the person:

(a) at any time between midnight on 25 March 2020 and 11:59:00pm on 16 August 2020 has been informed that they have been diagnosed with 2019-nCoV; and

(b) has not been given, or is not taken to have been given, **clearance from self-isolation** under clause 5.

Requirement to self-isolate

(2) A diagnosed person must **self-isolate** under these directions:

(a) if the diagnosis is communicated to the person on or after the commencement of these directions; or

(b) if the diagnosis was communicated to the person before the commencement of these directions.

Note: the requirements of self-isolation are specified in clause 8. A diagnosed person can still leave the premises at which they are self-isolating to obtain medical care.

Location of self-isolation

(3) A diagnosed person must self-isolate:

(a) if subclause (2)(a) applies, at the **premises** chosen by the person under subclause (4); or

(b) if subclause (2)(b) applies, at the premises at which the person was required to reside under a **Revoked Isolation Direction**.

(4) For the purposes of subclause (3)(a), the diagnosed person may choose to self-isolate at:

(a) a premises at which they ordinarily reside; or

(b) another premises that is suitable for the person to reside in for the purpose of self-isolation.

Note 1: a person can decide to self-isolate at a hotel or other suitable location, instead of self-isolating at their ordinary place of residence.

Note 2: once a person has chosen the premises at which to self-isolate, the person must reside at that premises for the entirety of the period of self-isolation: see clause 8(2)(a).

(5) If a diagnosed person who has chosen a premises under subclause (4) is not at the premises at the time when the choice is made, the person must immediately and directly travel to that premises, unless the person is

admitted to a **hospital** or other facility for the purposes of receiving medical care.

Self-isolation period

(6) For the purposes of subclause (2), the period of self-isolation begins:

(a) if subclause (2)(a) applies, when the diagnosis is communicated to the person; or

(b) if subclause (2)(b) applies, upon the commencement of these directions.

(7) For the purposes of subclause (2), the period of self-isolation ends when the person is given **clearance from self-isolation** under clause 5.

Notifications by the diagnosed person

(8) Immediately after choosing a premises under subclause (4), the diagnosed person must:

(a) if any other person is residing at the premises chosen by the diagnosed person, notify the other person that:

(i) the diagnosed person has been diagnosed with 2019-nCoV; and

(ii) the diagnosed person has chosen to self-isolate at the premises; and

(b) notify the Department of:

(i) the address of the premises chosen by the diagnosed person; and

(ii) the name of any other person who is residing at the premises chosen by the diagnosed person.

(9) If, during the period that a diagnosed person is self-isolating at a premises for the purposes of clause 4, another person informs the diagnosed person that they intend to commence residing at the premises chosen by the diagnosed person:

(a) the diagnosed person must inform the other person of their diagnosis; and

(b) if the other person commences residing at the premises, the diagnosed person must notify the Department that a person has commenced residing with the diagnosed person and of the name of that person.

5 Clearance from self-isolation

(1) A diagnosed person is given **clearance from self-isolation** if:

(a) an officer or nominated representative of the Department makes a determination under subclause (2) in relation to the person; and

(b) the person is given notice of the determination in accordance with subclause (3).

(2) For the purposes of subclause (1)(a), an officer or nominated representative of the Department may make a determination in relation to a person if the officer or nominated representative is satisfied that the person meets the criteria for discharge from self-isolation under existing **Departmental Requirements**.

(3) For the purposes of subclause (1)(b), the notice must be in writing but is not required to be in a particular form.

(4) A person who has been given clearance from self-isolation, however expressed, under a Revoked Isolation Direction is taken to have been given clearance from self-isolation under this clause.

6 Self-quarantine for close contacts

Who is a close contact?

(1) For the purposes of this clause, a person is a **close contact** if:

(a) an officer or nominated representative of the Department has made a determination under subclause (2) in relation to the person; and

(b) between midnight on 11 May 2020 and 11:59:00pm on 16 August 2020, the person has been given notice of the determination in accordance with subclause (3).

(2) For the purposes of subclause (1)(a), an officer or nominated representative of the Department may make a determination in relation to a person if the officer or nominated representative is satisfied, having regard to Departmental Requirements, that the person has had close contact with another person who:

(a) since the time of last contact, has become a diagnosed person; or

(b) at the time of last contact, was a diagnosed person.

Note: under the Departmental Requirements, a person is generally considered to have had close contact if, in the period extending from 48 hours before onset of symptoms in the diagnosed person:

- *they have had face-to-face contact in any setting with the diagnosed person for more than a total of 15 minutes over the course of a week; or*
- *they have shared a closed space with a diagnosed person for a prolonged period (for example, more than 2 hours).*

(3) For the purposes of subclause (1)(b), the notice:

(a) must specify the time (including by reference to an event) at which the person will no longer be required to self-quarantine, having regard to Departmental Requirements; and

Example: the notice could specify that a person is no longer required to self-quarantine from 14 days after a diagnosed person who the person is living with receives clearance from self-isolation.

(b) may be given orally or in writing, and, if given orally, must be confirmed in writing as soon as reasonably practicable; and

(c) is not required to be in a particular form.

Requirement to self-quarantine

(4) A **close contact** must **self-quarantine** under these directions.

Note: the requirements of self-quarantine are specified in clause 8.

Location of self-quarantine

(5) A close contact may choose to self-quarantine at:

(a) a premises at which they ordinarily reside; or

(b) another premises that is suitable for the person to reside in for the purpose of self-quarantine.

Note 1: a person can decide to self-quarantine at a hotel or other suitable location, instead of self-quarantining at their ordinary place of residence.

Note 2: once a person has chosen the premises at which to self-quarantine, the person must reside at that premises for the entirety of the period of self-quarantine: see clause 8(2)(a).

(6) If, at the time a person is given a notice under subclause (1)(b), the person is not at the premises chosen by the person under subclause (5), the person must immediately and directly travel to that premises.

End of self-quarantine period

(7) For the purposes of this clause, the period of self-quarantine ends:

(a) subject to paragraph (c), at the time specified in the notice given under subclause (1)(b) as given or as varied under subclause (9); or

(b) if the notice given to the person under subclause (1)(b) is revoked under subclause (9), at the time that revocation takes effect; or

(c) if the person becomes a diagnosed person following a test for 2019-nCoV—when the diagnosis is communicated to the person.

Note: a close contact who becomes a diagnosed person will then be required to self-isolate under clause 4, for a period ending when the person is given clearance from self-isolation under clause 5.

Exception — previous clearance

(8) A person is not required to self-quarantine under this clause if, before the time that notice is given under subclause (1)(b), the person has been given, or is taken to have been given, clearance from self-isolation under clause 5.

Review of determination and notice

(9) An **authorised officer**, who is authorised to exercise **emergency powers** by the Chief Health Officer under section 199(2)(a) of the PHW Act, may review a determination made under subclause (2) and, if satisfied that it is appropriate, having regard to Departmental Requirements, may vary or revoke the notice given to the person under subclause (1)(b), and must give the person notice of the authorised officer's decision.

Transitional provision — close contacts under Revoked Isolation Directions

(10) If a person was a close contact under a Revoked Isolation Direction:

(a) a determination made, or taken to have been made, under the Revoked Isolation Direction in relation to the person's status as a close contact is taken to be a determination made under subclause (2); and

(b) a notice given, or taken to have been given, to the person under the Revoked Isolation Direction in relation to the determination referred to in paragraph (a) is taken to be a notice given under subclause (1)(b); and

(c) for the purposes of subclause (5), the person is taken to have chosen to self-quarantine at the premises at which the person was required to self-quarantine under the Revoked Isolation Direction.

Note: a person who was required to self-quarantine under previous directions because they reside with a person who is, or was, a diagnosed person, are now treated as close contacts, and also continue to be required to self-quarantine for the period determined by the previous directions, unless that period is altered pursuant to subclause (9).

7 Testing of persons in self-quarantine

(1) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person:

(a) is tested for 2019-nCoV; and

(b) the period for which the person is required to self-quarantine under clause 6 expires during the period in which the person is awaiting the result of that test,

the period of self-quarantine is extended until the person receives the result of the test.

Note: persons who are in self-quarantine and experience a temperature higher than 37.5 degrees or symptoms of acute respiratory infection are encouraged to get tested. In certain circumstances, a person may be required to comply with an order that they undergo a medical test: PHW Act, section 113(3).

(2) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person receives a test result stating that they have been diagnosed with 2019-nCoV, the person becomes a diagnosed person and must self-isolate under clause 4.

(3) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person receives a test result stating that they have not been diagnosed with 2019-nCoV:

(a) if the period for which the person is required to self-quarantine under clause 6 has not expired—must continue to self-quarantine under that clause for the remainder of that period; or

(b) if the period of self-quarantine was extended under subclause (1)—may cease self-quarantining.

8 Requirements of self-isolation and self-quarantine

(1) This clause applies to a person who is required to:

(a) **self-isolate** at a premises under clause 4; or

(b) **self-quarantine** at a premises under clause 6.

(2) The person identified in subclause (1):

(a) must reside at that premises for the entirety of the period of self-isolation or self-quarantine, as the case requires, except for any period that the person is admitted to a hospital or other facility for the purposes of receiving medical care; and

(b) must not leave the premises, except:

(i) for the purposes of obtaining medical care or medical supplies; or

(ii) for the purposes of getting tested for 2019-nCoV; or

(iii) in any emergency situation; or

(iv) if required to do so by law; or

(v) for the purposes of visiting a patient in hospital if permitted to do so under the **Hospital Visitor Directions (No 9)**; or

(vi) for the purposes of working in a care facility if permitted to do so under the **Care Facilities Directions (No 9)**; and

(c) must not permit any other person to enter the premises unless:

(i) that other person:

(A) ordinarily resides at the premises; or

(B) is required to self-isolate or self-quarantine at the premises under these directions; or

(ii) it is necessary for the other person to enter for medical or emergency purposes; or

(iii) the other person is a **disability worker**, and it is necessary for the disability worker to enter for the purpose of providing a **disability service** to a person with a **disability**; or

(iv) it is necessary for the other person to enter for the purpose of providing personal care or household assistance to the person as a result of that person's age, disability or chronic health condition; or

Example: personal care includes assistance with showering, toileting, eating; household assistance includes help with cooking, house cleaning, laundry and gardening.

(v) the entry is otherwise required or authorised by law.

(3) Subclause (2)(c) does not apply to a person who is a **resident** of a **care facility**.

Note: the Care Facilities Directions (No 9) govern who can enter a care facility.

9 Exemption power

(1) A person is not required to comply with a requirement of these directions if the person is granted an exemption from that requirement under subclause (2).

(2) The Chief Health Officer or Deputy Chief Health Officer may exempt a person or a group of persons, from any or all requirements contained in these directions, if satisfied that an exemption is appropriate, having regard to the:

(a) need to protect public health; and

(b) principles in sections 5 to 10 of the PHW Act, as appropriate.

(3) An exemption under subclause (2) must:

(a) be given, in writing, to the person the subject of the exemption; and

(b) specify the requirement or requirements that the person need not comply with.

(4) An exemption granted to a person under this clause does not prevent an authorised officer from exercising an emergency power to give the person a different direction or impose a different requirement on the person.

10 Definitions

In these directions:

(1) **authorised officer** has the same meaning as in the PHW Act;

(2) **care facility** has the same meaning as in the **Care Facilities Directions (No 9)**;

(3) **Department** means the Victorian Department of Health and Human Services;

(4) **Departmental Requirements** means the document titled "COVID-19 Pandemic Plan for the Victorian Health Sector", as amended from time to time;

Note: the Departmental Requirements are available at:

https://www2.health.vic.gov.au/about/publications/ResearchAndReports/covid-19-pandemic-plan-for-vic

(5) **emergency powers** has the same meaning as in the PHW Act;

(6) **hospital** has the same meaning as in the **Hospital Visitor Directions (No 9)**;

(7) **premises** means:

(a) a building, or part of a building; and

(b) any land on which the building is located, other than land that is available for communal use;

(8) **resident** of a care facility has the same meaning as in the **Care Facilities Directions (No 9)**;

(9) **Revoked Isolation Direction** means the following directions:

(a) **Isolation (Diagnosis) Direction**, given on 25 March 2020;

(b) **Isolation (Diagnosis) Direction (No 2)**, given on 13 April 2020;

(c) **Diagnosed Persons and Close Contacts Directions**, given on 11 May 2020;

(d) **Diagnosed Persons and Close Contacts Directions (No 2)**, given on 31 May 2020;

(e) **Diagnosed Persons and Close Contacts Directions (No 3)**, given on 21 June 2020;

(f) **Diagnosed Persons and Close Contacts Directions (No 4)**, given on 1 July 2020;

(g) **Diagnosed Persons and Close Contacts Directions (No 5)**, given on 15 July 2020;

(h) **Diagnosed Persons and Close Contacts Direction (No 6)**, given on 19 July 2020;

(i) **Diagnosed Persons and Close Contacts Direction (No 7)**, given on 22 July 2020;

(j) **Diagnosed Persons and Close Contacts Direction (No 8)**, given on 3 August 2020;

(10) the following expressions have the same meaning that they have in the **Disability Service Safeguards Act 2018**:

(a) disability;

(b) disability service;

(c) disability worker.

11 Penalties

Section 203 of the PHW Act provides:

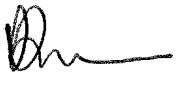
Compliance with direction or other requirement

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

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

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

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



Dr Finn Romanes

Public Health Commander, as authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the PHW Act.

13 August 2020

Direction from Public Health Commander in accordance with emergency powers arising from declared state of emergency

Diagnosed Persons and Close Contacts Directions (No 10)

Public Health and Wellbeing Act 2008 (Vic)
Section 200

I, Dr Finn Romanes, Public Health Commander, consider it reasonably necessary to eliminate or reduce the risk to public health—and reasonably necessary to protect public health—to give the following directions pursuant to section 200(1)(b) and (d) of the **Public Health and Wellbeing Act 2008** (Vic) (**PHW Act**):

1 Preamble

(1) The purpose of these directions is to require persons:

(a) diagnosed with Novel Coronavirus 2019 (**2019-nCoV**) to self-isolate;

(b) who are living with a diagnosed person, or who have been in close contact with a diagnosed person, to self-quarantine;

in order to limit the spread of 2019-nCoV.

(2) These directions replace the **Diagnosed Persons and Close Contacts Directions (No 9)**.

2 Citation

These directions may be referred to as the **Diagnosed Persons and Close Contacts Directions (No 10)**.

3 Commencement and revocation

(1) These directions commence at 11:59:00pm on 16 August 2020.

(2) The **Diagnosed Persons and Close Contacts Directions (No 9)** are revoked at 11:59:00pm on 16 August 2020.

4 Self-isolation for diagnosed persons

Who is a diagnosed person?

(1) A person is a **diagnosed person** if the person:

(a) at any time between midnight on 25 March 2020 and 11:59:00pm on 13 September 2020 has been informed that they have been diagnosed with 2019-nCoV; and

(b) has not been given, or is not taken to have been given, **clearance from self-isolation** under clause 5.

Requirement to self-isolate

(2) A diagnosed person must **self-isolate** under these directions:

(a) if the diagnosis is communicated to the person on or after the commencement of these directions; or

(b) if the diagnosis was communicated to the person before the commencement of these directions.

Note: the requirements of self-isolation are specified in clause 8. A diagnosed person can still leave the premises at which they are self-isolating to obtain medical care.

Location of self-isolation

(3) A diagnosed person must self-isolate:

(a) if subclause (2)(a) applies, at the **premises** chosen by the person under subclause (4); or

(b) if subclause (2)(b) applies, at the premises at which the person was required to reside under a **Revoked Isolation Direction**.

(4) For the purposes of subclause (3)(a), the diagnosed person may choose to self-isolate at:

(a) a premises at which they ordinarily reside; or

(b) another premises that is suitable for the person to reside in for the purpose of self-isolation.

Note 1: a person can decide to self-isolate at a hotel or other suitable location, instead of self-isolating at their ordinary place of residence.

Note 2: once a person has chosen the premises at which to self-isolate, the person must reside at that premises for the entirety of the period of self-isolation: see clause 8(2)(a).

(5) If a diagnosed person who has chosen a premises under subclause (4) is not at the premises at the time when the choice is made, the person must immediately and directly travel to that premises, unless the person is admitted to a **hospital** or other facility for the purposes of receiving medical care.

Self-isolation period

(6) For the purposes of subclause (2), the period of self-isolation begins:

(a) if subclause (2)(a) applies, when the diagnosis is communicated to the person; or

(b) if subclause (2)(b) applies, upon the commencement of these directions.

(7) For the purposes of subclause (2), the period of self-isolation ends when the person is given **clearance from self-isolation** under clause 5.

Notifications by the diagnosed person

(8) Immediately after choosing a premises under subclause (4), the diagnosed person must:

(a) if any other person is residing at the premises chosen by the diagnosed person, notify the other person that:

(i) the diagnosed person has been diagnosed with 2019-nCoV; and

(ii) the diagnosed person has chosen to self-isolate at the premises; and

(b) notify the Department of:

(i) the address of the premises chosen by the diagnosed person; and

(ii) the name of any other person who is residing at the premises chosen by the diagnosed person.

(9) If, during the period that a diagnosed person is self-isolating at a premises for the purposes of clause 4, another person informs the diagnosed person that they intend to commence residing at the premises chosen by the diagnosed person:

(a) the diagnosed person must inform the other person of their diagnosis; and

(b) if the other person commences residing at the premises, the diagnosed person must notify the Department that a person has commenced residing with the diagnosed person and of the name of that person.

5 Clearance from self-isolation

(1) A diagnosed person is given **clearance from self-isolation** if:

(a) an officer or nominated representative of the Department makes a determination under subclause (2) in relation to the person; and

(b) the person is given notice of the determination in accordance with subclause (3).

(2) For the purposes of subclause (1)(a), an officer or nominated representative of the Department may make a determination in relation to a person if the officer or nominated representative is satisfied that the person meets the criteria for discharge from self-isolation under existing **Departmental Requirements**.

(3) For the purposes of subclause (1)(b), the notice must be in writing but is not required to be in a particular form.

(4) A person who has been given clearance from self-isolation, however expressed, under a Revoked Isolation Direction is taken to have been given clearance from self-isolation under this clause.

6 Self-quarantine for close contacts

Who is a close contact?

(1) For the purposes of this clause, a person is a **close contact** if:

(a) an officer or nominated representative of the Department has made a determination under subclause (2) in relation to the person; and

(b) between midnight on 11 May 2020 and 11:59:00pm on 13 September 2020, the person has been given notice of the determination in accordance with subclause (3).

(2) For the purposes of subclause (1)(a), an officer or nominated representative of the Department may make a determination in relation to a person if the officer or nominated representative is satisfied, having regard to Departmental Requirements, that the person has had close contact with another person who:

(a) since the time of last contact, has become a diagnosed person; or

(b) at the time of last contact, was a diagnosed person.

Note: under the Departmental Requirements, a person is generally considered to have had close contact if, in the period extending from 48 hours before onset of symptoms in the diagnosed person:

- *they have had face-to-face contact in any setting with the diagnosed person for more than a total of 15 minutes over the course of a week; or*
- *they have shared a closed space with a diagnosed person for a prolonged period (for example, more than 2 hours).*

(3) For the purposes of subclause (1)(b), the notice:

(a) must specify the time (including by reference to an event) at which the person will no longer be required to self-quarantine, having regard to Departmental Requirements; and

Example: the notice could specify that a person is no longer required to self-quarantine from 14 days after a diagnosed person who the person is living with receives clearance from self-isolation.

(b) may be given orally or in writing, and, if given orally, must be confirmed in writing as soon as reasonably practicable; and

(c) is not required to be in a particular form.

Requirement to self-quarantine

(4) A **close contact** must **self-quarantine** under these directions.

Note: the requirements of self-quarantine are specified in clause 8.

Location of self-quarantine

(5) A close contact may choose to self-quarantine at:

(a) a premises at which they ordinarily reside; or

(b) another premises that is suitable for the person to reside in for the purpose of self-quarantine.

Note 1: a person can decide to self-quarantine at a hotel or other suitable location, instead of self-quarantining at their ordinary place of residence.

Note 2: once a person has chosen the premises at which to self-quarantine, the person must reside at that premises for the entirety of the period of self-quarantine: see clause 8(2)(a).

(6) If, at the time a person is given a notice under subclause (1)(b), the person is not at the premises chosen by the person under subclause (5), the person must immediately and directly travel to that premises.

End of self-quarantine period

(7) For the purposes of this clause, the period of self-quarantine ends:

(a) subject to paragraph (c), at the time specified in the notice given under subclause (1)(b) as given or as varied under subclause (9); or

(b) if the notice given to the person under subclause (1)(b) is revoked under subclause (9), at the time that revocation takes effect; or

(c) if the person becomes a diagnosed person following a test for 2019-nCoV—when the diagnosis is communicated to the person.

Note: a close contact who becomes a diagnosed person will then be required to self-isolate under clause 4, for a period ending when the person is given clearance from self-isolation under clause 5.

Exception — previous clearance

(8) A person is not required to self-quarantine under this clause if, before the time that notice is given under subclause (1)(b), the person has been given, or is taken to have been given, clearance from self-isolation under clause 5.

Review of determination and notice

(9) An **authorised officer**, who is authorised to exercise **emergency powers** by the Chief Health Officer under section 199(2)(a) of the PHW Act, may review a determination made under subclause (2) and, if satisfied that it is appropriate, having regard to Departmental Requirements, may vary or revoke the notice given to the person under subclause (1)(b), and must give the person notice of the authorised officer's decision.

Transitional provision — close contacts under Revoked Isolation Directions

(10) If a person was a close contact under a Revoked Isolation Direction:

(a) a determination made, or taken to have been made, under the Revoked Isolation Direction in relation to the person's status as a close contact is taken to be a determination made under subclause (2); and

(b) a notice given, or taken to have been given, to the person under the Revoked Isolation Direction in relation to the determination referred to in paragraph (a) is taken to be a notice given under subclause (1)(b); and

(c) for the purposes of subclause (5), the person is taken to have chosen to self-quarantine at the premises at which the person was required to self-quarantine under the Revoked Isolation Direction.

Note: a person who was required to self-quarantine under previous directions because they reside with a person who is, or was, a diagnosed person, are now treated as close contacts, and also continue to be required to self-quarantine for the period determined by the previous directions, unless that period is altered pursuant to subclause (9).

7 Testing of persons in self-quarantine

(1) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person:

(a) is tested for 2019-nCoV; and

(b) the period for which the person is required to self-quarantine under clause 6 expires during the period in which the person is awaiting the result of that test,

the period of self-quarantine is extended until the person receives the result of the test.

Note: persons who are in self-quarantine and experience a temperature higher than 37.5 degrees or symptoms of acute respiratory infection are encouraged to get tested. In certain circumstances, a person may be required to comply with an order that they undergo a medical test: PHW Act, section 113(3).

(2) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person receives a test result stating that they have been diagnosed with 2019-nCoV, the person becomes a diagnosed person and must self-isolate under clause 4.

(3) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person receives a test result stating that they have not been diagnosed with 2019-nCoV:

(a) if the period for which the person is required to self-quarantine under clause 6 has not expired—must continue to self-quarantine under that clause for the remainder of that period; or

(b) if the period of self-quarantine was extended under subclause (1)—may cease self-quarantining.

8 Requirements of self-isolation and self-quarantine

(1) This clause applies to a person who is required to:

(a) **self-isolate** at a premises under clause 4; or

(b) **self-quarantine** at a premises under clause 6.

(2) The person identified in subclause (1):

(a) must reside at that premises for the entirety of the period of self-isolation or self-quarantine, as the case requires, except for any period

that the person is admitted to a hospital or other facility for the purposes of receiving medical care; and

(b) must not leave the premises, except:

(i) for the purposes of obtaining medical care or medical supplies; or

(ii) for the purposes of getting tested for 2019-nCoV; or

(iii) in any emergency situation; or

(iv) if required to do so by law; or

(v) for the purposes of visiting a patient in hospital if permitted to do so under the **Hospital Visitor Directions (No 10)**; or

(vi) for the purposes of working in a care facility if permitted to do so under the **Care Facilities Directions (No 10)**; and

(c) must not permit any other person to enter the premises unless:

(i) that other person:

(A) ordinarily resides at the premises; or

(B) is required to self-isolate or self-quarantine at the premises under these directions; or

(ii) it is necessary for the other person to enter for medical or emergency purposes; or

(iii) the other person is a **disability worker**, and it is necessary for the disability worker to enter for the purpose of providing a **disability service** to a person with a **disability**; or

(iv) it is necessary for the other person to enter for the purpose of providing personal care or household assistance to the person as a result of that person's age, disability or chronic health condition; or

Example: personal care includes assistance with showering, toileting, eating; household assistance includes help with cooking, house cleaning, laundry and gardening.

(v) the entry is otherwise required or authorised by law.

(3) Subclause (2)(c) does not apply to a person who is a **resident** of a **care facility**.

Note: the Care Facilities Directions (No 10) govern who can enter a care facility.

9 Exemption power

(1) A person is not required to comply with a requirement of these directions if the person is granted an exemption from that requirement under subclause (2).

(2) The Chief Health Officer or Deputy Chief Health Officer may exempt a person or a group of persons, from any or all requirements contained in

these directions, if satisfied that an exemption is appropriate, having regard to the:

(a) need to protect public health; and

(b) principles in sections 5 to 10 of the PHW Act, as appropriate.

(3) An exemption under subclause (2) must:

(a) be given, in writing, to the person the subject of the exemption; and

(b) specify the requirement or requirements that the person need not comply with.

(4) An exemption granted to a person under this clause does not prevent an authorised officer from exercising an emergency power to give the person a different direction or impose a different requirement on the person.

10 Definitions

In these directions:

(1) **authorised officer** has the same meaning as in the PHW Act;

(2) **care facility** has the same meaning as in the **Care Facilities Directions (No 10)**;

(3) **Department** means the Victorian Department of Health and Human Services;

(4) **Departmental Requirements** means the document titled "COVID-19 Pandemic Plan for the Victorian Health Sector", as amended from time to time;

Note: the Departmental Requirements are available at:

https://www2.health.vic.gov.au/about/publications/ResearchAndReports/covid-19-pandemic-plan-for-vic

(5) **emergency powers** has the same meaning as in the PHW Act;

(6) **hospital** has the same meaning as in the **Hospital Visitor Directions (No 10)**;

(7) **premises** means:

(a) a building, or part of a building; and

(b) any land on which the building is located, other than land that is available for communal use;

(8) **resident** of a care facility has the same meaning as in the **Care Facilities Directions (No 10)**;

(9) **Revoked Isolation Direction** means the following directions:

(a) **Isolation (Diagnosis) Direction**, given on 25 March 2020;

(b) **Isolation (Diagnosis) Direction (No 2)**, given on 13 April 2020;

(c) **Diagnosed Persons and Close Contacts Directions**, given on 11 May 2020;

(d) **Diagnosed Persons and Close Contacts Directions (No 2)**, given on 31 May 2020;

(e) **Diagnosed Persons and Close Contacts Directions (No 3)**, given on 21 June 2020;

(f) **Diagnosed Persons and Close Contacts Directions (No 4)**, given on 1 July 2020;

(g) **Diagnosed Persons and Close Contacts Directions (No 5)**, given on 15 July 2020;

(h) **Diagnosed Persons and Close Contacts Direction (No 6)**, given on 19 July 2020;

(i) **Diagnosed Persons and Close Contacts Direction (No 7)**, given on 22 July 2020;

(j) **Diagnosed Persons and Close Contacts Direction (No 8)**, given on 3 August 2020;

(k) **Diagnosed Persons and Close Contacts Direction (No 9)**, given on 13 August 2020;

(10) the following expressions have the same meaning that they have in the **Disability Service Safeguards Act 2018**:

(a) disability;

(b) disability service;

(c) disability worker.

11 Penalties

Section 203 of the PHW Act provides:

Compliance with direction or other requirement

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

Penalty: In the case of a natural person, 120 penalty units;
In the case of a body corporate, 600 penalty units.

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

Dr Finn Romanes

Public Health Commander, as authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the PHW Act.

16 August 2020

Direction from Deputy Public Health Commander in accordance with emergency powers arising from declared state of emergency

Diagnosed Persons and Close Contacts Directions (No 11)

Public Health and Wellbeing Act 2008 (Vic)
Section 200

I, Associate Professor Michelle Giles, Deputy Public Health Commander, consider it reasonably necessary to eliminate or reduce the risk to public health—and reasonably necessary to protect public health—to give the following directions pursuant to section 200(1)(b) and (d) of the **Public Health and Wellbeing Act 2008** (Vic) (**PHW Act**):

1 Preamble

(1) The purpose of these directions is to require persons:

(a) diagnosed with Novel Coronavirus 2019 (**2019-nCoV**) to self-isolate;

(b) who are living with a diagnosed person, or who have been in close contact with a diagnosed person, to seif-quarantine;

in order to limit the spread of 2019-nCoV.

(2) These directions replace the **Diagnosed Persons and Close Contacts Directions (No 10)**.

2 Citation

These directions may be referred to as the **Diagnosed Persons and Close Contacts Directions (No 11)**.

3 Commencement and revocation

(1) These directions commence at 11:59:00pm on 13 September 2020.

(2) The **Diagnosed Persons and Close Contacts Directions (No 10)** are revoked at 11:59:00pm on 13 September 2020.

4 Self-isolation for diagnosed persons

Who is a diagnosed person?

(1) A person is a **diagnosed person** if the person:

(a) at any time between midnight on 25 March 2020 and 11:59:00pm on 11 October 2020 has been informed that they have been diagnosed with 2019-nCoV; and

(b) has not been given, or is not taken to have been given, **clearance from self-isolation** under clause 5.

Requirement to self-isolate

(2) A diagnosed person must **self-isolate** under these directions:

(a) if the diagnosis is communicated to the person on or after the commencement of these directions; or

(b) if the diagnosis was communicated to the person before the commencement of these directions.

Note: the requirements of self-isolation are specified in clause 8. A diagnosed person can still leave the premises at which they are self-isolating to obtain medical care.

Location of self-isolation

(3) A diagnosed person must self-isolate:

(a) if subclause (2)(a) applies, at the **premises** chosen by the person under subclause (4); or

(b) if subclause (2)(b) applies, at the premises at which the person was required to reside under a **Revoked Isolation Direction**.

(4) For the purposes of subclause (3)(a), the diagnosed person may choose to self-isolate at:

(a) a premises at which they ordinarily reside; or

(b) another premises that is suitable for the person to reside in for the purpose of self-isolation.

Note 1: a person can decide to self-isolate at a hotel or other suitable location, instead of self-isolating at their ordinary place of residence.

Note 2: once a person has chosen the premises at which to self-isolate, the person must reside at that premises for the entirety of the period of self-isolation: see clause 8(2)(a).

(5) If a diagnosed person who has chosen a premises under subclause (4) is not at the premises at the time when the choice is made, the person must immediately and directly travel to that premises, unless the person is admitted to a **hospital** or other facility for the purposes of receiving medical care.

Self-isolation period

(6) For the purposes of subclause (2), the period of self-isolation begins:

(a) if subclause (2)(a) applies, when the diagnosis is communicated to the person; or

(b) if subclause (2)(b) applies, upon the commencement of these directions.

(7) For the purposes of subclause (2), the period of self-isolation ends when the person is given **clearance from self-isolation** under clause 5.

Notifications by the diagnosed person

(8) Immediately after choosing a premises under subclause (4), the diagnosed person must:

(a) if any other person is residing at the premises chosen by the diagnosed person, notify the other person that:

(i) the diagnosed person has been diagnosed with 2019-nCoV; and

(ii) the diagnosed person has chosen to self-isolate at the premises; and

(b) notify the Department of:

(i) the address of the premises chosen by the diagnosed person; and

(ii) the name of any other person who is residing at the premises chosen by the diagnosed person.

(9) If, during the period that a diagnosed person is self-isolating at a premises for the purposes of clause 4, another person informs the diagnosed person that they intend to commence residing at the premises chosen by the diagnosed person:

(a) the diagnosed person must inform the other person of their diagnosis; and

(b) if the other person commences residing at the premises, the diagnosed person must notify the Department that a person has commenced residing with the diagnosed person and of the name of that person.

5 Clearance from self-isolation

(1) A diagnosed person is given **clearance from self-isolation** if:

(a) an officer or nominated representative of the Department makes a determination under subclause (2) in relation to the person; and

(b) the person is given notice of the determination in accordance with subclause (3).

(2) For the purposes of subclause (1)(a), an officer or nominated representative of the Department may make a determination in relation to a person if the officer or nominated representative is satisfied that the person meets the criteria for discharge from self-isolation under existing **Departmental Requirements**.

(3) For the purposes of subclause (1)(b), the notice must be in writing but is not required to be in a particular form.

(4) A person who has been given clearance from self-isolation, however expressed, under a Revoked Isolation Direction is taken to have been given clearance from self-isolation under this clause.

6 Self-quarantine for close contacts

Who is a close contact?

(1) For the purposes of this clause, a person is a **close contact** if:

(a) an officer or nominated representative of the Department has made a determination under subclause (2) in relation to the person; and

(b) between midnight on 11 May 2020 and 11:59:00pm on 11 October 2020, the person has been given notice of the determination in accordance with subclause (3).

(2) For the purposes of subclause (1)(a), an officer or nominated representative of the Department may make a determination in relation to a person if the officer or nominated representative is satisfied, having regard to Departmental Requirements, that the person has had close contact with another person who:

(a) since the time of last contact, has become a diagnosed person; or

(b) at the time of last contact, was a diagnosed person.

Note: under the Departmental Requirements, a person is generally considered to have had close contact if, in the period extending from 48 hours before onset of symptoms in the diagnosed person:

- *they have had face-to-face contact in any setting with the diagnosed person for more than a total of 15 minutes over the course of a week; or*
- *they have shared a closed space with a diagnosed person for a prolonged period (for example, more than 2 hours).*

(3) For the purposes of subclause (1)(b), the notice:

(a) must specify the time (including by reference to an event) at which the person will no longer be required to self-quarantine, having regard to Departmental Requirements; and

Example: the notice could specify that a person is no longer required to self-quarantine from 14 days after a diagnosed person who the person is living with receives clearance from self-isolation.

(b) may be given orally or in writing, and, if given orally, must be confirmed in writing as soon as reasonably practicable; and

(c) is not required to be in a particular form.

Requirement to self-quarantine

(4) A **close contact** must **self-quarantine** under these directions.

Note: the requirements of self-quarantine are specified in clause 8.

Location of self-quarantine

(5) A close contact may choose to self-quarantine at:

(a) a premises at which they ordinarily reside; or

(b) another premises that is suitable for the person to reside in for the purpose of self-quarantine.

Note 1: a person can decide to self-quarantine at a hotel or other suitable location, instead of self-quarantining at their ordinary place of residence.

Note 2: once a person has chosen the premises at which to self-quarantine, the person must reside at that premises for the entirety of the period of self-quarantine: see clause 8(2)(a).

(6) If, at the time a person is given a notice under subclause (1)(b), the person is not at the premises chosen by the person under subclause (5), the person must immediately and directly travel to that premises.

End of self-quarantine period

(7) For the purposes of this clause, the period of self-quarantine ends:

(a) subject to paragraph (c), at the time specified in the notice given under subclause (1)(b) as given or as varied under subclause (9); or

(b) if the notice given to the person under subclause (1)(b) is revoked under subclause (9), at the time that revocation takes effect; or

(c) if the person becomes a diagnosed person following a test for 2019-nCoV—when the diagnosis is communicated to the person.

Note: a close contact who becomes a diagnosed person will then be required to self-isolate under clause 4, for a period ending when the person is given clearance from self-isolation under clause 5.

Exception — previous clearance

(8) A person is not required to self-quarantine under this clause if, before the time that notice is given under subclause (1)(b), the person has been given, or is taken to have been given, clearance from self-isolation under clause 5.

Review of determination and notice

(9) An **authorised officer**, who is authorised to exercise **emergency powers** by the Chief Health Officer under section 199(2)(a) of the PHW Act, may review a determination made under subclause (2) and, if satisfied that it is appropriate, having regard to Departmental Requirements, may vary or revoke the notice given to the person under subclause (1)(b), and must give the person notice of the authorised officer's decision.

Transitional provision — close contacts under Revoked Isolation Directions

(10) If a person was a close contact under a Revoked Isolation Direction:

(a) a determination made, or taken to have been made, under the Revoked Isolation Direction in relation to the person's status as a close contact is taken to be a determination made under subclause (2); and

(b) a notice given, or taken to have been given, to the person under the Revoked Isolation Direction in relation to the determination referred to in paragraph (a) is taken to be a notice given under subclause (1)(b); and

(c) for the purposes of subclause (5), the person is taken to have chosen to self-quarantine at the premises at which the person was required to self-quarantine under the Revoked Isolation Direction.

Note: a person who was required to self-quarantine under previous directions because they reside with a person who is, or was, a diagnosed person, are now treated as close contacts, and also continue to be required to self-quarantine for the period determined by the previous directions, unless that period is altered pursuant to subclause (9).

7 Testing of persons in self-quarantine

(1) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person:

(a) is tested for 2019-nCoV; and

(b) the period for which the person is required to self-quarantine under clause 6 expires during the period in which the person is awaiting the result of that test,

the period of self-quarantine is extended until the person receives the result of the test.

Note: persons who are in self-quarantine and experience a temperature higher than 37.5 degrees or symptoms of acute respiratory infection are encouraged to get tested. In certain circumstances, a person may be required to comply with an order that they undergo a medical test: PHW Act, section 113(3).

(2) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person receives a test result stating that they have been diagnosed with 2019-nCoV, the person becomes a diagnosed person and must self-isolate under clause 4.

(3) If a person is required to self-quarantine under clause 6 and, during the period of self-quarantine, the person receives a test result stating that they have not been diagnosed with 2019-nCoV:

(a) if the period for which the person is required to self-quarantine under clause 6 has not expired—must continue to self-quarantine under that clause for the remainder of that period; or

(b) if the period of self-quarantine was extended under subclause (1)—may cease self-quarantining.

8 Requirements of self-isolation and self-quarantine

(1) This clause applies to a person who is required to:

(a) **self-isolate** at a premises under clause 4; or

(b) **self-quarantine** at a premises under clause 6.

(2) The person identified in subclause (1):

(a) must reside at that premises for the entirety of the period of self-isolation or self-quarantine, as the case requires, except for any period that the person is admitted to a hospital or other facility for the purposes of receiving medical care; and

(b) must not leave the premises, except:

(i) for the purposes of obtaining medical care or medical supplies; or

(ii) for the purposes of getting tested for 2019-nCoV; or

(iii) in any emergency situation; or

(iv) if required to do so by law; or

(v) for the purposes of visiting a patient in hospital if permitted to do so under the **Hospital Visitor Directions (No 11)**; or

(vi) for the purposes of working in a care facility if permitted to do so under the **Care Facilities Directions (No 11)**; and

(c) must not permit any other person to enter the premises unless:

(i) that other person:

(A) ordinarily resides at the premises; or

(B) is required to self-isolate or self-quarantine at the premises under these directions; or

(ii) it is necessary for the other person to enter for medical or emergency purposes; or

(iii) the other person is a **disability worker**, and it is necessary for the disability worker to enter for the purpose of providing a **disability service** to a person with a **disability**; or

(iv) it is necessary for the other person to enter for the purpose of providing personal care or household assistance to the person as a result of that person's age, disability or chronic health condition; or

Example: personal care includes assistance with showering, toileting, eating; household assistance includes help with cooking, house cleaning, laundry and gardening.

(v) the entry is otherwise required or authorised by law.

(3) Subclause (2)(c) does not apply to a person who is a **resident** of a **care facility**.

*Note: the **Care Facilities Directions (No 11)** govern who can enter a care facility.*

9 Exemption power

(1) A person is not required to comply with a requirement of these directions if the person is granted an exemption from that requirement under subclause (2).

(2) The Chief Health Officer or Deputy Chief Health Officer may exempt a person or a group of persons, from any or all requirements contained in these directions, if satisfied that an exemption is appropriate, having regard to the:

(a) need to protect public health; and

(b) principles in sections 5 to 10 of the PHW Act, as appropriate.

(3) An exemption under subclause (2) must:

(a) be given, in writing, to the person the subject of the exemption; and

(b) specify the requirement or requirements that the person need not comply with.

(4) An exemption granted to a person under this clause does not prevent an authorised officer from exercising an emergency power to give the person a different direction or impose a different requirement on the person.

10 Definitions

In these directions:

(1) **authorised officer** has the same meaning as in the PHW Act;

(2) **care facility** has the same meaning as in the **Care Facilities Directions (No 11)**;

(3) **Department** means the Victorian Department of Health and Human Services;

(4) **Departmental Requirements** means the document titled "COVID-19 Pandemic Plan for the Victorian Health Sector", as amended from time to time;

Note: the Departmental Requirements are available at:

www2.health.vic.gov.au/about/publications/ResearchAndReports/covid-19-pandemic-plan-for-vic.

(5) **emergency powers** has the same meaning as in the PHW Act;

(6) **hospital** has the same meaning as in the **Hospital Visitor Directions (No 11)**;

(7) **premises** means:

(a) a building, or part of a building; and

(b) any land on which the building is located, other than land that is available for communal use;

(8) **resident** of a care facility has the same meaning as in the **Care Facilities Directions (No 11)**;

(9) **Revoked Isolation Directions** means the following directions:

(a) **Isolation (Diagnosis) Direction**, given on 25 March 2020;

(b) **Isolation (Diagnosis) Direction (No 2)**, given on 13 April 2020;

(c) **Diagnosed Persons and Close Contacts Directions**, given on 11 May 2020;

(d) **Diagnosed Persons and Close Contacts Directions (No 2)**, given on 31 May 2020;

(e) **Diagnosed Persons and Close Contacts Directions (No 3)**, given on 21 June 2020;

(f) **Diagnosed Persons and Close Contacts Directions (No 4)**, given on 1 July 2020;

(g) **Diagnosed Persons and Close Contacts Directions (No 5)**, given on 15 July 2020;

(h) **Diagnosed Persons and Close Contacts Directions (No 6)**, given on 19 July 2020;

(i) **Diagnosed Persons and Close Contacts Directions (No 7)**, given on 22 July 2020;

(j) **Diagnosed Persons and Close Contacts Directions (No 8)**, given on 3 August 2020;

(k) **Diagnosed Persons and Close Contacts Directions (No 9)**, given on 13 August 2020;

(l) **Diagnosed Persons and Close Contacts Directions (No 10)**, given on 16 August 2020;

(10) the following expressions have the same meaning that they have in the **Disability Service Safeguards Act 2018**:

(a) disability;

(b) disability service;

(c) disability worker.

11 Penalties

Section 203 of the PHW Act provides:

Compliance with direction or other requirement

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

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

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

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

Associate Professor Michelle Giles

Deputy Public Health Commander, as authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the PHW Act.

13 September 2020

Coronavirus disease 2019 (COVID-19)

Case and contact management guidelines for health services and general practitioners

31 August 2020

Version 24

VICTORIA State Government | Health and Human Services

Contents

Background

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

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

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

Public health response objectives

This situation has evolved rapidly since the start of this year with new clinical and epidemiological information.

The overall objectives of the public health response are to:

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

Checklist for general practitioners

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

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

The department does not need to be notified about Suspected cases **(**Confirmed cases **and** Probable cases only**).**

6. If the patient is **not** tested – advise them to stay at home until their acute symptoms (including fever) have resolved and they feel well.
7. If a Suspected case of COVID-19 is unwell enough to require ambulance transfer to hospital, call Triple Zero (000) in the normal manner but advise that the patient may have suspected COVID-19 infection. Ambulance transfers do not need to be approved by the department. Where there is no clinical need for ambulance transfer, alternative means of transport should be used including private car driven by the case or an existing close contact (not bus, taxi or Uber).
8. Remember to provide a surgical face mask for the patient and driver if being transferred to an emergency department by any means.
9. If a patient is tested in the community by a general practitioner, the general practitioner should **undertake testing** as indicated in this guide. Ensure arrangements are in place for contacting the patient with the test result – this is the responsibility of the testing clinician.
10. **Advise a suspected case they must self-isolate at home**, and provide a factsheet for suspected cases from the department's COVID-19 website.
11. Undertake **cleaning and disinfection** of the room as detailed in the COVID-19 infection prevention and control guidelines available on the department's website <https://www.dhhs.vic.gov.au/covid19-infection-control-guidelines>
12. When the test result is available:

a) **If the test is negative** for COVID-19 provide the negative result from the laboratory to the patient and manage any other cause of illness you have assessed as requiring treatment. Symptomatic patients should stay home until their acute symptoms have resolves and they feel well. Consider advising the patient in the normal manner that admission to hospital and further testing may be required if they deteriorate.
b) **If the test is positive** for COVID-19, call the department on 1300 651 160 to confirm that the department is aware of the result and agree on next steps for management of the patient.

Checklist for health services

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

1. Staff at triage points should wear personal protective equipment for droplet and contact precautions (single-use surgical mask, eye protection, gown and gloves).
2. Triage high risk patients to a separate isolated waiting area away from low risk patients, staff and general public.
6. Provide a single-use surgical mask for the patient to put on.
3. Isolate the patient in a single room with the door closed.
4. Any person entering the room should don droplet and contact precautions personal protective equipment (single-use surgical mask, eye protection, gown and gloves).
5. Conduct a medical assessment, and ask specifically about :
   (a) the date of onset of illness and especially whether there are symptoms or signs of pneumonia
   (b) contact with confirmed cases of COVID-19
   (c) precise travel history and occupation
   (d) history of contact with sick travellers or other people or overseas health care facilities
   (e) work or residence in an at-risk setting for transmission (including residential aged care facilities, and meat processing)
   (f) residence in a geographically localised area with elevated risk of community transmission, as defined by the department.
7. Determine whether the patient meets the current criteria for testing. Refer to *Who should be tested for COVID-19*
6. If admission is not required and the patient can return to the community:
   a) for patients that do **not** meet the current criteria for testing for COVID-19 – advise the patient to stay at home until their acute symptoms (including fever) have resolved and they feel well.
   b) for patients that meet the current criteria for testing - the notifying clinician should **advise the patient to self-isolate at home** and avoid contact with other people. Provide a factsheet for suspected cases from the department's COVID-19 website.
   c) consider advising the patient in that admission to hospital and further testing may be required if they deteriorate
   d) ensure **arrangements are in place for the patient to be contacted with the test result** – this is the responsibility of the testing clinician and health service.
7. If admission is required:
   a) maintain infection control precautions and actively consider taking multiple samples for testing including from lower respiratory tract specimens.
8. When the test result is available:

a) **if the test is positive** for COVID-19, provide the result to the patient. The health service infectious diseases lead, or senior clinician should call the department on **1300 651 160** to confirm that the department is aware of the result and to provide any additional clinical information.
b) **if the test is negative** for COVID-19, provide the negative result to the patient and manage any other cause of illness you have assessed as requiring treatment.
c) consider advising the patient that admission to hospital and further testing may be required if they deteriorate.

Who should be tested for COVID-19?

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

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

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

Suspected case

Patients who meet the following clinical criteria should be tested:

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

OR

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

*Clinical discretion applies; consider potential for co-infection (e.g. SARS-CoV-2 and influenza).

**Older people may present with other atypical symptoms including functional decline, delirium, exacerbation of underlying chronic condition, falls, loss of appetite, malaise, nausea, diarrhea and myalgia.

Additional testing note:
People who are at higher risk of infection due to their environmental exposure or at increased risk of severe illness should also be tested if they have new onset of other clinical symptoms associated with COVID-19 (e.g headache, myalgia, stuffy nose, nausea, vomiting, diarrhoea) AND meet the following epidemiological criteria:

- Close contacts of a confirmed case of COVID-19
- Returned overseas travel in the past 14 days
- Healthcare or aged care workers.
- Residents of an aged care facility or older people in the community

Confirmed case

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

OR

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

OR

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

Probable case

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

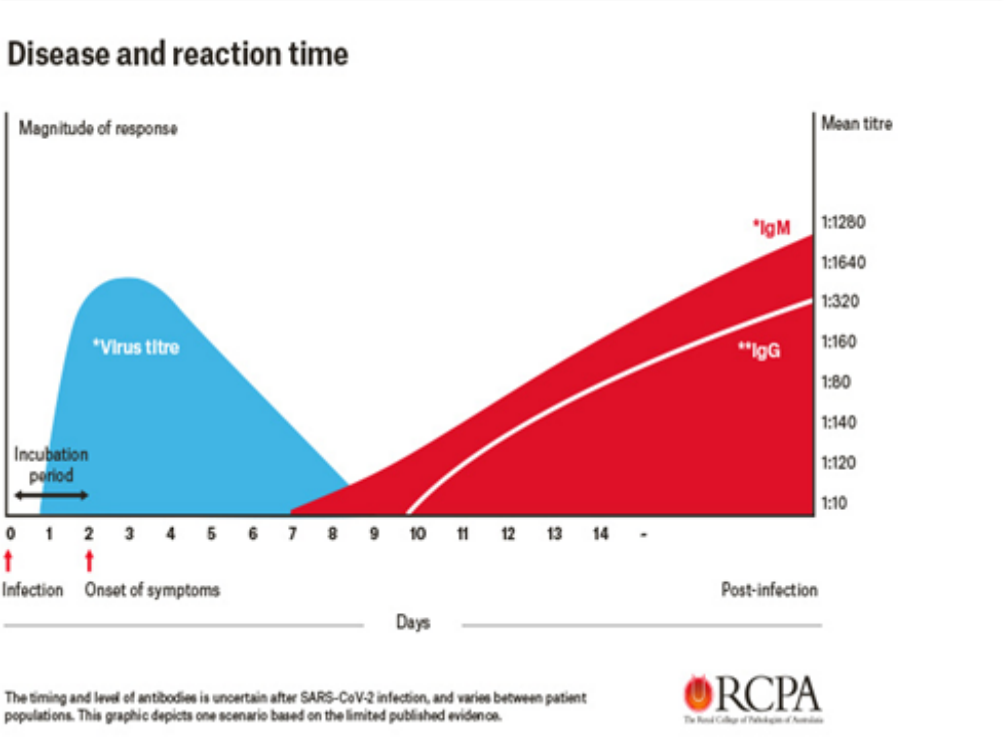
General comments:

- All patients being tested for COVID-19 should self isolate until test results are available or symptoms have resolved, whichever is longer. All patients should attend an emergency department if clinical deterioration occurs.

Serological testing

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

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



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

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

Decisions concerning the collection of samples for serology should be made in response to clinical and public health imperatives, and in consultation with the Department of Health and Human Services. If serological testing is deemed indicated or requested **serum can be collected from people with positive RT-PCR respiratory samples for assessment of COVID-19 serology.** If a sample is collected early in the disease course and returns a negative result, then **a repeat serum sample should be collected 14 or more days after onset of illness and marked as 'convalescent sera' for paired analysis.** If no acute sample was collected, sera collected 14 or more days after symptom onset may also be collected for testing. For contacts of a confirmed case, paired sera collected 4 weeks apart could be useful. **These samples should be forwarded to the Victorian Infectious Diseases Reference Laboratory (VIDRL) for storage and confirmatory testing. Note that the current Australian case definition requires an antibody rise between paired sera to define a COVID-19 case and deems demonstration of SARS-CoV-2 antibody in a single sample to be only a probable case.**

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

Deaths

If there is a suspicion that a deceased person may have had undiagnosed COVID-19 (such as a close contact of a known case or resident of an aged care facility where there is a known outbreak), including on request of paramedics or other first responders, an oropharyngeal and deep nasal swab for COVID-19 PCR testing should be taken, with the consent of the family.

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

Definition of close contact

For the purposes of testing, the department advises a precautionary understanding of close contact Close contact means greater than 15 minutes face-to-face, cumulative over a week, or the sharing of a closed space for more than two hours, with a confirmed case during their infectious period without recommended personal protective equipment (PPE). Recommended PPE includes droplet and contact precautions.

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

Examples of close contact include:

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

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

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

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

Triaging and managing high risk patients on arrival to hospital

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

- presenting with acute respiratory tract infection
- presenting with fever without another immediately apparent cause (e.g. UTI or cellulitis)
- they have travelled overseas and have onset of symptoms within 14 days of return
- they have been in close contact with a confirmed coronavirus (COVID-19) case with onset of symptoms within 14 days
- they are a confirmed coronavirus (COVID-19) case (this includes healthcare workers who are known confirmed cases).
- they are a resident in an aged care facility where there is an outbreak.

Patient transfer and destination health service

The following is advice on where patients should be managed:

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

Arrival to hospital and triage

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

Ambulance triage

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

Emergency department admissions

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

Patient transfers

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

Case management

Assessment and management of patients for COVID-19 testing

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

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

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

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

People who are tested for COVID-19 must self-isolate while awaiting results.

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

People who were **asymptomatic** at the time of testing for COVID-19 must self-isolate until COVID-19 is excluded, **unless advised otherwise by the department.**

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

People meeting testing criteria who are not tested for COVID-19 or any other infectious disease should self-isolate until the acute symptoms have resolved and they feel well.

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

Exclusion of COVID-19

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

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

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

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

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

Outbreak definition

The department currently defines an outbreak of COVID-19 as:

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

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

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

PCR positive tests in asymptomatic or pre-symptomatic persons

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

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

Clinical management of confirmed cases

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

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

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

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

Further advice on clinical management is available from:

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

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

Education

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

Criteria for inpatient discharge

A confirmed case may be discharged from hospital if the following criteria are met:

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

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

Release from isolation of a confirmed case

Cases must be cleared from isolation by an officer or nominated representative of the Department. The clinical or medical lead of the infection prevention or infectious diseases unit of a health service will be considered as the authorising clinician. The role will be primarily filled by an Infectious Diseases Physician. Services without the appropriate clinical or medical lead can be supported by their Cluster Lead health services.

The following information details the circumstances under which confirmed and probable cases can be released from isolation. Cases can be released from isolation if they meet the appropriate criteria in either point 1, 2, or 3 – whichever is applicable. Significantly immunocompromised cases can be released from isolation if they meet the appropriate criteria in point 1, 2, or 3 and the additional criterion in point 4. Healthcare workers and workers in aged care facilities who meet the below criteria can be released from isolation and **do not require further testing to return to work or an at-risk setting**.

1. **Confirmed cases who are asymptomatic**

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

2. Confirmed or probable cases with mild illness (not requiring hospitalisation or admitted to hospital for reasons not directly related to acute COVID-19)

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

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

3. Confirmed or probable cases with more severe illness (hospitalisation was indicated for acute COVID-19, regardless of whether or not the case was hospitalised)

a. Confirmed and probable cases with resolution of fever and respiratory symptoms of acute illness

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

- at least **14** days have passed since onset of symptoms; and
- there has been resolution of fever and respiratory symptoms of the acute illness for the previous **72** hours[1,2,3]

b. Confirmed and probable cases without complete resolution of symptoms of acute illness

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

- at least **14** days have passed since the onset of symptoms; and
- there has been substantial improvement in symptoms of the acute illness (including resolution of fever for the previous **72** hours)[1,2,3]; and
- the case has had two consecutive respiratory specimens negative[4] for SARS-CoV-2 by PCR taken **at least 24 hours apart at least 11 days from symptom onset**.

4. Significantly immunocompromised persons.

In **addition** to meeting the appropriate criteria described in points 1, 2, or 3a above, persons who are significantly immunocompromised[5] and are identified as confirmed or probable cases must meet a higher standard requiring additional assessment. They can be released from isolation when they meet the following additional criterion:

- PCR negative[4] on at least two consecutive respiratory specimens collected at least 24 hours apart at least 7 days after symptom onset[6].

Notes:

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

[2] If individuals have a persistent post-viral cough with negative test results, they are eligible for release from isolation

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

[4] In patients in which swabs are required to meet release from isolation criteria but where swabs remain positive, additional factors may be considered to determine the need for ongoing isolation, including the

clinical scenario and laboratory details (e.g. Ct values, viral culture results). This should be discussed with the treating medical practitioner, the testing laboratory and the department

[5] People who are clinically assessed as being significantly immunocompromised may have a reduced ability to effectively clear SaRS-CoV-2 and a prolonged infectious period. Significantly immunocompromised persons may include, but are not limited to, those who have had an organ transplant and are on immune suppressive therapy; have had a bone marrow transplant in the past 2 years; are on immune suppressive therapy for graft versus host disease; have had an active haematological malignancy; and human immunodeficiency virus infection with CD4 T lymphocyte count below 200 cells/mm3; or other conditions specifically noted by the treating medical practitioner

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

Routine PCR testing post-release from isolation is not recommended unless the person re-develops clinical features consistent with COVID-19.

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

Cases with gastrointestinal symptoms

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

- All cases with diarrhoea should be advised not to prepare food for others until 48 hours after symptoms have resolved.
- It is recommended that people whose faecal samples are PCR positive use soap and water for hand hygiene. If this is unavailable, alcohol hand gel should be used.
- Cases who are employed in a role where there is an increased risk of onward transmission (e.g. healthcare workers, restaurant workers and food handlers), should be excluded from work until 48 hours after any symptoms of diarrhoea have resolved.
- Cases with ongoing diarrhoea or faecal incontinence who may have limited capacity to maintain standards of personal hygiene should be isolated until 48 hours after the resolution of these symptoms.

Patients do not require repeat testing until they are PCR negative in faecal samples. It is recommended that people who remain persistently PCR positive in faecal samples use soap and water for hand hygiene. If this is unavailable, alcohol hand gel should be used.

Cases who have been released from isolation

Based on a review of current evidence, persons who fulfil the relevant criteria above are not considered to be infectious. Cases returning to a high risk setting can be released from isolation based on the clinical criteria above and **do not need to meet** a higher standard or undergo additional assessment before going into any high-risk settings. This includes persons returning to work in a health care setting, living in a residential age care setting, being transferred to another hospital or who regularly attend healthcare settings for any other reason.

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

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

Checklist of key actions for the department for confirmed cases

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

Checklist of key actions for the clinical team for confirmed cases

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

Signage and triage of people presenting to health and other services

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

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

For examples of posters that can be used, see the department's website <https://www.dhhs.vic.gov.au/promotional-material-coronavirus-covid-19>

Contact management

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

Close contacts

Self-quarantine

The following groups are now required to self-quarantine:

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

Any exception to quarantining of close contacts requires specific exemption from the department

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

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

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

If a recently recovered COVID-19 case becomes a close contact of a confirmed or probable case, they do not need to self-quarantine again. However, the recovered case should not attend high-risk settings until 14 days after the last unprotected contact with the confirmed case.

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

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

Testing

All close contacts are recommended to be tested prior to the end of their quarantine period (generally at day 11). Returned international travellers are tested both early (generally days 0-2) and prior to the end of their quarantine period. A negative test result will be required prior to the department issuing clearance for a person to exit quarantine.

Identification of potential source ('upstream') contacts

A close contact may also be tested as part of potential source or 'upstream' contact tracing, particularly in high risk settings.

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

Potential source contacts:

- are people who had close contact with the case during the time the case is likely to have **acquired** the infection
- close contact will have occurred between **24 hours and 14 days** (usually **5-7 days**) before symptom onset in the first reported case
- may be both close contacts and potential source contacts. Quarantine is required for potential source contacts who are also close contacts, unless given specific exemption by the department's Public Health Command. Such close contacts will receive clear instruction if they do not need to quarantine, such as if it is necessary to provide safe staffing in aged care or to maintain critical or essential services.
- may be unidentified cases, so should be:
  - screened for possible symptoms
  - have their temperature measured
  - undergo PCR testing for SARS-CoV-2 infections
  - considered for serological testing if well, and a validated serological assay is available
- if they test positive by PCR, clinical and public health judgement should be used to determine if they are currently infectious
- if deemed to be infectious, should be managed as any other confirmed case, including rapid contact tracing
- should be assessed as to whether they are likely to be:
  - the primary case who infected the first reported case (index case in an outbreak)
  - a secondary case infected by the first reported case
  - a separate transmission chain

Symptomatic and asymptomatic close contacts requiring treatment

If a close contact requires an assessment or treatment by a clinician during their 14-day quarantine period, regardless of whether they have symptoms or not, the following steps should be taken,

The department will:

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

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

- provide a single-use face mask (if the close contact does not already have one)
- use a single room and appropriate PPE as for a suspected case

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

Where the illness is diagnosed as acute respiratory illness:

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

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

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

Checklist of key actions for the department for close contacts

For all close contacts the department will:

- Advise self-quarantine including restriction on travel until 14 days from the last contact with confirmed case.
- Consider testing early in quarantine period to determine if close contact is a potential acquisition source for the case.
- Counsel close contacts about risk and awareness of potential symptoms.
- Provide a close contact fact sheet
- Make regular contact with the close contact to monitor for any symptoms, either through SMS, email or telephone call.
- All close contacts are recommended to have testing at day 11 of their quarantine period, regardless of whether or not they display symptoms. If tested, they must complete 14 days of quarantine and return a negative result prior to being released from quarantine
- If close contacts need to attend a health service at any stage during their 14-day quarantine period, regardless of symptoms, they should be treated as a suspected case, and appropriate PPE be worn.
- If a school or employer requests confirmation from the department that the quarantine period has been met, the department will provide evidence with the consent of the individual.

Healthcare workers

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

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

Hospital workers, except if for the purpose of seeking medical attention, must not enter or remain at a hospital in Victoria if:

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

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

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

Infection prevention and control

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

This guidance covers issues including:

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

Laboratory testing for COVID-19

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

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

Testing advice for clinicians

When any symptomatic patient presents for testing, all clinicians must ask if that patient has had previous exposure to a known COVID-19 case within the past 14 days.

If the patient has been exposed **and** the outbreak definition is met (see Outbreak definition section), the test sample is to be treated as an 'outbreak sample'

Sample labelling – prioritisation

On request slips:

- Provide **clinical details**
- Include the specimen type (e.g. deep nasal/oropharyngeal, partial sample, self-collected, saliva)
- copy results to the patient's treating physician
- include the patient's mobile number so that they can be contacted quickly.

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

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

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

The department is aware that many labs are already processing outbreak samples in-house due to the large number of ongoing investigations. In the current climate, splitting samples between laboratories may contribute to longer waiting times for the turn-around of results, therefore it is considered better that the receiving laboratories process these samples.

As of 26 July 2020, URGENT PRIORITY 1 – OUTBREAK samples (below) can now be processed by the receiving pathology provider or hospital laboratory. These samples **no longer** require referral to the Victorian Infectious Diseases Reference Laboratory for processing.

Priority groups for testing

Current as of 19 May 2020.

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

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

Priority 2 (P2)

- SYMPTOMATIC HEALTH CARE WORKERS including AGED CARE WORKERS and RESIDENTIAL DISABILITY setting workers
- SYMPTOMATIC aged care residents, disability setting residents and hospital patients.

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

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

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

- Prison/Justice settings (correctional facilities, detention centres)
- Aboriginal rural and remote communities
- Accommodation with shared facilities
- Defence force operational settings
- Boarding schools
- Other group residential settings (e.g. minors in out of home care)
- Non-residential disability settings
- Schools
- Childcare centres
- Remote industrial sites with accommodation (e.g. mine sites)
- Certain high-risk work sites where workers are unable to undertake physical distancing or where outbreaks have been identified in the past:
  - Meat processing or other manufacturing plants
  - Restaurants/industrial kitchens
  - Workplaces with highly casualised workforces (who may be less likely to report symptoms)
  - Critical infrastructure dependent workplaces – such as electricity worker
- Critical workforces in essential services – such as members of Victoria Police, Fire Victoria, child protection workers

Specimens for testing

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

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

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

Respiratory specimens

Collection of upper respiratory specimens is recommended for all patients – these would be oropharyngeal **and** deep nasal to optimise the chances of virus detection. Nasopharyngeal sampling, which is a deeper and less comfortable, is no longer recommended.

In some circumstances both the nasal & throat sample may not be possible. In these circumstances we recommend that if a partial sample is collected it still be tested. Note on the pathology referral form what specimen was collected.

In addition, lower respiratory specimens (sputum, if possible) are recommended for patients with a productive cough. For PPE recommendations, see .Coronavirus disease 2019 (COVID-19) infection prevention and control guideline, available on the department's website.

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

Patients with symptoms suggestive of pneumonia should be managed in hospital, and sample collection conducted in a negative pressure room, if available. If referral to hospital for specimen collection is not

possible, specimens should be collected in a single room. The door should be closed during specimen collection and the room left vacant for at least 30 minutes afterwards (cleaning can be performed during this time by a person wearing PPE for airborne and contact precautions).

Salivary specimens

Salivary testing may be useful in limited circumstances. The GP should discuss with their local pathology provider as to whether this is a specimen they can accept and process. All saliva specimens will be forwarded by your pathology provider to VIDRL for testing. This may result in an increased turn-around-times, in particular in rural and regional areas.

The decision regarding whether salivary testing is an appropriate option for an individual patient is up to the discretion of the treating clinician. It should be noted that 2-3 ml of saliva is required, and that the test has lower sensitivity than swab specimens – this may mean a slightly increased chance of a false negative result.

If the clinician would like specific expert advice, they can contact COVID-19pathology@dhhs.vic.gov.au and provide a contact telephone number for someone to call back to discuss.

Serum and other specimens

See section on serology testing (above)

The department is continuously reviewing whether there is a requirement for other specimens such as stool or urine to be sent to VIDRL. At the current time this is not routinely recommended in cases of respiratory illness.

Specimen collection and transport

- Specimens should preferably be collected by a health professional.
- A self-collected swab, partial swab, or saliva specimen should be clearly labelled and indicated on the Pathology Referral Form.

Preparation for specimen collection

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

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

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

Specimen collection process

Upper respiratory tract

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

- Perform hand hygiene before donning gown, gloves, eye protection and single-use surgical mask. See How to put on and take off your PPE poster on the department's website <https://www.dhhs.vic.gov.au/how-put-and-take-your-ppe>.
- Stand slightly to one side of the patient to reduce exposure to respiratory secretions should the patient cough or sneeze.
- Swab the oropharynx (throat) first: swab tonsillar beds and the back of the throat, avoiding the tongue (see figure 1).
- Using the **same** swab, sample the deep nasal area (see figure 2):
  - using a pencil grip and while gently rotating the swab, insert the tip to a depth according to age (below, or until resistance is met), into the nostril, parallel to the palate, to absorb mucoid secretion.
    - 1.5 cm if 2-6 years
    - 2 cm if 6-12 years
    - 2-3 cm if >12 years to adult
  - rotate the swab several times against the nasal wall.
  - withdraw the swab and repeat the process in the other nostril. To conserve swabs the same swab that has been used to sample the oropharynx should be utilised for nasal sampling
- Place the swab(s) back into the accompanying transport medium. Avoid repeated freezing and thawing of specimens.
- At the completion of the specimen collection process, remove all PPE and perform hand hygiene after removing gloves and when all PPE has been removed. See How to take off your PPE poster on the department's website <https://www.dhhs.vic.gov.au/how-put-and-take-your-ppe>.
- Clean room after sample collection -droplet and contact precautions PPE must be worn when cleaning the room. See the COVID-19 infection prevention and control guidelines available on the department's website <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19> for further information. Note that, for droplet and contact precautions, the room does not need to be left empty after sample collection.

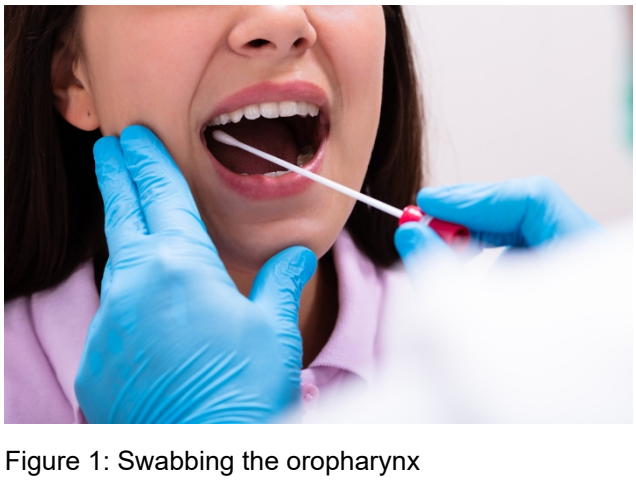


Figure 1: Swabbing the oropharynx

Figure 2: Swabbing the deep nose

Self-collected nasal (both nostrils) and oropharyngeal swab

If there are barriers to a health-professional collected swab, a self-collected swab may be a more acceptable option. Supervision and guidance from a health professional is recommended.

A health professional supervised parent/guardian/trusted carer collected swab may be an option for children and adults who cannot tolerate a health professional collected swab and are unable to perform a self-collected swab themselves.

- The **request form should identify that the specimen has been self-collected**.
- If a person does not choose self-collection or does not feel comfortable about their ability to self-collect, sampling should be performed by a trained HCW using PPE.

Note:

- Self-collected swabs are not appropriate for patients with severe symptoms or in hospital settings (i.e. emergency departments and wards). In these situations, collection of a specimen should be performed by a trained HCW using appropriate PPE.
- Self-collection should only be offered to people over 18 years of age who are considered to have the capability to perform the test correctly and safely.

Guiding documents on the use of self-collected swabs

These can be found at:

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

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

Lower Respiratory tract

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

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

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

Blood

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

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

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

Referral of positive samples

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

Handling of specimens within diagnostic laboratories

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

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

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

Indeterminate test results

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

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

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

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

Summary

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

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

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

Roles and responsibilities

Directions

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

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

The department will assist with:

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

- Making regular contact with close contact(s) of the case (through SMS, email or telephone call) to monitor for symptoms and advise on the need for testing, if relevant.
- Determining when healthcare workers should be tested for return-to-work clearance in consultation with the patient and their treating doctor. Testing should be arranged by the healthcare worker's employer, the healthcare or aged care worker's treating doctor, or at a coronavirus assessment centre if testing by the treating doctor is not feasible. The patient should inform the department of where they intend to be tested.
- Follow-up of clearance testing results and determining when the return-to-work criteria have been met
- Provision of a letter (via email) to cases once they are judged to meet the return-to-work criteria that the healthcare worker can provide to their employer.
- Monitoring outbreaks.

Role of healthcare service

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

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

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

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

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

Role of Safer Care Victoria

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

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

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

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

Healthcare service staff responsible for managing a case or an outbreak

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

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

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

Responsibilities of the healthcare service as an employer

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

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

- ensure employees understand when to stay away from the workplace and advise them of the requirement to self-quarantine for 14 days following return from overseas travel or contact with a confirmed case of COVID-19 without adequate infection control precautions.

When should a healthcare worker be tested?

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

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

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

Immediate management of a suspected or confirmed case

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

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

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

Rapid workplace risk assessment and contact tracing

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

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

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

Immediate actions

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

Ongoing actions

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

Case interview and contact tracing

Infectious period and close contacts

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

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

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

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

- If it is difficult to ascertain the level of contact that staff have had with a confirmed case, a risk assessment should be performed, and the names of these staff recorded by the health service. Decisions on close contact status may need to be considered on a case-by-case basis.
- Consideration should be given as to whether a potential close contact is immunocompromised and may be more likely to become infected with shorter periods of exposure.

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

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

PPE risk matrix

Where the contact and/or case are using PPE, a risk assessment should be performed to determine whether the contact should be designated as a close contact. Factors that may be considered include

- Case details: presence of symptoms and timing of exposure in relation to symptom onset
- Contact details: physical distancing, length of exposure time either directly to the case or within a shared environmental space
- PPE: use of PPE by the case, appropriate PPE use and any reports or suspicion of PPE breaches
- Environment: if aerosol generating procedures were performed, use of shared equipment and use of communal spaces (e.g. tea rooms or work stations)
- Staff mobility: if staff work across multiple facilities or are highly mobile within the facility (e.g. security guards or cleaning staff)

From the period 48 hours before onset of symptoms until the case is deemed to be no longer infectious Contact PPE:	Aerosol generating procedures	Close contact 15 min or more cumulative at less than 1.5m distance OR Greater than 2 hrs in a closed space	Limited contact Less than 15 mins cumulative at less than 1.5m distance OR Less than 2 hrs in closed space
No PPE	High Risk	High Risk	Individual Risk assessment
Surgical mask only	High Risk	High Risk	Low Risk
Mask and shield only	High Risk	Individual Risk assessment	Low Risk
Appropriate PPE as per latest guidance	Low Risk	Low Risk	Low Risk
High risk		Low risk	
• Quarantine for 14 days as a close contact • Test if symptomatic at any time • Test day 11 (no earlier than D11) • Negative		• Continue to work • HCW to be alert to mild symptoms • Test only if symptomatic or as part of outbreak response	

Source of infection

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

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

Workplace risk assessment

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

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

Control of exposure risks to staff and patients

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

- Ensure staff are adhering to current guidelines relating to the use of PPE in healthcare settings and that appropriate PPE is accessible. https://www.dhhs.vic.gov.au/coronavirus-covid-19-healthcare-workers-ppe-guidance-0
- Arrange for thorough cleaning and disinfection of areas which may pose an infection risk.
- Remove healthcare worker/staff close contacts from the workplace and advise them to quarantine for 14 days from last close contact with the case.
- Testing of close contacts should be undertaken early in quarantine for potential source contacts as well as on day 11, or if the close contact develops symptoms of COVID-19.
- Place any patients identified as close contacts into quarantine (for 14 days from last close contact with the case) and ensure that droplet and contact precautions (or airborne and contact precautions for AGPs) are followed when caring for these patients.

- Ensure staff are provided with information and support during this process. Access to services and additional fact sheets can be found here: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

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

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

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

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

Reinforce standard precautions (hand hygiene, cough etiquette) throughout facility.	
Increase frequency of environmental cleaning (minimum twice daily where there are confirmed cases in patients).	
Monitor/update	
Arrange for daily symptom check and observations for inpatients who are close contacts. Arrange prompt testing for those who develop symptoms of COVID-19 whilst in quarantine as a close contact. Arrange for clearance testing of close contacts at day 11 of their quarantine period. Ensure the IPC lead is informed of all positive results as soon as possible.	
The IPC lead must update the department (via the designated contact) on an agreed basis (daily, every second day, etc.) or when there is a significant issue (e.g. a cluster, a death). Update the case list with both positive and negative test results.	
Notify	
Contact the department on **1300 651 160**, when there is an outbreak or a COVID-related death (24 hours, 7 days a week).	
Email case and contact spreadsheet to publichealth.operations@dhhs.vic.gov.au	
Keep patients, staff and families informed.	
Restrict	
Restrict movement of staff between areas of facility.	
Avoid patient transfers if possible.	
Restrict visitors where practical and in compliance with most recent direction on hospital visitors (if applicable).	
Consider cohorting of staff (during shift work).	
Do not allow HCWs to return to work until they have met the DHHS HCW clearance criteria.	
Declare and review	
Declare the outbreak over when there have been no new cases for a defined period of time (in consultation with the department).	
Review and evaluate case and outbreak management – amend outbreak management plan if needed.	

Governance

International response

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

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

Public Health Incident Management Team

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

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

Communications and media

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

Role of Ambulance Victoria

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

Prevention

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

Risk management at ports of entry

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

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

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

The disease

Infectious agent

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

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

Reservoir

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

Mode of transmission

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

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

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

Incubation period

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

Infectious period

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

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

Clinical presentation

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

The elderly population may present with atypical symptoms of COVID-19 including functional decline, delirium, exacerbation of underlying chronic conditions, falls, loss of appetite, malaise, nausea, diarrhoea and myalgia..

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

For confirmed cases reported globally, the case fatality rate is approximately 3.5%; however, this is likely an overestimate for the Australian health setting. The true case fatality rate for COVID-19 is difficult to estimate due to variable case ascertainment, especially in regards to mild cases, and the impact of health systems on patient outcomes. Mortality of cases is, to a significant extent, determined by individual risk factors and healthcare quality and access. Based on surveillance data notified as of 19 August 2020, the crude Victorian case fatality rate is 2.0% (351 deaths/17,238 confirmed cases).

Information resources

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

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

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

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

Coronavirus disease 2019 (COVID-19)

Case and contact management guidelines for health services and general practitioners

20 March 2020

Version 15

VICTORIA State Government | Health and Human Services

Contents

Background

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

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

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

Public health response objectives

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

The overall objectives of the public health response are to:

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

Checklist for general practitioners

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

1. Place a single-use surgical mask on the patient.
2. Isolate the patient in a single room with the door closed.
3. Any person entering the room should don droplet and contact precautions personal protective equipment (single-use surgical mask, eye protection, gown and gloves).
4. Conduct a medical assessment, and focus on:
   (a) The date of onset of illness and especially whether there are symptoms or signs of pneumonia.
   (b) Precise travel history.
   (c) History of contact with sick travellers or people or overseas health care facilities.

   The department no longer needs to be notified about any suspected cases (only confirmed cases).
5. Determine:
   (a) Does the patient need testing for COVID-19?
   (b) Does the patient require further assessment in an emergency department? Where there is suspicion of pneumonia, a suspected case of COVID-19 should be managed in hospital.
   (c) If further assessment is required, how will the patient be transferred?
6. If a suspected case of COVID-19 is unwell enough to require ambulance transfer to hospital, call Triple Zero (000) in the normal manner but advise that the patient may have suspected COVID-19 infection. Ambulance transfers do not need to be approved by the department. Where there is no clinical need for ambulance transfer, alternative means of transport should be used including private car driven by the case or an existing close contact (not bus, taxi or uber).
7. Remember to provide a surgical face mask for the patient if being transferred to an emergency department by any means.
8. If it is agreed that a patient is tested in the community by a general practitioner, the general practitioner should **undertake testing** as indicated in this guide. Ensure arrangements are in place for contacting the patient with the test result – this is the responsibility of the general practitioner.
9. **Advise a suspected case they must self-isolate at home**, and provide a factsheet for suspected cases from the department's Coronavirus disease (COVID-19) website <https://www.dhhs.vic.gov.au/information-health-services-and-general-practitioners-novel-coronavirus>.
10. Undertake **cleaning and disinfection** of the room as detailed in this guide.
11. When the test result is available:
    a) **If the test is negative** for COVID-19 provide the negative result from the laboratory to the patient and manage any other cause of illness you have assessed as requiring treatment. Consider advising the patient in the normal manner that admission to hospital and further testing may be required if they deteriorate or the illness persists beyond 72 hours and no other cause is found.
    b) **If the test is positive** for COVID-19, call the department on 1300 651 160 to confirm that the department is aware of the result and agree on next steps for management of the patient.

Checklist for health services

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

1. Place a single-use surgical mask on the patient.
2. Isolate the patient in a single room with the door closed.
3. Any person entering the room should don droplet and contact precautions personal protective equipment (single-use surgical mask, eye protection, gown and gloves).
4. Conduct a medical assessment, and focus on:
   (a) The date of onset of illness and especially whether there are symptoms or signs of pneumonia.
   (b) Precise travel history.
   (c) History of contact with sick travellers or people or overseas health care facilities..
5. Consider the case definition. Does the patient fit the suspected case definition?
6. Call the department to notify any suspected case who is a healthcare worker, residential aged care worker or aged care resident urgently on 1300 651 160, 24 hours a day. Notification is not required for other suspected cases.
7. If admission is not required and the patient can return to the community:
   a) The notifying clinician should **advise the patient to self-isolate at home** (if not already) and minimise contact with other people, and provide a factsheet for suspected cases from the department's Coronavirus disease (COVID-19) website <https://www.dhhs.vic.gov.au/information-health-services-and-general-practitioners-novel-coronavirus>
   b) Consider advising the patient in the normal manner that admission to hospital and further testing may be required if they deteriorate or the illness persists beyond 72 hours and no other cause is found.
   c) Ensure arrangements are in place for the patient to be contacted with the test result – this is the responsibility of the testing clinician and health service.
8. If admission is required:
   a) Maintain infection control precautions and actively consider multiple samples including from lower respiratory tract specimens.
9. When the test result is available:
   a) **If the test is positive** for COVID-19, the health service infectious diseases lead, or senior clinician should call the department on 1300 651 160 to agree on an urgent management plan for the confirmed case. If the patient is in the community, admission or management under Hospital in the Home may be required by the department.
   b) **If the test is negative** for COVID-19, provide the negative result from the laboratory to the patient and manage any other cause of illness you have assessed as requiring treatment. Consider advising the patient in the normal manner that admission to hospital and further testing may be required if they deteriorate or the illness persists beyond 72 hours and no other cause is found.

Who should be tested for COVID-19

People without symptoms should not be tested.

Patients who meet at least one clinical AND at least one epidemiological criteria should be tested.

Clinical criteria:

*Fever **

OR

Acute respiratory infection (for example, shortness of breath, cough, sore throat)

Epidemiological criteria:

Travelers from overseas with onset of symptoms within 14 days of return

OR

Close contacts of confirmed COVID-19 cases with onset of symptoms within 14 days of last contact

OR

Healthcare workers and residential aged care workers meeting clinical criteria

OR

Aged and residential care residents meeting clinical criteria

OR

Patients who are Aboriginal or Torres Strait Islander people meeting clinical criteria

The following patients should also be tested:

Patients admitted to hospital with acute respiratory tract infection AND fever*

* ≥38 degrees, without another immediately apparent cause such as urinary tract infection or cellulitis

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

Confirmed case:

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

Definition of close contact

For the purposes of testing, the department advises a precautionary understanding of close contact. In keeping with definitions of close contact developed in other jurisdictions, close contact means greater than 15 minutes face-to-face or the sharing of a closed space for more than two hours with a confirmed case without recommended personal protective equipment (PPE) which is droplet and contact precautions for the definition of contact.

Contact needs to have occurred during the period of 24 hours prior to onset of symptoms in the confirmed case until the confirmed case is no longer considered infectious to be deemed close contact.

Examples of close contact include:

- living in the same household or household-like setting (for example, a boarding school or hostel)
- direct contact with the body fluids or laboratory specimens of a confirmed case without recommended PPE (droplet and contact precautions)
- a person who spent two hours or longer in the same room (such as a GP clinic or ED waiting room, a school classroom; an aged care facility)
- a person in the same hospital room when an aerosol generating procedure (AGP) is undertaken on the case, without recommended PPE for an AGP (airborne and contact precautions)
- Aircraft passengers who were seated in the same row as the case, or in the two rows in front or two rows behind a confirmed COVID-19 case.
- For aircraft crew exposed to a confirmed case, a case-by-case risk assessment should be conducted by the airline to identify which crew member(s) should be managed as close contacts. This will include:
  - Proximity of crew to confirmed case
  - Duration of exposure to confirmed case
  - Size of the compartment in which the crew member and confirmed case interacted
  - Precautions taken, including PPE worn, when in close proximity to the confirmed case
  - If an aircraft crew member is the COVID-19 case, contact tracing efforts should concentrate on passengers seated in the area where the crew member was working during the flight and all of the other members of the crew.
- Close contacts on cruise ships can be difficult to identify, and a case-by-case risk assessment should be conducted to identify which passengers and crew should be managed as close contacts.
- Face-to-face contact for more than 15 minutes with the case in any other setting not listed above.

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

Case management

Assessment and management of patients for COVID-19 testing

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

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

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

- The date of onset of illness and especially whether there are symptoms or signs of pneumonia.
- Precise travel history.
- History of contact with sick travellers or people.

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

Patient transfer and destination health service

The following is advice on where patients should be managed:

- Patients should be assessed and managed by the health service they present to.
- Transport of patients to other facilities should be avoided unless medically necessary.
- Ambulance transfer should be reserved for cases where there is clinical need; alternative means of transport should be used for other cases including a private car driven by the case or an existing close contact (not bus, taxi or uber).
- Suspected or confirmed cases in the community who require assessment or admission at a hospital should be seen and assessed at the nearest emergency department.
- Travellers identified as suspected cases at Melbourne Airport can also be transferred by private car to a screening assessment centre at a Victorian hospital. If ambulance transport is required the patient will likely be transferred to Royal Melbourne Hospital or Royal Children's Hospital for assessment.
- Travellers identified as suspected cases at Avalon Airport and requiring ambulance transport will likely be transferred to Geelong Hospital for assessment.

Exclusion of COVID-19

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

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

For patients who fit the testing criteria and who require admission for pneumonia (for example, fever and shortness of breath), two negative nasopharyngeal swabs (plus a lower respiratory tract specimen such as sputum if possible) are recommended to exclude COVID-19 infection. Further testing can also be considered if a patient deteriorates and clinical suspicion of COVID-19 remains high.

Clinical management of confirmed cases

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

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

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

Criteria for inpatient discharge

The department and treating team may agree to care of the patient at home through Hospital in the Home if all of the following criteria are met:

- An infectious diseases specialist determines the patient is clinically improved and well enough to be managed in the community, and
- The patient has been afebrile for the previous 24 hours, and
- A risk assessment has been conducted by the department to determine whether there is any risk to the household.

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

Release from isolation of a confirmed case

The department will determine when a confirmed case no longer requires to be isolated in hospital or in their own home, in consultation with the treating clinician. This will be actively considered when all of the following criteria are met:

- The patient 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.

Testing is no longer required to meet clearance criteria.

Checklist of key actions for the department for confirmed cases

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

Checklist of key actions for the clinical team for confirmed cases

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

Signage and triage of people presenting to health and other services

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

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

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

See Table 1 below for recommended signage and triage.

Table 1: Recommendations for signage and triage of people presenting to services

Type of service	Exposure (past 14 days)		Recommended approach to infection control
	(A) Posters and triage questions MUST address	(B) Additional questions COULD address	
Health services that manage unwell patients *This includes hospitals, general practices and ambulance services.*	Overseas travel	N/A	Any patient who has travelled overseas in the past 14 days should be isolated immediately, and all appropriate infection control precautions taken (contact and droplet) **prior** to an assessment by a health professional.
All other health services *This includes, but is not limited to, maternal and child health, community health centres, physiotherapy, occupational therapy, dental and Chinese medicine services*	Not recommended	Travel any country	Any client who has travelled to mainland China, Iran, South Korea or Italy in the past 14 days should be isolated at home. Any client who has travelled to any other country in the past 14 days and arrived back in Australia after midnight on Sunday 15th March should be isolated at home. Services working with healthy clients in the community should consider asking about travel to any country in the past 14 days. Appropriate infection control precautions should be taken if travel has occurred.
Any other service *Examples include restaurants, employers outside of health.*	Not recommended	Not recommended	No additional precautions are recommended.

Contact management

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

Close contacts

Self-quarantine

The following groups are now required to self-quarantine:

- People who were in mainland China, Iran, South Korea, or Italy are required to self-quarantine for 14 days since they were last in those countries.
- People who visited any other overseas country and who arrived in Australia after midnight on Sunday 15th March are required to self-quarantine for 14 days after arriving in Australia
- Close contacts of confirmed cases until 14 days after last close contact with the confirmed case.

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

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

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

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

In keeping with being in quarantine, children who attend early education and childcare and students in Victorian primary schools and secondary schools, who have been in mainland China, Iran, South Korea or Italy, or any other overseas country if they arrived after midnight on Sunday 15th March are excluded from attending that educational or care setting until 14 days after they were last in those countries.

Again, in keeping with being in quarantine, children who attend early education and childcare and students in Victorian primary schools and secondary schools are excluded from attending that educational or care setting for 14 days following close contact with a confirmed COVID-19 case.

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

Symptomatic close contacts

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

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

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

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

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

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

Where the illness is diagnosed as acute respiratory illness:

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

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

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

Checklist of key actions for the department for close contacts

For all close contacts the department will:

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

Healthcare workers

HCWs and other contacts who have taken recommended infection control precautions, including the use of recommended PPE, while caring for a confirmed case of COVID-19 are not considered to be close contacts. However, they should be advised to self-monitor and if they develop symptoms consistent with COVID-19 infection they should isolate themselves and notify the department on 1300 651 160 so they can be tested and managed as a suspected case of COVID-19.

Any healthcare worker or residential aged care worker who returned from overseas travel prior to midnight on Sunday 15 March 2020 and travelled to mainland China, South Korea, Iran or Italy must not attend work for a period of fourteen (14) days from the date of their return to Australia.

From midnight 15 March 2020, any healthcare worker or residential aged care worker arriving or returning from any overseas destination must self-quarantine (self-isolate) for a period of fourteen (14) days.

Healthcare workers who have been overseas in the past 14 days and are unwell with a compatible illness should not attend work and should seek appropriate medical care. All unwell healthcare workers should consider being tested for COVID-19.

Table 2A: Actions for travellers and healthcare workers returning from overseas *before midnight Sunday 15th March*

Country risk	Country	General actions	Action for healthcare and residential care workers
Higher risk	Mainland China Iran Italy South Korea	Self-quarantine for 14 days	No work for 14 days
Moderate risk	All other countries	Self-monitor for 14 days Isolate and seek medical attention if unwell	Can return to work if well

Table 2B: Actions for travellers and healthcare workers returning from overseas *after midnight Sunday 15th March*

Country risk	Country	General actions	Action for healthcare and residential care workers
All countries	All countries	Self-quarantine for 14 days	No work for 14 days

Infection prevention and control

Background

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

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

Transmission-based precautions

Caring for suspected and confirmed cases

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

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

- single-use surgical mask
- eye protection (for example, safety glasses/goggles or face shield)
- long-sleeved gown
- gloves (non-sterile).

All PPE should be single-use and disposed of into clinical waste when removed. Posters showing the order of putting on and taking off PPE (donning and doffing) can be found on the department's website <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>.

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

Visiting confirmed cases of COVID-19 is discouraged due to the high likelihood of contamination of the environment of the room of an infectious confirmed case. If a visitor attends a confirmed case in hospital, the visitor must wear PPE as described above and should be carefully donned and doffed by a person experienced in infection prevention and control requirements.

Undertaking diagnostic testing for COVID-19

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

In the community there is no requirement for airborne precautions when taking a nose and throat swab.

If the patient has symptoms of pneumonia, such as shortness of breath or productive sputum there may be a small chance of a higher viral load. As a precaution, airborne and contact precautions are recommended when taking upper respiratory specimens when pneumonia is present.

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

Table 3: When airborne precautions are recommended for specimen collection

Specimen type	**Patients *without* symptoms of pneumonia**	**Patients *with* symptoms of pneumonia** (fever and breathlessness and/or severe cough)
Nasopharyngeal swab	No	Yes
Oropharyngeal swab	No	Yes
Sputum (not induced)	No	Yes
Nasal wash/aspirate	No	Yes
Bronchoalveolar lavage	Yes	Yes
Induced sputum	Yes	Yes

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

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

Undertaking aerosol generating procedures

Aerosol generating procedures (AGPs) should be avoided where possible. Airborne and contact precautions should be used routinely for AGPs as listed below.

Examples of AGPs include:

- bronchoscopy
- tracheal intubation
- non-invasive ventilation (for example, BiPAP or CPAP)
- high flow nasal oxygen therapy
- manual ventilation before intubation
- intubation
- cardiopulmonary resuscitation
- sputum induction
- suctioning.

Nebuliser use should be discouraged and alternative administration devices (for example, spacers) should be used.

Airborne and contact precautions means the use of the following PPE:

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

P2/N95 respirators (mask) should be used only when required. Unless used correctly, that is with fit-checking, a P2/N95 respirator (mask) is unlikely to protect against airborne pathogen spread.

- An air-tight seal may be difficult to achieve for people with facial hair. Fit checking with a range of P2/N95 respirators must occur to assess the most suitable one to achieve a protective seal. If a tight seal cannot be achieved, facial hair should be removed.

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

Patient placement

A standard single room (Class S) with doors closed is sufficient, although cases may be placed into a negative-pressure ventilation room (Class N), where available. AGPs, wherever possible, should be conducted in a negative-pressure ventilation room.

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

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

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

Care of critically ill patients in ICU

- Patients who require admission to ICU with severe COVID-19 infection are likely to have a high viral load, particularly in the lower respiratory tract.
- Contact and airborne precautions (as above) are required for patient care and are adequate for most AGPs. The risk of aerosol transmission is reduced once the patient is intubated with a closed

ventilator circuit. There is a potential, but unknown, risk of transmission from other body fluids such as diarrhoeal stool or vomitus or inadvertent circuit disconnection.

- If a health care professional is required to remain in the patient's room continuously for a long period (for example, more than one hour), because of the need to perform multiple procedures, the use of a powered air purifying respirator (PAPR) may be considered for additional comfort and visibility. Several different types of relatively lightweight, comfortable PAPRs are now available and should be used according to manufacturer's instructions. Only **PPE marked as reusable** should be reused, following reprocessing according to manufacturer's instructions; all other PPE must be disposed of after use.

ICU staff caring for patients with COVID-19 (or any other potentially serious infectious disease) should be trained in the correct use of PPE, including by an infection control professional. This also applies particularly to the use of PAPRs, when used. Particular care should be taken on removal of PAPR, which is associated with a risk of contamination.

Case movement and transfers

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

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

Environmental management

Signage

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

Management of equipment

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

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

Environmental cleaning and disinfection

Required agents for cleaning and disinfection

Cleaning of a patient consultation room or inpatient room should be performed using a neutral detergent. Disinfection should then be undertaken using a chlorine-based disinfectant (for example, sodium hypochlorite) at a minimum strength of 1000ppm, or any hospital-grade, TGA-listed disinfectant with claims against coronaviruses or norovirus, following manufacturer's instructions.

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

Wearing PPE whilst undertaking cleaning and disinfection

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

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

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

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

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

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

Waste management

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

Linen

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

Reprocess linen as per standard precautions.

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

Cleaning and disinfection methods as below:

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

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

All linen, for example bedding or tablecloths, should be washed on the hottest setting items can withstand.

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

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

The same level of infection prevention and control precautions should be used for the management of a deceased person as were used before their death. As such, droplet and contact precautions should be used when handling deceased persons for whom COVID-19 infection is suspected or confirmed.

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

Laboratory testing for COVID-19

Prioritisation of testing

A number of Victorian laboratories are undertaking testing for COVID-19 in Victorian patients. There is significant pressure on supply of swabs and reagent kits for COVID-19 testing. It is **critical** that clinicians use the current testing criteria to guide patient investigation and use only one swab when testing. Please provide clinical details on request slips so high-risk patients and healthcare workers can be prioritised. Specimens taken from health care workers should be marked URGENT- Health Care Worker.

Specimens for testing

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

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

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

Respiratory specimens

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

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

    AND/OR

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

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

    d) A second swab is no longer necessary for influenza testing. Testing for other respiratory viruses (for example, multiplex PCR) can be undertaken on the same specimen.

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

2. Lower Respiratory tract (if possible)
    a) Sputum: Have the patient rinse the mouth with water and then expectorate deep cough sputum directly into a sterile, leak-proof, screw-cap sputum collection cup or sterile dry container. Refrigerate specimen at 2-8°C and send to VIDRL on ice pack.

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

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

Other specimens:

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

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

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

Specimen collection and transport

See also Undertaking diagnostic testing for PPE recommendations.

Specimen collection process

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

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

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

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

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

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

Handling of specimens within diagnostic laboratories

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

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

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

Information on testing for coronavirus at VIDRL

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

Real-time COVID-19 PCR assay

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

The current VIDRL testing algorithm is as follows:

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

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

Governance

International response

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

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

Department Incident Management Team

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

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

Communications and media

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

Role of Ambulance Victoria

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

Prevention

- From 9pm 20 March 2020, any Australian returning from any country outside Australia is required to self-isolate for 14 days
- Follow physical distancing advice
- Follow advice on influenza vaccination before travelling.
- Ensure adherence to good hand and respiratory hygiene practices.
- Adhere to good food safety practices.
- Consider avoiding live animal markets.
- Check for travel advice or restrictions at Smartraveller <https://www.smartraveller.gov.au>.

The department is finalising advice regarding social distancing for publication online.

Risk management at ports of entry

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

As of midnight on Sunday 15th March, all people arriving in Australia from any other overseas country are required to self-quarantine for 14 days. Australian citizens and permanent residents and their immediate family members (spouses, legal guardians or dependents only) are still able to enter Australia, but are required to self-quarantine at home for 14 days . As of 18th March, the Australian Government advises all Australians not to travel overseas to any country at this time.

Direct flights from mainland China are being met at the port of entry so that temperature screening, a check on health status and advice to self-quarantine can be provided. As there are no direct flights from Iran, South Korea or Italy currently arriving in Australia, passengers who have visited or transited through these countries are identified at passport control and diverted through an assessment process. As of midnight on 15th March, arrivals from all other countries are provided with written information and advised to self-quarantine for 14 days.

The disease

Infectious agent

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

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

Reservoir

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

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

Mode of transmission

The mode or modes of transmission of COVID-19 are not yet fully known, although based on the nature of other coronavirus infections, transmission is likely through droplet and contact. There have been cases with a strong history of exposure to the Hua Nan Seafood Wholesale Market in Wuhan City, China where live animals are sold. The WHO has confirmed that available evidence now indicates human to human transmission has occurred. Limited human to human transmission has been observed in healthcare facilities and among family members.

However, the mechanism by which transmission occurred in these cases, whether through respiratory secretions after coughing or sneezing, or direct physical contact with the patient or via fomites after contamination of the environment by the patient, is unknown.

As a result, droplet and contact precautions are recommended.

Incubation period

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

Infectious period

Evidence on the duration of infectivity for COVID-19 infection is evolving. The risk of pre-symptomatic transmission is thought to be low. However, as a precaution an infectious period of 24 hours prior to the onset of symptoms is being used to identify and manage close contacts. Infection control precautions should be applied throughout any admission and until the department has declared the confirmed case to be released from isolation.

Given that little information is currently available on viral shedding and the potential for transmission of COVID-19, testing to detect the virus may be necessary to inform decision-making on infectiousness.

Patient information (for example age, immune status and medication) should also be considered. Criteria for release from isolation are described in this guideline.

Clinical presentation

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

In more severe cases, it appears that infection can cause pneumonia, severe acute respiratory syndrome and kidney failure. In summary there appears to be evidence of mild cases, through to severe acute respiratory infection (SARI) cases.

Initial information suggests illness is more likely in the middle-aged and elderly.

The case fatality rate is unknown but appears to be lower than for SARS and higher than the common cold. The case fatality rate may be higher in elderly, people with immune compromise or who have co-morbidities. Current estimates are that the case fatality rate may be as high as two per cent.

Information resources

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

It is important that health professionals consult this website regularly, as case definitions and content of this guideline are likely to change regularly in the early days of the international response to this outbreak.

Coronavirus disease 2019 (COVID-19)

Case and contact management guidelines for health services and general practitioners

1 April 2020

Version 16

VICTORIA State Government | Health and Human Services

Contents

Background

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

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

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

Public health response objectives

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

The overall objectives of the public health response are to:

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

Checklist for general practitioners

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

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

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

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

Checklist for health services

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

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

a) **if the test is positive** for COVID-19, provide the result to the patient. The health service infectious diseases lead, or senior clinician should call the department on 1300 651 160 to confirm that the department is aware of the result and to provide any additional clinical information.
b) **if the test is negative** for COVID-19, provide the negative result to the patient and manage any other cause of illness you have assessed as requiring treatment.
c) consider advising the patient in the normal manner that admission to hospital and further testing may be required if they deteriorate and no other cause is found.

Who should be tested for COVID-19?

People without symptoms should not be tested.

Patients who meet at least one clinical AND at least one epidemiological criterion should be tested:

Clinical criteria:

Fever (≥38°C) or history of fever (for example night sweats, chills)

OR

Acute respiratory infection (for example, shortness of breath, cough, sore throat).

Epidemiological criteria:

Close contacts of confirmed COVID-19 cases with onset of symptoms within 14 days of last contact

OR

Travelers from overseas with onset of symptoms within 14 days of return

OR

Cruise ship passengers and crew with onset of symptoms within 14 days of return

OR

Paid or unpaid workers in healthcare, residential care, and disability care settings

OR

People who have worked in public facing roles within homelessness support, child protection and the police force within the last 14 days

OR

Immunosuppressed patients admitted to hospital

Note: Immunosuppressed refer to people at any age with significant immunosuppression, defined as:

- *Haematologic neoplasms: leukemias, lymphomas, myelodysplastic syndromes*
- *Post-transplant: solid organ (on immunosuppressive therapy), haematopoietic stem cell transplant (within 24 months or on treatment for GVHD)*
- *Immunocompromised due to primary or acquired immunodeficiency (including HIV infection)*
- *Current chemotherapy or radiotherapy*
- *High-dose corticosteroids (≥20 mg of prednisone per day, or equivalent) for ≥14 days*
- *All biologics and most disease-modifying anti-rheumatic drugs (DMARDs) as defined as follows:*
    - *Azathioprine >3.0 mg/kg/day*
    - *6-Mercaptopurine >1.5 mg/kg/day*
    - *Methotrexate >0.4 mg/kg/week*
    - *Tacrolimus (any dose)*
    - *Cyclosporine (any dose)*
    - *Cyclophosphamide (any dose)*
    - *Mycophenolate (any dose)*
    - *Combination (multiple) DMARDs irrespective of dose*

OR

Patients who are Aboriginal or Torres Strait Islander people

OR

Patients in other high-risk settings

Note: High risk settings include:

- *Aged care, disability and other residential care facilities*
- *Military operational settings*
- *Boarding schools*
- *Correctional facilities*
- *Detention centres*
- *Settings where COVID-19 outbreaks have occurred, in consultation with the department.*

The following patients should also be tested:

- Patients admitted to hospital with acute respiratory tract infection **AND** fever *(≥38°C*) without another immediately apparent cause such as urinary tract infection or cellulitis.

Confirmed case:

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

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

General comments:

- Clinical judgement should be exercised in testing hospitalised patients.
- All patients being tested for COVID-19 should home isolate until test results are available. All patients should attend an emergency department if clinical deterioration occurs.

Definition of close contact

For the purposes of testing, the department advises a precautionary understanding of close contact. In keeping with definitions of close contact developed in other jurisdictions, close contact means greater than 15 minutes face-to-face or the sharing of a closed space for more than two hours with a confirmed case without recommended personal protective equipment (PPE) which is droplet and contact precautions for the definition of contact.

Contact needs to have occurred during the period of 24 hours prior to onset of symptoms in the confirmed case until the confirmed case is no longer considered infectious to be deemed close contact.

Examples of close contact include:

- living in the same household or household-like setting (for example, a boarding school or hostel)
- direct contact with the body fluids or laboratory specimens of a confirmed case without recommended PPE (droplet and contact precautions)
- a person who spent two hours or longer in the same room (such as a GP clinic or ED waiting room, a school classroom; an aged care facility)
- a person in the same hospital room when an aerosol generating procedure (AGP) is undertaken on the case, without recommended PPE for an AGP (airborne and contact precautions)
- Aircraft passengers who were seated in the same row as the case, or in the two rows in front or two rows behind a confirmed COVID-19 case.
- For aircraft crew exposed to a confirmed case, a case-by-case risk assessment should be conducted by the airline to identify which crew member(s) should be managed as close contacts. This will include:
  - Proximity of crew to confirmed case
  - Duration of exposure to confirmed case
  - Size of the compartment in which the crew member and confirmed case interacted
  - Precautions taken, including PPE worn, when in close proximity to the confirmed case
  - If an aircraft crew member is the COVID-19 case, contact tracing efforts should concentrate on passengers seated in the area where the crew member was working during the flight and all of the other members of the crew.
- Close contacts on cruise ships can be difficult to identify, and a case-by-case risk assessment should be conducted to identify which passengers and crew should be managed as close contacts.
- Face-to-face contact for more than 15 minutes with the case in any other setting not listed above.

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

Triaging and managing high risk patients on arrival to hospital

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

- presenting with acute respiratory tract infection
- presenting with fever (≥38 degrees), without another immediately apparent cause (e.g. UTI or cellulitis)
- they have travelled overseas and have onset of symptoms within 14 days of return
- they have been in close contact with a confirmed coronavirus (COVID-19) case with onset of symptoms within 14 days
- they are a confirmed coronavirus (COVID-19) case.

Patient transfer and destination health service

The following is advice on where patients should be managed:

- patients should be assessed and managed by the health service they present to
- transport of patients to other facilities should be avoided unless medically necessary
- ambulance transfer should be reserved for cases where there is clinical need; alternative means of transport should be used for other cases including a private car driven by the case or an existing close contact (not bus, taxi or Uber).
- suspected or confirmed cases in the community who require assessment or admission at a hospital should be seen and assessed at the nearest emergency department
- travellers identified as suspected cases at Melbourne Airport can also be transferred by private car to a coronavirus assessment centre at a Victorian hospital. If ambulance transport is required the patient will likely be transferred to Royal Melbourne Hospital or Royal Children's Hospital for assessment.
- travellers identified as suspected cases at Avalon Airport and requiring ambulance transport will likely be transferred to Geelong Hospital for assessment.

Arrival to hospital and triage

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

Ambulance triage

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

Emergency department admissions

A dedicated floor plan should be established that clearly designates areas assigned for high-risk patients within the emergency department. If able, rostering of staff to these areas to support the separation and resourceful use of PPEs should be considered. For staff working directly in the area of suspected or

confirmed cases of coronavirus (COVID-19), PPE should be worn accordingly. Designated areas for donning and removing PPE should be in place.

Patient transfers

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

Case management

Assessment and management of patients for COVID-19 testing

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

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

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

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

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

Exclusion of COVID-19

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

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

For patients who fit the testing criteria and who require admission for pneumonia (for example, fever and shortness of breath), two negative nasopharyngeal swabs (plus a lower respiratory tract specimen such as sputum if possible) are recommended to exclude COVID-19 infection. Further testing can also be considered if a patient deteriorates and clinical suspicion of COVID-19 remains high.

Clinical management of confirmed cases

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

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

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

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

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

Criteria for inpatient discharge

The department and treating team may agree to care of the patient in the community for example through Hospital in the Home if all of the following criteria are met:

- an infectious diseases specialist determines the patient is clinically improved and well enough to be managed in the community, and
- the patient has been afebrile for the previous 24 hours, and
- a risk assessment has been conducted by the department to determine whether there is any risk to the household.

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

Release from isolation of a confirmed case

The department will determine when a confirmed case no longer requires to be isolated in hospital or in their own home, in consultation with the treating clinician. This will be actively considered when all of the following criteria are met:

- the patient 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.
- testing is no longer required to meet clearance criteria except for health care workers and workers in aged care facilities.

Health care workers and workers in aged care facilities must meet the following criteria for release from isolation

- the person has been afebrile for the previous 48 hours
- resolution of the acute illness for the previous 24 hours
- be at least seven days after the onset of the acute illness
- PCR negative on at least two consecutive respiratory specimens collected 24 hours apart after the acute illness has resolved

Checklist of key actions for the department for confirmed cases

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

- Undertake all public health response activities including risk communication and sharing of relevant resources.

Checklist of key actions for the clinical team for confirmed cases

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

Signage and triage of people presenting to health and other services

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

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

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

See Table 1 below for recommended signage and triage.

Table 1: Recommendations for signage and triage of people presenting to services

Type of service	Exposure (past 14 days)		Recommended approach to infection control
	(A) Posters and triage questions MUST address	**(B) Additional questions COULD address**	
Health services that manage unwell patients *This includes hospitals, general practices and ambulance services.*	Overseas travel	N/A	Any patient who has travelled overseas in the past 14 days should be quarantined immediately, and all appropriate infection control precautions taken (contact and droplet) **prior** to an assessment by a health professional.
All other health services *This includes, but is not limited to, maternal and child health, community health centres, physiotherapy, occupational therapy, dental and Chinese medicine services*	Symptoms of fever or acute respiratory tract infection Overseas travel	Travel any country	Any client who has travelled overseas in the past 14 days should be in home quarantine. Services working with healthy clients in the community should ask clients who have travelled overseas in the past 14 days not to attend non-urgent health appointments until isolation has been completed and they are well. Clients with symptoms of acute respiratory tract infection should not attend until they feel well or for 72 hours after their last fever. For urgent health care in symptomatic patients, appropriate infection control precautions should be implemented.
Any other service *Examples include take-away food outlets, employers outside of health.*	Not recommended	Symptoms of fever or acute respiratory infection OR overseas travel within 14 days	People with symptoms of acute respiratory infections or who have returned from overseas within the last 14 days should not attend public places.

Contact management

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

Close contacts

Self-quarantine

The following groups are now required to self-quarantine:

- close contacts of confirmed cases until 14 days after last close contact with the confirmed case.
- all travellers who arrived in Australia after midnight on Sunday 15 March 2020 but prior to 11:59pm on Saturday 28 March 2020 need to self-quarantine at home until 14 days after arriving in Australia
- As of midnight, 28 March 2020, all travellers arriving into Melbourne from overseas will be quarantined for two weeks in hotel rooms and other accommodation facilities after submitting an Isolation Declaration Card. Interstate travellers can return to their home states after fulfilling the mandatory quarantine requirements.

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

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

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

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

In keeping with being in quarantine, children who attend early education and childcare and students in Victorian primary schools and secondary schools, who have been in any overseas country if they arrived after midnight on Sunday 15th March are excluded from attending that educational or care setting until 14 days after they were last in those countries.

Again, in keeping with being in quarantine, children who attend early education and childcare and students in Victorian primary schools and secondary schools are excluded from attending that educational or care setting for 14 days following close contact with a confirmed COVID-19 case.

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

Symptomatic close contacts

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

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

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

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

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

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

Where the illness is diagnosed as acute respiratory illness:

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

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

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

Checklist of key actions for the department for close contacts

For all close contacts the department will:

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

Healthcare workers

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

From midnight 15 March 2020, any healthcare worker or residential aged care worker arriving or returning from any overseas destination must self-quarantine (self-isolate) for a period of fourteen (14) days.

- Any healthcare workers who is unwell with a compatible illness should not attend work and should seek appropriate medical care. All unwell healthcare workers should consider being tested for COVID-19.

Hospital workers must not enter or remain at a hospital in Victoria from midnight 23 March, if:

- the person has been diagnosed with COVID-19, and has not yet met the criteria for discharge from isolation
- if the person has travelled/arrived in Australia from any country in the past 14 days
- has had known contact with a person who is a confirmed COVID 19 case
- has a temperature higher than 37.5 degrees or symptoms of acute respiratory infection

Table 2: Actions for travellers and healthcare workers returning from overseas

Date of arrival	Country	General actions	Action for healthcare and residential care workers
Before 11:59 pm on Saturday 28 March 2020	All countries	Self-quarantine for 14 days	No work for 14 days
After 11:59pm on Saturday 28 March 2020	All countries	Mandatory quarantine for 14 days (accommodation provided)	No work for 14 days

Infection prevention and control

Background

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

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

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

Healthcare workers

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

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

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

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

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

Looking after yourself when wearing PPE

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

Using mobile phones in healthcare settings

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

- ensure mobile phones are cleaned regularly with disinfectant wipes
- ensure hands are cleaned before and after using mobile phone
- do not answer mobile phones when you are wearing PPE

- consider placing your mobile phone in a clear sealed bag at the commencement of each shift and discarding the bag prior to going home as an additional precaution.

Physical distancing measures in healthcare settings

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

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

Transmission-based precautions

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

Prioritising PPE for health care workers

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

Single-use face masks (surgical masks)

- Prioritise use to frontline staff (ICU, ED, coronavirus (COVID-19) wards, acute respiratory assessment clinics, theatre and birthing suites).
- Surgical mask supplies are to be stored in secure areas or supervised by a staff member and not accessible to patients
- Unless damp or soiled, a surgical mask may be worn for the duration of a clinic or shift of up to four hours.

General PPE

- Substitutions that may be considered include:
  - plastic apron instead of a long-sleeved disposable gown where appropriate
  - full-face shield instead of a surgical mask for situations that are appropriate.
- PPE training should use expired PPE stock only (if available)

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

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

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

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

Lung function testing should only be performed if it is deemed clinically essential by a respiratory physician, and staff performing testing should followed droplet and contact precautions as outlined below. For more information see https://www.thoracic.org.au/documents/item/1864

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

Caring for suspected and confirmed cases

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

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

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

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

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

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

Visiting confirmed cases of COVID-19 is discouraged due to the high likelihood of contamination of the environment of the room of an infectious confirmed case. If a visitor attends a confirmed case in hospital, the visitor must wear PPE as described above and should be carefully donned and doffed by a person experienced in infection prevention and control requirements.

Airborne and contact precautions

Airborne and contact precautions are now recommended in **specific circumstances** when undertaking aerosol generating procedures as outlined below.

Airborne and contact precautions are:

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

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

P2/N95 respirators (mask) should be used only when required. *Unless used correctly*, that is with fit-checking, a P2/N95 respirator (mask) is unlikely to protect against airborne pathogen spread.

An air-tight seal may be difficult to achieve for people with facial hair. Fit checking with a range of P2/N95 respirators must occur to assess the most suitable one to achieve a protective seal. If a tight seal cannot be achieved, facial hair should be removed.

When to discard P2 respirators (N95) masks

P2/N95 masks should be:

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

Undertaking diagnostic testing for COVID-19

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

In the **community**, there is no requirement for airborne precautions when taking a nose and throat swab.

If the patient has symptoms of **pneumonia**, such as shortness of breath or productive sputum there may be a small chance of a higher viral load. As a precaution, airborne and contact precautions are recommended when taking upper respiratory specimens when pneumonia is present.

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

Table 3: When airborne precautions are recommended for specimen collection

Specimen type	Patients *without* symptoms of pneumonia	Patients *with* symptoms of pneumonia (fever and breathlessness and/or severe cough)
Nasopharyngeal swab	No	Yes
Oropharyngeal swab	No	Yes
Sputum (not induced)	No	Yes
Nasal wash/aspirate	No	Yes
Bronchoalveolar lavage	Yes	Yes
Induced sputum	Yes	Yes

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

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

Undertaking aerosol generating procedures

Aerosol generating procedures (AGPs) should be avoided where possible.

Airborne and contact precautions are now recommended when undertaking aerosol generating procedures* in the following **specific circumstances**:

- where a patient is a suspected or confirmed case of COVID-19;
- where it is not possible to determine if a patient is a suspected case of COVID-19, for example, where a person is found unconscious and a history cannot be obtained;

- in a high-risk procedure on a patient (regardless of COVID-19 status) involving:
  - head and neck - including ENT surgery/endoscopy;
  - neurosurgery that involves sinus surgery;
  - dacryocystorhinostomy and other ophthalmological procedures that breach the nasal mucosa;
  - maxillofacial surgery;
  - gastroscopy, or
  - bronchoscopy.

**Examples of AGPs include:*

- *bronchoscopy*
- *tracheal intubation*
- *non-invasive ventilation (for example, BiPAP or CPAP)*
- *high flow nasal oxygen therapy*
- *manual ventilation before intubation*
- *intubation*
- *cardiopulmonary resuscitation*
- *sputum induction*
- *suctioning*
- *nebuliser use (nebulisers should be discouraged and alternative administration devices such as a spacer should be used).*

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

Patient placement

A standard single room (Class S) with doors closed is sufficient, although cases may be placed into a negative-pressure ventilation room (Class N), where available. AGPs, wherever possible, should be conducted in a negative-pressure ventilation room.

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

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

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

Care of critically ill patients in ICU

- Patients who require admission to ICU with severe COVID-19 infection are likely to have a high viral load, particularly in the lower respiratory tract.
- Contact and airborne precautions (as above) are required for patient care and are adequate for most AGPs. The risk of aerosol transmission is reduced once the patient is intubated with a closed ventilator circuit. There is a potential, but unknown, risk of transmission from other body fluids such as diarrhoeal stool or vomitus or inadvertent circuit disconnection.
- If a health care professional is required to remain in the patient's room continuously for a long period (for example, more than one hour), because of the need to perform multiple procedures, the use of a powered air purifying respirator (PAPR) may be considered for additional comfort and visibility. Several different types of relatively lightweight, comfortable PAPRs are now available and should be used according to manufacturer's instructions. Only **PPE marked as reusable** should be reused, following reprocessing according to manufacturer's instructions; all other PPE must be disposed of after use.

ICU staff caring for patients with COVID-19 (or any other potentially serious infectious disease) should be trained in the correct use of PPE, including by an infection control professional. This also applies particularly to the use of PAPRs, when used. Particular care should be taken on removal of PAPR, which is associated with a risk of contamination.

Case movement and transfers

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

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

Environmental management

Signage

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

Management of equipment

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

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

Environmental cleaning and disinfection

Required agents for cleaning and disinfection

Cleaning of a patient consultation room or inpatient room should be performed using a neutral detergent. Disinfection should then be undertaken using a chlorine-based disinfectant (for example, sodium hypochlorite) at a minimum strength of 1000ppm, or any hospital-grade, TGA-listed disinfectant with claims against coronaviruses or norovirus, following manufacturer's instructions.

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

Wearing PPE whilst undertaking cleaning and disinfection

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

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

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

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

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

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

Waste management

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

Linen

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

Reprocess linen as per standard precautions.

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

Cleaning and disinfection methods as below:

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

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

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

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

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

The same level of infection prevention and control precautions should be used for the management of a deceased person as were used before their death. As such, droplet and contact precautions should be used when handling deceased persons for whom COVID-19 infection is suspected or confirmed.

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

The Australian Government advice for funeral directors may be found at

<https://www.health.gov.au/resources/publications/coronavirus-covid-19-advice-for-funeral-directors>

Laboratory testing for COVID-19

Prioritisation of testing

A number of Victorian laboratories are undertaking testing for COVID-19 in Victorian patients. There is significant pressure on supply of swabs and reagent kits for COVID-19 testing. It is **critical** that clinicians use the current testing criteria to guide patient investigation and use **only one swab** when testing. Please provide **clinical details** on request slips so high-risk patients and healthcare workers, aged, residential care workers or disability workers can be prioritised where resources allow. Specimens taken from health care workers should be marked URGENT- Health Care Worker.

Specimens for testing

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

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

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

Respiratory specimens

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

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

    AND/OR

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

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

    d) A second swab is no longer necessary for influenza testing. Testing for other respiratory viruses (for example, multiplex PCR) can be undertaken on the same specimen.

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

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

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

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

Other specimens:

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

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

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

Specimen collection and transport

See also Undertaking diagnostic testing for PPE recommendations.

Specimen collection process

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

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

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

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

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

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

Handling of specimens within diagnostic laboratories

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

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

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

Information on testing for coronavirus at VIDRL

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

Real-time COVID-19 PCR assay

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

The current VIDRL testing algorithm is as follows:

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

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

Indeterminate test results

Indeterminate test results have been reported from a number of Victorian laboratories.

Indeterminate results should be referred to VIDRL for further testing. While awaiting the results of further testing at VIDRL:

- If the person with an indeterminate test result is a hospital inpatient with pneumonia, they should remain in isolation and a second nasopharyngeal swab (plus a lower respiratory tract specimen such as sputum if possible) should be sent for COVID-19 testing
- If the person with an indeterminate test result meets the criteria for a suspected case and does not require hospitalisation, they should be managed like a confirmed case and be advised to isolate until they meet the clearance criteria.

Governance

International response

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

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

Department Incident Management Team

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

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

Communications and media

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

Role of Ambulance Victoria

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

Prevention

- From 9pm 20 March 2020, any Australian returning from any country outside Australia is required to self-isolate for 14 days

- Follow physical distancing advice
- Follow advice on influenza vaccination.
- Ensure adherence to good hand and respiratory hygiene practices.
- Adhere to good food safety practices.
- Consider avoiding live animal markets.
- At the present time, travel both within Australia and overseas is not recommended. Check for overseas travel advice or restrictions at Smartraveller <https://www.smartraveller.gov.au>.
- Advice on physical distancing and other transmission reduction measures is available on the department's website <https://www.dhhs.vic.gov.au/coronavirus-covid-19-transmission-reduction-measures>.

Risk management at ports of entry

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

As of midnight on Sunday 15th March, all people arriving in Australia from any other overseas country are required to self-quarantine for 14 days. Australian citizens and permanent residents and their immediate family members (spouses, legal guardians or dependents only) are still able to enter Australia, but are required to self-quarantine at home for 14 days. As of 18th March, the Australian Government advises all Australians not to travel overseas to any country at this time.

A sample of all passengers from every arriving international aircraft are health screened. DHHS healthcare workers are also conducting health checks on passengers from any international flight if required by the biosecurity officer. Single-use facemasks are provided to arriving passengers who have been identified as unwell. As of midnight on 15th March, arrivals from all other countries are provided with written information and advised to self-quarantine for 14 days.

The disease

Infectious agent

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

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

Reservoir

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

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

Mode of transmission

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

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

Incubation period

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

Infectious period

Evidence on the duration of infectivity for COVID-19 infection is evolving. Epidemiological data suggests that the majority of transmission occurs from symptomatic cases. The risk of pre-symptomatic transmission is thought to be low. However, as a precaution an infectious period of 24 hours prior to the onset of symptoms is being used to identify and manage close contacts. Infection control precautions should be applied throughout any admission and until the department has declared the confirmed case to be released from isolation.

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

Clinical presentation

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

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

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

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

Information resources

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

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

Coronavirus disease 2019 (COVID-19)

Case and contact management guidelines for health services and general practitioners

XX May 2020

Version 22

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VICTORIA State Government | Health and Human Services

Contents

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Background

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

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

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

Public health response objectives

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

The overall objectives of the public health response are to:

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

Checklist for general practitioners

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

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

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

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

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

Checklist for health services

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

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

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b) **if the test is negative** for COVID-19, provide the negative result to the patient and manage any other cause of illness you have assessed as requiring treatment.
c) consider advising the patient in the normal manner that admission to hospital and further testing may be required if they deteriorate and no other cause is found.

Who should be tested for COVID-19?

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

- ~~recovered~~ confirmed cases who have recovered, as part of return-to-work testing for certain occupational groups, including health care workers or aged care workers
- recovered cases returning to high-risk settings such as a healthcare or aged care facility
- as part of an outbreak investigation/response or in returned international travellers (active case finding)
- as part of department-led enhanced surveillance (to investigate how widespread COVID-19 is in certain groups in the community).

Patients who meet the following clinical criteria should be tested:

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

OR

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

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

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

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

-OR

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

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

General comments:

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

Deaths

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

Commented [A6]: There was confusion as to whether 'recovered cases' meant all HCW who had been symptomatic but negative for COVID needed to be re-tested before going back to work

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A person who has detection of SARS-CoV-2 neutralising or IgG antibody[1] **AND** has had a compatible clinical illness **AND** meets one or more of the epidemiological criteria outlined in the suspect case definition (see below).

Suggest (leaving out as epi criteria interstate travel and People who have lived in or travelled through a geographically localised area with elevated risk of community transmission, as defined by public health authorities) or even leave out epi criteria altogether.

Probable case –
A person who has detection of SARS-CoV-2 neutralising or IgG antibody[1] AND meets the clinical criteria as above
AND
Meets one of the epidemiological criteria below.
In the 14 days prior to illness onset:
- close contact of a confirmed or probable case of COVID-19
-- international travel
-Passengers or crew who have travelled on a cruise ship
- Healthcare, aged or residential care workers and staff with direct patient contact
-[1] Antibody detection must be by a validated assay and included in an external quality assurance program. (same footnote for confirmed case seroconversion)
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In a community setting, taking swabs should be done by the medical practitioner certifying death. The testing medical practitioner should ensure that the results are given to the family, funeral director and any relevant first responders – if negative, this will enable less restrictive funeral practices. Positive test results must also be notified to the department on **1300 651 160**, 24 hours a day, to ensure contact tracing occurs

Definition of close contact

For the purposes of testing, the department advises a precautionary understanding of close contact. In keeping with definitions of close contact developed in other jurisdictions, close contact means greater than 15 minutes face-to-face, cumulative over the course of a week, or the sharing of a closed space for more than two hours, with a confirmed case during their infectious period without recommended personal protective equipment (PPE). Recommended PPE includes droplet and contact precautions.

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

Examples of close contact include:

- living in the same household or household-like setting (for example, a boarding school or hostel)
- direct contact with the body fluids or laboratory specimens of a confirmed case without recommended PPE (droplet and contact precautions)
- a person who spent two hours or longer in the same room (such as a GP clinic or ED waiting room, a school classroom; an aged care facility)
- a person in the same hospital room when an aerosol generating procedure (AGP) is undertaken on the case, without recommended PPE for an AGP (airborne and contact precautions)
- Aircraft passengers who were seated in the same row as the case, or in the two rows in front or two rows behind a confirmed COVID-19 case.
- For aircraft crew exposed to a confirmed case, a case-by-case risk assessment should be conducted by the airline to identify which crew member(s) should be managed as close contacts. This will include:
  - Proximity of crew to confirmed case
  - Duration of exposure to confirmed case
  - Size of the compartment in which the crew member and confirmed case interacted
  - Precautions taken, including PPE worn, when in close proximity to the confirmed case
  - If an aircraft crew member is the COVID-19 case, contact tracing efforts should concentrate on passengers seated in the area where the crew member was working during the flight and all of the other members of the crew.
- Close contacts on cruise ships can be difficult to identify, and a case-by-case risk assessment should be conducted to identify which passengers and crew should be managed as close contacts.
- Face-to-face contact for more than 15 minutes with the case in any other setting not listed above.

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

Triaging and managing high risk patients on arrival to hospital

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

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

Patient transfer and destination health service

The following is advice on where patients should be managed:

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

Arrival to hospital and triage

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

Ambulance triage

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

Emergency department admissions

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

Patient transfers

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

Case management

Assessment and management of patients for COVID-19 testing

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

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

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

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

Symptomatic Ppeople who were symptomatic at the time of testing for COVID-19 and are awaiting results of testings for COVID-19 should be isolated until COVID-19 is excluded. If their test is negative, they should continue to self-isolate until the acute symptoms have resolved and it has been 72 hours since the last feverthey feel well.

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

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

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

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

Exclusion of COVID-19

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

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

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Commented [A11]: 72h since last fever felt to be too conservative

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Commented [A12]: Please clarify that this is symptomatic/asymptomatic at the time of testing … as opposed to someone who is symptomatic at time of test and subsequently becomes asymptomatic whilst waiting for test results

Commented [A13]: 'SoNG Working Group members agree that asymptomatic persons who are tested through enhanced testing (i.e. no other epi risk factors), even if they have recently had symptoms, do not need to stay at home or isolate until a test result is returned.'

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

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

Outbreak definition

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

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

Note: Transmission within one household does not constitute an outbreak but will become part of an outbreak response if linked to a high priority setting. Also, in some circumstances, the department may identify other settings that are sensitive and where a single confirmed case will trigger an outbreak response. Relevant parties will be informed if this occurs.

PCR positive tests in asymptomatic or pre-symptomatic persons

The department may undertake eEnhanced testing of asymptomatic people in the community (that is, not in an outbreak setting). This may identify asymptomatic or pre-symptomatic PCR positive cases. The following steps should be taken:

- Isolate the case whilst investigations are underway
- cConfirm the veracity of the test in close liaison with the laboratory – this may involve re-running the test on an alternative platform, retesting, or testing at a reference laboratory.

1. Undertake a
had clinically compatiable symptoms.

- that are clinically compatible with COVID-19. If historical symptoms are identified, then for the purposes of contact tracing, the duration of infectivity is regarded as commencing **48 hours prior to symptom onset**.
- If no historical symptoms are identified, then for the purposes of contact tracing, the case is considered to have been infectious for **48 hours from the initial positive test**.
- Regardless of whether historical symptoms have been identified, follow the case prospectively for 10 days from the initial test, where feasible, after the initial test to determine if symptoms develop. If symptoms develop, the case is considered to have been pre-symptomatic and the case and contacts should be managed according to the time of symptom onset.

This is at the discretion of the treating team and at the present time is supportive care only.

Admission to hospital should occur when medically necessary or when directed by the department in order to reduce the risk of transmission or facilitate testing for clearance, such as if the case resides in a communal environment. Emerging information suggests COVID-19 may be associated with a delayed deterioration in clinical status in some cases.

Interim clinical guidelines for the management of patients with COVID-19 have been released by the following peak professional bodies:

- The Australasian Society for Infectious Diseases (ASID)

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- The Australian and New Zealand Intensive Care Society (ANZICS)

Further advice on clinical management is available from:

- WHO: ~~https://bit.ly/3eKZQs3~~
- National COVID-19 Clinical Evidence Taskforce: (https://covid19evidence.net.au/)
- Cochrane Library: Coronavirus (COVID-19): (https://www.cochranelibrary.com/covid-19)

Persons not requiring hospitalisation who have confirmed COVID-19 can be managed at home. The United States Centers for Disease Control and Prevention (USCDC) has developed principles for such home care management at https://www.cdc.gov/coronavirus/COVID-19/guidance-home-care.html.

Education

Cases should be educated about the nature of the illness, importance of isolation and infection control measures that prevent the transmission of COVID-19. A f~~F~~act sheet for confirmed cases is available on the department's website. Household contacts should be given the, as is a fact sheet for close contacts which should be given to their household contacts, fact sheet

Criteria for inpatient discharge

A confirmed case may be discharged from hospital if the following criteria are met:

- a senior member of the treating team (or appropriate consulting team) has determined the patient is clinically improved and well enough to be managed in the community, and
- appropriate infection control measures can be implemented in the community or household setting to ensure risk to other household members can be managed, and
- the department is notified about the pending discharge

Consideration should be given for the requirement to be PCR negative on at least two consecutive respiratory specimens collected at least 24 hours apart and at least 7 days after symptom onset, prior to patients going into a ~~higher at-~~**risk setting**. This can be discussed with the department on a case-by-case basis if required.

A confirmed case in the home must remain in isolation until criteria for release from isolation are met.

Release from isolation of a confirmed case

The department will determine when a confirmed case no longer requires to be isolated in their own home. Persons who have been released from isolation should still adhere to hygiene and physical distancing measures, as the extent of acquired immunity is unknown. ~~Education on hand hygiene is important for all released cases.~~

Confirmed cases who are symptomatic

Release from isolation will be actively considered when all of the following criteria are met:

- the person has been afebrile for the previous 72 hours, and
- at least **ten days** have elapsed after the onset of the acute illness, and
- there has been a noted improvement in symptoms, and
- a risk assessment has been conducted by the department and deemed no further criteria are needed

In the event that a confirmed case meets the above criteria during an inpatient hospital stay, the patient's treating clinician must consult with the department (and if applicable the department will also consult with the infectious diseases or infection prevention and control team) to determine whether release from isolation is appropriate. For patients with severe disease requiring hospital admission, or who are immunocompromised, consideration will be given to the need for testing prior to release from isolation or a longer period of isolation.

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Commented [A16]: SoNG: for discharge to high risk settings, requires release from isolation:
- be at least 10 days after the onset of the acute illness;
- the person has been afebrile for the previous 48 hours;
- resolution of the acute illness for the previous 24 hours[1];
- PCR negative on at least two consecutive respiratory specimens collected at least 24 hours apart at least 7 days after symptom onset [3,4]

Commented [A17]: Our language for priority settings is 'at-risk' rather than higher risk

Commented [A18]: SoNG: for those who have had more severe illness, If the case, at or prior to discharge, has had two consecutive swabs taken at least 24 hours apart which are negative for SARS-CoV-2 by PCR, then the case can simultaneously be discharged and released from isolation

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Commented [A20]: Is this too conservative even for a confirmed case?? However, fever may well be a sign of more severe disease.

Commented [A21]: SoNG for Confirmed or probable cases who did not require hospitalisation – includes 'there has been resolution of all symptoms of the acute illness for the previous 72 hours[1]'

Commented [A22]: Pending advices from Release from Isolation Working Group CDNA & PHLN -> currently SoNG has further criteria for those who will be regularly attending healthcare (including residential and aged case) settings for any purpose – includes clearance testing as for HCW, should not attend higher risk setting for 14d (hospital and aged care directions)

Commented [A23]:

In people who have met the criteria for a confirmed case of COVID-19, further test results for SARS-CoV-2 must be interpreted in context. ~~, and c~~Clinicians should be cautious in their interpretation of subsequent negative results for confirmed cases. A negative SARS-CoV-2 result does not necessarily mean that a case can be released from isolation, as this decision is also dependent on the criteria above.

Patients who meet clinical criteria for release from isolation but remain persistently positive on PCR testing should be discussed with the department. ~~— a decisions to release such patients from is~~

Routine PCR testing post-release from isolation is not recommended unless the person develops new clinical features consistent with COVID-19.

Commented [A24]: Routine PCR testing post-release from isolation is not recommended unless features of new a compatible illness develop.

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Confirmed cases who are asymptomatic

The case can be released from isolation if at least 10 days have passed since the first positive sample was taken and no symptoms have developed during this period. ~~.~~ If symptoms develop, the case is considered to have been pre-symptomatic and the case ~~and contacts~~ should be managed according to the time of symptom onset, as above. ~~.~~ |

Return-to-work criteria for health care workers and workers in aged care facilities who are confirmed cases

Healthcare workers and workers in aged care facilities (HCWs) must meet the following additional criteria before they can return to work in a healthcare setting or aged care facility:

- PCR negative on at least two consecutive respiratory specimens collected at least 24 hours apart after the acute illness has resolved.

Testing for return-to-work clearance can commence once the acute illness has resolved, provided this is at least **7 days** after the onset of illness. Testing should be arranged by the healthcare worker's employer, the healthcare or aged care worker's treating doctor, or at a coronavirus assessment centre if testing by the treating doctor is not feasible. The patient should inform the department of where they intend to be tested. The department will follow up test results and provide a letter indicating that the patient can return to work once the return-to-work criteria are met.

Commented [A26]: SoNG – at least 10 days after onset of acute illness, afebrile 48h, resolution of acute illness >24h

In the event that a healthcare worker or aged care worker returns a positive PCR result on either of their first two consecutive clearance tests (performed at least 24 hours apart), wait 3 days before performing another "round" of two tests, at least 24 hours apart. If a positive PCR result is returned in this "second round" of testing, a third round of testing should be undertaken after a further 5-7 days. In the event that respiratory specimens remain persistently PCR positive, a decision on suitability to return to work should be deferred until 21 days post symptom onset. At this time, a decision should be made on a case-by-case basis after consultation between the person's treating doctor, the testing laboratory and the department.

The following criteria should be considered in this discussion:

- the person has met the criteria for release from isolation, AND
- the person's symptoms have completely resolved, AND
- at least 21 days have passed since onset of the acute illness, AND
- consideration should be given to mitigating circumstances such as the characteristics of the patients/residents which the person would care for at work (e.g. elderly or immunocompromised patients/residents) and whether the healthcare worker is immunosuppressed. In certain high-risk settings (such as oncology wards), it may be appropriate for the HCW not to return to this setting until

they have returned two negative swabs at least 24 hours apart. The timing of repeat swabs should be discussed with the treating doctor and the department.

The following procedures should be followed when performing return-to-work clearance testing:

- all HCWs should seek medical care from a medical practitioner. They should not be their own testing or treating clinician.
- all HCWs presenting for testing must wear a single use face mask and comply with infection control standards applicable to a confirmed case of COVID-19 until the department determines that release from isolation criteria are met
- specimens should be collected using droplet and contact precautions
- pathology requests must be clearly labelled with the following content under 'clinical information' – **'HCW CLEARANCE TESTING, please notify result to DHHS**' and results should be copied to the department's COVID-19 Response team and the HCW's treating physician

The department will follow up the results of return-to-work testing and will contact healthcare and aged care workers regarding next steps. Once the return-to-work criteria are met, the department will provide healthcare and aged care workers with a letter confirming that they can return to work.

Checklist of key actions for the department for confirmed cases

- Confirm the diagnosis with testing laboratory.
- Contact the treating team/GP to confirm that the confirmed case is isolated and agree the management of the patient.
- Contact the confirmed case +/- parent/guardian (for cases under 18 years) to collect relevant social, clinical and epidemiological information.
- Identify close contacts and recommend immediate quarantining of any close contacts.
- Identify any potential exposure sites and assess whether any further action is required.
- Undertake all public health response activities including risk communication and sharing of relevant resources.

Commented [A27]: For asymptomatic people in community (not outbreak setting), may involve rerunning test on alternative platform. ?retesting. Thorough investigation of past 4-6wk for recent signs/symptoms of clinically compatible illness. Follow case for 10d after initial test to determine if symptoms develop

Commented [A28]: SoNG – identification of potential source contacts of confirmed case index case, i.e.' individuals who had contact with the first reported case during the time in which the case was likely to have acquired infection. For most cases, this will be 5-7 days prior to the first reported case becoming symptomatic (i.e. the median incubation period of the disease) but may be anyone who has had contact between 14 days and 24 hours before the first reported case became symptomatic (i.e. the longest and shortest possible incubation periods). These individuals may be unidentified cases and the transmission source for the first reported case along with other cases. Follow-up should occur for any person who in that period had:
- face-to-face contact with the index case in any setting fo greater than 15 minutes cumulative over the course of a week, or,
- sharing of a closed space with the index case for a prolonged period (e.g. more than 2 hours).'

Screen all potential source contacts for possible symptoms, take temperature and do PCR test where possible.' In settings with potential for rapid transmission – likely contacts will be both close contact and potential source, may not be able to determine which. Determine if source contact infectious (manage as confirmed case with rapid contact tracing). Assess if primary case, secondary case or separate transmission chain.

Checklist of key actions for the clinical team for confirmed cases

- If a patient is in the community at the time of diagnosis and if clinically necessary, the department will organise with the nearest appropriate health service to admit the patient, in order for care to be provided in hospital or via Hospital in the Home.
- For patients who do not require admission to hospital or Hospital in the Home, clinical teams only need to provide patients with the initial feedback of their results, information and counselling and usual advice to seek medical attention if their condition deteriorates. Clinical teams do not need to routinely contact cases unless clinically appropriate.
- Notify the department on 1300 651 160 as soon as possible (within 24 hours) if a patient becomes critically unwell, in the case of intensive care admission, or death.
- Commence list of all HCWs and visitors who enter the case's room. (If the case is at home and being visited by Hospital in the Home only a list of HCWs required.)
- Advise HCWs who provide care for the case (even with appropriate use of PPE) to self-monitor for symptoms of COVID-19 for 14 days after their last contact with the case.

Signage and triage of people presenting to health and other services

Diagnosis and management of COVID-19 must be undertaken by medical practitioners in accordance with the current guidelines from the Victorian Department of Health and Human Services. This will occur primarily in general practice and hospitals.

However, to reduce risks to service providers and detect people with COVID-19 risk factors, rapid pre-assessment is indicated by a broader range of service providers prior to the provision of a service. This pre-assessment may include enquiring about recent travel history and relevant symptoms. Only health-care services who manage unwell patients (such as general practice, hospitals and ambulance services) are expected to assess for symptoms.

For examples of posters that can be used, see the department's website <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>

Contact management

The department will conduct contact tracing for confirmed cases in the community and will seek assistance from a health service in relation to any contact tracing required for health service staff.

Close contacts

Self-quarantine

The following groups are now required to self-quarantine:

- close contacts of confirmed cases until 14 days after last close contact with the confirmed case.
- As of midnight, 28 March 2020, all travellers arriving into Melbourne from overseas will be quarantined for two weeks in hotel rooms and other accommodation facilities after submitting an Isolation Declaration Card. Interstate travellers can return to their home states after fulfilling the mandatory quarantine requirements.

Self-quarantine means remaining at home except in cases of medical emergency. This means a person recommended to self-quarantine:

- must not visit public settings or mass gatherings.
- must not use public transport.
- must not attend settings like health services, residential aged care facilities or educational settings.

This requirement for people who are in quarantine not to attend health services, includes a requirement that they do not attend a family member who is a confirmed case in a Victorian health service.

If a recently recovered COVID-19 case becomes a close contact of a confirmed or probable case, they do not need to self-quarantine again. However, the recovered case should not attend high-risk settings until 14 days after the last unprotected contact with the confirmed case and should vigilantly self-monitor for symptoms clinically consistent with COVID-19. If symptoms reappear, they should immediately self-isolate and be retested ~~for SARS-CoV-2~~.

Health services and GPs are not required to provide a certificate of medical clearance to those who have completed the required 14 days self-quarantine.

Close contacts should not travel within Australia or internationally within the 14 days after last contact with the infectious case.

Asymptomatic close contacts

People without symptoms should *not* be tested except in special circumstances as directed by the department such as:

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- recovered cases wishing to return to work for certain occupational groups, including health care workers or aged care workers
- people returning to high-risk settings such as a healthcare or aged care facility
- as part of outbreak management or in returned international travellers (as part of active case finding)
- to identify a potential source contact of a confirmed case, particularly in higherat- risk settings
- or enhanced surveillance (to investigate how widespread COVID-19 is certain groups in the community).

Testing for COVID-19 in close contacts is not indicated if they remain asymptomatic, unless specifically directed by the department ~~(for example, as part of an outbreak management response)~~.

Identification of potential source ('upstream') contacts

Where a confirmed case has no identified source of infection, potential source contact tracing of the 'first reported case' (or in an outbreak, index case) of the 'first reported case' (or in an outbreak, index case) should be undertaken. The aim is to identify potential unrecognised chains of transmission, and may be particularly useful to identify the source of introduction of disease in a setting where there is potential for rapid transmission (~~e.g. aged care facilities, correctional facilities, and closed community settings~~see section 'Priority groups for testing' ~~section~~). In such settings, potential source contact tracing should be done for the 'first reported case' or index case.

Potential source contacts ~~are~~:

- are people who had close contact with the case during the time the case is likely to have **acquired** the infection~~i~~
- may be both close contacts and potential source contacts
- close contact will have occurred between **24 hours and 14 days** (usually **5-7 days**) before symptom onset in the first reported case
- may be unidentified cases, so should be:~~:~~
  - ~~should be~~ screened for possible symptoms
  - have their ~~measure~~ temperature measured
  - undergo PCR testing for SARA-CoV-2 infections
  - ~~if well,~~ considered for serological testing if well, and a validated serological assay is available~~.~~s
- if they testif ~~PCR~~ positive by PCR or validated serological assay, clinical and public health judgement should be used to determine if they are currently infectious~~sued~~ –
- if deemed to be infectious, should be managed as any other confirmed case, including rapid contact tracing
- should be assessed to whether they are likely to be ~~the~~be:
  - the primary case who infected the first reported case (index case in an outbreak)
  - a secondary case infected by the first reported case
  - a separate transmission chain.

Symptomatic close contacts

~~**People without symptoms should *not* be tested except in special circumstances as directed by the department such as:**~~

For a symptomatic close contact during the 14-day quarantine period, the department will:

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- Advise the close contact to attend a suitable general practice, emergency department or coronavirus assessment centre for evaluation with a single-use face mask on and to identify themselves immediately on arrival.

Where a close contact has an illness during the 14-day period of quarantine after the step above, the treating clinician will:

- use a single room and appropriate PPE as for a suspected case
- test for COVID-19 and manage the person as a suspected case.
- If the test is positive, the person will be managed as a confirmed case. Notify the department.

Where the illness is diagnosed as acute respiratory illness:

- ~~I~~if testing for COVID-19 is negative and the treating clinician has diagnosed an acute respiratory illness or an illness that is highly compatible with COVID-19, the close contact may then require a subsequent test at a short period thereafter.
- if the second PCR test is ~~test still~~also negative, another test may be conducted on day 14 of the quarantine period.
- ~~t~~They will still need to be monitored for 14 days after their last contact with a confirmed or probable COVID-19 case.

Where the illness is diagnosed as likely to be some other form of infection or is not an infection:

- If testing for COVID-19 is negative and the treating clinician has diagnosed some other infection or a non-infectious cause, then the treating team should consider, in conjunction with an infectious disease specialist, whether testing of relevant specimens such as urine and faeces for COVID-19 might be of value or whether evidence is now clear for an alternative cause, including legionellosis.
- The close contact can be advised to continue to self-quarantine until a full 14 days have expired from date of last close contact with confirmed case.

Checklist of key actions for the department for close contacts

For all close contacts the department will:

- Advise self-quarantine including restriction on travel until 14 days from the last contact with confirmed case.
- Counsel close contacts about risk and awareness of potential symptoms.
- Provide a close contact fact sheet
- Make regular contact with the close contact to monitor for any symptoms, either through SMS, email or telephone call.
- If after 14 days of quarantine (from the last contact with a confirmed case), the contact remains asymptomatic, the individual is cleared and may cease quarantine.
- If a school or employer requests confirmation from the department that the quarantine period has been met, the department will provide evidence with the consent of the individual.

Healthcare workers

HCWs and other contacts who have taken recommended infection control precautions, including the use of recommended PPE, while caring for a confirmed case of COVID-19 are not considered to be close contacts. However, they should be advised to self-monitor and if they develop symptoms consistent with COVID-19 infection they should isolate themselves. See also Infection prevention and control.

Any healthcare workers who is unwell with a compatible illness should not attend work and should seek appropriate medical care. All healthcare workers with fever or symptoms of acute respiratory infection should be tested for COVID-19, as per the testing criteria.

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Hospital workers currently must not enter or remain at a hospital in Victoria if:

- the person has been diagnosed with COVID-19, and has not yet met the criteria for discharge from isolation OR
- if the person has travelled/arrived in Australia from any country in the past 14 days OR
- has had known contact with a person who is a confirmed COVID 19 case in the previous 14 days OR
- has a fever or symptoms of acute respiratory infection.

The current Directions and accompanying frequently asked questions can be viewed on the department's website at <https://www.dhhs.vic.gov.au/coronavirus>

Further criteria apply to healthcare workers who become confirmed cases before they can return to work in healthcare settings (see section Return-to-work criteria for health care workers and workers in aged care facilities who are confirmed cases).

Infection prevention and control

Consult the COVID-19 infection prevention and control guidelines available on the department's website <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>

This guidance covers issues including:

- healthcare and non-healthcare sector
- standard, transmission, contact and airborne precautions
- personal protective equipment (PPE)
- environmental and equipment management
- care of the deceased.

Laboratory testing for COVID-19

A number of Victorian laboratories are undertaking testing for COVID-19 in Victorian patients. There is significant pressure on supply of swabs and reagent kits for COVID-19 testing as well as laboratory capacity.

- Use the **current testing criteria** to guide patient investigation
- Use **only one swab** when testing, unless testing for other respiratory viruses is indicated (for example, multiplex PCR) **and** your local testing laboratory is unable to undertake this on the same specimen. Contact your laboratory to clarify if an additional specimen needs to be collected.

Testing advice for clinicians in an outbreak setting

When any symptomatic patient presents for testing, all clinicians must ask if that patient has had previous exposure to a known COVID-19 case within the past 14 days. If the patient confirms there has been an exposure of that kind, and the outbreak definition is met (see Outbreak definition section), the test sample is to be treated as an 'outbreak sample'

Sample labelling – prioritisation

On request slips:

- Provide **clinical details**
- copy results to the patient's treating physician
- include the patient's mobile number so that they can be contacted quickly.

To ensure all outbreak samples and other urgent priority samples are prioritised for testing in laboratories please follow these instructions:

1. The outside of the **sample bag/s** must be clearly labelled with a **red sticker** and marked for URGENT PRIORITY sample
2. The **pathology slip** must be clearly labelled with a **red sticker** and marked as **URGENT PRIORITY** sample with the **PRIORITY GROUP 1, 2 or 3**. For example, Priority 1 - OUTBREAK to clearly identify the reason why the sample is urgent. See below for list of priority groups.
3. The **sample** should be clearly labelled with the patients name and date of birth and marked as **P1, P2 or P3** to indicate the priority groups as below.
4. Samples should then be forwarded on for laboratory testing using normal processes.

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This will ensure that certain samples are prioritised for testing in laboratories and results returned within a 24 to 48-hour turnaround time. Labelling becomes particularly important for laboratories in time of high-volume testing workloads.

Samples from outbreaks will be processed at the **Victorian Infectious Diseases Reference Laboratory (VIDRL)** at the Doherty Institute. Outbreak samples may be sent to your usual pathology provider who will forward it on to VIDRL.

If an outbreak occurs within a **healthcare setting which has capacity for on-site COVID-19 testing**, then the testing can be conducted at these laboratories with appropriate liaison with VIDRL as required.

Priority groups for testing

Current as of 19 May 2020.

The following samples are considered URGENT PRIORITY samples and are listed in priority order:
Priority 1 (P1) OUTBREAK

- including CLOSE CONTACT(s) OF CONFIRMED CASE
- people located in QUARANTINE HOTEL(s)
- SYMPTOMATIC resident or staff member of a known RACF OUTBREAK

Priority 2 (P2)

- SYMPTOMATIC HEALTH CARE WORKERS including AGED CARE WORKERS
- SYMPTOMATIC aged care residents and hospital patients.

Priority 3 (P3) OTHER 'AT-RISK SETTINGS'

- for SYMPTOMATIC people identified to be from other 'at-risk' settings as determined by the referring clinician.

Clinicians may determine other 'AT-RISK' SETTINGS to be:

- Prison/Justice settings (correctional facilities, detention centres)
- Aboriginal rural and remote communities
- Accommodation with shared facilities
- Defence force operational settings
- Boarding schools
- Other group residential settings (eg. disability)
- Schools
- Childcare centres

- Remote industrial sites with accommodation (e.g. mine sites)
- Certain high-risk work sites where workers are unable to undertake physical distancing or where outbreaks have been identified in the past:
  - Meat processing or other manufacturing plants
  - Restaurants/industrial kitchens
  - Workplaces with highly casualised workforces (who may be less likely to report symptoms)
  - Critical infrastructure dependent workplaces – such as electricity worker

Specimens for testing

Guidance from the Public Health laboratory Network on laboratory testing for SARS-CoV-2 can be found at <https://www1.health.gov.au/internet/main/publishing.nsf/content/Publications-13>

For initial diagnostic testing for COVID-19, the department recommends collection of the following samples:

1. upper respiratory tract specimens.
2. lower respiratory tract specimens (if possible).
3. serum, where possible (to be stored for later analysis at VIDRL).

Respiratory specimens

Collection of upper respiratory specimens is recommended for all patients – these would be oropharyngeal **and** deep nasal to optimise the chances of virus detection. In addition, lower respiratory specimens (sputum, if possible) are recommended for patients with a productive cough. For PPE recommendations, see ~~Undertaking diagnostic testing~~ .Coronavirus disease 2019 (COVID-19) infection prevention and control guideline, available on the department's website.

If the patient has severe symptoms suggestive of pneumonia, for example, fever and breathing difficulty, or frequent, severe or productive coughing episodes then **airborne and contact precautions** should be observed. This means that a P2 respirator must be used instead of a single-use surgical mask.

Patients with symptoms suggestive of pneumonia should be managed in hospital, and sample collection conducted in a negative pressure room, if available. If referral to hospital for specimen collection is not possible, specimens should be collected in a single room. The door should be closed during specimen collection and the room left vacant for at least 30 minutes afterwards (cleaning can be performed during this time by a person wearing PPE for airborne and contact precautions).

Serum and other specimens

At the current time there is no serological test for COVID-19 and blood when received at VIDRL will be stored for future testing, when testing is available and if the case is confirmed as COVID-19 infection.

The department is continuously reviewing whether there is a requirement for other specimens such as stool or urine to be sent to VIDRL. At the current time this is not routinely recommended in cases of respiratory illness. A stool specimen may be recommended by the department to provide additional reassurance before a confirmed case is released from isolation.

Specimen collection and transport

Preparation for specimen collection

- Obtain the following equipment:
  - Personal protective equipment (PPE). ~~For See also Undertaking diagnostic testing for~~ PPE recommendations, see Coronavirus disease 2019 (COVID-19) Infection Prevention and Control guideline on the department's website.

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  - A single swab for oropharynx and deep nasal sampling (one swab per patient only – unless your laboratory requires a second swab for other respiratory virus testing).

Sampling **both the oropharynx and deep nose** is recommended to optimise the chances of virus detection; both sites should be sampled with a single swab

- Use a **swab with a synthetic tip** (e.g. Dacron® or Rayon; flocked preferred) and aluminium or plastic shaft. Do not use calcium alginate swabs or swabs with wooden shafts, as they may contain substances that inactivate some viruses and inhibit PCR testing
- Swabs should be placed in **transport medium**, which may be viral transport medium (VTM) or Liquid Amies
- **Label tube** appropriately (patient's ID number, specimen type and swab date). Request slips should include clinical details identifying high-risk patients and healthcare workers.

Specimen collection process

Upper respiratory tract

Collection of upper respiratory specimens (that is, deep nasal and oropharyngeal samples) can be performed using **droplet and contact** precautions.

- Perform hand hygiene before donning gown, gloves, eye protection and single-use surgical mask. See How to put on and take off your PPE poster on the department's website <https://www.dhhs.vic.gov.au/how-put-and-take-your-ppe>.
- Stand slightly to one side of the patient to reduce exposure to respiratory secretions should the patient cough or sneeze.
- Swab the oropharynx (throat) first: swab tonsillar beds and the back of the throat, avoiding the tongue (see figure 1).
- Using the **same** swab, sample the deep nasal area (see figure 2):
  - using a pencil grip and while gently rotating the swab, insert the tip 2–3 cm (or until resistance is met), into the nostril, parallel to the palate, to absorb mucoid secretion.
  - rotate the swab several times against the nasal wall.
  - withdraw the swab and repeat the process in the other nostril. To conserve swabs the same swab that has been used to sample the oropharynx should be utilised for nasal sampling
- Place the swab(s) back into the accompanying transport medium. Avoid repeated freezing and thawing of specimens.
- At the completion of the specimen collection process, remove all PPE and perform hand hygiene after removing gloves and when all PPE has been removed. See How to take off your PPE poster on the department's website <https://www.dhhs.vic.gov.au/how-put-and-take-your-ppe>.
- Clean room after sample collection -droplet and contact precautions PPE must be worn when cleaning the room. See Environmental cleaning and disinfection for further information. Note that, for droplet and contact precautions, the room does not need to be left empty after sample collection.

Commented [A41]: Do we want to include self-collection? SoNG:
1.Self-collected deep nasal and oropharyngeal swab using a single swab
- *Clear instructions should be provided to the patient. A self-collected combined deep nasal, oropharyngeal swab can be used that accesses the throat, and then a deep nasal swab inserted as far as comfortably possible into the depth of the nasal cavity. The process is then repeated in the second nostril. The swab is then placed into viral transport medium (VTM) or Liquid Amies.*

Page Break

- *This broadens the use of swabs available, reduces infection risk to the health care worker providing the collection and also reduces the requirements for Personal Protective Equipment. PHLN has reviewed data that suggests this has been determined to be equivalent to combined nasal/nasopharyngeal and throat swabs in detecting coronavirus.*
- *To maximise control of the collection process, it is recommended that the self-collect process be undertaken with medical oversight.*
- *It is recommended that laboratories validate their ability to obtain equivalent viral loads and monitor positivity rates using these self-collection kits compared to other methods of collection.*
- *A self-collected sample should be clearly identified as such on the report.*

Figure 1: Swabbing the oropharynx

Figure 2: Swabbing the deep nose

Lower Respiratory tract

If possible, obtain lower respiratory tract specimens as they are likely to contain the highest virus loads, based on experience with SARS and MERS coronaviruses

- **Sputum** – have the patient rinse the mouth with water and then expectorate deep cough sputum directly into a sterile, leak-proof, screw-cap sputum collection cup or sterile dry container. Refrigerate specimen at 2-8°C. If sending to Victorian Infectious Diseases Reference Laboratory (VIDRL), send on an ice pack.
- **Bronchoalveolar lavage, tracheal aspirate** – collect 2-3 mL into a sterile, leak-proof, screw-cap sputum collection cup or sterile dry container. Refrigerate specimen at 2-8°C - if sending to VIDRL, use ice pack.

Blood

Blood (serum) for storage for serology at a later date:

- Children and adults: Collect 1 tube (5-10mL) of whole blood in a serum separator tube.
- Infant: A minimum of 1ml of whole blood is needed for testing paediatric patients. If possible, collect 1mL in a serum separator tube.

There are no special requirements for transport of samples. They can be transported as routine diagnostic samples for testing (that is, Biological substance, Category B).

Referral of positive samples

All positive samples are to be labelled as “POSITIVE SAMPLE FOR STORAGE” and couriered to the Victorian Infectious Diseases Reference Laboratory (VIDRL) for ongoing storage and genomics.

Handling of specimens within diagnostic laboratories

All diagnostic laboratories should follow appropriate biosafety practices, and testing on clinical specimens, including for other respiratory viruses, should only be performed by adequately trained scientific staff.

Current advice from the WHO is that respiratory samples for molecular testing should be handled at Biosafety Level 2 (BSL2), with the USCDC recommending that the following procedures involving manipulation of potentially infected specimens are performed at BSL2 within a class II biosafety cabinet:

- aliquoting and/or diluting specimens
- inoculating bacterial or mycological culture media
- performing diagnostic tests that do not involve propagation of viral agents in vitro or in vivo
- nucleic acid extraction procedures involving potentially infected specimens
- preparation and chemical- or heat-fixing of smears for microscopic analysis.

Commented [A42]: There is a larger section on this in SoNG – probably not necessary here? Includes POC testing outside of a PC2

Indeterminate test results

Indeterminate test results have been reported from a number of Victorian laboratories. These are usually samples that have had one gene detected in the assay but not both genes.

Indeterminate results may be referred to VIDRL for further testing, although **these samples should be considered as positive**. Confirmatory testing may not be possible as the sample may already be low titre and degradation due to processing may mean that VIDRL’s PCR may not be sufficiently sensitive to offset loss of titre in the sample.

Cases with indeterminant results should be managed as confirmed cases. If the treating clinician feels that the pre-test probability for COVID-19 is low, another sample may be collected for further testing. If the second sample tests negative, the department will discuss the case with the treating doctor and the testing laboratory to determine whether the case should continue to be managed as a confirmed case.

Healthcare services – management of healthcare workers with suspected or confirmed COVID-19

Summary

This guidance outlines the roles and responsibilities of healthcare services in the event of a suspected or confirmed case or suspected or confirmed outbreak of COVID-19 among staff (and/or patients). It is primarily intended for use by hospitals but could be applied to other healthcare settings where appropriate.

For the purposes of this guide, healthcare workers are defined as people in contact with patients or the patient space. For example, doctors and nurses and cleaners who enter the patient's room or cubicle and frontline administrative staff would be included as healthcare workers. Staff who work in non-clinical areas and who do not enter patient rooms are not included as healthcare workers for this purpose.

An outbreak is defined as two or more epidemiologically linked cases of COVID-19 with symptom onset within 14 days. To be considered linked (and therefore constitute an outbreak), cases must be linked in both time (symptom onset dates within 14 days) and place (a common geographical link, such as staff who work in the same ward, patients who are cared for by the same staff member). However, even a single confirmed case of COVID-19 in a sensitive setting such as a healthcare service requires immediate control measures and the active involvement (resources permitting) of the Department of Health and Human Services (the department).

Roles and responsibilities

Directions

The current State of Emergency in Victoria provides the Chief Health Officer with additional powers to issue directions to help contain the spread of COVID-19 and keep Victorians safe. Hospital Visitor Directions that restrict entry into hospitals to minimise the risk of spreading COVID-19 among hospital patients and staff are currently in place. Please see the department's website for the latest details.

Role of Department of Health and Human Services (the department)

The department will assist with:

- Performing a situation assessment and confirming the presence of an outbreak (if relevant).
- Notifying the employer if a staff member attended work while potentially infectious.
- Providing advice on measures to prevent further transmission in the workplace.
- Providing other specialist public health advice on other topics as needed.
- Conducting interviews with confirmed cases (or their next of kin or healthcare provider where relevant) and contact tracing in parallel with and supported by the healthcare service's investigation.
- Providing the healthcare service with a "Case and contact data spreadsheet template" to assist them in collecting information about patients and staff who have been in close contact with a case.
- Consolidating information collected by the department with that obtained by the healthcare service.
- Information management of test results and clinical information of close contacts and confirmed cases in the Public Health Events Surveillance System (PHESS).
- Making daily contact with cases (through SMS, email or telephone call) until they are judged to meet release from isolation / return-to-work criteria

- Making regular contact with close contact(s) of the case (through SMS, email or telephone call) to monitor for symptoms and advise on the need for testing, if relevant.
- Determining when healthcare workers should be tested for return-to-work clearance in consultation with the patient and their treating doctor. Testing should be arranged by the healthcare worker's employer, the healthcare or aged care worker's treating doctor, or at a coronavirus assessment centre if testing by the treating doctor is not feasible. The patient should inform the department of where they intend to be tested.
- Follow-up of clearance testing results and determining when the return-to-work criteria have been met
- Provision of a letter (via email) to cases once they are judged to meet the return-to-work criteria that the healthcare worker can provide to their employer.
- Monitoring outbreaks.

Role of healthcare service

In the event of a confirmed case *or* confirmed outbreak involving a staff member or patient, the healthcare service is responsible for the following:

- Notifying the department immediately on 1300 651 160 (including after hours).
- Nominating a staff member (usually the infection prevention and control lead) to be the point of contact with the department.
- In the event of a confirmed case or confirmed outbreak in a healthcare service (including among staff members), it is the expectation that the healthcare service will perform a rapid assessment of risk in the workplace and commence contact tracing functions where possible. Healthcare services should also implement immediate infection prevention and control measures (as per the section on Control of exposure risks to staff and patients).
- Assess practices are aligned to policies and procedures in order to identify potential breaches and shortfalls.
- In the event that a healthcare worker has worked while infectious, it is the expectation that healthcare services in which they worked perform thorough contact tracing of all **patients**, **staff and visitors** who have been in close contact with the case during their infectious period. The healthcare service should also inform these people that they have been in close contact with a case and provide them with the necessary advice and information. While the healthcare service will need to identify all close contacts, the department can assist with contacting them.
- Providing the department with the information obtained from their risk assessment and contact tracing.
- Maintaining an up-to-date case and contact list and sending this to the department at agreed times (e.g. every second day, depending on the situation). Use the "Case and contact data spreadsheet template" provided by the department.
- Notifying the department on 1300 651 160 as soon as possible (within 24 hours) if a confirmed case becomes critically unwell, requires intensive care admission or dies, or in the event of additional suspected or confirmed cases.
- The caller should specify that they need to speak to the **Case and Contact Sector Lead**.
- Facilitate testing of their healthcare worker for return-to-work clearance, where possible.
- Provide psychological support to the healthcare worker if required.
- Engage with and share findings of internal review of confirmed cases with Safer Care Victoria

Role of the treating doctor / doctor who has requested COVID-19 testing

- It is the responsibility of the testing doctor (and the testing laboratory) to notify the department of any confirmed case of COVID-19 on **1300 651 160**.

- It is the responsibility of the treating doctor to inform the case of their test result and advise them of the appropriate actions they must take (i.e. isolation, and if appropriate, the need for medical treatment).
- Clearance testing should be arranged by the healthcare worker's employer, the healthcare worker's treating doctor, or at a coronavirus assessment centre if testing by the treating doctor is not feasible.

Role of Safer Care Victoria

Safer Care Victoria is responsible for the oversight of quality and safety in Victorian health services. This includes a role in supporting and assisting health services to review clinical incidents.

In the event of a confirmed case or confirmed outbreak involving a staff member or patient, Safer Care Victoria has a responsibility for:

- providing guidance and support to health services regarding review processes and where required participation in conducting reviews for a confirmed case or outbreak.
- to share findings for the purpose of learning with the health sector and the Department of Health and Human Services.
- to update any relevant Safer Care Victoria guidance based on findings and recommendations of review.

Safer Care Victoria can be contacted by phone on 1300 650 172 or email at info@safercare.vic.gov.au.

Healthcare service staff responsible for managing a case or an outbreak

A single confirmed case (either a staff member or patient) in a sensitive setting such as healthcare requires the active involvement of the department. Where there is an infection prevention and control (IPC) unit or an infectious diseases department, they should be involved as soon as possible. Ideally, a member of staff from the IPC team should be designated the **outbreak lead** as a point of contact between the healthcare service and the department. The outbreak lead should:

- Coordinate contact tracing, particularly in staff and patients of the healthcare service.
- Keep a case list of confirmed cases, suspected cases and deaths, and a close contacts list.
- They should update the department regularly (timeframe to be agreed between the department and the IPC lead) and email the updated case list through where necessary.
- The department must be notified immediately on **1300 651 160** (including after hours) if:
  - an outbreak is suspected
  - a new confirmed case of COVID-19 is identified
  - a death due to confirmed or suspected COVID-19 occurs.

Contact the Case and Contact Sector Lead on **1300 651 160.**

Responsibilities of the healthcare service as an employer

Employers (including healthcare services) have a duty to provide and maintain, so far as is reasonably practicable, a working environment that is safe and without risks to health. This includes a responsibility to:

- identify whether there is a risk to health of employees from exposure to COVID-19 at their workplace
- implement appropriate measures to reduce or eliminate risk (for example, by implementing social distancing initiatives, providing adequate facilities or products to allow employees to maintain good hand hygiene, and providing appropriate personal protective equipment and training on how to use it)
- facilitating testing of employees who meeting current testing criteria for COVID-19

- ensure employees understand when to stay away from the workplace and advise them of the requirement to self-quarantine for 14 days following return from overseas travel or contact with a confirmed case of COVID-19.

When should a healthcare worker be tested?

All healthcare workers who meet the criteria for testing as described on the department's health services and general practitioners COVID-19 webpage (https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19) should be tested.

If testing healthcare workers, doctors are reminded to clearly mark pathology slips with **'Urgent - HCW'** (healthcare worker) to ensure the swabs can be easily identified for priority testing, and to include the healthcare worker's mobile number so they can be promptly contacted.

Healthcare workers should NOT be their own testing or treating doctor.

Immediate management of a suspected or confirmed case

Any symptomatic healthcare worker who meets the testing criteria for COVID-19 should be advised to isolate immediately and testing for COVID-19 should be facilitated. While they are awaiting test results they should remain in isolation until they have been notified of the test result and the appropriate course of action is subsequently determined. The following steps should be taken by the healthcare service:

- Ensure that the staff member is currently self-isolating.
- If the staff member is not currently in self-isolation, they must remove themselves from the workplace immediately with the least possible risk of transmission to others. This may include the following:
  - if possible, they should wear a single-use surgical mask
  - they should avoid public transport and return home immediately without detour
  - if possible, they should take a private car
  - if they are not driving, they should sit in the rear seat
  - they should minimise contact with any other persons and should practise strict physical distancing.
- Ensure that the staff member has had testing arranged.
- Ensure they have the appropriate information. Inform them that they must remain in isolation until they have been notified of the test result and they must **not** attend work during this time.
- Consider whether the member of staff shares a house with other healthcare workers or older or vulnerable people. In these circumstances it may be preferable for the case to isolate in another location to reduce the risk of transmission. They may be eligible for free accommodation provided by the department. Contact **covid19.hcwaccom@dhhs.vic.gov.au**.
- If the healthcare worker was tested for COVID-19 within your institution and returns a positive result, ensure that the doctor requesting the test has notified the department of the confirmed case (notifications should be directed to **1300 651 160**).
- Instruct any healthcare worker diagnosed with COVID-19 to remain in self-isolation until cleared by the department and encourage them to seek urgent medical attention if they become very unwell.

Further information for individuals diagnosed with COVID-19 and close contacts can be found here: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

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Rapid workplace risk assessment and contact tracing

A rapid assessment of the workplace risk should be performed as soon as is practicable following identification of a confirmed case in a staff member. Nominate a dedicated member of staff to manage staff COVID-19 cases and to serve as a point of contact between the department and the healthcare

service. The point of contact in the department will be an appointed member of the **Case and Contact Management Team**.

For a full list of actions and processes which should be undertaken in the event of a confirmed case in a staff member, please see the checklist below.

Immediate actions

- Perform a rapid workplace risk assessment and contact tracing (see below).
- Ensure you provide the department with the completed "Case and contact data spreadsheet template" as soon as possible.
- Notify and quarantine any close contacts from the hospital – including staff, clients, patients and visitors. Provide close contacts with a copy of the "Factsheet – close contact" available under "Factsheets for patients" on the department's website (see: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19). Triage them for symptoms and test for COVID-19 if indicated. For guidance on whether testing is indicated, please refer to the *'Cases and contact management guidelines for health services and general practitioners'* available here: https://www.dhhs.vic.gov.au/coronavirus-disease-2019-covid-19-guideline-health-services-and-general-practitioners

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Ongoing actions

- Maintain an outbreak case list using the "Case and contact data spreadsheet template".
- Provide the department with regular updates; - how frequently this will be required depends on the level of risk and size of the outbreak.
- Consider enhanced surveillance for symptoms of COVID-19 within the workplace and among patients other than the identified contacts.
- Notify the department of any COVID-related deaths as soon as possible, including after hours.
- Ensure that confirmed cases who are healthcare workers do not return to work until the department has determined that they meet the current return-to-work criteria for healthcare workers.
- Ensure that close contacts who are healthcare workers do not return to work until the department has determined that their quarantine period has ended.

Case interview and contact tracing

Infectious period and close contacts

The department will conduct a comprehensive case interview with all confirmed cases to confirm the date and timing of symptom onset as well as their infectious period. This does not preclude the health services from doing their own interview and urgently instituting appropriate isolation of close contacts.

- Cases are considered infectious from 48 hours prior to symptom onset until they meet the criteria for release from isolation or return to work.

The health service should compile a list of people who the case has been in close contact with while infectious using the "Case and contact data spreadsheet template".

- A **close contact** is defined as a person who has spent, cumulatively, at least 15 minutes face-to-face OR at least 2 hours in the same closed space as the confirmed case during their infectious period without wearing appropriate PPE.
- A review of medical records/charts may be helpful to determine what staff/patients are possible contacts.
- Consideration should be given as to whether a potential close contact is immunocompromised and may be more likely to become infected with shorter periods of exposure.

Ensure all sections of the spreadsheet are completed including accurate and up to date contact information for all close contacts.

If you have identified multiple confirmed cases within your institution, ensure each confirmed case has a separate form/tab completed.

Source of infection

Consider whether the staff member's infection may have been acquired within your health service (via another patient or staff member) or via an external exposure event.

- Ask whether the healthcare worker has had contact with anyone with apparent or reported fever or acute respiratory symptoms in the 14 days prior to their symptom onset (i.e. potential source of infection).
- Consider whether the staff member engaged in any recent aerosol generating procedures (AGPs) that may have increased their exposure risk.
- Consider whether the staff member may have had a breach of personal protective equipment (PPE) which may have led to an exposure.
- Document any recent travel (international or domestic) and consider whether the staff member had been in close contact with any confirmed cases prior to diagnosis.
  - Determine whether the staff member was in quarantine at the time of symptom onset.
  - Document date from which staff member has been in isolation/quarantine.
  - Document attendance at any other sensitive settings during the staff member's infectious period (from 48 hours prior to onset of symptoms until appropriately isolated) including: other healthcare services, clinics, education or learning centres, residential and aged care facilities, correctional facilities or attendance at patients' homes for home visits.

Workplace risk assessment

As part of the risk assessment, the following should be taken into consideration:

- Whether the case was infectious while at the workplace.
- Whether cleaning and disinfection of certain areas are required.
- Whether closure of certain areas is required to facilitate cleaning and allow for the investigation to be completed.
- Whether there are ~~high a~~risk/vulnerable patients for which enhanced surveillance for symptoms and possibly enhanced use of PPE could be considered (e.g. immunocompromised patients).

Commented [A43]: Should this be *at-risk* also?

Control of exposure risks to staff and patients

The following actions should be taken immediately to reduce the risk of exposure to staff and patients:

- Ensure staff are adhering to current guidelines relating to the use of PPE in healthcare settings and that appropriate PPE is accessible. https://www.dhhs.vic.gov.au/coronavirus-covid-19-healthcare-workers-ppe-guidance-0
- Arrange for thorough cleaning and disinfection of areas which may pose an infection risk.
- Remove healthcare worker/staff close contacts from the workplace and advise them to quarantine for 14 days from last close contact with the case.
- If any close contact develops symptoms of COVID-19 while in quarantine, they should be tested.
- Place any patients identified as close contacts into quarantine (for 14 days from last close contact with the case) and ensure that droplet and contact precautions (or airborne and contact precautions for AGPs) are followed when caring for these patients.

- Ensure staff are provided with information and support during this process. Access to services and additional fact sheets can be found here: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

Checklist for healthcare service when there is a confirmed case in a staff member

This process should be managed by the IPC lead, who can delegate the following activities to members of the outbreak management team with the support of local staff.

Checklist	■
Detection and confirmation of case(s)	
Support staff with fever or acute respiratory infection to self-isolate. Facilitate testing for symptomatic staff where possible. Confirm diagnosis. Determine the symptom onset date and determine whether the staff member attended work during the infectious period.	
Management of case(s)	
Ensure that the staff member is currently self-isolating and reiterate that they should not return to work until the department has determined that they meet the return-to-work criteria. Ensure the staff member knows where to seek psychological support as well as medical advice if they become more unwell. Facilitate clearance testing for the staff member where possible.	
Contact tracing	
Enter the staff member's details in the "Case and contact data spreadsheet template".	
If you have identified multiple confirmed cases within your institution, ensure each confirmed case has a separate form/tab completed. Ensure accurate contact details for each person you record in the spreadsheet.	
Immediately compile a list of all **staff** (paid and unpaid) who may be contacts of the staff member. Check rosters, sign-in sheets and other records as necessary. Liaise with staff member's manager and medical workforce.	
Immediately compile a list of all **patients** who may be contacts of the staff member. Check ward lists, admissions, discharges and transfers for the relevant ward / department.	
Immediately compile a list of all **visitors** who may have been exposed to the staff member. Check visitor sign-in sheets and other records.	
Review **medical records** to determine if the staff member documented contact with patients.	
From the above lists, identify *potential* **close contacts** from the available evidence (see definition of close contact above).	
Discuss with the staff member (case) to **confirm** the type and duration of contact they had with the above contacts and identify any further people who qualify as **close contacts** of the case.	
Record all information in the case and contact spreadsheet and provide this to a case and contact officer (CCO) at the department.	
Quarantine contacts and isolate cases	
For all close contacts of the confirmed case identified within the healthcare setting (staff members, patients or visitors):	

• Notify them that they have been identified as a contact of a confirmed case and inform them of the next steps required (please note that an employer cannot disclose confidential information about the confirmed case, and should only notify close contacts that they have been identified as a close contact with a confirmed case). • Distribute close contact information as provided by the department, including information on psychological support.	
For staff members and visitors, additionally: • Ensure they are excluded from work and are self-quarantining for 14 days after last contact with the case • Encourage them to seek testing if they develop symptoms and further medical advice if they become more unwell.	
For patients, additionally: • Implement droplet and contact precautions, including if patient is readmitted during quarantine/ isolation period • Advise isolation at home if already discharged • Facilitate testing if they develop symptoms	
Keep a record of each close contact and when they were informed of their potential exposure.	
Implement infection control measures	
Quarantine patients who are close contacts of the case (cohort patients if necessary).	
Consider temporary closures (e.g. rooms, wards) to facilitate investigation of the positive case and allow terminal cleaning. This decision can be made in consultation with the department	
Implement droplet and contact precautions (e.g. masks, gloves, gowns, eye protection) for all patients identified as a case or close contacts of a case.	
Provide PPE outside rooms / wards / facility.	
Display sign outside rooms / wards.	
Reinforce standard precautions (hand hygiene, cough etiquette) throughout facility.	
Increase frequency of environmental cleaning (minimum twice daily where there are confirmed cases in patients).	
Monitor/update	
Arrange for daily symptom check and observations for inpatients who are close contacts. Arrange prompt testing for those who develop symptoms of COVID-19 whilst in quarantine as a close contact. Ensure the IPC lead is informed of all positive results as soon as possible.	
The IPC lead must update the department (via the designated contact) on an agreed basis (daily, every second day, etc.) or when there is a significant issue (e.g. a cluster, a death). Update the case list with both positive and negative test results.	
Notify	
Contact the department on **1300 651 160**, when there is an outbreak or a COVID-related death (24 hours, 7 days a week).	
Email case and contact spreadsheet to publichealth.operations@dhhs.vic.gov.au	
Keep patients, staff and families informed.	

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Restrict	
Restrict movement of staff between areas of facility.	
Avoid patient transfers if possible.	
Restrict visitors where practical and in compliance with most recent direction on hospital visitors (if applicable).	
Consider cohorting of staff (during shift work).	
Do not allow HCWs to return to work until they have met the DHHS HCW clearance criteria.	
Declare and review	
Declare the outbreak over when there have been no new cases for a defined period of time (in consultation with the department).	
Review and evaluate case and outbreak management – amend outbreak management plan if needed.	

Governance

International response

The WHO declared COVID-19 a Public Health Emergency of International Concern (PHEIC) under the *International Health Regulations 2005* and on 30 January 2020. A pandemic has now been declared.

A State of Emergency was declared in Victoria on 16 March 2020.

Public Health Incident Management Team

The Department of Health and Human Services (the department, DHHS) has formed a Public Health Incident Management Team, chaired by a Public Health Commander, to coordinate the public health and sector response. A Class 2 Emergency, or public health emergency, was declared on 1 February 2020.

The Infection Clinical Network of Safer Care Victoria will be a network that is requested to provide comment and advice to the department, alongside national committees including the Communicable Diseases Network Australia (CDNA).

Communications and media

The department will coordinate communications and media in relation to suspected and confirmed cases of COVID-19. In some instances, the department may – in collaboration with a Victorian health service – request a service to provide media responses in relation to one of more cases associated with that service. A health service should contact the department's Media Unit with any queries.

Role of Ambulance Victoria

Where clinically appropriate, Ambulance Victoria can be used to transport any suspected cases of COVID-19 from a port of entry or unwell suspected cases from general practice or other settings to an emergency department. Triple 000 should be called in the normal manner but advise that the patient may have suspected COVID-19 infection.

Prevention

- From midnight, 28 March 2020, all travellers arriving into Melbourne from overseas will be quarantined for two weeks in hotel rooms and other accommodation facilities
- Follow physical distancing advice
- Follow advice on influenza vaccination.
- Ensure adherence to good hand and respiratory hygiene practices.
- Adhere to good food safety practices.
- Consider avoiding live animal markets.
- At the present time, travel within Australia is not recommended, and a ban on overseas travel is currently in place. Check for overseas travel advice or restrictions at Smartraveller <https://www.smartraveller.gov.au>.
- Advice on physical distancing and other transmission reduction measures is available on the department's website <https://www.dhhs.vic.gov.au/coronavirus-covid-19-transmission-reduction-measures>.

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Risk management at ports of entry

Infection with COVID-19 was designated a Listed Human Disease (LHD) under the *Biosecurity Act 2015* on 21 January 2020.

As of 18th March, the Australian Government advises all Australians not to travel overseas to any country at this time.

Currently all passengers from every arriving international aircraft are health screened. The department's healthcare workers are also conducting health checks on passengers from any international flight if required by the biosecurity officer. Single-use facemasks are provided to arriving passengers who have been identified as unwell. As of midnight, 28 March 2020, all travellers arriving into Melbourne from overseas will be quarantined for two weeks in hotel rooms and other accommodation facilities after submitting an Isolation Declaration Card. Interstate travellers can return to their home states after fulfilling the mandatory quarantine requirements.

The disease

Infectious agent

Severe Acute Respiratory Syndrome coronavirus 2 (SARS-CoV-2) has been confirmed as the causative agent. Coronaviruses are a large and diverse family of viruses that include viruses that are known to cause illness of variable severity in humans, including the common cold, severe acute respiratory syndrome (SARS-CoV), and Middle East Respiratory Syndrome (MERS-CoV). They are also found in animals such as camels and bats.

First termed 2019 novel coronavirus (2019-nCoV), the virus was officially named Severe Acute Respiratory Syndrome coronavirus 2 (SARS-CoV-2) 11 February 2020. The disease it causes is now called coronavirus disease 2019 (COVID-19).

Reservoir

The reservoir is essentially unknown, but probably zoonotic, meaning they are likely transmitted between animals and people; however, an animal reservoir has not yet been identified for COVID-19.

Initial cases were business operators at the Hua Nan Seafood Wholesale Market, which sold live animals such as poultry, bats, marmots, and wildlife parts. The source of the outbreak is still under investigation in Wuhan. Preliminary investigations have identified environmental samples positive for COVID-19 in Hua Nan Seafood Wholesale Market in Wuhan City, however some laboratory-confirmed patients did not report visiting this market.

Mode of transmission

The mode or modes of transmission of COVID-19 are not yet fully understood, although based on the nature of other coronavirus infections, transmission is likely through droplet and contact. There were cases with a strong history of exposure to the Hua Nan Seafood Wholesale Market in Wuhan City, China where live animals are sold. However, the mechanism by which transmission occurred in these cases, whether through respiratory secretions after coughing or sneezing, or direct physical contact with the patient or via fomites after contamination of the environment by the patient, is unknown.

Person to person transmission has now occurred worldwide and the WHO declared a pandemic on 11 March 2020. As a result, droplet and contact precautions are recommended.

Incubation period

The incubation period is not yet known. However, the interim view on the incubation period is that it is 4 to 14 days, based on the nature of previous coronavirus infections.

Infectious period

Evidence on the duration of infectivity for COVID-19 infection is evolving. Epidemiological data suggests that the majority of transmission occurs from symptomatic cases, however there is ~~some~~ evidence ~~to support the occurrence~~ of pre-symptomatic and possibly asymptomatic transmission. Viral loads appear to be highest at the time of symptom onset and decreased quickly within ~~g and~~ As a precautionary approach, cases are considered to be infectious from 48 hours prior to onset of symptoms until they meet the criteria for release from isolation.. Infection control precautions should be applied throughout any admission and until the department has declared the confirmed case to be released from isolation.

Given that little information is currently available on viral shedding and the potential for transmission of COVID-19, testing to detect the virus may be necessary to inform decision-making on infectiousness.

Commented [A44]: Check this section for rest of SoNG updated info

Commented [A45]: SoNG v3.0: It is highly likely that the virus has come from an animal source. Genomic analysis suggests that bats appear to be the reservoir of SARS-CoV-2 virus (2), but the intermediate host has not yet been identified (3).

Commented [A46]: Human-to-human transmission of SARS-CoV-2 is via droplets and fomites from an infected person (3).
There is some evidence that COVID-19 infection may lead to intestinal infection and virus can be present in the faeces of infected persons (4). Additionally, airborne transmission of COVID-19 may occur during aerosol-generating procedures. Despite this, current evidence does not support faecal-oral or airborne spread as major drivers in transmission; however, aerosol-generating procedures should be undertaken with appropriate precautions (refer to Aerosol-generating procedures). Estimates for the basic reproductive number (R_0) of SARS-CoV-2 range from 2–4, with R_0 for confined settings, e.g. cruise ships, at the higher end of this range. Estimates of the effective reproductive number (R_{eff}) vary from between settings and at different time points are dependent on a range of factors, including, public health interventions such as isolation, quarantine and physical distancing to limit close contact between people (5, 6)

Commented [A47]: Current estimates suggest a median incubation period of 5 to 6 days, with a range of 1 to 14 days (7). The advice in this guideline uses an upper range of 14 days based upon what is currently known about the incubation period for COVID-19.

Patient information (for example age, immune status and medication) should also be considered. Criteria for release from isolation are described in this guideline.

Clinical presentation

Common signs of infection include respiratory symptoms, fever, cough, shortness of breath and breathing difficulties. Sore throat, coryzal symptoms, headache and fatigue have been reported.

In more severe cases, it appears that infection can cause pneumonia, severe acute respiratory syndrome and multi-organ failure (including renal failure). In summary the clinical spectrum varies from mild cases, through to severe acute respiratory infection (SARI) cases.

Illness is more likely in the middle-aged and elderly.

The case fatality rate is unknown but appears to be lower than for SARS and higher than the common cold. The case fatality rate may be higher in elderly, people with immune compromise or who have co-morbidities. The case fatality rate also appears to be higher in countries where the rate of infection has overwhelmed the ability of the relevant health system to care for unwell patients. Current estimates are that the case fatality rate may be as high as two to four per cent.

Information resources

The department places resources for health professionals on the department's coronavirus (COVID-19) website <https://www.dhhs.vic.gov.au/coronavirus>.

It is important that health professionals consult this website frequently, as case definitions and content of this guideline change regularly during the response to this outbreak.

Keeping informed of emergencies affecting the health sector and critical public health issues impacting your work is made easier if you:

- Subscribe now to information including Chief Health Officer updates and emergency advice from the Department of Health and Human Services.
- Follow the Chief Health Officer on Twitter
- Subscribe to the COVID-19 stakeholder newsletter

Coronavirus disease 2019 (COVID-19)

Case and contact management guidelines for health services and general practitioners

10 July 2020

Version 23

VICTORIA State Government | Health and Human Services

Contents

Background

Coronavirus disease 2019 (COVID-19) was first identified in Wuhan City, Hubei Province, China in December 2019. Updated epidemiological information is available from the World Health Organization (WHO) and other sources. Current information on COVID-19 is summarised in a section at the end of this guideline entitled 'The disease'.

These guidelines and a range of other resources for health services and general practitioners can be found at the department's Coronavirus disease (COVID-19) website <https://www.dhhs.vic.gov.au/novelcoronavirus>.

A hotline is available for the general public who have questions or concerns – 1800 675 398.

Public health response objectives

This situation has evolved rapidly since the start of this year with new clinical and epidemiological information. Following the declaration of a State of Emergency in Victoria on Monday 16 March and subsequent Directions, the Department of Health and Human Services' (the department) public health response has now transitioned from the Initial Containment stage (which encompassed an inclusive approach to identifying cases and a precautionary approach to the management of cases and contacts), to the Targeted Action stage, with implementation of physical distancing measures and shutdowns of non-essential services to slow disease transmission, prioritisation of diagnostic testing to critical risk groups, and adoption of sustainable strategies and models of care.

The overall objectives of the public health response are to:

1. Reduce the morbidity and mortality associated with COVID-19 infection through an organised response that focuses on containment of infection.
2. Rapidly identify, isolate and treat cases, to reduce transmission to contacts, including health care, household and community contacts.
3. Characterise the clinical and epidemiological features of cases in order to adjust required control measures in a proportionate manner.
4. Minimise risk of transmission in healthcare and residential aged care environments, including minimising transmission to healthcare and residential aged care workers.
5. Respond rapidly to contain outbreaks through enhanced outbreak response activities.

Checklist for general practitioners

The following actions should be undertaken when a patient presents to a general practice or community health service who may be a case of COVID-19:

1. Provide a single-use surgical mask for the patient to put on.
2. Isolate the patient in a single room with the door closed.
3. Any person entering the room should don droplet and contact precautions personal protective equipment (single-use surgical mask, eye protection, gown and gloves).
4. Conduct a medical assessment, and focus on:
   a) the date of onset of illness and especially whether there are symptoms or signs of pneumonia
   b) contact with confirmed cases of COVID-19
   c) precise travel history and occupation
   d) history of contact with sick travellers or other people or overseas health care facilities
   e) work or residence in an at-risk setting for transmission
   f) residence in a geographically localised area with elevated risk of community transmission, as defined by the department.
5. Determine:
   (a) Does the patient need testing for COVID-19? Refer to *Who should be tested for COVID-19*
   (b) Does the patient require further assessment in an emergency department? Where there is suspicion of pneumonia or the patient is quite unwell, a suspected case of COVID-19 should be tested and managed in hospital.
   (c) If further assessment is required, how will the patient be transferred?

   The department no longer needs to be notified about suspected cases (only confirmed cases).

   If the patient is **not** tested – advise them to stay at home until their acute symptoms (including fever) have resolved and they feel well.
6. If a suspected case of COVID-19 is unwell enough to require ambulance transfer to hospital, call Triple Zero (000) in the normal manner but advise that the patient may have suspected COVID-19 infection. Ambulance transfers do not need to be approved by the department. Where there is no clinical need for ambulance transfer, alternative means of transport should be used including private car driven by the case or an existing close contact (not bus, taxi or Uber).
7. Remember to provide a surgical face mask for the patient and driver if being transferred to an emergency department by any means.
8. If a patient is tested in the community by a general practitioner, the general practitioner should **undertake testing** as indicated in this guide. Ensure arrangements are in place for contacting the patient with the test result – this is the responsibility of the general practitioner.
9. **Advise a suspected case they must self-isolate at home**, and provide a factsheet for suspected cases from the department's COVID-19 website.
10. Undertake **cleaning and disinfection** of the room as detailed in the COVID-19 infection prevention and control guidelines available on the department's website <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>.
11. When the test result is available:
    a) **If the test is negative** for COVID-19 provide the negative result from the laboratory to the patient and manage any other cause of illness you have assessed as requiring treatment. Symptomatic patients should stay home until their acute symptoms have resolved and they feel

well. Consider advising the patient in the normal manner that admission to hospital and further testing may be required if they deteriorate.

b) **If the test is positive** for COVID-19, call the department on 1300 651 160 to confirm that the department is aware of the result and agree on next steps for management of the patient.

Checklist for health services

The following actions should be undertaken when a patient presents to an emergency department or urgent care centre who may be a suspected case of COVID-19:

1. Staff at triage points should wear personal protective equipment for droplet and contact precautions (single-use surgical mask, eye protection, gown and gloves).
2. Triage high risk patients to a separate isolated waiting area away from low risk patients, staff and general public.
3. Provide a single-use surgical mask for the patient to put on.
4. Isolate the patient in a single room with the door closed.
5. Any person entering the room should don droplet and contact precautions personal protective equipment (single-use surgical mask, eye protection, gown and gloves).
6. Conduct a medical assessment, and focus on:
   (a) the date of onset of illness and especially whether there are symptoms or signs of pneumonia
   (b) contact with confirmed cases of COVID-19
   (c) precise travel history and occupation
   (d) history of contact with sick travellers or other people or overseas health care facilities
   (e) work or residence in an at-risk setting for transmission
   (f) residence in a geographically localised area with elevated risk of community transmission, as defined by the department.
7. Determine whether the patient fits the current criteria for testing. Refer to *Who should be tested for COVID-19*
8. If admission is not required and the patient can return to the community:
   a) for patients that do **not** fit the current criteria for testing for COVID-19 – advise the patient to stay at home until their acute symptoms (including fever) have resolved and they feel well.
   b) for patients that fit the current criteria for testing - the notifying clinician should **advise the patient to self-isolate at home** (if not already) and minimise contact with other people. Provide a factsheet for suspected cases from the department's coronavirus disease (COVID-19) website <https://www.dhhs.vic.gov.au/novel-coronavirus-suspected-case-what-you-need-know>
   c) consider advising the patient in the normal manner that admission to hospital and further testing may be required if they deteriorate
   d) ensure **arrangements are in place for the patient to be contacted with the test result** – this is the responsibility of the testing clinician and health service.
9. If admission is required:
   a) maintain infection control precautions and actively consider taking multiple samples for testing including from lower respiratory tract specimens.
10. When the test result is available:
    a) **if the test is positive** for COVID-19, provide the result to the patient. The health service infectious diseases lead, or senior clinician should call the department on 1300 651 160 to

confirm that the department is aware of the result and to provide any additional clinical information.

b) **if the test is negative** for COVID-19, provide the negative result to the patient and manage any other cause of illness you have assessed as requiring treatment.

c) consider advising the patient in the normal manner that admission to hospital and further testing may be required if they deteriorate and no other cause is found.

Who should be tested for COVID-19?

People without symptoms should *not* be tested except in special circumstances as directed by the department such as:

- as part of an outbreak investigation/response (active case finding)
- as part of department-led enhanced surveillance (to investigate how widespread COVID-19 is in certain groups in the community).
- All close contacts and returned international travelers prior to the end of quarantine as directed by the department.

Patients who meet the following clinical criteria should be tested:

Fever OR chills in the absence of an alternative diagnosis that explains the clinical presentation*

OR

Acute respiratory infection (e.g. cough, sore throat, shortness of breath, runny nose, anosmia or loss of smell or loss of taste)

Additional testing note: testing is also recommended for people with new onset of other clinical symptoms consistent with COVID-19** AND who are close contacts of a confirmed case of COVID-19; who have returned from overseas in the past 14 days; or who are healthcare or aged care workers

*Clinical discretion applies including consideration of the potential for co-infection (e.g. concurrent infection with SARS-CoV-2 and influenza)
**headache, myalgia, stuffy nose, nausea, vomiting, diarrhoea

Confirmed case:

A person who tests positive to a validated SARS-CoV-2 nucleic acid test;

OR

has the virus isolated in cell culture, with PCR confirmation using a validated method;

OR

undergoes a seroconversion to or has a significant rise in SARS-CoV-2 neutralising or IgG antibody level (i.e. four-fold or greater rise in titre).

Probable case:

A person who has detection of SARS-CoV-2 neutralising or IgG antibody **AND** has had a compatible clinical illness **AND** meets on or more of the epidemiological criteria outlined in the additional testing note above.

Only confirmed and probable cases need to be notified to the department. Notify the department of confirmed cases as soon as practicable by calling 1300 651 160, 24 hours a day.

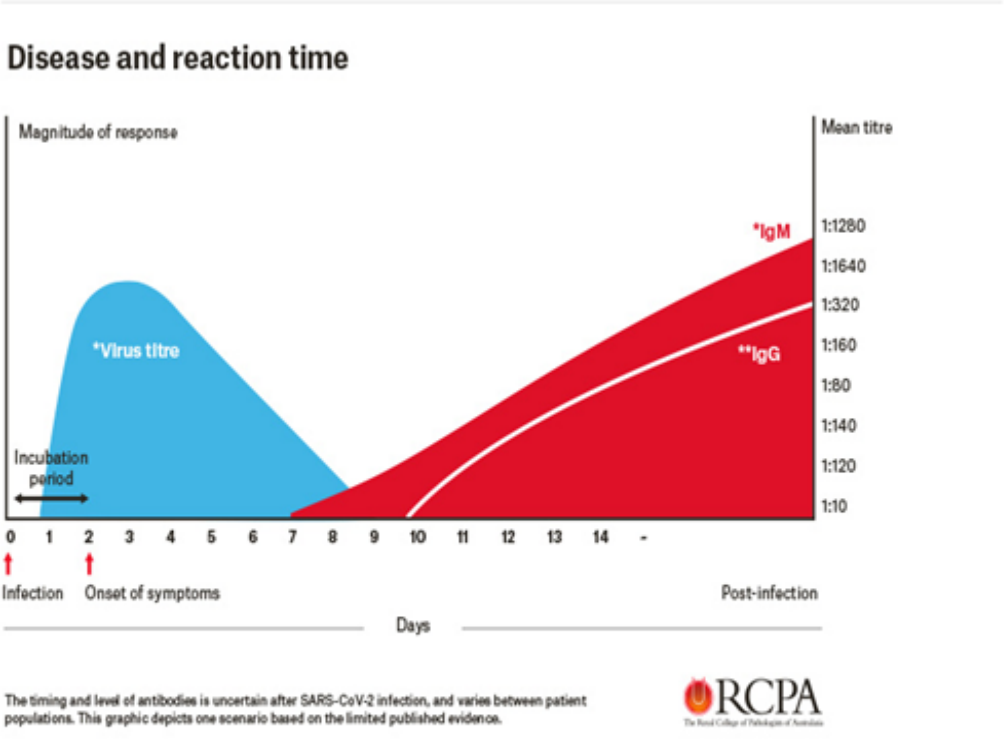
General comments:

- All patients being tested for COVID-19 should home isolate until test results are available. All patients should attend an emergency department if clinical deterioration occurs.

Serological testing

Serology tests detect the presence of antibodies (IgA/IgM/IgG) produced against the SARS-CoV-2 virus, the cause of COVID-19 infection. Once an individual is infected with the SARS-CoV-2 virus, a detectable (IgG) antibody response usually takes between 7 and 21 days to develop (Figure 1). The timing, strength and duration of the response vary between individuals.

Figure 1: The antibody response to a SARS-CoV-2 (COVID-19) infection over time. Reproduced with the permission of the Royal College of Pathologists of Australasia.



Currently, based on the limited sensitivity of the available serology tests in early COVID-19 infection, serology does not have a role in the acute diagnosis of COVID-19 cases. Reverse Transcriptase Polymerase Chain Reaction (RT-PCR) done on respiratory samples is the best approach to diagnosis of acute cases (see below). In addition, the very low prevalence of COVID-19 disease within the community makes an accurate distinction between true positive serology tests and false positive tests very challenging with the serology tests currently available. However, in limited circumstances, serology may have a role to supplement RT-PCR testing in confirmation of recent exposure to COVID-19 infection as per the current case definition.

Further, it is recognised that serology has a potential role in supporting public health measures such as contact tracing, outbreak management and case finding (e.g. identifying the missing link in cluster analysis), and population surveillance testing (e.g. assessing the seroprevalence of COVID-19 infection, and assist in providing an estimate of the extent of undiagnosed COVID-19 infection in the community).

Decisions concerning the collection of samples for serology should be made in response to clinical and public health imperatives, and in consultation with the Department of Health and Human Services. If serological testing is deemed indicated or requested **serum can be collected from people with positive RT-PCR respiratory samples for assessment of COVID-19 serology.** If a sample is collected early in the disease course and returns a negative result, then **a repeat serum sample should be collected 14 or more days after onset of illness and marked as 'convalescent sera' for paired**

analysis. If no acute sample was collected, sera collected 14 or more days after symptom onset may also be tested. For contacts of a confirmed case, paired sera collected 4 weeks apart could be useful. **These samples should be forwarded to the Victorian Infectious Diseases Reference Laboratory (VIDRL) for storage and confirmatory testing. Note that the current Australian case definition requires an antibody rise between paired sera to define a COVID-19 case, and deems demonstration of SARS-CoV-2 antibody in a single sample to be only a probable case.**

Additional studies are needed to determine a correlate of protection (i.e. which antibodies, and what levels of these antibodies correlate with protective immunity).

Deaths

If there is a suspicion that a deceased person may have had undiagnosed COVID-19, including on request of paramedics or other first responders, an oropharyngeal and deep nasal swab for COVID-19 PCR testing should be taken, with the consent of the family.

In a community setting, swabs should be performed by the medical practitioner certifying death. The testing medical practitioner should ensure that the results are given to the family, funeral director and any relevant first responders – if negative, this will enable less restrictive funeral practices. Positive test results must also be notified to the department on **1300 651 160**, 24 hours a day, to ensure contact tracing occurs

Definition of close contact

For the purposes of testing, the department advises a precautionary understanding of close contact. In keeping with definitions of close contact developed in other jurisdictions, close contact means greater than 15 minutes face-to-face, cumulative, or the sharing of a closed space for more than two hours, with a confirmed case during their infectious period without recommended personal protective equipment (PPE). Recommended PPE includes droplet and contact precautions.

Contact needs to have occurred during the period of 48 hours prior to onset of symptoms in the confirmed case until the confirmed case is no longer considered infectious to be deemed close contact.

Examples of close contact include:

- living in the same household or household-like setting (for example, a boarding school or hostel)
- direct contact with the body fluids or laboratory specimens of a confirmed case without recommended PPE (droplet and contact precautions)
- a person who spent two hours or longer in the same room (such as a GP clinic or ED waiting room, a school classroom; an aged care facility)
- a person in the same hospital room when an aerosol generating procedure (AGP) is undertaken on the case, without recommended PPE for an AGP (airborne and contact precautions)
- Aircraft passengers who were seated in the same row as the case, or in the two rows in front or two rows behind a confirmed COVID-19 case.
- For aircraft crew exposed to a confirmed case, a case-by-case risk assessment should be conducted by the airline to identify which crew member(s) should be managed as close contacts. This will include:
  - Proximity of crew to confirmed case
  - Duration of exposure to confirmed case
  - Size of the compartment in which the crew member and confirmed case interacted
  - Precautions taken, including PPE worn, when in close proximity to the confirmed case
  - If an aircraft crew member is the COVID-19 case, contact tracing efforts should concentrate on passengers seated in the area where the crew member was working during the flight and all of the other members of the crew.

- Close contacts on cruise ships can be difficult to identify, and a case-by-case risk assessment should be conducted to identify which passengers and crew should be managed as close contacts.
- Face-to-face contact for more than 15 minutes with the case in any other setting not listed above.

Healthcare workers (HCWs) and other contacts who have taken recommended infection control precautions, including the use of recommended PPE (droplet and contact precautions for the purposes of this contact definition), while caring for a suspected or confirmed case of COVID-19 are **not** considered to be close contacts.

If the case (source) is a healthcare worker and has worn a mask while infectious, a health service may consider additional factors in determining who should be considered a close contacts. For example, if two staff members interact (a case and a contact) and both are wearing a mask, this contact may not necessarily constitute close contact. Additional factors that should be considered in this assessment include the presence of symptoms in the case, the duration of contact and the distance between the case and contact.

Triaging and managing high risk patients on arrival to hospital

A patient is considered high-risk for COVID-19 if:

- presenting with acute respiratory tract infection
- presenting with fever without another immediately apparent cause (e.g. UTI or cellulitis)
- they have travelled overseas and have onset of symptoms within 14 days of return
- they have been in close contact with a confirmed coronavirus (COVID-19) case with onset of symptoms within 14 days
- they are a confirmed coronavirus (COVID-19) case (this includes healthcare workers who are known confirmed cases and are attending for clearance testing to determine when they can return to work).

Patient transfer and destination health service

The following is advice on where patients should be managed:

- patients should be assessed and managed by the health service they present to
- transport of patients to other facilities should be avoided unless medically necessary
- ambulance transfer should be reserved for cases where there is clinical need; alternative means of transport should be used for other cases including a private car driven by the case or an existing close contact (not bus, taxi or Uber).
- suspected or confirmed cases in the community who require assessment or admission at a hospital should be seen and assessed at the nearest emergency department

Arrival to hospital and triage

Upon arrival to the emergency department, patients assessed as high-risk should be triaged to a separate isolated section of the waiting area, away from the general public and provided with a surgical mask. Assessment centres can support the management of high-risk patients if they are in place at the health service. All staff at triage points and assessment centres should be wearing PPE required for suspected or confirmed cases of coronavirus (COVID-19).

Ambulance triage

Patients assessed as high-risk and arriving by ambulance should be triaged to an isolated section of the waiting area away from the general public and be provided with a surgical mask as appropriate. For patients who cannot go to the waiting area (for example, stretcher, ongoing clinical care), they should remain in the ambulance vehicle until their triage and cubicle allocation is completed. Once allocated, the patient should move directly from the ambulance to the cubicle, and not stop in the corridors.

Emergency department admissions

A dedicated floor plan should be established that clearly designates areas assigned for high-risk patients within the emergency department. If able, rostering of staff to these areas to support the separation and resourceful use of PPEs should be considered. For staff working directly in the area of suspected or confirmed cases of coronavirus (COVID-19), PPE should be worn accordingly. Designated areas for donning and removing PPE should be in place.

Patient transfers

Should high-risk patients need to be moved outside of the initial isolation section, they should be transferred using a route that minimises contact with the general hospital population including clinicians (for example, dedicated lift service, external path). Staff involved in patient transfer should wear PPE required for suspected or confirmed cases of coronavirus (COVID-19). Physical distancing rules apply during all stages of the transfer.

Case management

Assessment and management of patients for COVID-19 testing

A checklist above indicates key actions for the assessment of patients for testing.

Victorian health services and general practitioners are only required to notify the department of **confirmed** cases.

The medical assessment of the patient should focus on the following:

- the date of onset of illness and especially whether there are symptoms or signs of pneumonia.
- contact with confirmed cases of COVID-19
- precise travel history and occupation
- history of contact with sick travellers or other people or overseas healthcare facilities
- work or residence in an at-risk setting for transmission.

People who were symptomatic at the time of testing for COVID-19 and are awaiting results of testing should be isolated until COVID-19 is excluded. If their test is negative, they should continue to self-isolate until the acute symptoms have resolved and they feel well.

People who were **asymptomatic** at the time of testing for COVID-19 and are awaiting results of tests are not required to self-isolate **unless** they develop symptoms OR are advised otherwise by the department.

People who are tested for COVID-19 during a period of quarantine and who receive a negative result must continue to quarantine until they have completed the required period of quarantine as directed by the department.

People meeting testing criteria who are not tested for COVID-19 or any other infectious disease should self-isolate until the acute symptoms have resolved and they feel well.

Further information is available for healthcare services managing healthcare workers with suspected or confirmed COVID-19 in the section Healthcare services – management of healthcare workers with suspected or confirmed COVID-19.

Exclusion of COVID-19

For patients with fever or respiratory tract infection who are not hospitalised, a single negative oropharyngeal and deep nasal swab (plus sputum if possible) is sufficient to exclude COVID-19 infection.

Repeat testing (especially of lower respiratory tract specimens) in clinically compatible cases should be performed if initial results are negative and there remains a high index of suspicion of infection. In unwell patients, consideration should also be given to a respiratory virus panel test, especially if the first COVID-19 test is negative.

Clearance testing of all close contacts is recommended at Day 11 of quarantine, as directed by the department.

There is no strong evidence to support a required time interval between exclusion swabs or the need for multiple practitioners performing the swab. Health services should apply discretion and consider the need for this on a case by case basis.

A patient who developed symptoms while in self-quarantine, for example because of recent overseas travel or contact with a confirmed case, who has then tested negative for COVID-19 should continue their quarantine period but be considered for a second test if they deteriorate and require hospitalisation.

Outbreak definition

The department's current definition of an outbreak of COVID-19 for the purposes of outbreak management is:

- A **single** confirmed case of COVID-19 in a resident, staff member or frequent attendee of residential and aged care facilities (RACF), OR
- **Two or more** epidemiologically linked cases outside of a household with symptom onset within 14 days.

Note: Transmission within one household does not constitute an outbreak but will become part of an outbreak response if linked to a high priority setting. Also, in some circumstances, the department may identify other settings that are sensitive and where a single confirmed case will trigger an outbreak response. Relevant parties will be informed if this occurs.

Determining whether a person is a frequent or infrequent visitor may be based on frequency of visits, time spent in the setting, and number of contacts within the setting.

PCR positive tests in asymptomatic or pre-symptomatic persons

The department may undertake enhanced testing of asymptomatic people in the community (that is, not in an outbreak setting). This may identify asymptomatic or pre-symptomatic PCR positive cases. The following steps should be taken:

- Isolate the case while investigations are underway
- Confirm the interpretation of the test in close liaison with the laboratory.
- Undertake a thorough investigation of the past 4-6 weeks to determine if the individual has recently had clinically compatible symptoms.
- If historical symptoms are identified, then for the purposes of contact tracing, the duration of infectivity is regarded as commencing 48 hours prior to symptom onset.
- If no historical symptoms are identified, then for the purposes of contact tracing, the case is considered to have been infectious for 48 hours from the initial positive test.
- Follow the case prospectively for 10 days from the initial test, where feasible, to determine if symptoms develop. If symptoms develop, the case is considered to have been pre-symptomatic and the case and contacts should be managed according to the time of symptom onset.

Note: any test that is reported by a lab as having detected SARS-CoV-2 on PCR will be treated as a positive, regardless of repeat testing of the sample at a separate lab or further swabs. Clinicians are requested NOT to suggest to patients that a test may be a false positive unless this has been directed by the lab. Such information compromises public health action.

Clinical management of confirmed cases

This is at the discretion of the treating team and at the present time is supportive care only.

Admission to hospital should occur when medically necessary or when directed by the department in order to reduce the risk of transmission or facilitate testing for clearance, such as if the case resides in a

communal environment. Emerging information suggests COVID-19 may be associated with a delayed deterioration in clinical status in some cases.

Interim clinical guidelines for the management of patients with COVID-19 have been released by the following peak professional bodies:

- The Australasian Society for Infectious Diseases (ASID)
- The Australian and New Zealand Intensive Care Society (ANZICS)

Further advice on clinical management is available from:

- WHO
- National COVID-19 Clinical Evidence Taskforce: <https://covid19evidence.net.au/>
- Cochrane Library: Coronavirus (COVID-19): <https://www.cochranelibrary.com/covid-19>

Persons not requiring hospitalisation who have confirmed COVID-19 can be managed at home. The United States Centers for Disease Control and Prevention (USCDC) has developed principles for such home care management at https://www.cdc.gov/coronavirus/COVID-19/guidance-home-care.html.

Education

Cases should be educated about the nature of the illness, importance of isolation and infection control measures that prevent the transmission of COVID-19. A fact sheet for confirmed cases is available on the department's website. Household contacts should be given the close contacts fact sheet.

Criteria for inpatient discharge

A confirmed case may be discharged from hospital if the following criteria are met:

- a senior member of the treating team (or appropriate consulting team) has determined the patient is clinically improved and well enough to be managed in the community, and
- appropriate infection control measures can be implemented in the community or household setting to ensure risk to other household members can be managed, and
- the department is notified about the pending discharge

Consideration should be given for the requirement to be PCR negative on at least two consecutive respiratory specimens collected at least 24 hours apart and at least 7 days after symptom onset, prior to patients going into an **at-risk setting**. This can be discussed with the department on a case-by-case basis if required.

A confirmed case in the home must remain in isolation until criteria for release from isolation are met.

Release from isolation of a confirmed case

The following information details the circumstances under which confirmed and probable cases can be released from isolation. Cases can be released from isolation if they meet the appropriate criteria in either point 1, 2, or 3 – whichever is applicable. Significantly immunocompromised cases can be released from isolation if they meet the appropriate criteria in point 1, 2, or 3 and the additional criterion in point 4.

Healthcare workers and workers in aged care facilities who meet the above criteria can be released from isolation and **do not require further testing to return to work or an at-risk setting**.

1. Confirmed cases who are asymptomatic.

The case can be released from isolation if at least 10 days have passed since the first respiratory specimen positive for SARS-CoV-2 by PCR was taken and no symptoms have developed during this period.

2. Confirmed or probable cases with mild illness who did not require hospitalisation.

The case can be released from isolation if they meet all of the following criteria:

- at least 10 days have passed since the onset of symptoms; and
- there has been resolution of all symptoms of the acute illness for the previous 72 hours[1,2,3]

3. Confirmed or probable cases with more severe illness who have been in hospital.

   a. Confirmed and probable cases clinically ready for hospital discharge.

If the case is ready clinically for hospital discharge then they can be discharged to isolation at home or another facility.

The case can be released from home isolation if they meet all of the following criteria:

- at least 10 days have passed since hospital discharge; and
- there has been resolution of all symptoms of the acute illness for the previous 72 hours[1,2,3]

   b. Confirmed and probable cases who will be remaining in hospital.

A case that remains in hospital can be released from isolation if they meet all the following criteria:

- at least 10 days have passed since the onset of symptoms; and
- there has been resolution of all symptoms of the acute illness for the previous 72 hours[1,2,3]; and
- the case has had two consecutive respiratory specimens negative for SARS-CoV-2 by PCR taken at least 24 hours apart at least 7 days from symptom onset.

4. Significantly immunocompromised persons.

In **addition** to meeting the appropriate criteria described in points 1, 2, or 3 above, persons who are significantly immunocompromised and are identified as confirmed or probable cases must meet a higher standard requiring additional assessment. They can be released from isolation when they meet the following additional criterion:

- PCR negative[4] on at least two consecutive respiratory specimens collected at least 24 hours apart at least 7 days after symptom onset [5].

Notes:

[1] Some people may have pre-existing illnesses with chronic respiratory signs or symptoms, such as chronic cough. For these people, the treating medical practitioner should make an assessment as to whether the signs and symptoms of COVID-19 have resolved.

[2] If individuals have a persistent post-viral cough with negative test results, they are eligible for release from isolation. If individuals with a persistent post-viral cough are persistently PCR positive, they can be managed as per note 4 below.

[3] If a case who meets these criteria is additionally swabbed and tests positive, then the case can still be released from isolation based on current evidence from the literature and Australian public health experience that indicates these people are unlikely to be infectious.

[4] In lieu of PCR negative test results, results with high cycle threshold (Ct) values may also be used to inform release from isolation for significantly immunocompromised persons, after discussion between the

treating medical practitioner, the testing laboratory and public health. Viral culture, where available, may also be considered.

[5] If the patient has a productive cough due to a pre-existing respiratory illness or other ongoing lower respiratory tract disease, then the sputum or other lower respiratory tract specimens must be PCR negative for SARS-CoV-2. Otherwise upper respiratory tract specimens (deep nasal and oropharyngeal swabs) must be PCR negative.

Routine PCR testing post-release from isolation is not recommended unless the person re-develops clinical features consistent with COVID-19. If there is recrudescence of symptoms, the person should be tested for SARS-CoV-2 and other relevant medical conditions and managed accordingly.

If a case is identified retrospectively through serology, clinical and public health judgement should be used in determining case management and whether or not a case requires isolation. If the case had a clinically compatible illness some time ago, it may not be necessary to isolate. If isolation is required, the case can be released from isolation when the appropriate criteria (above) is met.

Based on a review of current evidence, persons who fulfil the appropriate criteria above are not considered to be infectious. Cases returning to a high risk setting can be released from isolation based on the clinical criteria above and **do not need to meet** a higher standard or undergo additional assessment before going into any high-risk settings. This includes persons returning to work in a health care setting, living in a residential age care setting, or who regularly attend healthcare settings for any other reason. Note that for patients who are being transferred to another ward or hospital, they should remain in isolation with transmission-based precautions and appropriate PPE until the above criteria (point 3) is met.

People who have recovered from COVID-19 and have been released from isolation based on the criteria above do not require COVID-19 testing if they are hospitalised for a non-COVID-19 related condition.

Persons who have been released from isolation should adhere to hygiene and physical distancing measures, as the extent of acquired immunity is unknown. If a recently recovered COVID-19 case becomes a close contact of a confirmed or probable case, they do not need to self-quarantine again. However, the recovered case should not attend high-risk settings (refer to Outbreak investigation and management in high-risk settings for examples of settings) until 14 days after the last unprotected contact with the confirmed case and should self-monitor for symptoms clinically consistent with COVID-19. If symptoms reappear, they should immediately self-isolate and be retested for SARS-CoV-2. If the recently recovered case is a household contact of a currently isolated case, particular care should be taken with regards to consistent hand hygiene. If the recently recovered case needs medical attention, they should follow the processes outlined in Medical care for quarantined individuals. As further evidence becomes available on the duration of immunity, these recommendations may be amended.

Faecal sampling is not recommended as a standard test, however, it may be done for patients with gastrointestinal symptoms. For cases who do have faecal samples tested, and remain persistently PCR positive in these samples after all the release from isolation criteria (above) are met, further or extended precautions and exclusions should be implemented on a case-by-case basis:

- All cases with diarrhoea should be advised not to prepare food for others until 48 hours after symptoms have resolved.
- Cases who are employed in a role where there is an increased risk of onward transmission (e.g. healthcare workers, restaurant workers and food handlers), should be excluded from work until 48 hours after any symptoms of diarrhoea have resolved.
- Cases with ongoing diarrhoea or faecal incontinence who may have limited capacity to maintain standards of personal hygiene should be isolated until 48 hours after the resolution of these symptoms.

Patients do not require repeat testing until they are PCR negative in faecal samples. It is recommended that people who remain persistently PCR positive in faecal samples use soap and water for hand hygiene. If this is unavailable, alcohol hand gel should be used. Education emphasising the importance of proper hand hygiene should be provided to **all** cases upon release from isolation.

The department will determine when a confirmed case no longer requires to be isolated in their own home. Persons who have been released from isolation should still adhere to hygiene and physical distancing measures, as the extent of acquired immunity is unknown.

Checklist of key actions for the department for confirmed cases

- Confirm the diagnosis with testing laboratory.
- Contact the treating team/GP to confirm that the confirmed case is isolated and agree the management of the patient.
- Contact the confirmed case +/- parent/guardian (for cases under 18 years) to collect relevant social, clinical and epidemiological information.
- Identify close contacts and recommend immediate quarantining of any close contacts.
- Identify any potential exposure sites and assess whether any further action is required.
- Undertake all public health response activities including risk communication and sharing of relevant resources.

Checklist of key actions for the clinical team for confirmed cases

- If a patient is in the community at the time of diagnosis and if clinically necessary, the department will organise with the nearest appropriate health service to admit the patient, in order for care to be provided in hospital or via Hospital in the Home.
- For patients who do not require admission to hospital or Hospital in the Home, clinical teams only need to provide patients with the initial feedback of their results, information and counselling and usual advice to seek medical attention if their condition deteriorates. Clinical teams do not need to routinely contact cases unless clinically appropriate.
- Notify the department on 1300 651 160 as soon as possible (within 24 hours) if a patient becomes critically unwell, in the case of intensive care admission, or death.
- Commence list of all HCWs and visitors who enter the case's room. (If the case is at home and being visited by Hospital in the Home only a list of HCWs required.)
- Advise HCWs who provide care for the case (even with appropriate use of PPE) to self-monitor for symptoms of COVID-19 for 14 days after their last contact with the case.

Signage and triage of people presenting to health and other services

Diagnosis and management of COVID-19 must be undertaken by medical practitioners in accordance with the current guidelines from the Victorian Department of Health and Human Services. This will occur primarily in general practice and hospitals.

However, to reduce risks to service providers and detect people with COVID-19 risk factors, rapid pre-assessment is indicated by a broader range of service providers prior to the provision of a service. This pre-assessment may include enquiring about recent travel history and relevant symptoms. Only health-care services who manage unwell patients (such as general practice, hospitals and ambulance services) are expected to assess for symptoms.

For examples of posters that can be used, see the department's website <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>

Contact management

The department will conduct contact tracing for confirmed cases in the community and will seek assistance from a health service in relation to any contact tracing required for health service staff.

Close contacts

Self-quarantine

The following groups are now required to self-quarantine:

- Close contacts of confirmed cases until 14 days after last close contact with the confirmed case.
- As of midnight, 28 March 2020, all travellers arriving into Melbourne from overseas will be quarantined for two weeks in hotel rooms and other accommodation facilities after submitting an Isolation Declaration Card. Interstate travellers can return to their home states after fulfilling the mandatory quarantine requirements.

Self-quarantine means remaining at home except in cases of medical emergency. This means a person recommended to self-quarantine:

- must not visit public settings or mass gatherings.
- must not use public transport.
- must not attend settings like health services, residential aged care facilities or educational settings.

This requirement for people who are in quarantine not to attend health services, includes a requirement that they do not attend a family member who is a confirmed case in a Victorian health service.

If a recently recovered COVID-19 case becomes a close contact of a confirmed or probable case, they do not need to self-quarantine again.

Health services and GPs are not required to provide a certificate of medical clearance to those who have completed the required 14 days self-quarantine.

Close contacts should not travel within Australia or internationally within the 14 days after last contact with the infectious case.

Testing

All close contacts and international returned travelers will be tested prior to the end of their quarantine period (generally at day 11). A negative test result will be required prior to the department issuing clearance for a person to exit quarantine.

Identification of potential source (‘upstream’) contacts

A close contact may also be tested as part of potential source or ‘upstream’ contact tracing.

Where a confirmed case has no identified source of infection, potential source contact tracing of the ‘first reported case’ (or in an outbreak, index case) should be undertaken. The aim is to identify potential unrecognized chains of transmission, and may be particularly useful to identify the source of introduction of disease in a setting where there is potential for rapid transmission (see section ‘Priority groups for testing’). In such settings, potential source contact tracing whould be done for the ‘first reported case’ or index case.

Potential source contacts:

- are people who had close contact with the case during the time the case is likely to have acquired the infection
- may be both close contacts and potential source contacts
- close contact will have occurred between 24 hours and 14 days (usually 5-7 days) before symptom onset in the first reported case
- may be unidentified cases, so should be:

screened for possible symptoms

have their temperature measured

undergo PCR testing for SARS-CoV-2 infections

Considered for serological testing if well, and a validated serological assay is available

- if they test positive by PCR, clinical and public health judgement should be used to determine if they are currently infectious
- if deemed to be infectious, should be managed as any other confirmed case, including rapid contact tracing
- should be assessed as to whether they are likely to be:
  - the primary case who infected the first reported case (index case in an outbreak)
  - a secondary case infected by the first reported case
  - a separate transmission chain.

Symptomatic close contacts

The approach to a symptomatic close contact requires an assessment by a treating clinician. The next steps depend on whether a treating clinician has identified the patient as having a non-infectious cause, a likely non-respiratory infectious cause, or an acute respiratory illness.

For a symptomatic close contact during the 14-day quarantine period, the department will:

- Advise the close contact to attend a suitable general practice, emergency department or coronavirus assessment centre for evaluation with a single-use face mask on and to identify themselves immediately on arrival.

Where a close contact has an illness during the 14-day period of quarantine after the step above, the treating clinician will:

- use a single room and appropriate PPE as for a suspected case
- test for COVID-19 and manage the person as a suspected case.
- If the test is positive, the person will be managed as a confirmed case. Notify the department.

Where the illness is diagnosed as acute respiratory illness:

- if testing for COVID-19 is negative and the treating clinician has diagnosed an acute respiratory illness or an illness that is highly compatible with COVID-19, the close contact may then require a subsequent test at a short period thereafter.
- if the second PCR test is also negative, another test may be conducted on day 14 of the quarantine period.
- they will still need to be monitored for 14 days after their last contact with a confirmed or probable COVID-19 case.

Where the illness is diagnosed as likely to be some other form of infection or is not an infection:

- If testing for COVID-19 is negative and the treating clinician has diagnosed some other infection or a non-infectious cause, then the treating team should consider, in conjunction with an infectious

disease specialist, whether testing of relevant specimens such as urine and faeces for COVID-19 might be of value or whether evidence is now clear for an alternative cause, including legionellosis.
- The close contact can be advised to continue to self-quarantine until a full 14 days have expired from date of last close contact with confirmed case.

Checklist of key actions for the department for close contacts

For all close contacts the department will:

- Advise self-quarantine including restriction on travel until 14 days from the last contact with confirmed case.
- Counsel close contacts about risk and awareness of potential symptoms.
- Provide a close contact fact sheet
- Make regular contact with the close contact to monitor for any symptoms, either through SMS, email or telephone call.
- If after 14 days of quarantine (from the last contact with a confirmed case), the contact remains asymptomatic, the individual is cleared and may cease quarantine.
- If a school or employer requests confirmation from the department that the quarantine period has been met, the department will provide evidence with the consent of the individual.

Healthcare workers

HCWs and other contacts who have taken recommended infection control precautions, including the use of recommended PPE, while caring for a confirmed case of COVID-19 are not considered to be close contacts. However, they should be advised to self-monitor and if they develop symptoms consistent with COVID-19 infection they should isolate themselves. See also Infection prevention and control.

Any healthcare workers who is unwell with a compatible illness should not attend work and should seek appropriate medical care. All healthcare workers with fever or symptoms of acute respiratory infection should be tested for COVID-19, as per the testing criteria.

Hospital workers currently must not enter or remain at a hospital in Victoria if:

- the person has been diagnosed with COVID-19, and has not yet met the criteria for discharge from isolation OR
- if the person has travelled/arrived in Australia from any country in the past 14 days OR
- has had known contact with a person who is a confirmed COVID 19 case in the previous 14 days OR
- has a fever or symptoms of acute respiratory infection.

The current Directions and accompanying frequently asked questions can be viewed on the department's website at <https://www.dhhs.vic.gov.au/coronavirus>

Further criteria apply to healthcare workers who become confirmed cases before they can return to work in healthcare settings (see section Return-to-work criteria for health care workers and workers in aged care facilities who are confirmed cases).

Infection prevention and control

Consult the COVID-19 infection prevention and control guidelines available on the department's website <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>

This guidance covers issues including:

- healthcare and non-healthcare sector
- standard, transmission, contact and airborne precautions
- personal protective equipment (PPE)
- environmental and equipment management
- care of the deceased.

Laboratory testing for COVID-19

A number of Victorian laboratories are undertaking testing for COVID-19 in Victorian patients. There is significant pressure on supply of swabs and reagent kits for COVID-19 testing as well as laboratory capacity.

- Use the **current testing criteria** to guide patient investigation
- Use **only one swab** when testing, unless testing for other respiratory viruses is indicated (for example, multiplex PCR) **and** your local testing laboratory is unable to undertake this on the same specimen. Contact your laboratory to clarify if an additional specimen needs to be collected.

Testing advice for clinicians in an outbreak setting

When any symptomatic patient presents for testing, all clinicians must ask if that patient has had previous exposure to a known COVID-19 case within the past 14 days. If the patient confirms there has been an exposure of that kind, and the outbreak definition is met (see Outbreak definition section), the test sample is to be treated as an 'outbreak sample'

Sample labelling – prioritisation

On request slips:

- Provide **clinical details**
- copy results to the patient's treating physician
- include the patient's mobile number so that they can be contacted quickly.

To ensure all outbreak samples and other urgent priority samples are prioritised for testing in laboratories please follow these instructions:

1. The outside of the **sample bag/s** must be clearly labelled with a **red sticker** and marked for URGENT PRIORITY sample
2. The **pathology slip** must be clearly labelled with a **red sticker** and marked as **URGENT PRIORITY** sample with the **PRIORITY GROUP 1, 2 or 3**. For example, Priority 1 - OUTBREAK to clearly identify the reason why the sample is urgent. See below for list of priority groups.
3. The **sample** should be clearly labelled with the patients name and date of birth and marked as **P1, P2 or P3** to indicate the priority groups as below.
4. Samples should then be forwarded on for laboratory testing using normal processes.

This will ensure that certain samples are prioritised for testing in laboratories and results returned within a 24 to 48-hour turnaround time. Labelling becomes particularly important for laboratories in time of high-volume testing workloads.

Samples from outbreaks will be processed at the **Victorian Infectious Diseases Reference Laboratory (VIDRL)** at the Doherty Institute. Outbreak samples may be sent to your usual pathology provider who will forward it on to VIDRL.

If an outbreak occurs within a **healthcare setting which has capacity for on-site COVID-19 testing**, then the testing can be conducted at these laboratories with appropriate liaison with VIDRL as required.

Priority groups for testing

Current as of 19 May 2020.

The following samples are considered URGENT PRIORITY samples and are listed in priority order:
Priority 1 (P1) OUTBREAK

- including CLOSE CONTACT(s) OF CONFIRMED CASE
- people located in QUARANTINE HOTEL(s)
- SYMPTOMATIC resident or staff member of a known RACF OUTBREAK

Priority 2 (P2)

- SYMPTOMATIC HEALTH CARE WORKERS including AGED CARE WORKERS
- SYMPTOMATIC aged care residents and hospital patients.

Priority 3 (P3) OTHER 'AT-RISK SETTINGS'

- for SYMPTOMATIC people identified to be from other 'at-risk' settings as determined by the referring clinician.

Clinicians may determine other 'AT-RISK' SETTINGS to be:

- Prison/Justice settings (correctional facilities, detention centres)
- Aboriginal rural and remote communities
- Accommodation with shared facilities
- Defence force operational settings
- Boarding schools
- Other group residential settings (eg. disability)
- Schools
- Childcare centres
- Remote industrial sites with accommodation (e.g. mine sites)
- Certain high-risk work sites where workers are unable to undertake physical distancing or where outbreaks have been identified in the past:
    - Meat processing or other manufacturing plants
    - Restaurants/industrial kitchens
    - Workplaces with highly casualised workforces (who may be less likely to report symptoms)
    - Critical infrastructure dependent workplaces – such as electricity worker

Specimens for testing

Guidance from the Public Health laboratory Network on laboratory testing for SARS-CoV-2 can be found at <https://www1.health.gov.au/internet/main/publishing.nsf/content/Publications-13>

For initial diagnostic testing for COVID-19, the department recommends collection of the following samples:

1. upper respiratory tract specimens.
2. lower respiratory tract specimens (if possible).
3. serum, where possible (to be stored for later analysis at VIDRL).

Respiratory specimens

Collection of upper respiratory specimens is recommended for all patients – these would be oropharyngeal **and** deep nasal to optimise the chances of virus detection. In addition, lower respiratory specimens (sputum, if possible) are recommended for patients with a productive cough. For PPE recommendations, see .Coronavirus disease 2019 (COVID-19) infection prevention and control guideline, available on the department's website.

If the patient has severe symptoms suggestive of pneumonia, for example, fever and breathing difficulty, or frequent, severe or productive coughing episodes then **airborne and contact precautions** should be observed. This means that a P2 respirator must be used instead of a single-use surgical mask.

Patients with symptoms suggestive of pneumonia should be managed in hospital, and sample collection conducted in a negative pressure room, if available. If referral to hospital for specimen collection is not possible, specimens should be collected in a single room. The door should be closed during specimen collection and the room left vacant for at least 30 minutes afterwards (cleaning can be performed during this time by a person wearing PPE for airborne and contact precautions).

Serum and other specimens

See section on serology testing (above)

The department is continuously reviewing whether there is a requirement for other specimens such as stool or urine to be sent to VIDRL. At the current time this is not routinely recommended in cases of respiratory illness. A stool specimen may be recommended by the department to provide additional reassurance before a confirmed case is released from isolation.

Specimen collection and transport

Preparation for specimen collection

- Obtain the following equipment:
  - Personal protective equipment (PPE). For PPE recommendations, see Coronavirus disease 2019 (COVID-19) Infection Prevention and Control guidelines on the department's website.
  - A single swab for oropharynx and deep nasal sampling (one swab per patient only – unless your laboratory requires a second swab for other respiratory virus testing).

Sampling **both the oropharynx and deep nose** is recommended to optimise the chances of virus detection; both sites should be sampled with a single swab

- Use a **swab with a synthetic tip** (e.g. Dacron® or Rayon; flocked preferred) and aluminium or plastic shaft. Do not use calcium alginate swabs or swabs with wooden shafts, as they may contain substances that inactivate some viruses and inhibit PCR testing
- Swabs should be placed in **transport medium**, which may be viral transport medium (VTM) or Liquid Amies
- **Label tube** appropriately (patient's ID number, specimen type and swab date). Request slips should include clinical details identifying high-risk patients and healthcare workers.

Specimen collection process

Upper respiratory tract

Collection of upper respiratory specimens (that is, deep nasal and oropharyngeal samples) can be performed using **droplet and contact** precautions.

- Perform hand hygiene before donning gown, gloves, eye protection and single-use surgical mask. See How to put on and take off your PPE poster on the department's website <https://www.dhhs.vic.gov.au/how-put-and-take-your-ppe>.
- Stand slightly to one side of the patient to reduce exposure to respiratory secretions should the patient cough or sneeze.
- Swab the oropharynx (throat) first: swab tonsillar beds and the back of the throat, avoiding the tongue (see figure 1).
- Using the **same** swab, sample the deep nasal area (see figure 2):
  - using a pencil grip and while gently rotating the swab, insert the tip 2–3 cm (or until resistance is met), into the nostril, parallel to the palate, to absorb mucoid secretion.
  - rotate the swab several times against the nasal wall.
  - withdraw the swab and repeat the process in the other nostril. To conserve swabs the same swab that has been used to sample the oropharynx should be utilised for nasal sampling
- Place the swab(s) back into the accompanying transport medium. Avoid repeated freezing and thawing of specimens.
- At the completion of the specimen collection process, remove all PPE and perform hand hygiene after removing gloves and when all PPE has been removed. See How to take off your PPE poster on the department's website <https://www.dhhs.vic.gov.au/how-put-and-take-your-ppe>.
- Clean room after sample collection -droplet and contact precautions PPE must be worn when cleaning the room. See the COVID-19 infection prevention and control guidelines available on the department's website <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19> for further information. Note that, for droplet and contact precautions, the room does not need to be left empty after sample collection.

Figure 1: Swabbing the oropharynx

Figure 2: Swabbing the deep nose

Self-collected nasal and oropharyngeal swab

These are interim recommendations and may be subject to change as more information becomes available and the epidemiology of the pandemic changes.

Self-collected nasal and throat swabs, taken under supervision and direct observation of a trained healthcare worker (HCW), may be a viable option in the current COVID-19 outbreak in limited circumstances.

The Department of Health and Human Services refers laboratories and collection services to the new advice of the Therapeutic Goods Administration that the 'use of self-collected samples for SARS-CoV-2 requires validation by the laboratory as an in-house IVD (if the test kit being used isn't validated by the manufacturer for use with these specimen types).' https://www.tga.gov.au/legal-supply-covid-19-test-kits (date accessed 2/6/2020).

Therefore, a validated self-collected swab for SARS-CoV-2 testing should only be used provided the following conditions are met:

- If self-collection of swabs is used, it should only be done under the supervision and direct observation of a trained HCW to maximise control and quality assurance of the whole collection process. Clear instructions are to be provided to the patient.
- The request form should identify that the specimen has been self-collected.
- If a person does not choose self-collection or does not feel comfortable about their ability to self-collect, sampling should be performed by a trained HCW using PPE.
- A self-collected, combined deep nasal (deep from both nostrils) and oropharyngeal specimen is collected using a single swab. The swab is then sent for polymerase chain reaction (PCR) testing for the acute diagnosis of SARS-CoV-2 infection, in an accredited laboratory.

Note:

- Decisions concerning self-collection should be made in response to clinical and public health imperatives with Public Health advice.
- Self-collected swabs are not appropriate for patients with severe symptoms or in hospital settings (i.e. emergency departments and wards). In these situations, collection of a specimen should be performed by a trained HCW using appropriate PPE.
- Self-collected swabs are also not appropriate in home environments and are not supported.
- Self-collection should only be offered to people over 18 years of age who are considered to have the capability to perform the test correctly and safely.

- Swabbing of infants and children should only be conducted by a trained HCW, not a parent or carer.

Guiding documents on the use of self-collected swabs can be found at:

Public Health Laboratory Network – PHLN guidance on laboratory testing for SARS-CoV-2
https://www1.health.gov.au/internet/main/publishing.nsf/Content/Publications-13

Communicable Diseases Network Australia – COVID-19 SoNG
https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm

Lower Respiratory tract

If possible, obtain lower respiratory tract specimens as they are likely to contain the highest virus loads, based on experience with SARS and MERS coronaviruses

- **Sputum** – have the patient rinse the mouth with water and then expectorate deep cough sputum directly into a sterile, leak-proof, screw-cap sputum collection cup or sterile dry container. Refrigerate specimen at 2-8°C. If sending to Victorian Infectious Diseases Reference Laboratory (VIDRL), send on an ice pack.
- **Bronchoalveolar lavage, tracheal aspirate** – collect 2-3 mL into a sterile, leak-proof, screw-cap sputum collection cup or sterile dry container. Refrigerate specimen at 2-8°C - if sending to VIDRL, use ice pack.

Blood

Blood (serum) for storage for serology at a later date:

- Children and adults: Collect 1 tube (5-10mL) of whole blood in a serum separator tube.
- Infant: A minimum of 1ml of whole blood is needed for testing paediatric patients. If possible, collect 1mL in a serum separator tube.

There are no special requirements for transport of samples. They can be transported as routine diagnostic samples for testing (that is, Biological substance, Category B).

Referral of positive samples

All positive samples are to be labelled as “POSITIVE SAMPLE FOR STORAGE” and couriered to the Victorian Infectious Diseases Reference Laboratory (VIDRL) for ongoing storage and genomics.

Handling of specimens within diagnostic laboratories

All diagnostic laboratories should follow appropriate biosafety practices, and testing on clinical specimens, including for other respiratory viruses, should only be performed by adequately trained scientific staff.

Current advice from the WHO is that respiratory samples for molecular testing should be handled at Biosafety Level 2 (BSL2), with the USCDC recommending that the following procedures involving manipulation of potentially infected specimens are performed at BSL2 within a class II biosafety cabinet:

- aliquoting and/or diluting specimens
- inoculating bacterial or mycological culture media
- performing diagnostic tests that do not involve propagation of viral agents in vitro or in vivo
- nucleic acid extraction procedures involving potentially infected specimens
- preparation and chemical- or heat-fixing of smears for microscopic analysis.

Indeterminate test results

Indeterminate test results have been reported from a number of Victorian laboratories. These are usually samples that have had one gene detected in the assay but not both genes.

Indeterminate results may be referred to VIDRL for further testing, although **these samples should be considered as positive**. Confirmatory testing may not be possible as the sample may already be low titre and degradation due to processing may mean that VIDRL's PCR may not be sufficiently sensitive to offset loss of titre in the sample.

Cases with indeterminant results should be managed as confirmed cases. If the treating clinician feels that the pre-test probability for COVID-19 is low, another sample may be collected for further testing. If the second sample tests negative, the department will discuss the case with the treating doctor and the testing laboratory to determine whether the case should continue to be managed as a confirmed case.

Healthcare services – management of healthcare workers with suspected or confirmed COVID-19

Summary

This guidance outlines the roles and responsibilities of healthcare services in the event of a suspected or confirmed case or suspected or confirmed outbreak of COVID-19 among staff (and/or patients). It is primarily intended for use by hospitals but could be applied to other healthcare settings where appropriate.

For the purposes of this guide, healthcare workers are defined as people in contact with patients or the patient space. For example, doctors and nurses and cleaners who enter the patient's room or cubicle and frontline administrative staff would be included as healthcare workers. Staff who work in non-clinical areas and who do not enter patient rooms are not included as healthcare workers for this purpose.

An outbreak is defined as two or more epidemiologically linked cases of COVID-19 with symptom onset within 14 days. To be considered linked (and therefore constitute an outbreak), cases must be linked in both time (symptom onset dates within 14 days) and place (a common geographical link, such as staff who work in the same ward, patients who are cared for by the same staff member). However, even a single confirmed case of COVID-19 in a sensitive setting such as a healthcare service requires immediate control measures and the active involvement (resources permitting) of the Department of Health and Human Services (the department).

Roles and responsibilities

Directions

The current State of Emergency in Victoria provides the Chief Health Officer with additional powers to issue directions to help contain the spread of COVID-19 and keep Victorians safe. Hospital Visitor Directions that restrict entry into hospitals to minimise the risk of spreading COVID-19 among hospital patients and staff are currently in place. Please see the department's website for the latest details.

Role of Department of Health and Human Services (the department)

The department will assist with:

- Performing a situation assessment and confirming the presence of an outbreak (if relevant).
- Notifying the employer if a staff member attended work while potentially infectious.
- Providing advice on measures to prevent further transmission in the workplace.
- Providing other specialist public health advice on other topics as needed.
- Conducting interviews with confirmed cases (or their next of kin or healthcare provider where relevant) and contact tracing in parallel with and supported by the healthcare service's investigation.
- Providing the healthcare service with a "Case and contact data spreadsheet template" to assist them in collecting information about patients and staff who have been in close contact with a case.
- Consolidating information collected by the department with that obtained by the healthcare service.
- Information management of test results and clinical information of close contacts and confirmed cases in the Public Health Events Surveillance System (PHESS).
- Making daily contact with cases (through SMS, email or telephone call) until they are judged to meet release from isolation / return-to-work criteria

- Making regular contact with close contact(s) of the case (through SMS, email or telephone call) to monitor for symptoms and advise on the need for testing, if relevant.
- Determining when healthcare workers should be tested for return-to-work clearance in consultation with the patient and their treating doctor. Testing should be arranged by the healthcare worker's employer, the healthcare or aged care worker's treating doctor, or at a coronavirus assessment centre if testing by the treating doctor is not feasible. The patient should inform the department of where they intend to be tested.
- Follow-up of clearance testing results and determining when the return-to-work criteria have been met
- Provision of a letter (via email) to cases once they are judged to meet the return-to-work criteria that the healthcare worker can provide to their employer.
- Monitoring outbreaks.

Role of healthcare service

In the event of a confirmed case *or* confirmed outbreak involving a staff member or patient, the healthcare service is responsible for the following:

- Notifying the department immediately on 1300 651 160 (including after hours).
- Nominating a staff member (usually the infection prevention and control lead) to be the point of contact with the department.
- In the event of a confirmed case or confirmed outbreak in a healthcare service (including among staff members), it is the expectation that the healthcare service will perform a rapid assessment of risk in the workplace and commence contact tracing functions where possible. Healthcare services should also implement immediate infection prevention and control measures (as per the section on Control of exposure risks to staff and patients).
- Assess practices are aligned to policies and procedures in order to identify potential breaches and shortfalls.
- In the event that a healthcare worker has worked while infectious, it is the expectation that healthcare services in which they worked perform thorough contact tracing of all **patients**, **staff and visitors** who have been in close contact with the case during their infectious period. The healthcare service should also inform these people that they have been in close contact with a case and provide them with the necessary advice and information. While the healthcare service will need to identify all close contacts, the department can assist with contacting them.
- Providing the department with the information obtained from their risk assessment and contact tracing.
- Maintaining an up-to-date case and contact list and sending this to the department at agreed times (e.g. every second day, depending on the situation). Use the "Case and contact data spreadsheet template" provided by the department.
- Notifying the department on 1300 651 160 as soon as possible (within 24 hours) if a confirmed case becomes critically unwell, requires intensive care admission or dies, or in the event of additional suspected or confirmed cases.
- The caller should specify that they need to speak to the **Case and Contact Sector Lead**.
- Facilitate testing of their healthcare worker for return-to-work clearance, where possible.
- Provide psychological support to the healthcare worker if required.
- Engage with and share findings of internal review of confirmed cases with Safer Care Victoria

Role of the treating doctor / doctor who has requested COVID-19 testing

- It is the responsibility of the testing doctor (and the testing laboratory) to notify the department of any confirmed case of COVID-19 on **1300 651 160**.

- It is the responsibility of the treating doctor to inform the case of their test result and advise them of the appropriate actions they must take (i.e. isolation, and if appropriate, the need for medical treatment).
- Clearance testing should be arranged by the healthcare worker's employer, the healthcare worker's treating doctor, or at a coronavirus assessment centre if testing by the treating doctor is not feasible.

Role of Safer Care Victoria

Safer Care Victoria is responsible for the oversight of quality and safety in Victorian health services. This includes a role in supporting and assisting health services to review clinical incidents.

In the event of a confirmed case or confirmed outbreak involving a staff member or patient, Safer Care Victoria has a responsibility for:

- providing guidance and support to health services regarding review processes and where required participation in conducting reviews for a confirmed case or outbreak.
- to share findings for the purpose of learning with the health sector and the Department of Health and Human Services.
- to update any relevant Safer Care Victoria guidance based on findings and recommendations of review.

Safer Care Victoria can be contacted by phone on 1300 650 172 or email at info@safercare.vic.gov.au.

Healthcare service staff responsible for managing a case or an outbreak

A single confirmed case (either a staff member or patient) in a sensitive setting such as healthcare requires the active involvement of the department. Where there is an infection prevention and control (IPC) unit or an infectious diseases department, they should be involved as soon as possible. Ideally, a member of staff from the IPC team should be designated the **outbreak lead** as a point of contact between the healthcare service and the department. The outbreak lead should:

- Coordinate contact tracing, particularly in staff and patients of the healthcare service.
- Keep a case list of confirmed cases, suspected cases and deaths, and a close contacts list.
- They should update the department regularly (timeframe to be agreed between the department and the IPC lead) and email the updated case list through where necessary.
- The department must be notified immediately on **1300 651 160** (including after hours) if:
  - an outbreak is suspected
  - a new confirmed case of COVID-19 is identified
  - a death due to confirmed or suspected COVID-19 occurs.

Contact the Case and Contact Sector Lead on **1300 651 160.**

Responsibilities of the healthcare service as an employer

Employers (including healthcare services) have a duty to provide and maintain, so far as is reasonably practicable, a working environment that is safe and without risks to health. This includes a responsibility to:

- identify whether there is a risk to health of employees from exposure to COVID-19 at their workplace
- implement appropriate measures to reduce or eliminate risk (for example, by implementing social distancing initiatives, providing adequate facilities or products to allow employees to maintain good hand hygiene, and providing appropriate personal protective equipment and training on how to use it)

- facilitating testing of employees who meeting current testing criteria for COVID-19
- ensure employees understand when to stay away from the workplace and advise them of the requirement to self-quarantine for 14 days following return from overseas travel or contact with a confirmed case of COVID-19.

When should a healthcare worker be tested?

All healthcare workers who meet the criteria for testing as described on the department's health services and general practitioners COVID-19 webpage <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19> should be tested.

If testing healthcare workers, doctors are reminded to clearly mark pathology slips with **'Urgent - HCW'** (healthcare worker) to ensure the swabs can be easily identified for priority testing, and to include the healthcare worker's mobile number so they can be promptly contacted.

Healthcare workers should NOT be their own testing or treating doctor.

Immediate management of a suspected or confirmed case

Any symptomatic healthcare worker who meets the testing criteria for COVID-19 should be advised to isolate immediately and testing for COVID-19 should be facilitated. While they are awaiting test results they should remain in isolation until they have been notified of the test result and the appropriate course of action is subsequently determined. The following steps should be taken by the healthcare service:

- Ensure that the staff member is currently self-isolating.
- If the staff member is not currently in self-isolation, they must remove themselves from the workplace immediately with the least possible risk of transmission to others. This may include the following:
  - if possible, they should wear a single-use surgical mask
  - they should avoid public transport and return home immediately without detour
  - if possible, they should take a private car
  - if they are not driving, they should sit in the rear seat
  - they should minimise contact with any other persons and should practise strict physical distancing.
- Ensure that the staff member has had testing arranged.
- Ensure they have the appropriate information. Inform them that they must remain in isolation until they have been notified of the test result and they must **not** attend work during this time.
- Consider whether the member of staff shares a house with other healthcare workers or older or vulnerable people. In these circumstances it may be preferable for the case to isolate in another location to reduce the risk of transmission. They may be eligible for free accommodation provided by the department. Contact **covid19.hcwaccom@dhhs.vic.gov.au**.
- If the healthcare worker was tested for COVID-19 within your institution and returns a positive result, ensure that the doctor requesting the test has notified the department of the confirmed case (notifications should be directed to **1300 651 160**).
- Instruct any healthcare worker diagnosed with COVID-19 to remain in self-isolation until cleared by the department and encourage them to seek urgent medical attention if they become very unwell.

Further information for individuals diagnosed with COVID-19 and close contacts can be found here: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

Rapid workplace risk assessment and contact tracing

A rapid assessment of the workplace risk should be performed as soon as is practicable following identification of a confirmed case in a staff member. Nominate a dedicated member of staff to manage staff COVID-19 cases and to serve as a point of contact between the department and the healthcare

service. The point of contact in the department will be an appointed member of the **Case and Contact Management Team**.

For a full list of actions and processes which should be undertaken in the event of a confirmed case in a staff member, please see the checklist below.

Immediate actions

- Perform a rapid workplace risk assessment and contact tracing (see below).
- Ensure you provide the department with the completed "Case and contact data spreadsheet template" as soon as possible.
- Notify and quarantine any close contacts from the hospital – including staff, clients, patients and visitors. Provide close contacts with a copy of the "Factsheet – close contact" available under "Factsheets for patients" on the department's website (see: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19). Triage them for symptoms and test for COVID-19 if indicated. For guidance on whether testing is indicated, please refer to the *'Cases and contact management guidelines for health services and general practitioners'* available here: https://www.dhhs.vic.gov.au/coronavirus-disease-2019-covid-19-guideline-health-services-and-general-practitioners

Ongoing actions

- Maintain an outbreak case list using the "Case and contact data spreadsheet template".
- Provide the department with regular updates; - how frequently this will be required depends on the level of risk and size of the outbreak.
- Consider enhanced surveillance for symptoms of COVID-19 within the workplace and among patients other than the identified contacts.
- Notify the department of any COVID-related deaths as soon as possible, including after hours.
- Ensure that confirmed cases who are healthcare workers do not return to work until the department has determined that they meet the current return-to-work criteria for healthcare workers.
- Ensure that close contacts who are healthcare workers do not return to work until the department has determined that their quarantine period has ended.

Case interview and contact tracing

Infectious period and close contacts

The department will conduct a comprehensive case interview with all confirmed cases to confirm the date and timing of symptom onset as well as their infectious period. This does not preclude the health services from doing their own interview and urgently instituting appropriate isolation of close contacts.

- Cases are considered infectious from 48 hours prior to symptom onset until they meet the criteria for release from isolation or return to work.

The health service should compile a list of people who the case has been in close contact with while infectious using the "Case and contact data spreadsheet template".

- A **close contact** is defined as a person who has spent, cumulatively over the course of a week, at least 15 minutes face-to-face OR at least 2 hours in the same closed space as the confirmed case during their infectious period without wearing appropriate PPE.
- A review of medical records/charts may be helpful to determine what staff/patients are possible contacts.

- Consideration should be given as to whether a potential close contact is immunocompromised and may be more likely to become infected with shorter periods of exposure.

Ensure all sections of the spreadsheet are completed including accurate and up to date contact information for all close contacts.

If you have identified multiple confirmed cases within your institution, ensure each confirmed case has a separate form/tab completed.

Source of infection

Consider whether the staff member's infection may have been acquired within your health service (via another patient or staff member) or via an external exposure event.

- Ask whether the healthcare worker has had contact with anyone with apparent or reported fever or acute respiratory symptoms in the 14 days prior to their symptom onset (i.e. potential source of infection).
- Consider whether the staff member engaged in any recent aerosol generating procedures (AGPs) that may have increased their exposure risk.
- Consider whether the staff member may have had a breach of personal protective equipment (PPE) which may have led to an exposure.
- Document any recent travel (international or domestic) and consider whether the staff member had been in close contact with any confirmed cases prior to diagnosis.
  - Determine whether the staff member was in quarantine at the time of symptom onset.
  - Document date from which staff member has been in isolation/quarantine.
  - Document attendance at any other sensitive settings during the staff member's infectious period (from 48 hours prior to onset of symptoms until appropriately isolated) including: other healthcare services, clinics, education or learning centres, residential and aged care facilities, correctional facilities or attendance at patients' homes for home visits.

Workplace risk assessment

As part of the risk assessment, the following should be taken into consideration:

- Whether the case was infectious while at the workplace.
- Whether cleaning and disinfection of certain areas are required.
- Whether closure of certain areas is required to facilitate cleaning and allow for the investigation to be completed.
- Whether there are at risk/vulnerable patients for which enhanced surveillance for symptoms and possibly enhanced use of PPE could be considered (e.g. immunocompromised patients).

Control of exposure risks to staff and patients

The following actions should be taken immediately to reduce the risk of exposure to staff and patients:

- Ensure staff are adhering to current guidelines relating to the use of PPE in healthcare settings and that appropriate PPE is accessible. https://www.dhhs.vic.gov.au/coronavirus-covid-19-healthcare-workers-ppe-guidance-0
- Arrange for thorough cleaning and disinfection of areas which may pose an infection risk.
- Remove healthcare worker/staff close contacts from the workplace and advise them to quarantine for 14 days from last close contact with the case.
- If any close contact develops symptoms of COVID-19 while in quarantine, they should be tested.

- Place any patients identified as close contacts into quarantine (for 14 days from last close contact with the case) and ensure that droplet and contact precautions (or airborne and contact precautions for AGPs) are followed when caring for these patients.
- Ensure staff are provided with information and support during this process. Access to services and additional fact sheets can be found here: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

Checklist for healthcare service when there is a confirmed case in a staff member

This process should be managed by the IPC lead, who can delegate the following activities to members of the outbreak management team with the support of local staff.

Checklist	☑
Detection and confirmation of case(s)	
Support staff with fever or acute respiratory infection to self-isolate. Facilitate testing for symptomatic staff where possible. Confirm diagnosis. Determine the symptom onset date and determine whether the staff member attended work during the infectious period.	
Management of case(s)	
Ensure that the staff member is currently self-isolating and reiterate that they should not return to work until the department has determined that they meet the return-to-work criteria. Ensure the staff member knows where to seek psychological support as well as medical advice if they become more unwell. Facilitate clearance testing for the staff member where possible.	
Contact tracing	
Enter the staff member's details in the "Case and contact data spreadsheet template".	
If you have identified multiple confirmed cases within your institution, ensure each confirmed case has a separate form/tab completed. Ensure accurate contact details for each person you record in the spreadsheet.	
Immediately compile a list of all **staff** (paid and unpaid) who may be contacts of the staff member. Check rosters, sign-in sheets and other records as necessary. Liaise with staff member's manager and medical workforce.	
Immediately compile a list of all **patients** who may be contacts of the staff member. Check ward lists, admissions, discharges and transfers for the relevant ward / department.	
Immediately compile a list of all **visitors** who may have been exposed to the staff member. Check visitor sign-in sheets and other records.	
Review **medical records** to determine if the staff member documented contact with patients.	
From the above lists, identify *potential* **close contacts** from the available evidence (see definition of close contact above).	

Discuss with the staff member (case) to **confirm** the type and duration of contact they had with the above contacts and identify any further people who qualify as **close contacts** of the case.	
Record all information in the case and contact spreadsheet and provide this to a case and contact officer (CCO) at the department.	
Quarantine contacts and isolate cases	
For all close contacts of the confirmed case identified within the healthcare setting (staff members, patients or visitors): • Notify them that they have been identified as a contact of a confirmed case and inform them of the next steps required (please note that an employer cannot disclose confidential information about the confirmed case, and should only notify close contacts that they have been identified as a close contact with a confirmed case). • Distribute close contact information as provided by the department, including information on psychological support.	
For staff members and visitors, additionally: • Ensure they are excluded from work and are self-quarantining for 14 days after last contact with the case • Encourage them to seek testing if they develop symptoms and further medical advice if they become more unwell.	
For patients, additionally: • Implement droplet and contact precautions, including if patient is readmitted during quarantine/ isolation period • Advise isolation at home if already discharged • Facilitate testing if they develop symptoms	
Keep a record of each close contact and when they were informed of their potential exposure.	
Implement infection control measures	
Quarantine patients who are close contacts of the case (cohort patients if necessary).	
Consider temporary closures (e.g. rooms, wards) to facilitate investigation of the positive case and allow terminal cleaning. This decision can be made in consultation with the department	
Implement droplet and contact precautions (e.g. masks, gloves, gowns, eye protection) for all patients identified as a case or close contact of a case.	
Provide PPE outside rooms / wards / facility.	
Display sign outside rooms / wards.	

Reinforce standard precautions (hand hygiene, cough etiquette) throughout facility.	
Increase frequency of environmental cleaning (minimum twice daily where there are confirmed cases in patients).	
Monitor/update	
Arrange for daily symptom check and observations for inpatients who are close contacts. Arrange prompt testing for those who develop symptoms of COVID-19 whilst in quarantine as a close contact. Ensure the IPC lead is informed of all positive results as soon as possible.	
The IPC lead must update the department (via the designated contact) on an agreed basis (daily, every second day, etc.) or when there is a significant issue (e.g. a cluster, a death). Update the case list with both positive and negative test results.	
Notify	
Contact the department on **1300 651 160**, when there is an outbreak or a COVID-related death (24 hours, 7 days a week).	
Email case and contact spreadsheet to publichealth.operations@dhhs.vic.gov.au	
Keep patients, staff and families informed.	
Restrict	
Restrict movement of staff between areas of facility.	
Avoid patient transfers if possible.	
Restrict visitors where practical and in compliance with most recent direction on hospital visitors (if applicable).	
Consider cohorting of staff (during shift work).	
Do not allow HCWs to return to work until they have met the DHHS HCW clearance criteria.	
Declare and review	
Declare the outbreak over when there have been no new cases for a defined period of time (in consultation with the department).	
Review and evaluate case and outbreak management – amend outbreak management plan if needed.	

Governance

International response

The WHO declared COVID-19 a Public Health Emergency of International Concern (PHEIC) under the *International Health Regulations 2005* and on 30 January 2020. A pandemic has now been declared.

A State of Emergency was declared in Victoria on 16 March 2020.

Public Health Incident Management Team

The Department of Health and Human Services (the department, DHHS) has formed a Public Health Incident Management Team, led by a Public Health Commander, to coordinate the public health and sector response. A Class 2 Emergency, or public health emergency, was declared on 1 February 2020.

The Infection Clinical Network of Safer Care Victoria will be a network that is requested to provide comment and advice to the department, alongside national committees including the Communicable Diseases Network Australia (CDNA).

Communications and media

The department will coordinate communications and media in relation to suspected and confirmed cases of COVID-19. In some instances, the department may – in collaboration with a Victorian health service – request a service to provide media responses in relation to one of more cases associated with that service. A health service should contact the department's Media Unit with any queries.

Role of Ambulance Victoria

Where clinically appropriate, Ambulance Victoria can be used to transport any suspected cases of COVID-19 from a port of entry or unwell suspected cases from general practice or other settings to an emergency department. Triple 000 should be called in the normal manner but advise that the patient may have suspected COVID-19 infection.

Prevention

From midnight, 28 March 2020, all travellers arriving into Melbourne from overseas will be quarantined for two weeks in hotel rooms and other accommodation facilities

- Follow physical distancing advice
- Follow advice on influenza vaccination.
- Ensure adherence to good hand and respiratory hygiene practices.
- Adhere to good food safety practices.
- Consider avoiding live animal markets.

At the present time, travel within Australia is not recommended, and a ban on overseas travel is currently in place. Check for overseas travel advice or restrictions at Smartraveller <https://www.smartraveller.gov.au>.

Advice on physical distancing and other transmission reduction measures is available on the department's website <https://www.dhhs.vic.gov.au/coronavirus-covid-19-transmission-reduction-measures>.

Risk management at ports of entry

Infection with COVID-19 was designated a Listed Human Disease (LHD) under the *Biosecurity Act 2015* on 21 January 2020.

As of 18th March, the Australian Government advises all Australians not to travel overseas to any country at this time.

Currently all passengers from every arriving international aircraft are health screened. The department's healthcare workers are also conducting health checks on passengers from any international flight if required by the biosecurity officer. Single-use facemasks are provided to arriving passengers who have been identified as unwell. As of midnight, 28 March 2020, all travellers arriving into Melbourne from overseas will be quarantined for two weeks in hotel rooms and other accommodation facilities after submitting an Isolation Declaration Card. Interstate travellers can return to their home states after fulfilling the mandatory quarantine requirements.

The disease

Infectious agent

Severe Acute Respiratory Syndrome coronavirus 2 (SARS-CoV-2) has been confirmed as the causative agent. Coronaviruses are a large and diverse family of viruses that include viruses that are known to cause illness of variable severity in humans, including the common cold, severe acute respiratory syndrome (SARS-CoV), and Middle East Respiratory Syndrome (MERS-CoV). They are also found in animals such as camels and bats.

First termed 2019 novel coronavirus (2019-nCoV), the virus was officially named Severe Acute Respiratory Syndrome coronavirus 2 (SARS-CoV-2) 11 February 2020. The disease it causes is now called coronavirus disease 2019 (COVID-19).

Reservoir

It is highly likely that the virus has come from an animal source. Genomic analysis suggests that bats appear to be the reservoir of SARS-CoV-2 but the intermediate host has not yet been identified.

Mode of transmission

Human-to-human transmission of SARS-CoV-2 is via droplets and fomites from an infected person.

There is some evidence that COVID-19 infection may lead to intestinal infection and virus can be present in the faeces of infected persons. Additionally, airborne transmission of COVID-19 may occur during aerosol-generating procedures. Despite this, current evidence does not support faecal-oral or airborne spread as major drivers in transmission; however, aerosol-generating procedures should be undertaken with appropriate precautions (refer to Aerosol-generating procedures).

Estimates for the basic reproductive number (R0) of SARS-CoV-2 range from 2–4, with R0 for confined settings, e.g. cruise ships, at the higher end of this range. Estimates of the effective reproductive number (Reff) vary from between settings and at different time points are dependent on a range of factors, including, public health interventions such as isolation, quarantine and physical distancing to limit close contact between people.

Incubation period

The median incubation period is estimated to be 5 to 6 days, with a range of 1 to 14 days.

Infectious period

Evidence on the duration of infectivity for COVID-19 infection is evolving. Epidemiological data suggests that the majority of transmission occurs from symptomatic cases, however there is evidence of pre-symptomatic and possibly asymptomatic transmission. Viral loads appear to be highest at the time of symptom onset and decreased quickly within 7 days. As a precautionary approach, cases are considered to be infectious from 48 hours prior to onset of symptoms until they meet the criteria for release from isolation. Infection control precautions should be applied throughout any admission and until the department has declared the confirmed case to be released from isolation.

Given that little information is currently available on viral shedding and the potential for transmission of COVID-19, testing to detect the virus may be necessary to inform decision-making on infectiousness. Patient information (for example age, immune status and medication) should also be considered. Criteria for release from isolation are described in this guideline.

Clinical presentation

For 80% of cases, COVID-19 presents as a mild illness. Common signs of COVID-19 infection include respiratory symptoms, fever, cough, shortness of breath and breathing difficulties. Other symptoms include sore throat, coryzal symptoms, headache, fatigue, myalgia, anosmia, dysgeusia, chills and vomiting.

In more severe cases, it appears that infection can cause pneumonia, severe acute respiratory syndrome and multi-organ failure (including renal failure). Severe and fatal outcomes occur more frequently in the elderly and individuals with comorbid conditions. Some individuals remain asymptomatic. In summary, the clinical spectrum varies from mild cases, through to severe acute respiratory infection (SARI) cases.

For confirmed cases reported globally, the case fatality rate is approximately 6%; however, this is likely an overestimate for the Australian health setting. The true case fatality rate for COVID-19 is difficult to estimate due to variable case ascertainment, especially in regards to mild cases, and the impact of health systems on patient outcomes. Mortality of cases is, to a significant extent, determined by individual risk factors and healthcare quality and access. Based on surveillance data notified in Australia as of 04 June 2020, the crude national case fatality rate is 1.4% (102 deaths/7,229 confirmed cases).

Information resources

The department places resources for health professionals on the department's coronavirus (COVID-19) website <https://www.dhhs.vic.gov.au/coronavirus>.

It is important that health professionals consult this website frequently, as case definitions and content of this guideline change regularly during the response to this outbreak.

Keeping informed of emergencies affecting the health sector and critical public health issues impacting your work is made easier if you:

- Subscribe now to information including Chief Health Officer updates and emergency advice from the Department of Health and Human Services.
- Follow the Chief Health Officer on Twitter
- Subscribe to the COVID-19 stakeholder newsletter

Coronavirus disease 2019 (COVID-19)

Case and Contact Management Guide

Version 11

29 April 2020

VICTORIA State Government | Health and Human Services

Version control

Version number	Comment	Date of approval
v 2	Updated countries with risk	11 February 2020
v 3	Updated with new case definition and biosecurity screening	20 February 2020
v 4	Updated case definition; updates to countries with risk, travel restrictions and quarantine requirements	6 March 2020
v 5	Updated case definition	10 March 2020
v 6	Updated case definition	14 March 2020
v 7	Changes to checklists and overall structure of document	23 March 2020
v 8	Changes to structure and inclusion of procedures for notifications, case interviews and onboarding	26 March 2020
v 9	Updated case definition	01 April 2020
v 10	Updated case definition	05 April 2020
v 11	Complete overhaul	28 April 2020

Last updated: 10 May 2020

This document is available at:

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Table of Contents

1 Background

Coronavirus disease 2019 (COVID-19) was first identified in December 2019. It has since spread globally and has been declared a pandemic by the WHO.

1.1 Public health response objectives

This situation is evolving rapidly with new clinical and epidemiological information. Following the declaration of a State of Emergency in Victoria on Monday 16th March 2020 and subsequent Directions, the public health response of the Department of Health and Human Services (the department) has now transitioned from the Initial Containment stage (which encompassed an inclusive approach to identifying cases and a precautionary approach to the management of cases and contacts), to the Targeted Action stage, with implementation of social distancing measures and shutdowns of non-essential services to slow disease transmission, prioritisation of diagnostic testing to critical risk groups, and adoption of sustainable strategies and models of care.

The overall objectives of the public health response are to:

1. Reduce the morbidity and mortality associated with COVID-19 infection through an organised response that focuses on containment of infection.
2. Rapidly identify, isolate and treat cases, to reduce transmission to contacts, including health care, household and community contacts.
3. Characterise the clinical and epidemiological features of cases in order to adjust required control measures in a proportionate manner.
4. Minimise risk of transmission in healthcare and residential aged care environments, including minimising transmission to healthcare and residential aged care workers.

1.2 Staying up to date with advice

Definitions, criteria and guidance around optimal public health management for COVID-19 is constantly changing, as understanding of the virus progresses. Guidelines developed by the Department of Health and Human Services will be regularly updated, however constant vigilance is required for all people involved in COVID-19 operations.

To ensure you are aware of the most recent advice, it is recommended you access and review online definitions and guidelines daily on the department's website (https://www.dhhs.vic.gov.au/coronavirus).

1.2.1 Daily update

The Chief Health Officers daily update, including developments in the outbreak and updated advice for clinicians can be accessed at https://www.dhhs.vic.gov.au/coronavirus-covid-19-daily-update

1.2.2 Testing criteria

The current case testing criteria for Victoria can be accessed at https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

1.2.3 Who is required to self-quarantine?

Requirements for self-quarantine in Victoria can be accessed at https://www.dhhs.vic.gov.au/victorian-public-coronavirus-disease-covid-19

1.3 Information technology and documentation

Before team members commence working they need to have access to and competence with the following IT processes:

- DHHS computer access (to access completable electronic forms). This includes access to the following databases and systems
  - PHESS
  - TRIM
  - Microsoft Office/Sharepoint
  - Teams
- Genesys PureCloud (to make and receive phone calls)

Formal requests, escalations and decisions should be clearly documented by email to the relevant lead position. Most other communications can be performed through the 'chat' and 'posts' functions on Teams.

1.3.1 Guidelines

- Coronavirus disease 2019 (COVID-19) Case and Contact Management Guidelines (this document)
- Coronavirus disease 2019 (COVID-19) Guidelines for Health Services and General Practitioners – Available from:
- PHESS Quick Entry Guide

1.3.2 Factsheets

- Confirmed case – Available from: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19
- Close Contact – Available from: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19
- Telephone Interpreter Service – see the SOP for accessing the Translating and Interpreting Service (TIS)
- Location of coronavirus testing centres (Acute Respiratory Assessment Clinics and GP respiratory clinics) – list available on the department's webpage under "Where can I get tested for coronavirus?": https://www.dhhs.vic.gov.au/victorian-public-coronavirus-disease-covid-19

1.3.3 Completable Forms

- Notification of COVID-19 (novel coronavirus) by Medical Practitioners (paper form)
- Notification of COVID-19 electronic form: https://forms.business.gov.au/smartforms/servlet/SmartForm.html?formCode=internalnovelcoronav&tmFormVersion=0.1.2
- Communicable Disease Call Log Sheet (paper form)
- Communicable Disease Call Log -electronic form
- Call log sheet (used in the triage team to record calls received) accessed at https://forms.office.com/Pages/ResponsePage.aspx?id=H2DgwKwPnESciKEExOufKBgNxs0yxExHhPbFAW8y1dBUQ1JMMkRFSEVGMzdDOENQR0hTTDRGT0RWVyQlQCN0PWcu (I hope this link works)
- Case questionnaire COVID-19 (Novel Coronavirus) Part A and Part B (paper form)

2 Testing criteria, case and contact definitions

2.1 Testing criteria

The latest testing criteria can be accessed under 'Current Victorian coronavirus disease (COVID-19) case definition and testing criteria' at: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

2.2 Case definition

The confirmed case definition is also available in the Coronavirus disease 2019 (COVID-19) General Practice quick reference guide: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

2.2.1 Confirmed case

A person who tests positive to a validated SARS-CoV-2 nucleic acid test or has the virus identified by electron microscopy or viral culture.

2.2.2 Probable case

Victoria does not currently employ a probable case definition

2.3 Close contact definition

The close contact definition is also available on the Coronavirus disease 2019 (COVID-19) – Guidelines for health services and general practitioners: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

Close contact means greater than 15 minutes face-to-face, cumulative, or the sharing of a closed space for more than two hours with a confirmed case without recommended personal protective equipment (PPE) which is droplet and contact precautions.

Contact needs to have occurred during the period of 48 hours prior to onset of symptoms in the confirmed case until the confirmed case is no longer considered infectious.

2.3.1 Examples of close contact include:

- living in the same household or household-like setting (for example, a boarding school or hostel)
- direct contact with the body fluids or laboratory specimens of a confirmed case without recommended PPE (droplet and contact precautions)
- a person who spent two hours or longer in the same room (such as a GP clinic or ED waiting room, a school classroom; an aged care facility)
- a person in the same hospital room when an aerosol generating procedure (AGP) is undertaken on the case, without recommended PPE for an AGP (airborne and contact precautions)
- Aircraft passengers who were seated in the same row as the case, or in the two rows in front or two rows behind a confirmed COVID-19 case.
- For aircraft crew exposed to a confirmed case, a case-by-case risk assessment should be conducted by the airline to identify which crew member(s) should be managed as close contacts. This will include:
  - Proximity of crew to confirmed case
  - Duration of exposure to confirmed case
  - Size of the compartment in which the crew member and confirmed case interacted

  - Precautions taken, including PPE worn, when in close proximity to the confirmed case
  - If an aircraft crew member is the COVID-19 case, contact tracing efforts should concentrate on passengers seated in the area where the crew member was working during the flight and all of the other members of the crew.
- Close contacts on cruise ships can be difficult to identify, and a case-by-case risk assessment should be conducted to identify which passengers and crew should be managed as close contacts.
- Face-to-face contact for more than 15 minutes with the case in any other setting not listed above.

Healthcare workers (HCWs) and other contacts who have followed recommended infection control precautions, including the use of recommended PPE (droplet and contact precautions for the purposes of this contact definition), while caring for a suspected or confirmed case of COVID-19 are **not** considered to be close contacts.

3 Triage and Notification

DHHS operates a 24-hour communicable diseases hotline (1300 651 160). This number receives urgent communicable disease notifications from clinicians, including notifications for COVID-19. Some health services have instituted processes to send notifications via text message or email. As case numbers evolve, different models of notification are being explored.

In addition to receiving notifications, DHHS receives a large number of calls through the 24-hour communicable disease hotline, including:

- Queries from confirmed cases or close contacts of confirmed cases.
- Queries from members of the public on testing criteria, symptoms of concern and other risks.
- Queries from institutions regarding processes and risks relating to suspected or actual cases.
- Offers of assistance to the department in providing services or equipment.

The objectives of the Triage and Notification team are to:

- Ensure 24-hour coverage of the COVID-19 hotline through the 1300 number
- Record notifications of confirmed cases of COVID-19
- Manage enquiries from confirmed cases, close contacts and other stakeholders relating to case and contact management
- Manage other miscellaneous enquiries and where relevant, triage to the correct part of the response

3.1 Processes and workflow

3.1.1 Receiving a new notification of COVID-19

When receiving a new notification of COVID-19, the team member needs to access the form “Notification of COVID-19 (novel coronavirus) by Medical Practitioners”. This form may be completed in hardcopy (paper) form OR electronic form (do not complete both).

3.1.2 Managing other non-notification enquiries

Non-notification enquiries can be segmented into case and contact related enquiries and other.

Any enquiries relating to a new case, new close contact, existing confirmed case, or existing close contact should be recorded in the call log and where relevant, escalated to the appropriate team leader.

All phone calls to the 1300 number should be related to case and contact management. Other enquiries may need to be re-directed to the appropriate number or contact address. There are several generic inboxes that have been created for managing other parts of the response. Discuss with your team leader if you are not sure of where to direct an enquiry.

3.1.3 Escalation and workflow

Team members may escalate any concerns to the Assistant Team Leader. This includes enquiries about the correct interpretation and completion of the “Notification of COVID-19 (novel coronavirus) by Medical Practitioners).

Any notifications that require an urgent public health response or that are received from a sensitive setting must be escalated to the Team Leader. This includes the following situations:

- The case is a health care or aged care worker
- The case lives in a residential aged care facility or other care facility

- The case works in or attends a school or childcare centre
- The case is in an intensive care unit
- The case has died
- The case is part of a known outbreak or cluster

Complete notifications are sent for data entry before the “New Cases” team will contact cases to begin the case and contact management process.

3.2 Troubleshooting common issues

3.2.1 Misdirected phone call

All incoming calls to the 1300 number should be related to case and contact management. Any other enquiries should be re-directed, if required, to one of the below hotlines.

Number/email	Title	Functions
1800 675 398	Victorian Coronavirus hotline	1: Health information or symptom assessment or health professional 2: Information on social distancing measure (business or individual) 3: Self isolating and have urgent relief needs (e.g. food, personal care, wellbeing) 4: Alleged breach of Chief Health Officer directions
1800 020 080	National Coronavirus hotline	1: Health information or symptom assessment 2: For health professionals
1800 960 944	DJPR ‘concierge support’ for those in hotel quarantine	Relief, accommodation and other requests from people in mandatory hotel quarantine
1800 825 955	Homelessness support team	For Hospitals/clinicals to provide advice on accommodation for homeless people (for example a homeless COVID-19 patient in hospital who is medically fit for discharge)

3.2.2 Incomplete notification form

An incomplete form should be discussed with the Assistant Team Leader, to discuss whether sufficient information has been provided. As a guide the following information must be provided:

- The name (first and last name) of the case
- A contact phone number for the case
- The name and contact phone number of the notifying clinician
- Occupation of the case (where available)

If it is determined that sufficient information to complete the public health response is provided, then notification can be finalised in the usual manner.

If insufficient information to complete the public health response has been provided, a solution should be discussed with the Assistant Team Leader or Team Leader that does not breach confidentiality of the case. For example, if a notification has been provided by a laboratory, the requesting clinician may be contacted for further information.

If no solution can be found to complete the necessary information, escalate to the Team Leader who will finalise the notification.

3.2.3 Indeterminant/Suspected/Low positive test results

Current testing for the SARS-CoV-2 virus (the virus that causes COVID-19) is undertaken by laboratories using a method called Nucleic Acid Amplification Test (NAAT), also called Polymerase Chain Reaction (PCR). Due to the rapid rollout of laboratory testing for SARS-CoV-2, the methods of laboratory testing have not undergone the same, intense, validation that occurs with more established tests. Some test results may not be clearly positive or clearly negative. Depending on the laboratory, these may be reported as “suspected”, “indeterminant” or “low positive”.

For the purpose of the public health response, cases with laboratory tests results that are not negative (i.e. “suspected”, “indeterminant” or “low positive”) should be managed as confirmed cases, and should undergo the same isolation and contact tracing procedures as all cases with a “positive” test result.

If the treating clinician or testing laboratory calls the department to discuss an indeterminant/low positive test result, the call should be escalated to the Operations Lead (and/or the Strategy, Policy and Planning Lead). In select cases, such as where the treating clinician feels that the pre-test probability for COVID-19 is low, it may be appropriate for the patient to be re-tested for COVID-19. If the second sample tests negative, the Operations/Strategy, Policy and Planning Lead (or someone they delegate) should discuss the case with the treating clinician and testing laboratory to determine whether it is appropriate to continue to manage the case as a confirmed case. Approval should be sought from the deputy Public Health Commander: Case, Contact and Outbreak Management before a decision is made to reject a case.

This information is subject to change as the pandemic progresses and team members should ensure they are aware of the most up to date guidance.

3.2.4 Patient has not been notified of their positive test result

It is preferable that patients are contacted by the requesting clinician and informed of their positive test result before the DHHS case and contact management begins. This allows the clinician to review the medical requirements of the patient and answer any questions that the patient may have.

When receiving a notification from a clinician who has not informed the case of their positive test result, you should request the clinician contact the patient ASAP to discuss their result and follow usual processes. Document on the notification form your request to the clinician to contact the case and the clinician’s response. The DHHS response will proceed as usual (DHHS will not confirm the case has been contacted or wait for the clinician to contact the case before beginning the usual follow-up).

4 New Case and Contact Management

The New Case and Contact (NCAC) Team are the first point of contact between the DHHS and a confirmed case of COVID-19.

The objectives of the NCAC team are to:

- Identify the likely source of exposure of a case, including if they are part of an outbreak or cluster
- Identify if a case is from a sensitive setting (e.g. a healthcare worker)
- Provide a case with clear instructions about their public health requirements (e.g. their period of isolation)
- Identify close contacts of a case of COVID-19
- Inform close contacts of confirmed cases of COVID-19 of their isolation requirements
- Complete appropriate documentation in case questionnaire and PHESS

4.1 Processes and workflow

4.1.1 New Case

Following receipt of a confirmed COVID-19 notification from either a laboratory or a clinician, a PHESS event is created by the data entry team. New cases appear on the 'Confirmed cases, actions pending' workflow. After checking to ensure the case is not a duplicate entry or a case being managed in another jurisdiction, the case is allocated for interview by the New Cases team leader.

The NCAC Team Leader will distribute cases for interview to team members. The following cases should be prioritised for urgent interview:

- Case is a healthcare worker
- Case lives in or works in a sensitive setting (e.g. correctional facility, aged care facility, childcare centre)
- Case is related to a known cluster or outbreak
- Case presents significant public health risk

Team members should review the notification form and data in PHESS prior to contacting the case.

4.1.2 Taking the history

The "case questionnaire COVID-19 (Novel Coronavirus) Part A and Part B" for provides the structure to taking a targeted public health history from a confirmed case of COVID-19. All sections of the form should be completed.

The incubation period for COVID-19 is up to 14 days. This is the time between exposed to the SARS-CoV-2 virus and the development of symptoms.

The infectious period for COVID-19 is currently unknown. However, for the purposes of isolation and contact tracing, cases are considered to be infectious (able to transmit the virus to others) from 48 hours before onset of symptoms until they meet the criteria for release from isolation.

The incubation period and infectious period are used to determine specific timelines used in the case questionnaire. For example:

- Considering case exposures (including travel) in the 14 days before symptom onset (incubation period)
- Identifying close contacts of the case from **48** hours prior to the onset of symptoms (infectious period)

The incubation period and the infectious period are subject to change as understanding of the SARS-CoV-2 virus progresses. The most up-to-date guidelines should be reviewed to ensure accurate definitions of incubation period and infectious period are being applied.

4.1.3 Initial management of cases

Confirmed cases should be informed that a member of the DHHS Existing Cases team will contact the case every day. Verbal information must be followed up with written information – send the case the Factsheet – confirmed case via email. The fact sheet provides the 24-hour communicable diseases phone number should the case need to speak with DHHS.

The Isolation (Diagnosis) Direction that is currently in effect (see: https://www.dhhs.vic.gov.au/state-emergency) makes it **compulsory** for anyone with a confirmed diagnosis of COVID-19 to go into isolation for a minimum period, and to meet other compulsory conditions before being able to resume normal activities. Penalties apply to those who refuse or fail to comply with this direction.

Cases must isolate themselves at home until they are advised otherwise by a Public Health Officer:

- They must not leave their house or accommodation except to seek medical attention or limited other permitted reasons, such as an emergency or if required by law
- They should stay in a different room to other people as much as possible. Sleep in a separate bedroom and use a separate bathroom if available.
- They should wear a surgical face mask when they are in the same room as another person and when seeking medical care.
- They should not go to work, school, university, or attend public places or events. Do not use public transport or taxi services.
- Where possible, they should get others such as friends or family who are not required to be isolated to get food or other necessities for them.

If they have difficulties getting food or necessities, call 1800 675 398 for support.

The above isolation requirements are outlined on the Factsheet – confirmed cases, available from: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

It is important to reiterate to the case the implications of not maintaining appropriate self-isolation and the risks that this can pose to other people including close contacts located in their household. If they do not sufficiently isolate themselves 5n

- The period of time for which household contacts will be required to self-quarantine will be extended. This is because household contacts will be required to self-quarantine from the time that they are identified as a close contact of a case until 14 days have elapsed since the date they last had close contact with the case while they were infectious (i.e. their total quarantine period may be >14 days).

4.1.4 Close Contacts

It is desirable, but not essential, that the case contacts people they have identified as close contacts themselves and advises them that they (the case) have been diagnosed with COVID-19. Regardless of whether they have been contacted by the case, all close contacts must be contacted by the New Case and Contact Team to explain their requirement to quarantine at home and provide instructions on testing should they develop symptoms. If any close contact requires medical advice, they need to seek this from their usual sources (e.g. their GP).

Close contacts should be informed that a member of the department's close contact team will contact them. Verbal information must be followed up with written information, send the Factsheet – close contacts via email. The fact sheet provides the 24-hour communicable diseases phone number should they need to speak with DHHS.

Close contacts should quarantine themselves at home (or in other appropriate accommodation) until 14 days after they were last exposed to the infectious person.

- They should not leave their house except to seek medical attention.
- They should stay in a different room to other people as much as possible. Sleep in a separate bedroom and use a separate bathroom if available.
- They should not go to work, school, university, or attend public places or events. Do not use public transport or taxi services.
- Where possible, they should get others such as friends or family who are not required to be quarantined to get food or other necessities for them.
- If they have difficulties getting food or necessities, call 1800 675 398 for support.

The above isolation requirements for close contacts are outlined on the Factsheet – close contacts: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

4.1.4.1 Interstate/overseas cases and close contacts

An interstate resident who is isolating in Victoria should be followed up and managed by the department (i.e. the Department of Health and Human Services, Victoria).

If interstate or overseas close contacts of a confirmed Victorian case of COVID-19 are identified, collect their details and email these to the relevant jurisdiction. Provide as much information as has been obtained, for example:

- Name
- Date of birth
- Phone number
- Date of exposure
- Any other relevant information obtained.

The team leader has access to the appropriate email address for each jurisdiction. For international close contacts email publichealth.intelligence@dhhs.vic.gov.au

4.1.5 Households

When multiple cases within a single household are interviewed together, it is appropriate to assess their close contacts together and determine the close contacts' last date of exposure to the case(s) at this time.

If the interviews of the household members occur separately, the last exposure date to any of the confirmed cases must be identified for each close contact. The close contact's quarantine period must be updated to reflect a 14-day period from last exposure to any confirmed case. This must be communicated to the close contact at the time of interview.

4.1.6 Hotel Detention

International arrivals into Australia are subject to a 14-day mandatory quarantine period in designated hotels. For couples and families, there are a number of room sharing options. The team leader at the hotel must communicate these options in advance of hotel check-in and inform people of the consequences of their choice. These consequences include an increased risk of infection, and a prolonged quarantine period should their roommate become a confirmed case of COVID-19.

When a person who is a current confirmed case of COVID-19 arrives in Australia, they will be placed in mandatory quarantine and asked to provide confirmation of their diagnosis. If there is doubt surrounding the certainty of the diagnosis, they will be offered additional testing at the hotel.

If an individual arriving in Australia states that they are a recovered (confirmed) COVID-19 case, they will initially be placed in mandatory quarantine, and asked to provide evidence of their diagnosis and that the required amount of time has passed such that they are no longer considered infectious. The department will decide on a case-by-case basis whether evidence from other sources is sufficient.

Further information relating to hotel detention can be found in sections 5.1.4 and 6.1.4.

4.1.7 Escalation and workflow

Team members may escalate any concerns to the Assistant Team Leader. This includes enquiries about the correct interpretation and completion of the "Case Questionnaire COVID-19 (Novel Coronavirus)" or any issues contacting confirmed cases.

Any notifications that require an urgent public health response or are received from a sensitive setting must be escalated to the Team Leader. This includes the following situations:

- The case is a healthcare worker
- The case works in or lives in a residential aged care facility
- The case works in or attends a school or childcare centre
- The case is in an intensive care unit
- The case has died
- The case is part of (or suspected to be part of) a known outbreak or cluster
- The case may trigger a large response (i.e. a large number of close contacts have been identified or if the case has been at work while infectious)
- The case is from a cruise ship
- The case is likely to generate media interest (for example if they are a celebrity or politician)
- The case appears resistant or reluctant to isolate
- The case appears resistant or reluctant to identify close contacts

Complete notifications are sent for data entry to complete the data entry requirements.

4.2 Troubleshooting common issues

4.2.1 Aeroplane flights taken by the case

For flights that were taken by the case, while infectious, obtain:

- flight number
- ports of departure and arrival
- date of arrival
- seat number

Currently, there is no contact tracing requirements for international flights or domestic flights < 2 hours duration. Contact tracing is required on domestic flights of > 2 hours duration. For the purposes of airline crew follow up, inform the National Incident Room by emailing publichealth.intelligence@dhhs.vic.gov.au regarding any flights that had an infectious case on board.

4.2.2 Outbreaks and sensitive settings

Outbreaks (sometimes called clusters) may occur in any setting but are of particular concern when they occur in sensitive settings, such as healthcare settings or residential aged care facilities.

The definition of an outbreak varies according to context. Outbreak definitions usually have elements of person, place and time. In Residential Aged Care Facilities, a confirmed outbreak is defined as "two or more cases of fever or acute respiratory infection in residents or staff within 3 days (72 hours) AND at least one case of COVID-19 confirmed by laboratory testing".

Established outbreak definitions do not currently exist for other sensitive settings. However, an outbreak should be suspected if two or more cases of suspected or confirmed COVID-19 (linked by time and place) occur within a sensitive setting.

When an outbreak is suspected, the details of the outbreak (for example the setting) should be recorded by the Team Leader. The Team Leader should also inform the Operations Lead, who will decide if escalation to the Deputy Public Health Commanders/Public Health Commanders is required. The Operations Lead will also arrange for the outbreak to be investigated by the "outbreak" team within the NCAC team. If extra support is required, the Team Leader can request input from the Strategy, Policy and Planning Operations Liaison and/or the Strategy, Policy and Planning

Lead.

In some cases, a single confirmed case of COVID-19 in a sensitive setting may warrant investigation. Team Leaders should inform the Operations Lead of cases in sensitive settings, to determine if escalation or further investigation is warranted.

4.2.3 Contacts who are healthcare workers

The same definition of close contact applies to healthcare workers (HCW) as other members of the community and should be managed in the same way. If a HCW is determined to be a close contact of a confirmed case, they must be isolated for a period of 14 days following their last contact with the case. A HCW who is a close contact of a confirmed case should not be swabbed for SARS-CoV-2 unless they develop symptoms (unless direction to do so is provided by a Deputy Public Health Commander/Public Health Commander).

A HCW who has had contact with a confirmed case of COVID-19 but does not satisfy the criteria as a close contact does not require isolation but should isolate immediately if they become unwell and seek testing for COVID-19.

4.2.3.1 Emergency Accommodation

The Victorian Government's COVID-19 Healthcare worker Emergency Accommodation (CHEA) Program (also known as the "Hotels for Heroes" program) provides access to free accommodation for hospital workers and paramedics who need to self-quarantine or self-isolate because of COVID-19 (i.e. as confirmed cases or close contacts) and who do not have a suitable home environment to do so. Examples of unsuitable home environments include HCWs who live with a member of an at-risk population group (e.g. people aged >65, or people who are immunosuppressed or have an underlying chronic condition), those who live in share houses, and those who live with other HCWs. If a contact wishes to access emergency accommodation, they should be advised to contact their employing health service, who will complete a request form on their behalf and send it to the email address covid19.hcwaccom@dhhs.vic.gov.au

4.2.4 Healthcare workers and PPE

HCWs who wear adequate PPE when caring for confirmed cases of COVID-19 are not considered to be close contacts, as is outlined in the close contact definition.

For routine care of confirmed COVID-19 cases (during their infectious period), adequate PPE consists of:

- surgical mask
- long sleeved gown
- face shield or goggles
- gloves

For aerosol generating procedures (AGPs), adequate PPE consists of:

- N95 mask / P2 respirator
- long sleeved gown
- face shield or goggles
- gloves

Further details, including a list of what constitutes an AGP can be found in the document "Coronavirus disease 2019 (COVID-19) Healthcare worker personal protective equipment (PPE) guidance for performing clinical procedures" which is available under the "Guidelines for health services and general practitioners" tab on the following webpage: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

If a HCW works in a setting that has an infection control unit (such as a hospital), an assessment of the adequacy of PPE should be undertaken in consultation with the facility's infection control unit.

Healthcare workers who are assessed as wearing inadequate PPE (e.g. incomplete/inappropriately applied PPE or where a PPE breach occurred) and who meet the definition of a close contact should be considered close contacts and managed accordingly. For example, if a nurse spends 30 minutes directly caring for a patient, wearing a surgical mask, gloves and long sleeve gown, but no eye protection, they are not wearing adequate PPE and should therefore be considered a close contact.

Judgement may be applied in some circumstances for HCWs who are wearing most of the required PPE and have had a low risk contact. In these situations, the department has recommended that a case not attend work for 14 days, but do not need to be in isolation. This can only be recommended after discussion with a Cell Lead.

4.2.5 Close contacts unable to isolate from confirmed cases

Every effort should be made for close contacts with ongoing contact to a confirmed case to isolate from that case. For example, a husband and wife couple should make every attempt isolate. Ideally this would mean having access to alternative accommodation. If this is not possible then every attempt to live

separately within their house including, not sleeping together, not eating or preparing meals together, using separate bathrooms, cleaning appropriately between use of common areas, kitchen and bathrooms (where alternative is not available). Isolating from each other protects the contact from an ongoing risk of infection with COVID-19, and reduces the period that they will be required to remain in isolation. If DHHS is not satisfied that a contact living in the same house as a case is isolated, the contacts period of quarantine will extend for 14 days after the last infectious period of the case (i.e for 14 days after the case is cleared).

If the close contact were to become unwell and test positive for COVID-19, the couple should continue to attempt to isolate from each other. If this is not possible, the original case can still be “cleared” by the Existing Cases Team when they meet the appropriate clearance criteria. No further quarantine is required for the exposure to their spouse or housemate. The Existing Close Contact and Existing Cases team will need to work together to identify cases and contacts requiring changes to their management based on inadequate isolation.

5 Existing Cases Team

The Existing Cases Team maintain contact with cases following their initial interview (conducted by the NCAC team). The Existing Cases Team make daily contact with confirmed cases of COVID-19, to monitor the isolation, health of the case, and to escalate any concerns as necessary. The Existing Cases Team also assess and provide clearance to cases who have met the end of isolation criteria.

The objectives of the existing cases team is

- Reduce the morbidity experienced by cases by:
  - Providing daily contact with cases and ensuring they have access to necessary medical support
  - Ensuring minimal impact of isolation requirements by releasing cases from isolation when they meet the appropriate criteria.
- Reduce transmission of COVID-19 by:
  - Ensure cases are aware of their isolation requirement through reinforcement of the message provided at first contact, and as a portal to answer questions cases may have.
  - Provide support and encouragement to cases to maintain their isolation requirements through daily contact with cases.
- Minimise the risk of transmission in healthcare settings by:
  - Applying the appropriate return to work criteria to healthcare workers
  - Advising confirmed cases on how to safely access medical care during their infectious period.

5.1 Processes and workflow

Confirmed cases of COVID-19 are entered into PHESS following receipt of the notification. Case interviews must be completed before the existing confirmed team takes over management.

Existing cases team generate a workflow from PHESS that is populated into an excel spreadsheet that outlines the required actions.

The Existing Cases Team Leader distributes the actions to the Team Members.

For the purpose of the public health management, confirmed cases are categorised into one of three groups, general community, healthcare workers, hospitalised patients and hotel detention.

5.1.1 Hospitalised patients

Together with the Intelligence team, the Existing Cases team collect information on hospitalised patients to ensure up-to-date statistics are available for decision makers. This includes understanding the number of COVID-19 patients in Victoria who are hospital inpatients, patients in an Intensive Care Unit (ICU) and those ventilated in ICU.

Up to date clinical data about COVID-19 patients who are currently in hospital is obtained via VICNISS (VICCNISS Healthcare Associated Infection Surveillance Coordinating Centre) and updated in PHESS by the Intelligence team. The Existing Cases team do not regularly contact cases while they are in hospital.

In the 'Guidelines for health services and general practitioners', the department recommends that a confirmed case may be discharged if the following criteria are met:

- a senior member of the treating team (or appropriate consulting team) has determined the patient is clinically improved and well enough to be managed in the community, and
- appropriate infection control measures can be implemented in the community or household setting to ensure risk to other household members can be managed, and
- the department is notified about the pending discharge

A confirmed case in the home must remain in isolation until criteria for release from isolation are met.

5.1.2 Healthcare workers

Healthcare workers who are in home isolation are contacted daily during their isolation by the Existing Cases Team.

When the case is eligible to meet end of **isolation** criteria (see below) they are called by an Existing Case team member to confirm criteria is met. An email of a standardised letter is provided. When the case is eligible to meet **return to work** criteria (see below) they are called by an Existing Case team member to confirm criteria are met. An email of a standardised letter is provided.

5.1.3 General community members

A person in isolation at home, who is not a healthcare worker, is contacted daily during their isolation by the Existing Cases Team. This contact, particularly for those deemed to be low risk, may be made through text message (via Soprano).

The team member provides a daily check on the cases condition. When the case is eligible to be "cleared" from isolation (see clearance criteria below) this is provided by the team member and confirmed by emailing the standardised letter.

5.1.4 Hotel detention

Confirmed cases of COVID-19 that are in hotel detention are managed, as per all cases, by the Existing Cases team.

When the confirmed case in hotel detention meets the criteria for release from isolation, the clearance certificate is provide (via email) to COVID.quarantine@dhhs.vic.gov.au.

Confirmed cases that meet the criteria for release from isolation, will also be eligible to be released from hotel detention.

A confirmed case that requires ongoing isolation, will not be detained longer than the 14 day quarantine period and appropriate conditions for them to maintain their isolation need to be arranged. The following table summarises situations provided in the *Guidelines for managing COVID-19 in mandatory quarantine*.

Excerpt from *Guidelines for managing COVID-19 in mandatory quarantine*

Scenario	Exit plan
Confirmed case of COVID-19 who has met criteria for release from isolation (i.e. is declared no longer infectious as per release from isolation), even if they have not completed their 14-day detention period	**Can leave** Must not be prevented from leaving if the AO is aware they are cleared and the person demands to leave They are non-infectious and therefore not a public health risk • End of isolation letter provided by PH Operations to COVID Quarantine Inbox and EOC inbox • Release from isolation by Case Manager following Health and Welfare checks • Transport should be arranged as part of the standard exit arrangements • Release outcome provided to EOC, PH Operations and Compliance Team via Case Manager
Confirmed case of COVID-19 who is still potentially infectious and has been in detention less than 14 days	• Must stay in detention.
Confirmed case of COVID-19 who is still potentially infectious but has reached the end of their 14 day detention period	**Can leave** Detention but is now subject to the Isolation (Diagnosis) Direction If Victorian Resident • Accommodation needs to be identified and EOC informed of needs prior to end of detention period – either home isolation with transport or continued hotel voluntary isolation • Safe travel to be arranged by EOC to place of isolation in Victoria (mask, stay separate, go straight to home; but preferred travel by non-emergency patient transport with PPE'd ambulance officers) If Interstate Resident • Not permitted to travel interstate / not permitted to fly domestically but no detention order needed to prevent • Accommodation needs identified and EOC informed of needs prior to end of detention period – continued hotel voluntary isolation (noting that interstate travel is not allowed)

5.2 Troubleshooting common issues

5.2.1 Confirmed case suspected of not isolating or putting others at risk

In the event that DHHS would like police attendance, either due to non-compliance with self-isolation or concern about a person's welfare (including when an officer is unable to reach case via phone after multiple attempts) - call 000 and ask for **welfare check** (the terminology is important). Explain that you are calling from DHHS about a confirmed case of COVID-19 and the nature of your concerns.

5.2.2 A close contact of a confirmed case, living in the same residence, becomes a confirmed case

Where a confirmed case lives in the same residence as a close contact, the opportunity for the confirmed case to isolate within their own house needs to be explored. If the close contact becomes a confirmed case, attempts for the two cases to remain isolated separately within their own house should be maintained. It is not yet known how likely reinfection is for recovered cases, although it is currently believed to be low.

When one of the confirmed cases in the residence is provided with "clearance from isolation" before the other, attempts at ongoing isolation within the residence should be maintained.

While attempts to isolate should be maintained, the confirmed case who has been provided clearance from isolation does not require isolation as a "close contact" of the confirmed case who is continuing isolation even if the attempts at isolation appear unsatisfactory.

5.2.3 Subsequent exposure of a confirmed case

If a confirmed case who has been "cleared" from isolation is subject to a second exposure (i.e is identified as a close contact of a confirmed case of COVID-19 after they have completed their isolation as a confirmed case), they will not need to undergo a period of isolation as a close contact

5.2.4 End of isolation criteria

A confirmed case who is isolating at home, no longer requires to be isolated in their own home, when all of the following criteria are met:

- the person has been afebrile for the previous 72 hours, and
- at least **ten days** have elapsed after the onset of the acute illness, and
- there has been a noted improvement in symptoms, and
- a risk assessment has been conducted by the department and deemed no further criteria are needed

5.2.5 Healthcare worker, return to work

Healthcare workers and workers in aged care facilities (HCWs) must meet the following additional criteria before they can return to work in a healthcare setting or aged care facility:

- PCR negative on at least two consecutive respiratory specimens collected 24 hours apart after the acute illness has resolved.

Testing for return-to-work clearance can commence once the acute illness has resolved, provided this is at least **7 days** after the onset of illness. Testing should be arranged by the healthcare worker's employer, the healthcare or aged care worker's treating doctor, or at a coronavirus assessment centre if testing by the treating doctor is not feasible. The patient should inform the department of where they intend to be tested. The department will follow up test results and provide a letter indicating that the patient can return to work once the return-to-work criteria are met.

In the event that a healthcare worker or aged care worker returns a positive PCR result from either of their first two consecutive clearance tests, wait 3 days before performing another “round” of 2 tests, 24 hours apart. If a positive PCR result is returned in this “second round” of testing, a third round of 2 tests, taken 24 hours apart should be undertaken after a further 5-7 days. In the event that respiratory specimens remain persistently PCR positive, a decision on suitability to return to work should be deferred until 21 days post symptom onset. At this time, a decision should be made on a case-by-case basis after consultation between the person’s treating doctor, the testing laboratory and the department.

The following criteria should be considered in this discussion:

- The person has met the criteria for release from isolation; AND
- The person’s symptoms have completely resolved; AND
- At least 21 days have passed since onset of the acute illness; AND
- Consideration should be given to mitigating circumstances such as the characteristics of the patients/residents which the person would care for at work (e.g. elderly or immunocompromised patients/residents). In certain high-risk settings (such as oncology wards), it may be appropriate for the HCW not to return to this setting until they have returned two negative swabs at least 24 hours apart. The timing of repeat swabs should be discussed with the treating doctor and the department.

The following procedures should be followed when performing return-to-work clearance testing:

- All HCWs should seek medical care from a medical practitioner. They should not be their own testing or treating clinician.
- All HCWs presenting for testing must wear a single use face mask and comply with infection control standards applicable to a confirmed case of COVID-19 until the department determines that release from isolation criteria are met
- Specimens should be collected using droplet and contact precautions
- Pathology requests must be clearly labelled with the following content under ‘clinical information’: **‘URGENT: HCW CLEARANCE TESTING, please notify result to DHHS**’ and results should be copied to the department’s COVID-19 Response team and the HCW’s treating physician.
- HCWs attending for return-to-work testing should be triaged as priority patients for testing.

The department will follow up the results of return-to-work testing and will contact healthcare and aged care workers regarding next steps. Once the return-to-work criteria are met, the department will provide healthcare and aged care workers with a letter confirming that they can return to work.

6 Existing close contacts

The Existing Close Contacts Team maintain contact with close contacts following an initial contact (conducted by the NCAC team). The Existing Close Contact Team make regular contact with known close contacts of confirmed COVID-19 cases to monitor their isolation, health, and escalate any concerns as necessary.

The objectives of the Existing Close Contact Team are to:

- Reduce the morbidity experienced by close contacts by:
  - Providing support and encouragement through daily contact with close contacts. Including ensuring they have accessto necessary medical support including COVID-19 testing if they develop symptoms.
- Reduce transmission of COVID-19 by:

- Ensure close contacts are aware of their isolation requirement (including known how long they must isolate for) through reinforcement of the message provided at first contact, and as a portal to answer questions cases may have.

6.1 Processes and workflow

Close contacts of confirmed cases of COVID-19 are entered into PHESS following their identification and primary consultation by the New Cases and Contact Team.

Existing Close Contact Team generate a workflow from PHESS that is populated into an excel spreadsheet that is used as a reference form for contact and outsourced to a third party (HelloWorld).

The third party (HelloWorld) records their interaction with close contacts on the spreadsheet, which is sent to the Existing Close Contact Team leader via Sharepoint twice daily; at 11:30am and end of day. The returned spreadsheet includes details of interactions with close contacts that requires further action – principally for one of three reasons:

1. The close contact has become unwell
2. The close contact is not isolating
3. The close contact requires that their last date of isolation be clarified

6.1.1 Close contacts who become unwell

Close contacts of confirmed cases of COVID-19, are at a higher risk of becoming infected themselves. It is therefore important for close contacts of confirmed cases of COVID-19, with appropriate symptoms, to undergo laboratory testing for COVID-19, to confirm the diagnosis and ensure appropriate clinical and public health management.

Close contacts of confirmed cases of COVID-19 who become unwell should present to the medical facility that is most equipped to manage the significance of their symptoms.

After being tested for COVID-19, close contacts must remain in isolation while awaiting their test result. If the test result is negative they must continue to isolate as a close contact until their 14 day isolation period has been completed. If their test result is positive, they begin a new period of isolation as a confirmed case. They will be informed of these requirements by the New Case and Contact Team, after the notification is received by DHHS (via the Notification and Triage Team).

6.1.2 Close contacts who are not isolating

Close contacts of confirmed cases of COVID-19 are informed of their isolation requirements when they are contacted by the New Cases and Contacts Team. This includes being emailed or posted the “Factsheet – close contact” that provides the details of isolation requirements in writing.

The factsheet may be re-provided to a close contact who has not received it (they should also check the SPAM or Junk folders of their email if they have not received it).

If the close contact indicates they will not comply with the home isolation requirements, they should be advised non-compliance will be escalated to police. If the close contact continues to indicate they will not comply with the isolation requirements, the Existing Close Contact Team Member contacts the Police Hotline on 131-444 to advise that this person has indicated non-compliance with the isolation requirement.

6.1.3 Close contact who requires their last date of isolation to be clarified

A dispute about the last day of isolation may be a result of misunderstanding, a change in the date that has not been conveyed to the close contact or incorrect recording in PHESS.

The last date of isolation may change if the close contact has had further (or ongoing) contact with the confirmed case, or if they have been identified as a close contact of more then one confirmed case (for example, a second person in the same house has been identified as a confirmed case.)

If there has misunderstanding or change in the date of last contact with a confirmed case the following process should be undertaken to confirm the date:

- Review PHESS notes of the contact and confirmed case
- Review original questionnaire (available on TRIM)

Once the date is confirmed, the contact must be advised of the correct end of isolation date. This must be updated and recorded in PHESS, and resent in writing, via email, to the close contact.

6.1.4 Hotel Detention

See the “guidelines for managing COVID-19 in mandatory quarantine” for further information.

- Close contacts of confirmed cases of COVID-19 that are in hotel detention are managed, as per all close contacts, by the Close Contacts Team.
- Close contact’s end date of quarantine may be past that of 14-day detention period, if they are exposed to a confirmed case during their period of hotel detention.
- No detention order required, and no legal order preventing flying, but must be advised by case and contact management sector not to fly and that they need to quarantine.

If **Victorian** Resident

- Need for accommodation is to be identified and EOC informed of needs prior to end of detention period – either home isolation with transport or continued hotel voluntary isolation
- Safe travel to be arranged by EOC to place of isolation in Victoria (mask, stay separate, go straight to home; but preferred travel by non-emergency patient transport with PPE’d ambulance officers)
- Continued management by the Close Contacts Team.

If **Interstate** Resident

- Should be advised not to travel to interstate jurisdiction, but there are no legislative powers to prevent travel
- Accommodation needs to be identified and EOC informed of needs prior to end of detention period – either interstate transport or continued hotel voluntary isolation
- Appropriate hygiene precautions must be taken if travelling by air (i.e. face masks) and people must return straight home.
- The home jurisdiction must be informed so they can be followed up as close contacts by their home jurisdiction

6.2 Troubleshooting common issues

6.2.1 A close contact who becomes unwell and refuses testing

A close contact of a confirmed case of COVID-19 who develops any symptoms consistent with COVID-19 should be requested to undergo testing. For the purposes of this guide, symptoms consistent with COVID-19 are:

- Fever or chills
- Cough
- Sore throat

- Shortness of breath
- Headache
- Myalgia
- Runny or stuffy nose
- Anosmia
- Nausea
- Vomiting
- Diarrhoea

People meeting testing criteria who are not tested for COVID-19 or any other infectious disease should self-isolate until the acute symptoms have resolved and it has been 72 hours since the last fever.

6.2.2 A close contact who needs to seek medical attention during their isolation period

Seeking medical attention is an acceptable reason for a close contact of a confirmed case of COVID-19 to leave isolation.

If an ambulance is required (for emergency treatment), when speaking to the 000 operator, the close contact should inform them that they are a close contact of a confirmed case of COVID-19 and are currently in home quarantine.

When seeking other medical attention, the close contact should call ahead and inform the staff at the facility they are attending that they are a close contact of a confirmed case of COVID-19.

If required to be driven by another person or utilise a taxi they should be informed to sit in the back seat (if possible), wear a mask if available and minimise time spent together in vehicle.

After receiving the required medical care, a close contact of a confirmed case of COVID-19 should ensure they are provided with a medical certificate that can be provided to VicPol if required, as proof of the legitimacy to leave their isolation requirements.

6.2.3 Request for documentation of quarantine end date

A contact may request an ‘end of isolation letter’. This can be emailed providing that the contact is not symptomatic, awaiting results and/or has not breached isolation guidelines if isolating with a confirmed case.

7 Management of asymptomatic cases and their contacts

Asymptomatic testing is currently being performed in Victoria in two different contexts:

1) Testing is being offered to asymptomatic individuals belonging to specific occupational groups and individuals at higher risk of severe illness as part of a 'testing blitz'. These people have a lower pre-test probability for COVID-19.
2) Testing of asymptomatic individuals is also occurring in selected high-risk outbreak settings (e.g. aged care facilities) as part of an 'active case finding' approach. These people have a higher pre-test probability for COVID-19.

7.1 Testing blitz

The current Victorian coronavirus testing blitz includes testing of asymptomatic individuals belonging to certain occupational groups. The aim of this testing is to gain information on the degree of community transmission that is occurring. Asymptomatic testing will be made available to various groups throughout the blitz. This testing is not compulsory.

Testing of asymptomatic individuals belonging to specific occupational groups may only be conducted at designated testing sites including:

- Respiratory Assessment Centres at Victorian public health services
- Respiratory Assessment Centres at community health centres
- Designated mobile drive-through testing clinics (located in retail settings)

Asymptomatic testing is being offered to those that cannot easily move their work to the home environment. This includes workers in the following industries:

- Construction
- Supermarkets
- Healthcare
- Police force
- Emergency services

Asymptomatic testing is also focusing on those who are at a higher risk of developing severe illness from infections with SARS-CoV-2. This includes members of the following groups:

- People living with chronic illness
- Aboriginal and Torres Strait Islanders

7.2 Testing protocol

Asymptomatic person offered testing as part of 'testing blitz'

Eligible populations may present for testing (SARS-CoV-2 PCR) on a voluntary basis in the absence of symptoms. There is no requirement for asymptomatic individuals to self-isolate whilst awaiting the result of a PCR test. However, asymptomatic individuals who have been identified by the department as close contacts of a case should self-quarantine until advised otherwise by the department (including whilst awaiting test results).

Samples from asymptomatic patients should be labelled as “asymptomatic testing” when sent to the laboratory.

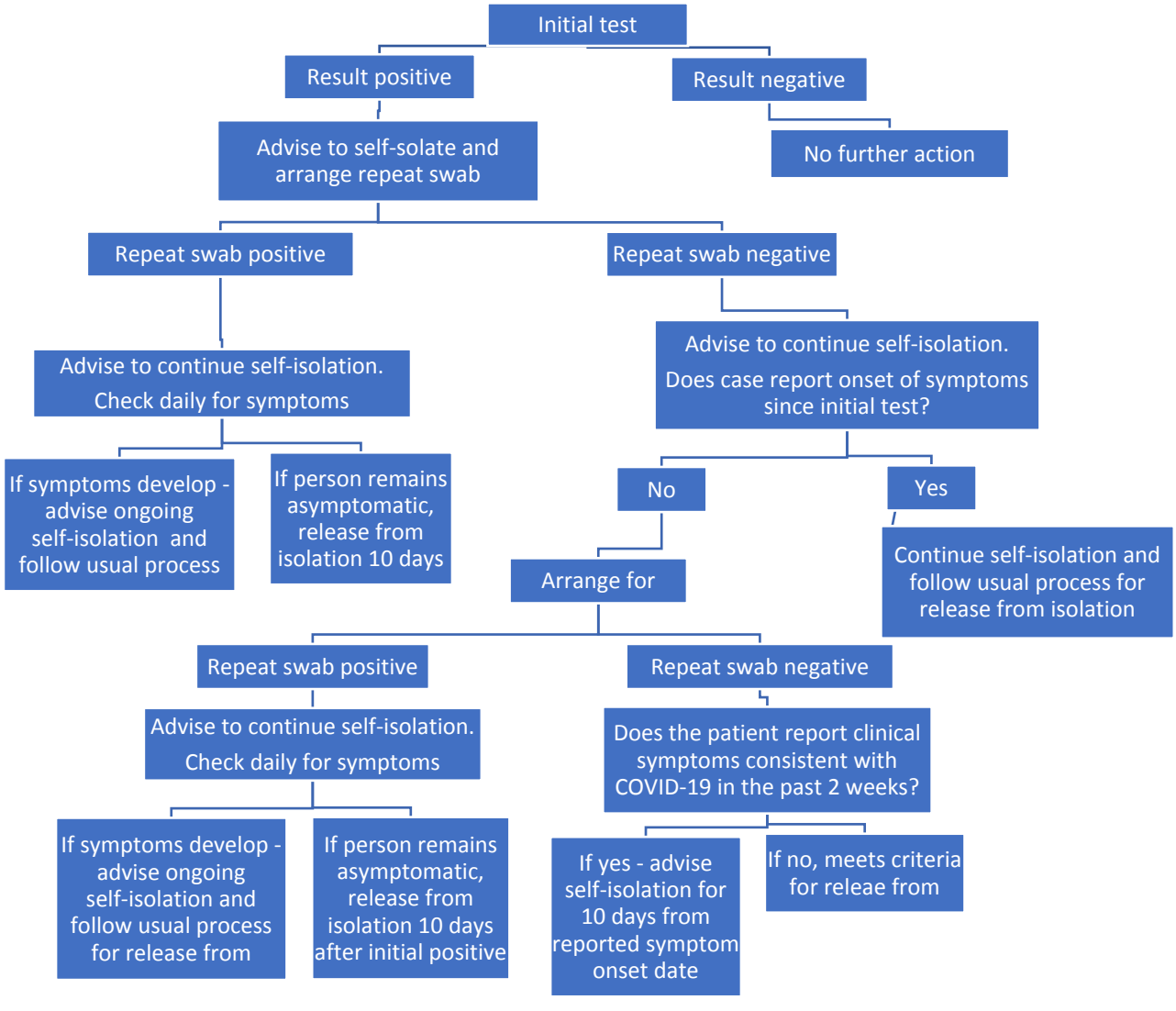
Individuals should be notified directly of the positive or negative result of the test. The current arrangement for notification of results for people who attend mobile testing centres is that those with a positive test will receive a phone call from a doctor advising them of the positive result, and those with a negative result will receive a text message from the testing laboratory.

It is the responsibility of the requesting clinician or health service to notify the department in the event of a positive result. The person will be treated as a confirmed case and a case interview and contact tracing will commence.

The requesting clinician or health service should contact the case to advise them of their positive result and request that they present for a second test. If possible, the second sample should be sent unprocessed the Victorian Infectious Diseases Reference Laboratory (VIDRL). Please ensure that the following information is provided on the pathology request form: “Repeat testing of asymptomatic positive”.

Any asymptomatic person with a positive test should be regarded as a confirmed case and should be advised to isolate. However, further testing should be undertaken as per the following algorithm:

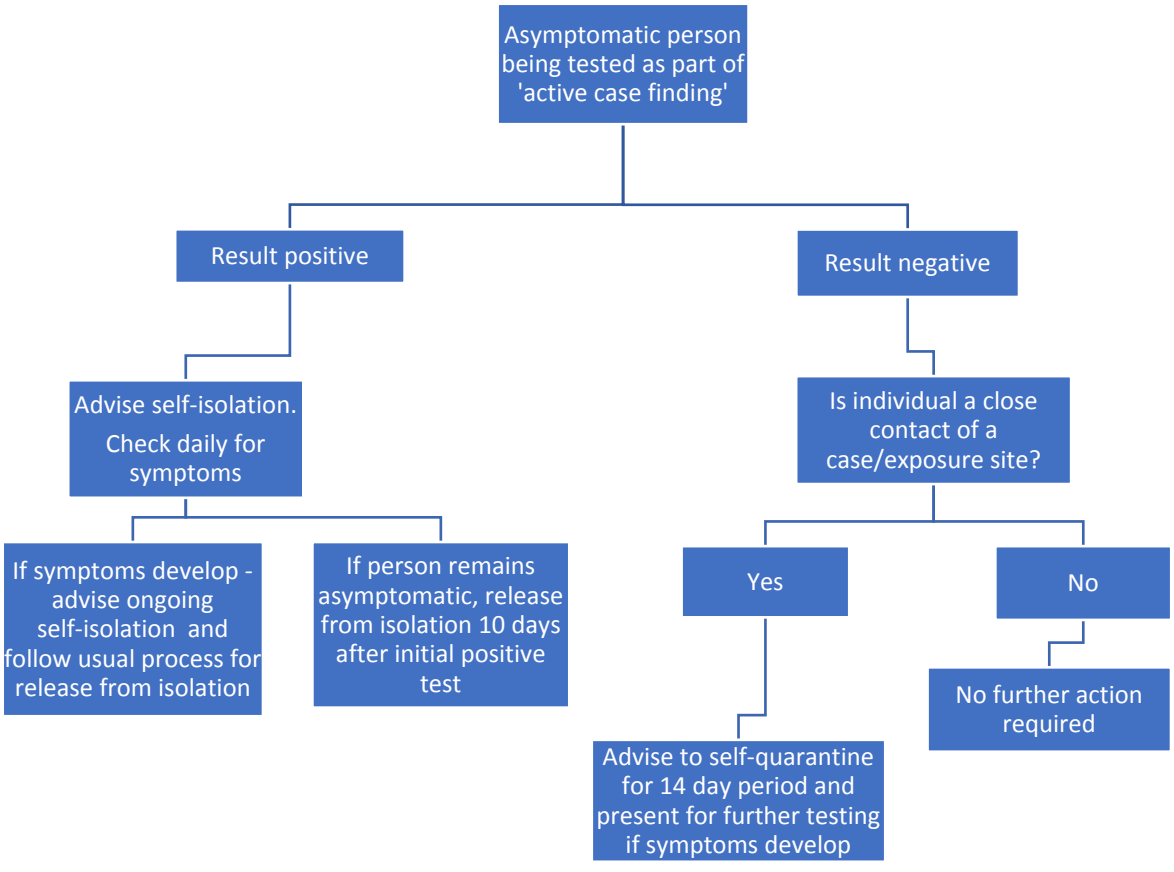
Algorithm 1: Asymptomatic person offered testing as part of testing blitz



Asymptomatic person tested as part of active case finding

In selected high-risk outbreak settings (e.g. aged care facilities), asymptomatic individuals may be offered testing as part of an 'active case finding' approach. Test results should be managed as per the following algorithm.

Algorithm 2: Asymptomatic person offered testing as part of testing blitz



7.3 Confirmed Cases

In the case of a positive result, the New Cases Team will contact the individual to conduct a case interview in the usual way. The interview will aim to establish whether the individual reports having had any recent symptoms consistent with COVID-19 preceding the positive screening test.

- If symptoms are identified, the date of onset of these symptoms should be recorded as the symptom onset date.
- If no symptoms are identified, the date of the initial positive test should be recorded as the symptom onset date

In either case, for the purposes of contact tracing the infectious period will be taken as beginning at least 48 hours prior to the recorded symptom onset date. Further investigation may extend this period.

7.4 Management of close contacts of asymptomatic cases

Close contacts of asymptomatic cases should isolate for 14 days since last contact with the case during their infectious period.

If the case is an asymptomatic person who was offered testing as part of the 'testing blitz' and has had 2 subsequent negative tests after their positive test, the close contacts may come out of isolation at the same time as the case (i.e. after the second negative test result). This is based on the following rationale:

- The pre-test probability is very low which increases the likelihood that the result is a false positive.
- It takes around seven days to return all three test results (sometimes longer).
- The case is likely at the very end of their period of infection and their infectivity is likely to be minimal in the days leading up to the initial test.

8 Glossary – Key terms

Confirmed case	A person who has the disease and meets the case definition. For COVID-

	19, the case definition is a person who tests positive to a validated SARS-CoV-2 nucleic acid test or has the virus identified by electron microscopy or viral culture.
Contact	A person who has been in contact with a confirmed case during their infectious period. Contacts are typically defined as either close contacts or casual contacts
Close contact	A person who has had greater than 15 minutes face-to-face contact (cumulative) or who has shared a closed space for more than two hours with a confirmed case during their infectious period without recommended personal protective equipment (PPE). See section 2.3.
Casual contact	A person who has been in contact with a confirmed case during their infectious period but who does not meet the definition of a close contact.
Contact tracing	The process of identifying people who are close contacts of a case, and ensuring they are quarantined for the maximum incubation period (14 days) after last close contact with the case.
COVID-19	Coronavirus disease 2019 (the name of the disease). COVID-19 was initially referred to as “novel coronavirus” (2019-nCoV) and is sometimes referred to as just “coronavirus”
Incubation period	The period of time between exposure to the disease and the onset of symptoms. For COVID-19 this is not yet known, but the interim view is up to 14 days (mean incubation period ~5-6 days)
Infectious agent	An infectious microorganism that causes disease – including viruses, bacteria, protozoa and fungi. The infectious agent that causes COVID-19 is the virus SARS-CoV-2.
Infectious period	Also known as the “communicable period,” this is the period during which an infected person can transmit an infectious agent to a susceptible person. The duration of the infectious period for COVID-19 is unknown. However, for the purposes of isolation and contact tracing, cases are considered to be infectious from 48 hours prior to the onset of symptoms, until they meet criteria for release from isolation.
Isolation	Isolation refers to the physical separation of ill people with a communicable disease (e.g. COVID-19) from those who are healthy
PPE	Personal protective equipment. This is clothing or equipment designed to be worn by someone to protect them from the risk of illness. For COVID-19, this usually means a mask, eye protection, gown and gloves.
Quarantine	Quarantine refers to the physical separation of people who are well but who may have been exposed with a communicable disease (e.g. contacts of a COVID-19 case) and are potentially infectious to see if they become ill.
SARS-CoV-2	Severe acute respiratory syndrome coronavirus 2 (the virus that causes COVID-19)
Sensitive settings	Settings at high risk for rapid transmission of infectious diseases and/or that have vulnerable people at high risk of serious illness or death. Sensitive settings include: • Healthcare settings • Aged care and residential care facilities • Prison / justice settings (correctional facilities, detention centres) • Aboriginal rural and remote communities

	• Boarding schools • Military operational settings • Educational settings where students are present (e.g. schools) • Childcare centres • Settings where COVID-19 outbreaks have previously occurred (e.g. cruise ships) Cases in these settings are likely to attract media attention.
Transmission	The spread of an infectious agent from one host (person or animal) to another is called transmission. COVID-19 is primarily transmitted through direct or indirect contact with respiratory droplets containing the virus, typically produced when and infectious person coughs or sneezes.

Case Questionnaire
COVID-19 (Novel Coronavirus) —Part A

VICTORIA State Government | Health and Human Services

Case classification
- ☐ Confirmed
- ☐ Suspected
- ☐ Person Under Investigation
- ☐ Contact
- ☐ Rejected

PHESS ID
320

Information

Transmission
Person-to-person transmission and possible animal-to-human transmission.

Incubation period
Uncertain, probably 2–14 days.

Infectious period
Generally 48 hours prior to symptom onset to 10 days post symptom onset, BUT can vary for individuals

Interview information

Person interviewed
- ☐ Case
- ☐ Parent/guardian/carer
- ☐ General practitioner
- ☐ Treating doctor
- ☐ Other, specify > _____

Interviewed by _____

Date of interview ___ ___ ___

Privacy message (must be provided at the beginning of interview)

The information we require is for the purpose of investigating the cause of your illness and preventing further cases. This means that we may need to speak with people you have been in contact with, in line with Public Health and Wellbeing legislation. All information collected is held in confidence by the department and protected by legislation. Information is only shared where necessary and only with authorised relevant parties. Further information on the department's privacy policy is available should you require it.

☐ Statement read to case or person representing the case

Further information for the case

A state of emergency was declared for Victoria on the 16 March 2020 which provides the Chief Health Officer with additional powers to do whatever is necessary to contain the spread of COVID-19 and reduce its risk to the health of Victorians.
Under the Public Health and Wellbeing Act I am authorised to collect the necessary information in order to prevent further cases. We require this information to investigate the cause of your illness. All information collected is held in confidence by the department and protected by legislation. Your privacy is protected and information is only shared where necessary.

Case details

Family name | **First name(s)**

Birth date ___ ___ ___ | **Age**

Sex
- ☐ Male
- ☐ Female
- ☐ Other > _____

Address

City | **State/Territory** | **Postcode** | **Country**

Telephone | **Email**

Accommodation type
- ☐ Private residence
- ☐ Hospital
- ☐ Psych facility
- ☐ Prison/remand
- ☐ Aged care
- ☐ Hostel/boarding
- ☐ Other, specify > _____

Name (if applicable) of ☐ Parent ☐ Guardian ☐ Carer

320

Demographics

Aboriginal or Torres Strait Islander

- ☐ No
- ☐ Aboriginal
- ☐ Torres Strait Islander
- ☐ Both Aboriginal and Torres Strait Islander
- ☐ Unknown
- ☐ Not stated

Country of birth **...year arrived in Australia**

- ☐ Australia
- ☐ Overseas, specify country > _____ _____

Interpreter required

- ☐ No
- ☐ Yes, specify language > _____

Alive/deceased **...date of death** **...cause of death** (if other than the notifiable condition)

- ☐ Alive
- ☐ Died from the notifiable condition > _____ _____
- ☐ Died from other/unknown causes >
- ☐ Unknown

Work / Study / Care

Is the case a healthcare worker

- ☐ Yes
- ☐ No

Occupation

Employer/school/child care centre

Address

City **State/Territory** **Postcode** **Country**

Contact person **Telephone work** **Telephone mobile**

Email **Fax**

Normal hours of attendance **Last attended before onset** **During the period of interest**

- ☐ Yes
- ☐ No

Notes

320

General Practitioner

Doctor name

Medicare provider number

Clinic/centre/hospital name

Address

City

State/Territory

Postcode

Country

Contact person

Telephone work

Telephone mobile

Email

Fax

Hospital Presentation

Presented to hospital
☐ Yes
☐ No

Presentation date

Admitted to hospital
☐ Yes
☐ No

Admission date

Discharged date

Discharged
☐ Alive
☐ Deceased

Admitted to ICU
☐ Yes
☐ No

Hospital name

Ward

Hospital UR

Address

Treating doctor/team

Telephone work

Pager

Email

Fax

Treating doctor informed that DHHS will conduct follow-up interview with case or NOK
☐ Yes
☐ No

Infection control notified
☐ Yes >
☐ No
☐ Not applicable

...ICC notified on

ICC name

ICC telephone

Home Isolation

Where is the case currently
☐ Hospital admission (as above)
☐ Home isolation, date commenced >
☐ Hotel detention, date commenced >

Hotel name and address >

320

Clinical risks

Date of first symptom(s)

Symptoms

ARDS	☐ Yes ☐ No
Cough	☐ Yes ☐ No
Diarrhoea	☐ Yes ☐ No
Fever _____°C	☐ Yes ☐ No
Fever by self report	☐ Yes ☐ No
Pneumonia - clinical diagnosis	☐ Yes ☐ No
Pneumonia - diagnosed by CXR	☐ Yes ☐ No
→ Describe	
Pneumonitis	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No
Sore throat	☐ Yes ☐ No
Other symptoms	☐ Yes ☐ No
→ Describe	

Clinical notes

Received oxygen therapy
☐ Yes
☐ No

Intubated
☐ Yes
☐ No

Received Extracorporeal Membrane Oxygenation (ECMO)
☐ Yes
☐ No

Does the case have any of the following conditions that may place them at risk of severe complications

☐ Chronic respiratory conditions (incl. asthma and COPD)
☐ Cardiac disease (not simple hypertension)
☐ Diabetes mellitus
  ☐ Type 1 ☐ Type 2
☐ Immunosuppression (incl. cancer, HIV/AIDS)
☐ Immunosuppressive therapy
☐ Haemoglobinopathies
☐ Neurological
☐ Renal failure
☐ Morbid obesity
☐ Metabolic diseases
☐ Pregnancy
☐ Other, specify >
☐ No conditions identifed

Epidemiological risks

Within 14 days of symptom onset did the case have contact with a case of confirmed COVID-19
☐ Yes, specify >
☐ No

PHESS ID or name of case

Location
☐ Case in Australia
☐ Overseas, specify

Likely exposed on

At the time of testing, was the case aware they had had contact with a case of confirmed COVID-19 ☐ Yes ☐ No

From 48 hours prior to symptom onset has the case been in isolation / quarantine ☐ Yes ☐ No

In the 14 days prior to symptom onset did the case have any contact with hospitals / other healthcare
☐ Yes, specify setting >
☐ No

Since 48 hours prior to symptom onset has the case had any contact with hospitals / other healthcare
☐ Yes, specify setting >
☐ No

Did the case travel in Australia in the 14 days prior to symptom onset
☐ Yes, specify >
☐ No

☐ VIC ☐ QLD
☐ ACT ☐ SA
☐ NSW ☐ TAS
☐ NT ☐ WA

Purpose / destination Provide full travel details on page 5

Did the case travel overseas in the 14 days prior to symptom onset
☐ Yes, specify >
☐ No

Country

Purpose / destination Provide full travel details on page 5

320

Incubation period - Interview prompts

It is important to determine where the case could have acquired their illness.

Incubation period
Uncertain, probably 2–14 days.

In the 14 days prior to symptom onset

- **Has the case travelled? If Yes:**
  - When?
  - Where did they travel?
  - With whom?
  - How? Obtain flight / train / ship / bus / tram details. Also consider: seat number / cruise name / stopovers.

- **If the case denies travel:**
  - Have they used public transport?
  - Have they been to their workplace? Their partner's workplace? Their children's school or childcare? How did they get there?
  - Have they attended a function? Wedding / birthday party / meal / sporting event / any social gathering
  - Have they attended a public site? Shopping centre / mall / sports ground / train station
  - Who have they spent time with?

- **Other things to ask:**
  - Have they been in contact with anyone who has been ill with an influenza-like illness? Who? Where? When?
  - Have they been in contact with anyone who is ill? Who? Where? When?
  - Have they been in contact with a person who has recently returned from travelling? Who? Where? When? Had the person been travelling overseas, or within Australia?

Notes

Provide the timeline of exposure history below (from 14 days prior to symptom onset)

Date	Exposure / City / Country	Details of exposure / travel

320

Exposure history - Interview prompts

It is important to identify who the case may have exposed.
Any close contacts identified MUST be documented in Part B of this questionnaire.

Infectious period
Generally 48 hours prior to symptom onset to 10 days post symptom onset, BUT can vary for individuals

From 48 hours prior to symptom onset:

- **Has the case travelled? If Yes:**
  - When?
  - Where did they travel?
  - With whom?
  - How? Obtain flight / train / ship / bus / tram details. Also consider: seat number / cruise name / stopovers.

- **If the case denies travel:**
  - Have they used public transport?
  - Have they been to their workplace? Their partner's workplace? Their children's school or childcare? How did they get there?
  - Have they attended a function? Wedding / birthday party / meal / sporting event / any social gathering
  - Have they attended a public site? Shopping centre / mall / sports ground / train station
  - Who do they live with?
  - Who have they spent time with?

Notes

Timeline of activity and travel from 48 hours BEFORE symptom onset

Date	Exposure type	Specify (country, suburb, flight, etc.)	Details of travel or activity

Case Questionnaire Part B: Close Contacts

320

Contact with others (for a confirmed case)

For the purposes of the case definition, Close contact is defined as any of the following:

- Living in the same household or household-like setting (e.g. in a boarding school or hostel);
- A person who spent 2 hours or longer in the same room (such as a GP or ED waiting room);
- Direct contact with body fluids or laboratory specimens of a confirmed case without recommended PPE;
- A person in the same hospital room when an aerosol generating procedure is undertaken on the case, without recommended PPE
- Face-to-face contact for more than 15 minutes with the case in any other setting not listed above

Please provide details of any close contact identified below.
This page should be photocopied if more than 7 close contacts are identified.

Contact name

Birth date

Contacted by DHHS
☐ Contact called
☐ Contact emailed

Address

Sex ☐ Female ☐ Male ☐ Other

Date called/emailed

Phone number

Email address

Aboriginal or Torres Strait Islander
☐ No
☐ Aboriginal
☐ Torres Strait Islander
☐ Both Aboriginal and Torres Strait Islander
☐ Unknown

Contact type
☐ Health care
☐ Work/school
☐ Travel
☐ Household

Relationship to case

Date of last contact

Contact name

Birth date

Contacted by DHHS
☐ Contact called
☐ Contact emailed

Address

Sex ☐ Female ☐ Male ☐ Other

Date called/emailed

Phone number

Email address

Aboriginal or Torres Strait Islander
☐ No
☐ Aboriginal
☐ Torres Strait Islander
☐ Both Aboriginal and Torres Strait Islander
☐ Unknown

Contact type
☐ Health care
☐ Work/school
☐ Travel
☐ Household

Relationship to case

Date of last contact

Contact name

Birth date

Contacted by DHHS
☐ Contact called
☐ Contact emailed

Address

Sex ☐ Female ☐ Male ☐ Other

Date called/emailed

Phone number

Email address

Aboriginal or Torres Strait Islander
☐ No
☐ Aboriginal
☐ Torres Strait Islander
☐ Both Aboriginal and Torres Strait Islander
☐ Unknown

Contact type
☐ Health care
☐ Work/school
☐ Travel
☐ Household

Relationship to case

Date of last contact

Contact with others - Part B: Close Contacts; continued

Contact name

Birth date

Contacted by DHHS
- [ ] Contact called
- [ ] Contact emailed

Date called/emailed

Address

Sex
- [ ] Female
- [ ] Male
- [ ] Other

Phone number

Email address

Aboriginal or Torres Strait Islander
- [ ] No
- [ ] Aboriginal
- [ ] Torres Strait Islander
- [ ] Both Aboriginal and Torres Strait Islander
- [ ] Unknown

Contact type
- [ ] Health care
- [ ] Work/school
- [ ] Travel
- [ ] Household

Relationship to case

Date of last contact

Contact name

Birth date

Contacted by DHHS
- [ ] Contact called
- [ ] Contact emailed

Date called/emailed

Address

Sex
- [ ] Female
- [ ] Male
- [ ] Other

Phone number

Email address

Aboriginal or Torres Strait Islander
- [ ] No
- [ ] Aboriginal
- [ ] Torres Strait Islander
- [ ] Both Aboriginal and Torres Strait Islander
- [ ] Unknown

Contact type
- [ ] Health care
- [ ] Work/school
- [ ] Travel
- [ ] Household

Relationship to case

Date of last contact

Contact name

Birth date

Contacted by DHHS
- [ ] Contact called
- [ ] Contact emailed

Date called/emailed

Address

Sex
- [ ] Female
- [ ] Male
- [ ] Other

Phone number

Email address

Aboriginal or Torres Strait Islander
- [ ] No
- [ ] Aboriginal
- [ ] Torres Strait Islander
- [ ] Both Aboriginal and Torres Strait Islander
- [ ] Unknown

Contact type
- [ ] Health care
- [ ] Work/school
- [ ] Travel
- [ ] Household

Relationship to case

Date of last contact

Contact name

Birth date

Contacted by DHHS
- [ ] Contact called
- [ ] Contact emailed

Date called/emailed

Address

Sex
- [ ] Female
- [ ] Male
- [ ] Other

Phone number

Email address

Aboriginal or Torres Strait Islander
- [ ] No
- [ ] Aboriginal
- [ ] Torres Strait Islander
- [ ] Both Aboriginal and Torres Strait Islander
- [ ] Unknown

Contact type
- [ ] Health care
- [ ] Work/school
- [ ] Travel
- [ ] Household

Relationship to case

Date of last contact

320

Public health actions

Is the case in a high risk occupation, such as a health care worker
☐ Yes → **Exclusion discussed with case** ☐ Yes ☐ No
☐ No → **Exclusion letter sent by DHHS** ☐ Yes ☐ No
☐ Not applicable → **Infection control guidelines sent to institution** ☐ Yes ☐ No

Part of a cluster or outbreak
☐ Yes > PHESS Exposure site ID
☐ No

Voluntary home quarantine commenced
☐ Yes, commenced on
☐ No
☐ Not applicable

Case informed to notify doctor or hospital if symptoms worsen
☐ Yes, informed on →
☐ No
☐ Not applicable

All close contacts identified
☐ Yes → **All close contacts contacted** ☐ Yes ☐ No
☐ No

Public exposure sites identified
☐ Yes → **Public exposure sites documented** ☐ Yes ☐ No ☐ Not applicable
☐ No

Public health actions completed
☐ Yes
☐ No

Other actions

Education

Preventing transmission of COVID-19 discussed
☐ Yes →
☐ No
☐ Not applicable

Case provided with factsheet
☐ Yes, sent on →
☐ No
☐ Not applicable

Information sent to workplace / school / child care / institution
☐ Yes, sent on →
☐ No
☐ Not applicable

Privacy information requested by case
☐ Yes, sent on →
☐ No
☐ Not applicable

Directed to website for further information
☐ Yes, sent on →
☐ No
☐ Not applicable

Case summary

Investigation type
☐ Single case
☐ Contact, specify >
☐ Outbreak investigation, specify >
☐ Cluster investigation

PHESS ID & name

Notifying doctor informed of our intent to contact case
☐ Yes, informed on →
☐ No
☐ Not applicable

320

Interview log

Date	Time	Completed	Interviewer	Notes
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		

Notes

Coronavirus disease 2019 (COVID-19)

Case and Contact Management

Quick Guide

Health Protection Branch

Version 9

1 April 2020

VICTORIA State Government | Health and Human Services

Version control

Version number	Comment	Date of approval
v 2	Updated countries with risk	11 February 2020
v 3	Updated with new case definition and biosecurity screening	20 February 2020
v 4	Updated case definition; updates to countries with risk, travel restrictions and quarantine requirements	6 March 2020
v 5	Updated case definition	10 March 2020
v 6	Updated case definition	14 March 2020
v 7	Changes to checklists and overall structure of document	23 March 2020
V 8	Changes to structure and inclusion of procedures for notifications, case interviews and onboarding	26 March 2020

Last updated: 26/03/2020

This document is available at:

[HHSD/20/109310]

Contents

Summary

Coronavirus disease 2019 (COVID-19) was first diagnosed in Wuhan City, Hubei Province, China in December 2019. The knowledge and understanding of this disease and public health impact is rapidly evolving, therefore the information contained in this short guide is purposely concise and will be updated as regularly as possible, and where appropriate date stamped to indicate version control.

This short guide provides a series of checklists, procedures and links to relevant resources for the following scenarios:

1) Taking a notification
2) Suspected case
3) Confirmed case
4) Close contact
5) Casual contact

This short guide is to be used in conjunction with the Guideline for health services and general practitioners which provides a comprehensive overview of roles, responsibilities and tasks.

Orientation

Notification and Case Officer (NCO) role

The NCO role may involve:

- Taking a notification.
- Performing case interviews with confirmed cases.
- Identifying close contacts and casual contacts.
- Providing advice directly to close contacts.
- Escalating instances of higher risk to Team Leaders.

Key steps for orientation

1. Read your specific role card
2. Read this guide.
3. Obtain a calendar for calculation of time between travel, onset of symptoms and a map of affected parts of the world.
4. Familiarise yourself with the department's website - https://www.dhhs.vic.gov.au/novelcoronavirus.
5. Read the *Coronavirus Disease 2019 (COVID-19) Guideline for Health Services and General Practitioners*, and *Coronavirus Disease (COVID-19) General Practice Quick Reference Guide* and other factsheets at https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-novel-coronavirus.
6. Briefly role play scenarios with a public health officer including key tasks as outlined in the role description above.
7. Practice taking down the critical information associated with notifications and case management:
    a. **Where** the person has travelled to (domestic or international)
    b. The **date the person left the country or other domestic location.**
    c. Whether the person has been in **close contact with a confirmed case**, and if so the date and nature of the contact;
    d. Whether the person was **required to be in quarantine** and was in quarantine (self-isolation) – currently all people who have returned from international travel or those who have been a close contact of a confirmed case;
    e. The **date of onset of first symptoms** of illness (date of onset)
    f. Symptoms including whether these meet the clinical case definition and the **date any evidence of pneumonia** began (shortness of breath, cough) (as the person MAY be more infectious at that point);
    g. Any attendance at a **sensitive setting** while symptomatic (school, hospital, public spaces);
    h. The **occupation** of the person with a particular focus on those who may work in sensitive settings (e.g. health services, education and learning centres, aged care homes)
    i. **Date of isolation** – the time when the patient was placed into isolation.
8. Note situations requiring escalation. At the current time these are:
    a. Any calls from an airport or seaport;
    b. Confirmed case who was symptomatic while in a sensitive setting (school, health service);

c. Any instance where the NCO is unsure of the advice or actions required.

9. Note the key elements of a handover / escalation for suspected case (given as an example):

- *35 year old female Victorian resident*
- *Was in Sichuan Province of mainland China and left on 29 January*
- *Stayed in Hong Kong on 1 February and entered Australia on 2 February*
- *Date of onset 4 February with cough and fever*
- *Attended St Elsewhere's School on 5 February for one day*
- *Presented to A Good Medical Practice on 6 February*
- *Meets suspected case definition and agreed to be tested in the practice*
- *Advised to isolate and talked through and provided access to factsheet*

Key resources

The following resources should be accessed and read.

Title	Main audience	TRIM/Sharepoint Link
Notifiable Conditions Form – 2019-nCoV	Internal	HHSD/20/43559
Case Questionnaire	Internal	HHSD/20/40106
Suspected case factsheet	External	HHSD/20/67126 Webpage
Confirmed contact factsheet	External	HHSD/20/67125 Webpage
Close contact factsheet	External	HHSD/20/67123 Webpage
Casual contact factsheet	External	HHSD/20/67121 Webpage
Novel Coronavirus Case and Contact Management Quick Guide	Internal	HHSD/20/109310 **This document**
Novel Coronavirus GP Quick Guide	External	HHSD/20/67141 Webpage
Novel Coronavirus Guideline for health services and general practitioners	External	Webpage
CDNA National Guidelines for Public Health Units – COVID-19	External	https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm
Commonwealth Department of Health resources (collection)	External	https://www.health.gov.au/resources/collections/coronavirus-covid-19-resources-for-health-professionals-including-aged-care-providers-pathology-providers-and-healthcare-managers

Webpage for all documents noted above is: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-novel-coronavirus

Core assessment tools

Importance of checking on versions

The current case definition and close and casual contact definitions are regularly updated and are located in three places.

Always check you have the most up to date version at the start of each shift.

1. The DHHS webpage at https://www.dhhs.vic.gov.au/novelcoronavirus
2. The current version of the Guideline for health services and general practitioners, also available at https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-novel-coronavirus
3. This guide.

Case definitions/testing criteria

People without symptoms should not be tested.

Patients who meet at least one clinical AND at least one epidemiological criterion should be tested:

Clinical criteria:

Fever (≥38°C) or history of fever (for example night sweats, chills)

OR

Acute respiratory infection (for example, shortness of breath, cough, sore throat).

Epidemiological criteria:

Close contacts of confirmed COVID-19 cases with onset of symptoms within 14 days of last contact

OR

Travelers from overseas with onset of symptoms within 14 days of return

OR

Cruise ship passengers and crew with onset of symptoms within 14 days of return

OR

Paid or unpaid workers in healthcare, residential care, and disability care settings

OR

Homelessness support, child protection workers (including youth justice workers), and police officers who have worked in public facing roles within the last 14 days

OR

Immunosuppressed patients admitted to hospital

Note: Patients who are considered immunosuppressed include:

- *Patients with primary or acquired immunodeficiency*
    - *Haematologic neoplasms: leukaemias, lymphomas, myelodysplastic syndromes*

  - *Post-transplant: solid organ (on immunosuppressive therapy), haematopoietic stem cell transplant (within 24 months)*
  - *People living with HIV who have symptomatic infection/AIDS or CD4 <200 cells/mm³*
- *People who are receiving the following medical treatments:*
  - *Chemotherapy or radiotherapy (within last 3 months)*
  - *Oral corticosteroids (≥20mg per day of prednisolone equivalent dose for ≥14 days)*
  - *Biologic or targeted synthetic disease-modifying anti-rheumatic drugs*

OR

Patients who are Aboriginal or Torres Strait Islander people

OR

Patients in other high-risk settings

Note: High risk settings include:

- *Aged care, disability and other residential care facilities*
- *Military operational settings*
- *Boarding schools*
- *Correctional facilities*
- *Detention centres*
- *Settings where COVID-19 outbreaks have occurred, in consultation with the department.*

The following patients should also be tested:

- Patients admitted to hospital with acute respiratory tract infection **AND** fever *(≥38°C)* without another immediately apparent cause such as urinary tract infection or cellulitis.

Confirmed case:

A person who tests positive to a validated SARS-CoV-2 nucleic acid test or has the virus identified by electron microscopy or viral culture.

Only confirmed cases need to be notified to the department. Notify the department of confirmed cases as soon as practicable by calling 1300 651 160, 24 hours a day.

General comments:

- Clinical judgement should be exercised in testing hospitalised patients.
- All patients being tested for COVID-19 should home isolate until test results are available. All patients should attend an emergency department if clinical deterioration occurs.

Definition of close contact

For the purposes of testing, the department advises a precautionary understanding of close contact. In keeping with definitions of close contact developed in other jurisdictions, close contact means greater than 15 minutes face-to-face or the sharing of a closed space for more than two hours with a confirmed case without recommended personal protective equipment (PPE) which is droplet and contact precautions for the definition of contact.

Contact needs to have occurred during the period of 24 hours prior to onset of symptoms in the confirmed case until the confirmed case is no longer considered infectious to be deemed close contact.

Examples of close contact include:

- living in the same household or household-like setting (for example, a boarding school or hostel)
- direct contact with the body fluids or laboratory specimens of a confirmed case without recommended PPE (droplet and contact precautions)
- a person who spent two hours or longer in the same room (such as a GP clinic or ED waiting room, a school classroom; an aged care facility)
- a person in the same hospital room when an aerosol generating procedure (AGP) is undertaken on the case, without recommended PPE for an AGP (airborne and contact precautions)
- Aircraft passengers who were seated in the same row as the case, or in the two rows in front or two rows behind a confirmed COVID-19 case.
- For aircraft crew exposed to a confirmed case, a case-by-case risk assessment should be conducted by the airline to identify which crew member(s) should be managed as close contacts. This will include:
  - Proximity of crew to confirmed case
  - Duration of exposure to confirmed case
  - Size of the compartment in which the crew member and confirmed case interacted
  - Precautions taken, including PPE worn, when in close proximity to the confirmed case
  - If an aircraft crew member is the COVID-19 case, contact tracing efforts should concentrate on passengers seated in the area where the crew member was working during the flight and all of the other members of the crew.
- Close contacts on cruise ships can be difficult to identify, and a case-by-case risk assessment should be conducted to identify which passengers and crew should be managed as close contacts.
- Face-to-face contact for more than 15 minutes with the case in any other setting not listed above.

Healthcare workers (HCWs) and other contacts who have taken recommended infection control precautions, including the use of recommended PPE (droplet and contact precautions for the purposes of this contact definition), while caring for a suspected or confirmed case of COVID-19 are **not** considered to be close contacts.

Process for taking a notification of COVID-19

Notifications are received by the Triage and Notification Team via telephone.

The notifications being received are provided by laboratories and clinicians.

1. Complete a 'Notification of COVID-19 (novel coronavirus) by Medical Practitioners' form (HHSD/20/43559).
    a. If the notification is from a laboratory, collect and complete the form as much information as possible, including the following as core data sets.
        i. If the laboratory has already notified the testing clinician and if not, when they will be doing so.
        ii. Patient demographic details (full name, date of birth, other).
        iii. Patient contact information (mobile, telephone number).
        iv. Testing clinician details (name, health service, practitioners' details, contact details).
        v. Clinical details included on the pathology request (symptoms, onset, comorbidities)
        vi. Any details which suggest that the case may be from a sensitive setting (e.g. health care worker, aged care resident, school student).
    b. If the notification is from a clinician, collect as much information as possible, as above and including the following.
        i. Ask if the clinician has advised the patient of their diagnosis and if not, when they will be doing so.
        ii. If they have not already called the patient, ask that they inform the patient that the Victorian Department of Health and Human Services will be contacting them to discuss their illness, recent history and contact information.

Patient demographic and contact information in vital for the completion of case and contact management during this response, this include patient phone numbers and occupational details. If a laboratory is unable to provide this information, you must ensure that the testing clinicians details are collected and that they are accurate.

2. Notifications should be given to the data entry team for input. These are processed, entered into the Public Health Events Surveillance System (PHESS) and provided to the New Case and Contact Team.

Escalation of notifications

Advise your team leader of the new case and highlight if there is any information linking the case to a sensitive setting. This may include the cases occupation or notes from the testing clinician indicating that the case attended a sensitive setting while symptomatic.

Sensitive settings currently include

a. Schools
b. Hospitals, or
c. Age care or residential care facilities
d. Large gatherings or public places

Process for interviewing confirmed cases of COVID-19

The New Case and Contact Tracing Team is informed of all notifications by the Triage and Notification Team. The Team Lead is responsible for notifying the Operations Lead if there is any suggestion that the case is related to a sensitive setting or may indicate community transmission

A 'COVID-19 tracker' form is attached to the front of each case questionnaire and allocated for interviewing by the New Case and Contact Trace Team Lead.

To undertake existing close contact management:

1. Contact the case and complete the 'Case Questionnaire COVID-19 (Novel Coronavirus)' (HHSD/20/40106).
    a. All interviewers must introduce themselves and explain the purpose of the call, the details that will be collected, announce the privacy statement included in each questionnaire and inform the case of the steps that will be undertaken during their period of quarantine.
        i. This will include daily monitoring, contact tracing, health recovery status (further detail is provided below under case tracing).
    b. Collect and complete the questionnaire with as much information as possible, including the following as core data sets
        i. Case details: basic demographic information and contact information.
        ii. Work/study/care: ensure that any sensitive settings are identified.
        iii. General practitioner and hospital presentation details.
        iv. Clinical risks: ensure that you capture the date of first symptoms.
        v. Travel/exposure history in the 14 days to symptom onset: assists in determining potential acquisition site (i.e. where the case was infected).
        vi. Activity and travel from 24 hours before symptom onset: assists in determining people and places at risk (i.e. reflects the infectious period for the case).
        vii. Contact with others: identify close contacts (see definition above and in questionnaire).
2. Conclude the interview by explaining the requirements of home isolation for the case and that contact will be made by the department with the identified close contacts.
3. Send the generic 'confirmed case' email and fact-sheet to the case from the publichealth.operations@dhhs.vic.gov.au inbox.
4. If there are any issues relating to the identification of close contacts, discuss with the new case and contact tracing lead.

Escalation of notifications

Advise your team leader if there are any issues relating to the identification of close contacts, sensitive settings (as defined above).
It is the team leader's responsibility to escalate the case to the case and contact manger or operations lead.
It is the team leader's responsibility to ensure all case questionnaires, contacts and exposure sites are entered into PHESS.

Process for managing existing confirmed cases

Daily contact is made with confirmed cases of COVID-19. The purpose is to monitor the isolation, health and recovery status of the case, and to escalate any concerns of health issues.

After being interviewed, confirmed cases are informed of the required daily contact and are instructed to reply to contact made by the department.

Existing Case Team leaders will allocate cases to be contact to each officer.

To undertake management of existing confirmed cases:

1. Contact the case daily through Soprano. See guide for Soprano here. The following text should be used.
    a. Hello, this is a message from the Victorian Department of Health and Human Services for confirmed cases of COVID-19. If your condition remains stable or you are asymptomatic, you should continue to isolate until advised otherwise by the department. If you require assistance or have specific concerns, please call 1300 651 160 and ask to speak to someone in the Existing Cases team. If your condition is worsening and you require medical attention, please contact your local health care provider or hospital for review. Thank you.
    b. If the case does not have a mobile phone, but has an email address, send the above message by email using the publichealth.operations@dhhs.vic.gov.au inbox.
    c. If the case has neither or a mobile phone or an email address, or has been identified as vulnerable and requiring additional support, call the case.
2. Existing confirmed cases are likely to make contact with the department with questions or concerns. Health services where existing cases may present or are being managed may also call for advice.
3. Any concerns regarding an existing confirmed case should be escalated to the sector lead with consultation (as required) with the Existing Case lead, Operations lead and Specialist Medical Advice cell.
4. It is the department's responsibility to advise confirmed cases when they can be released from self-isolation. The following criteria must be met to clear a case from isolation. The earliest that a case can be cleared is ten days after the onset of symptoms.
    a. The patient has been afebrile for the previous 72 hours, and
    b. At least ten days have elapsed after the onset of the acute illness, and
    c. There has been a noted improvement in symptoms, and
    d. A risk assessment has been conducted by the department and deemed no further criteria are needed.
    e. **Testing is not required to be cleared.**
5. Health care workers and workers in aged care facilities must meet the following criteria for release from isolation
    a. the person has been afebrile for the previous 48 hours
    b. resolution of the acute illness for the previous 24 hours
    c. be at least seven days after the onset of the acute illness
    d. PCR negative on at least two consecutive respiratory specimens collected 24 hours apart after the acute illness has resolved

6. Generate a ‘Clearance letter – to Case’ form from PHESS and email to the case when they have been cleared.

Process for managing new contacts of confirmed cases

All cases of COVID-19 are interviewed to determine their exposure history and identify contacts or individuals. Each of these contacts must be informed of their exposure and instructed to remain isolated at home, to monitor their symptoms and report any illness to the department as soon as possible.

New Case and Contact Tracing Team leaders will allocate each officer to a group of contacts.

To undertake new close contact management:

1. Call the case to provide information and obtain an email address or an alternative mobile contact number. Send the generic 'close contact' email and factsheet from the publichealth.operations@dhhs.vic.gov.au inbox.
    i. The following script can be used if needed.

Hello, my name is – officer name.
Am I speaking to – case name.
I'm calling from the Department of Health and Human Services. I work in the Infectious Diseases Unit as part of the response to the coronavirus virus pandemic.

The reason for may call is that you have been identified as a close contact of someone who is a confirmed case of coronavirus or COVID-19.

This means that you have been in close proximity to someone with COVID-19 for a sufficient period of time to be considered at risk.

I need to provide you with some information regarding what this means for your health as well as some information regarding your obligations as someone identified as a close contact

You are required to isolate at home for 14 days from the date of your exposure, which was on xx Month year. This means you need to be in isolation at home until midnight on xx Month Year.

You must also monitor yourself for symptoms during this period. If you develop symptoms of concern, you should seek medical attention. You should call the service ahead of time to let them know of your attendance. If it's a medical emergency, call 000.

We will be making regular contact with you via text message. You must respond to these text messages by following the link provided.

Can I please verify your contact and person details?
Verify identity of recipient of call as well as obtain demographic data.
- *Full name*
- *DOB*
- *Residential address*
- *Email address and Mobile Number*

Thank you for your time today, I appreciate your assistance.

You will receive an email with your contact reference number a factsheet on being a close contact with all the information mentioned before included. This will also have contact details of the department if you have any questions or concerns.

End the call.

2. Verified personal contact information must be entered or confirmed in the allocated spreadsheet. This should be returned to your New Case and Contact Tracing Team leader.

Escalation of contact management

Advise your team leader if there are any issues relating contact management, questions or points of clarification.

It is the team leader’s responsibility to escalate the case to the case and contact manger or operations lead.

It is the team leader’s responsibility to ensure all verified contact information is entered into PHESS and that they initial contact email is sent to the new contact.

Process for management of existing close contacts

Existing close contacts are monitored to ensure they have not developed symptoms and that they have remained isolated as required.

Existing Contact Team leaders will allocate each officer to a group of contacts.

To undertake existing close contact management:

1. Contact the close contact daily through Soprano. See the guide for Soprano here. The following text can be used.
    a. Hello, this is a message from the Victorian Department of Health and Human Services for close contacts of a confirmed case of the novel coronavirus. If you have fever or cough or other respiratory symptoms, please seek medical attention, calling ahead to advise the health service of your attendance. There is no need to respond to this message. Thank you.
2. If the contact does not have a mobile phone, but has an email address, send the above message by email using the publichealth.operations@dhhs.vic.gov.au inbox.
3. Close contacts or health services or clinicians managing close contacts may call the 1300 number for advice or with concerns. Testing is recommended for any close contact with symptoms consistent with COVID-19. Any concerns regarding the management of close contacts should be escalated to the sector lead with consultation (as required) with the Case and Contact management lead, Operations lead and Specialist Medical Advice cell.
4. At the end of the 14 day isolation period, the following message can be sent through Soprano. See the guide for Soprano here. Please note that any close contact who develops symptoms has been tested, must remain in isolation until the test result returns. Assuming a negative result, the close contact may only be released from isolation at the end of the 14 days or when the test result returns, whichever is later.
    a. Hello, this is a message from the Victorian Department of Health and Human Services for close contacts of a confirmed case of the novel coronavirus. Provided you are well, your 14 day period of home isolation will end at midnight tonight. There is no need to respond to this message. Thank you.

Text Messaging Service – Soprano

Soprano WebSMS is an online messaging service that can be used to send text messages to an individual or multiple recipients.

To send a SMS

1. Login to the Soprano WebSMS website using the following details:

   URL: http://dhs.soprano.com.au/

   Username: REDACTED

   Password: REDACTED
2. Select the SMS tab on the top bar and then select SMS
3. You will see previous details of sent messages. To send a new one, click on New SMS
4. You can give the message a name or you can leave it as the default name and you can also add a description
5. On the "Destinations tab" you enter the numbers you wish to send an SMS too (Double check to make sure you have entered the number correctly)
6. Go on the "Message tab" and type/enter the message that is required. (Ensure all details are correct)
7. Select ‘Send’.

Case and Contact Management – New Cases

Standard Operating Procedure

Updated { DATE \@ "d MMMM yyyy" * MERGEFORMAT }

VICTORIA State Government | Health and Human Services

Version Control

Version	Date	Detail
1	26 April 2020	Version 1
1.2	8 May 2020	Adding future process for using the COVIDSafe App web portal for DHHS use for contact and tracing
1.3	6 July 2020	Updated escalation process

Contents

New Cases

Introduction

The intention of this document is to describe the Standard Operating Procedures to be followed by team members within the New Cases team. The document will be used to:

- Support new team members in their orientation and induction to the New Cases team
- Detail the operating procedures across all key tasks and functions completed
- Detail the roles and responsibilities across the team
- Outline the relevant forms, reference materials and system requirements
- Outline key troubleshooting tips and frequently asked questions

Team Overview

The New Cases and team are the first point of contact between the DHHS and a confirmed case of COVID-19.

The objectives of the New Cases team are to:

- Investigate and follow up all new confirmed cases
- Identify the likely source of exposure of a case (including if they are part of an outbreak or cluster)
- Identify if a case is from a sensitive setting (for example, a healthcare worker)
- Identify close contacts of a case of COVID-19
- Provide cases with clear instructions about their public health requirements (their period of isolation or quarantine)
- Facilitate the ongoing public health management of cases and contacts (ensure appropriate data entry so that cases and contacts are followed up by the correct teams in DHHS).

The team is comprised of Team Leaders, Assistant Team Leaders and Officers. The New Cases team operating hours and overall number of team members varies depending on which Cell the team is part of.

Roles and Responsibilities

Job Cards have been developed for each position. These Job Cards provide the key details related to the overall Team and Position Objectives and describe the Initial Actions/Tasks that each position is responsible for.

Team Leaders

On each shift the New Cases Team Leaders and Assistant Team Leaders have overall responsibility for leading and providing advice to the team, ensure that interviews and data entries are completed in a timely manner, conduct quality assurance on both hard copies of questionnaire and PHESS data entry provide updates and report to the Cell Lead, allocate work and tasks to Officers, resolve escalation issues and further discussion as required with the Cell Lead.

Officers

New Cases Officers are required to complete the tasks and actions in accordance with their Job Card, under the direction of Team Leaders.

Procedures for New Case team

Section A: Notifications of new cases

There are multiple methods in which the New Case team members are notified of a new case.

- PHESS Workflow inputted by the Data Entry team, which then is allocated to the New Case Team.
- Urgent notifications can be are made via a phone call/email from the Triage and Notification Team Leader.

This information should also be documented via the PHESS Workflow.

Section B: Start of Shift procedures

Reference	Subtask	Responsible
1.1.1	Log into DHHS IT systems (either via laptop or desktop computer) and confirm access to all required systems	All
1.1.2	Ensure access to phone system to make outgoing calls	All
1.1.3	Ensure up to date with latest changes to guidelines and Fact Sheets	All
1.1.4	Participate in Briefing with Cell Lead/Operational Leaders	Team Leader
1.1.5	Participate in Handover briefing with Team Leaders	Team Leader
1.1.6	Identify team members for the shift and provide any additional information their role or team function	Team Leader
1.1.7	If you are new to the team, make yourself known to the Team Leader	Officer
1.1.8	Review New Case folder in the Operations Mailbox outstanding action items and any other outstanding tasks list items	Team Leader
1.1.9	Review Situational Report to gather relevant information related to potential clusters and new trends	Team Leader
1.1.10	Ensure you have the latest version of the Quick Entry Guide and *Case Questionnaire COVID-19 (Novel Coronavirus)*.	All

Section C: Managing New Cases

Reference	Subtask	Responsible
1.2.1	Allocate or self-allocate new *cases* from Workflow to the Cell	Team Leader
1.2.2	Allocate or self-allocate new case in PHESS and have a copy of *Case Questionnaire COVID-19 (Novel Coronavirus)* (Case Questionnaire) and *COVID-19 Public Health Actions* cover sheet (cover sheet).	All

Reference	Subtask	Responsible
	Write PHESS Number on cover sheet.	
1.2.3	Review notification form and PHESS data prior to contacting the case (e.g. lab report)	Officer
1.2.4	Contact case using the phone number(s) provided in PHESS. If a mobile phone number has been provided attempt to contact the case using this number first. Attempt a second time or try an alternative phone number (if one has been provided). If unsuccessful, record your attempts on the Case Questionnaire and return the case to the Team Leader.	Officer
1.2.4	Identify yourself and that you work for the Department for Health and Human Services and confirm identity of case or next of kin. For cases under the age of 16, refer to Appendix A – Script for interacting with people under the age of 16.	Officer
1.2.5	1. Read the privacy statement and explain the purpose of the call. 2. Ask if they use the COVIDSafe App "Have you downloaded and registered with COVIDSafe - a mobile phone application sponsored by the Australian Government?" • If **Yes** and **have access** to COVIDSafe App portal, follow 1.2.6. • If **Yes** but **don't** have access to COVIDSafe App portal, flag with Team Leader or Assistance Team Leader • If **No**, proceed to 1.2.7.	Officer
1.2.6	**COVIDSafe App Steps** 1. Use the COVIDSafe App Questionnaire to record Contacts identified through the App. This cannot be recorded in PHESS or TRIM at this step yet, as the data is owned by the Commonwealth. 2. Read the privacy statement and explain the purpose of the call. Explain to the Case that you have been authorised to access the COVIDSafe App data and reassure the Case about data use and Privacy. 3. If **Yes**, follow the script here: **a)** Would you consider uploading the information your COVIDSafe app has collected? We ask this so that we can notify people who have potentially been exposed to COVID-19 and take appropriate action. i. If YES: Proceed ii. If NO: Inform them they can read the Consent notice again on the App, and there is publicly available information on the Privacy of the App, and they can change their mind later. Do not force the person to upload the data	Team Lead

Reference	Subtask	Responsible
	b) May I confirm the number of the mobile phone you registered with in the App? i. If CONFIRMED: Proceed ii. If NOT CONFIRMED: Repeat Phone Number. If no correct phone number can be found, abandon process (and/or contact technical support) **c)** May I confirm the name that is registered against the App (if not the person's name as you know it)? i. If CONFIRMED: Proceed ii. If NOT CONFIRMED: Check to see if they can identify the postcode they used to register. Advise if they remember the process can begin again if they remember the name they registered with. **d)** If you consent to uploading your information, please click on the COVIDSafe App on your phone. Scroll down to the bottom of the screen. You should see the following question: "Has a health official asked you to upload your information?" If you consent, please click, "Upload my information". When you have done this, please let me know. i. If YES: Proceed ii. If NO: Clarify steps **e)** On the next page, you should see a consent notice. Please read it and scroll to the bottom. When you have done this, please let me know i. If YES: Proceed ii. If NO: Clarify steps **f)** Now you should see the question, "Do you agree to upload your i. information". If you consent, please click, "I agree". When you have done this, ii. please let me know **g)** Now you should be presented with a screen asking you for a Personal Identification Number. Do you see this? i. If YES: Proceed ii. If NO: Clarify steps **h)** Now you should be presented with a screen asking you for a Personal Identification Number. Do you see this? i. If YES: Proceed ii. If NO: Clarify steps **i)** Thanks again. Please let me know when you've entered your PIN, or if you've had any issues. i. If YES: Proceed ii. If NO: Clarify steps **j)** Complete the Questionnaire.	

Reference	Subtask	Responsible
1.2.7	On the call, Complete *Case Questionnaire COVID-19 (Novel Coronavirus) – Part A* and *Part B Close Contacts* with case. Ensure all questions have been answered. *If a case refuses consent at any time, discontinue the Questionnaire, record it on PHESS and inform your Team Leader.*	Officer
1.2.8	Advise cases of COVID-19 Worker Support Payment Policy (see Section F for script, more information and if they would like to be referred.	Officer
1.2.9	Advise case of: • isolation requirements, • website details, • calling 000 if symptoms worsen, • clearance team will be in touch, • contacts will be contacted, • return-to-work criteria for an HCW or a worker in Aged Care End call.	Officer
1.2.10	Complete *Case Questionnaire Part A* and *Part B (Close Contacts)* using the Phone Questionnaire Wizard (Wizard) in PHESS. Wizard must be completed with detailed notes. If a question is NOT answered, provide an explanation for why on the hard copy of the cover sheet.	Officer
1.2.11 (optional)	Determine if the case requires escalation. See *Section D: Escalation of Cases.*	Officer/Team Lead
1.2.12	Complete PHESS notes as per PHESS Summary notes. Ensure appropriate details are included and specific addresses.	Officer
1.2.13	*Email case the Confirmed Case Factsheet using the template email to from the publichealth.operations@dhhs.vic.gov.au inbox.*	Officer
1.2.14	If the New Case has agreed to handing over their COVIDSafe information, follow to the *COVIDSafe Contacts Portal User Guide* in order to verify all contacts. *NOTE: Any identified contacts cannot be included in PHESS and/or TRIM yet.*	Officer / Team Leader
1.2.13	Undertake review of the questionnaire for completeness and approve if complete. If necessary, return Questionnaire back to the Officer to complete.	Team Leader
1.2.14	If required, call the case back to clarify any details.	Officer
1.2.15	Place completed questionnaires in Data Entry tray.	Team Leader
1.2.16	Insert workflow of the COVIDSafe App Questionnaires	Team Leader

Reference	Subtask	Responsible
	• How will the forms be stored and flow through data entry in the future **New Contacts Team** • Only after verifying with the Contacts identified by the App, then information can be recorded in PHESS.	
1.2.17	Resolve any escalation from Officers. Including notifying **external stakeholders** when required. WorkSafe must be notified if a case is identified to have worked during their acquisition or infectious period. (See Section G - Worksafe)	Team Leader
1.2.18	Inform the workplace(s) that the Contact has attended either during their acquisition or infectious periods even if there are no close contacts. • Contact workplace and ensure you are speaking to the appropriate person. Record their name and role as well as name of company • advise them that an employee attended site during their infectious or acquisition period • Ask if there are any other staff/others at site who are unwell • Suggest they provide communications to staff around increased vigilance for symptoms and testing if needed. Staff who are symptomatic should be strongly advised to seek testing and not attend work Refer them to DHHS website via follow up email (Insert email template)	Team Leader

Section D: Escalation of Cases

Team members may escalate any concerns to the Team Leader or in certain circumstances, Public Health Operations Lead.

This includes enquiries about the correct interpretation and completion of the Case Questionnaire or any issues contacting confirmed cases.

Any notifications that require an urgent public health response or are received from a sensitive setting must be escalated to the Team Leader. This includes the following situations where there is:

- a health care worker;
- works or attends a high-risk setting (Aged care, school, boarding schools childcare centre, prison, defence force, cruise ship);
- Aboriginal and/or Torres Strait Islander;
- is in an intensive care unit;
- has died;
- is part of (or suspected to be part of) a known outbreak or cluster;
- may trigger a large response;
- is likely to generate media interest;
- appears resistant or reluctant to isolate;
- appears resistant or reluctant to identify close contacts.
- is emotionally distressed or aggressive.

When escalating to the Public Health Operations include the following information:

- PHESS Reference (e.g. *32020*)
- Sex, Age, Suburb (e.g. *28-year-old male, resides in Northcote*)
- Primary Risk History (e.g. *contact with confirmed case*)
- Occupation (e.g. *Nurse at Country Health Service*

Recipients:

Public Health Operations Leads, publichealth.operations@dhhs.vic.gov.au, AND the New Case Team Leader for the shift.

Section E: External notification requirements – Workplaces

WorkSafe must be notified if a case is identified to have worked during their *acquisition* or *infectious period*. Email the following to – hygieneunit@worksafe.vic.gov.au – and info@worksafe.vic.gov.au cc; the cell and operations lead.

Any workplace that the case has attended during either their acquisition or infectious periods must also be informed, even if there are no close contacts associated with these sites.

Section F: COVID-19 Worker Support Payment Policy

At the completion of the case / contact interview please ask the following regarding the COVID-19 Worker Support Payment Policy.

> *The COVID-19 Worker Support Payment complements Victoria's public health strategies to respond to the pandemic. It operates alongside existing departmental supports, including the provision of emergency relief accommodation and food relief for people quarantining due to COVID-19.*
>
> *The aim of the COVID-19 Worker Support Payment is to financially support workers without paid sick leave or special pandemic leave entitlements or other income support, to prevent them from transmitting the virus by reporting to work in order to avoid a loss of income. In order to refer you to our Emergency Management colleagues for assessment, I would like to ask you a few questions.*
>
> *During self-isolation they can*
>
> - *Continue to work from home Yes/No*
> - *Take paid sick leave from work Yes/No*
> - *Receive a form of COVID-19 financial assistance (such as JobKeeper) Yes/No*
> - *Receive any other form of income Yes/No*
>
> *Thank you for this information. If you consent, are you happy for me to share your details with our colleagues? If Yes – This assessment is undertaken by our Emergency Management Branch, they will be in contact for further information.*

People must reply **No** to all to be referred for an eligibility assessment. People should not be referred if they are unemployed or not in the workforce.

Referral Process: Referrals are to be sent through to the semc email in a similar way that emergency

relief accommodation is sought (semc@dhhs.vic.gov.au). It is critical that we receive the following information from PH Operations to inform the assessment:

1. Full name
2. Address
3. PHESS number
4. Phone number
5. Email address
6. Close contact or Positive Case
7. What (if any) outbreak is it related to
8. Brief description of circumstances
9. Isolation dates (start – end)
10. Employment status
11. A phone number for the relevant case and contact team member for follow up

Section G: Worksafe

WorkSafe must be notified if a case is identified to have worked during their acquisition or infectious period.

Email the following to – hygieneunit@worksafe.vic.gov.au and info@worksafe.vic.gov.au
– cc; the clinical and operations lead.

Email Message
Dear Team,
Please note the case below has been notified to the department and is currently under investigation.

Statement regarding risk and case information

****Example* A confirmed case working during their acquisition and infectious period in the business below – dates if appropriate.***

Workplace Name – *Business/Trading Name*
Workplace Address –
Workplace Contact Person – *Name and Number*

Case and Contact Management Team #
Officer Name

Do not disclose any case or contact information in these emails

All after hours notifications should be called through to **132 360.**

Section G: End of Shift procedures

Reference	Subtask	Responsible
1.3.1	Participate in Team Leader Briefing (if handing over to PM shift)	Team Leader
1.3.2	Update Teams with any outstanding tasks and cases of interest	All

Forms

1. Case Questionnaire. COVID-19 (Novel Coronavirus) – Part A & Part B
2. COVIDSafe – Web Portal Guide

Reference Documents

Guidelines

Document	Audience	SharePoint
Case Questionnaire COVID-19 (Novel Coronavirus)	Internal	Link
COVID-19 PHESS Quick Entry	Internal	Link
COVID-19 Public Health Actions	Internal	Link
COVIDSafe – Web Portal Guide	Internal	Link
Contact Case and Contact Management Guidelines	Internal	Link
Coronavirus Disease 2019 (COVID-19)	Internal	Link
Flights Standard Operating Procedures	Internal	Link
Healthcare worker PPE guidance	External	Link
Managing upset, angry, confused or challenging callers	Internal	Link
PHESS Summary Notes	Internal	Link
Screening of visitors for COVID-19 - Advice for sensitive settings	External	Link

Factsheets

Factsheet	Audience	SharePoint Link
Confirmed Case	External	Link
Suspected Case	External	Link
Close Contact	External	Link
Telephone Interpreter Service	External	Link

Job Cards

Document	Audience	SharePoint Link
New Cases Team Leaders/Assistant Team Leaders	Internal	Link
New Cases Contact Officer	Internal	Link

System Requirements

1. COVIDSafe App
2. PHESS
3. TRIM/EDRM
4. DHHS Intranet
5. Microsoft Teams/SharePoint
6. Tanda Rostering Application

Troubleshooting Guide/FAQs

New Cases who are in Hotel Quarantine

When the interview is completed for a case in hotel quarantine, Officers must advise the groups:

1. DHHSOpSoteriaEOC <>;
2. COVIDquarantine <COVIDquarantine@dhhs.vic.gov.au>;
3. Public Health Operations <publichealth.operations@dhhs.vic.gov.au>
4. Murray Smith (DHHS)REDACTED
5. REDACTED (DHHS)REDACTED
6. REDACTED (DHHS)REDACTED
7. Leanne Hughson (DHHS)REDACTED

Please include the following information:

1. Name
2. Date of birth
3. PHESS Number
4. Arrival Date
5. Earliest possible clearance (if can be estimated)
6. Identified close contacts (if applicable)

Unable to Contact Case

Following notification or identification

1. Confirm contact details with patient through health service or through case in the instance of a contact. Three attempts are made over multiple days and are documented in PHESS.
2. A welfare assessment is made through Victoria Police by sending an email to OP-SENTINEL-MGR@police.vic.gov.au and by calling the Police Assistance Line on 131444.
3. Further three attempts to be made over multiple days, all being documented in PHESS

If contact remains unsuccessful, review the class and recommend the cessation of follow-up to Operations Lead.

Consideration should be given to the risk history of the case, likely acquisition or source, occupation, onset date, previous symptoms and likelihood of being infectious If endorsed, designate case as lost to follow-up and document outcome in PHESS.

Escalate outcome to Deputy Public Health Commander for information only.

Appendix A

Script for interacting with people who are under the age of 16

Saved to this PC

As per existing jurisdictional processes, following age verification ensure that you are speaking to the minor's parent or guardian. If you cannot be assured of this, the process should not progress and no COVIDSafe data can be released from the App

Has (name of minor) downloaded and registered with COVIDSafe, a mobile phone application sponsored by the Australian Government?
- ✓ If YES: Proceed
- ✗ If NO: Follow normal Standard Operation Procedures

The COVIDSafe app on (name of minor's) phone has collected information on people they may have come in contact with. We will need your express permission for the information on the app to be uploaded. Would you consider uploading the information your COVIDSafe app has collected on people (name of minor) may have come into close contact with? We ask this so that we can notify (name of minor's) close contacts that they may have been exposed to COVID-19 and take appropriate actions.
- ✓ If YES: Proceed
- ✗ If NO: Inform they can read the Consent notice again on the App, and there is publicly available information on the Privacy of the App. Do not force the person to upload the data

May I confirm the number of the mobile phone (name of minor) registered with in the App? What is it?
- ✓ If CONFIRMED: Proceed
- ✗ If NOT-CONFIRMED: Repeat, if still not confirmed then disengage.

If you consent to uploading (name of minor) information, please click on the COVIDSafe App on (name of minor's) phone. Scroll down to the bottom of the screen. You should see the following question: "Has a health official asked you to upload your information?" If you consent, please click, "Upload my information". When you have done this, please let me know
- ✓ If YES: Proceed
- ✗ If NO: Clarify steps

On the next page, you should see a consent notice. Please read it and scroll to the bottom. When you have done this, please let me know
- ✓ If YES: Proceed
- ✗ If NO: Clarify steps

Now you should see the question, "Do you agree to upload your information". If you consent on behalf of (name of minor), please click, "I agree". When you have done this, please let me know
- ✓ If YES: Proceed
- ✗ If NO: Clarify steps

Now you should be presented with a screen asking you for a Personal Identification Number. Do you see this?
- ✓ If YES: Proceed
- ✗ If NO: Clarify steps

Thanks very much for your help. The government has received your consent, and I can now provide your PIN. I am going to read it out to you for you to enter into your phone. Are you ready?
- ✓ If YES: Slowly read PIN
- ✗ If NO: Clarify steps

Thanks again. Please let me know when you've entered your PIN, or if you've had any issues
- ✓ If YES: Proceed
- ✗ If NO: Clarify steps

Thank you - we have recorded your consent.

If calling a Close Contact who is under 16:
I'm calling because you have registered on the COVIDSafe App. I note that you are under the age of 16, could I please speak to your parent or guardian?
If they're not available, could you ask them to call me on xx.

36

Appendix B – CovidSafe App Scenario

Scenario – You would only contact **Person A** and **Person C** as there are Close Contact for a long period of time

	Location	**Time**	**Location**	**Time**	**Location**	**Time**
Case	Supermarket	2 – 3 pm	Sports Oval	10-11am	Home	9-10am
Person A - Close contact identified by App	Supermarket	2 – 3 pm				
Person B - Close contact identified by App		4 – 5pm				
Person C - Close contact identified by App			Sports Oval	10-11am		

Coronavirus disease - confirmed case

What you need to know

You have been identified as having the 2019 novel coronavirus (COVID-19). You must isolate yourself in your home, hotel or health care setting until Public Health authorities inform you it is safe for you to return to your usual activities.

Please read this information carefully.

What is novel coronavirus?

Coronaviruses are a large family of viruses which may cause illness in animals or humans.

The most recently discovered coronavirus (COVID-19) is a new virus that can cause an infection in people, including a severe respiratory illness.

What is a confirmed case?

A confirmed case is someone who has been tested for the novel coronavirus and the result was positive for the virus. **This means that you have been infected with novel coronavirus and there is a risk that you could spread the virus to other people.** As such, it is very important that you follow the recommendations outlined in this fact sheet.

What do I need to do?

Stay at home or in your hotel room

- Isolate yourself at home or in your hotel room until you are advised by a Public Health Officer that you can return to your usual activities.
  - **You must not leave your house or hotel room except to seek medical attention.**
  - You should stay in a different room to other people as much as possible. Use a separate bathroom if available.
  - Wear a surgical face mask when you are in the same room as another person and when seeking medical care.
  - Do not go to work, school, university, work or attend public places or events. Do not use public transport or taxi services.
- Where possible, get others such as friends or family, who are not required to be isolated, to get food or other necessities for you.
- If you have difficulties getting food or necessities, call 1800 675 398 for support.
- If you need a translator first call 131 450, then request the hotline on 1800 675 398. More information is available on our website: dhhs.vic.gov.au/novelcoronavirus
- Please keep Triple Zero (000) for emergencies only.

Going outside

If you live in a private house, then it is safe for you to go outside into your garden, balcony or courtyard.

If you live in an apartment it is also safe for you to go outside into the garden while wearing a surgical mask. You should, however, go quickly through any common areas on the way to the garden. Wear a surgical mask if you have to move through these areas.

Monitor your symptoms

If your illness gets worse, you should call the doctor who cared for you or the emergency department where you were assessed. If it is a medical emergency (for example, shortness of breath at rest or difficulty breathing) you should:

- Call 000 and request an ambulance
- Inform the ambulance officers that you have novel coronavirus.

Your doctor or treating medical team will contact you daily to ask about your symptoms.

How can I prevent the spread of the virus to others?

Separate yourself from others

If you share a house with others, you should stay in a different room as much as possible. Wear a surgical mask when you are in the same room as another person. Use a separate bathroom if available. Avoid shared or communal areas.

Make sure you do not share a room with people who are at risk of severe disease, such as elderly people, those who have heart, lung or kidney conditions or diabetes.

Visitors who do not have an essential need to be in the home should not visit while you are in isolation.

Wash your hands and cover your coughs and sneezes

You should wash your hands regularly with soap and water for at least 20 seconds. You can use an alcohol-base hand sanitiser if your hands are not visibly dirty. Wash your hands or use a hand sanitiser before entering an area or touching items shared with others.

You should cover your coughs and sneezes with either a tissue or your elbow. Dispose of tissue into a waste bin and make sure you wash your hands afterwards.

Avoid sharing household items

You should not share dishes, drinking glasses, cups, eating utensils, towels bedding or other items with people in your house. After using these items, they should be washed thoroughly with detergent and water. A dishwasher may be used to wash crockery and utensils. Use the hottest settings possible.

Regularly clean household surfaces

Surfaces in shared areas should be cleaned daily with a household disinfectant or diluted bleach solution. Clean all frequently touched surfaces, such as counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables. Also, clean any surfaces that may have blood, body fluids and/or secretions or excretions on them.

Read labels of cleaning products and follow recommendations on product labels. Labels contain instructions for safe and effective use of the cleaning product including precautions you should take when applying the product, such as wearing gloves or aprons and making sure the areas is well ventilated when using the product.

Use a household disinfectant or a diluted bleach solution on hard surfaces. To make a bleach solution at home, add 1 tablespoon of bleach to 4 cups of water.

Wash laundry thoroughly

Immediately remove and wash clothes or bedding that have blood, body fluids and/or secretions or excretions on them.

Wear a surgical mask and disposable gloves while handling soiled items. Wash your hands immediately after removing gloves.

Read and follow directions on labels of laundry or clothing items and detergent. In general, wash and dry with the hottest temperatures recommended on the clothing label.

Disposing of contaminated items

Place all disposable gloves, face masks, and other contaminated items in a lines waste bin before disposing of them with other household waste. Wash your hands immediately after handling these items.

When will I be able to come out of isolation?

This will depend on a number of factors including when your symptoms cease and how well you are feeling. You may need to have further specimens collected, such as nose and throat swabs, to determine that you are no longer infectious.

A Public Health Officer will advise you of these requirements and when your isolation has finished. **You must not cease your isolation until you have been advised by the Public Health Officer that you can leave.**

If your employer, school or university requires confirmation that you are no-longer infectious, please contact the department on 1300 651 160.

Looking after your well-being during isolation

Being confined to home for an extended period of time can cause stress and conflict. Tips for looking after yourself include:

- Talk to the other members of the family about the infection. Understanding novel coronavirus will reduce anxiety.
- Reassure young children using age-appropriate language.
- Think about how you have coped with difficult situations in the past and reassure yourself that you will cope with this situation too. Remember that self-isolation won't last for long.
- Exercise regularly. Options could include exercise DVDs, dancing, floor exercises, yoga, walking around the backyard or using home exercise equipment, such as a stationary bicycle, if you have it. Exercise is a proven treatment for stress and depression.
- Keep in touch with family members and friends via telephone, email or social media.
- Keep up a normal daily routine as much as possible.
- Arrange with your employer to work from home, if possible.
- Ask your child's school to supply assignments, work sheets and homework by post or email, or if the student can join the class using online options.
- Don't rely too heavily on the television and technology. Treat self-isolation as an opportunity to do some of those things you never usually have time for, such as board games, craft, drawing and reading.
- If you are struggling to cope you call Lifeline on 13 11 14 or Beyond Blue on 1300 22 4636.

Information for caregivers and household members of a confirmed case of novel coronavirus

There should only be people in the home who are essential for providing care for the person, or who cannot find alternative accommodation.

Monitor for symptoms

If you are a caregiver or household member you should monitor yourself for symptoms of novel coronavirus. These include fever or cough or shortness. Other early signs and symptoms of infection can include chills, body aches, sore throat, headache, runny nose, muscle pain or diarrhoea.

If you develop any of the symptoms listed above:

- Call a doctor or a hospital and inform them that you are a contact of a confirmed case of novel coronavirus.
- Put on a mask if you have one.
- Keep yourself away from others (for example, in a different room).
- Do not travel on public transport and do not attend any public places.
- When you arrive at the doctor's surgery or hospital, tell them again that you are a contact of a confirmed case of novel coronavirus.

If you are experiencing severe symptoms, such as shortness of breath:

- Call 000 and request an ambulance
- Inform the ambulance officers that you have been in contact with someone with a confirmed case of novel coronavirus.

Wash your hands

Wash your hands often and thoroughly with soap and water for at least 20 seconds. You can use an alcohol-based hand sanitiser if your hands are not visibly dirty. Avoid touching your eyes, nose, and mouth with unwashed hands.

Wear a surgical face mask

Wear a surgical face mask and disposable gloves when you are in the same room as the person with confirmed of suspected infection, or when you touch or have contact with the person's blood, body fluids and/or secretions, such as sweat, saliva, sputum, nasal mucus, vomit, urine, or diarrhoea.

- Throw out disposable facemasks and disposable gloves directly into a bin after use.
- Wash your hands immediately after removing the face mask and gloves.

Where can I find out more information?

Call the Department of Health and Human Services on to discuss any questions you have. If you need a translator first call 131 450, then request the hotline on 1300 651 160.

For Victorian updates to the current incident, go to: https://www.dhhs.vic.gov.au/novelcoronavirus

For national updates: https://www.health.gov.au/news/latest-information-about-novel-coronavirus

For international updates: https://www.who.int/westernpacific/emergencies/novel-coronavirus

WHO resources https://www.who.int/health-topics/coronavirus

To receive this publication in an accessible format phone 1300 651 160, using the National Relay Service 131 450 if required, or email Public Health branch <public.health@dhhs.vic.gov.au>.

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Novel coronavirus confirmed case

What you need to know

You have been identified as having the 2019 novel coronavirus (2019-nCoV). You must isolate yourself in your home, hotel or health care setting until Public Health authorities inform you it is safe for you to return to your usual activities.

Please read this information carefully.

What is novel coronavirus?

Coronaviruses are a type of virus that can affect humans and animals. An outbreak of novel coronavirus (2019-nCoV) was detected in Wuhan, China in late December 2019. Cases have been reported predominantly in mainland China, as well as other countries, including confirmed cases in Victoria. This virus can cause a severe respiratory illness.

What is a confirmed case?

A confirmed case is someone who has been tested for the novel coronavirus and the result was positive for the virus. **This means that you have been infected with novel coronavirus and there is a risk that you could spread the virus to other people.** As such, it is very important that you follow the recommendations outlined in this fact sheet.

What do I need to do?

Stay at home or in your hotel room

- Isolate yourself at home or in your hotel room until you are advised by a Public Health Officer that you can return to your usual activities.
  - **You must not leave your house or hotel room except to seek medical attention.**
  - You should stay in a different room to other people as much as possible. Use a separate bathroom if available.
  - Wear a surgical face mask when you are in the same room as another person and when seeking medical care.
  - Do not go to work, school, university, work or attend public places or events. Do not use public transport or taxi services.
- Where possible, get others such as friends or family, who are not required to be isolated, to get food or other necessities for you.
- If you have difficulties getting food or necessities, call 1800 675 398 for support.
- If you need a translator first call 131 450, then request the hotline on 1800 675 398. More information is available on our website: dhhs.vic.gov.au/novelcoronavirus

Going outside

If you live in a private house, then it is safe for you to go outside into your garden, balcony or courtyard.

If you live in an apartment it is also safe for you to go outside into the garden while wearing a surgical mask. You should, however, go quickly through any common areas on the way to the garden. Wear a surgical mask if you have to move through these areas.

Monitor your symptoms

If your illness gets worse, you should call the doctor who cared for you or the emergency department where you were assessed. If it is a medical emergency (for example, shortness of breath at rest or difficulty breathing) you should:

- Call 000 and request an ambulance
- Inform the ambulance officers that you have novel coronavirus.

Your doctor or treating medical team will contact you daily to ask about your symptoms.

How can I prevent the spread of the virus to others?

Separate yourself from others

If you share a house with others, you should stay in a different room as much as possible. Wear a surgical mask when you are in the same room as another person. Use a separate bathroom if available. Avoid shared or communal areas.

Make sure you do not share a room with people who are at risk of severe disease, such as elderly people, those who have heart, lung or kidney conditions or diabetes.

Visitors who do not have an essential need to be in the home should not visit while you are in isolation.

Wash your hands and cover your coughs and sneezes

You should wash your hands regularly with soap and water for at least 20 seconds. You can use an alcohol-base hand sanitiser if your hands are not visibly dirty. Wash your hands or use a hand sanitiser before entering an area or touching items shared with others.

You should cover your coughs and sneezes with either a tissue or your elbow. Dispose of tissue into a waste bin and make sure you wash your hands afterwards.

Avoid sharing household items

You should not share dishes, drinking glasses, cups, eating utensils, towels bedding or other items with people in your house. After using these items, they should be washed thoroughly with detergent and water. A dishwasher may be used to wash crockery and utensils. Use the hottest settings possible.

Regularly clean household surfaces

Surfaces in shared areas should be cleaned daily with a household disinfectant or diluted bleach solution. Clean all frequently touched surfaces, such as counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables. Also, clean any surfaces that may have blood, body fluids and/or secretions or excretions on them.

Read labels of cleaning products and follow recommendations on product labels. Labels contain instructions for safe and effective use of the cleaning product including precautions you should take when applying the product, such as wearing gloves or aprons and making sure the areas is well ventilated when using the product.

Use a household disinfectant or a diluted bleach solution on hard surfaces. To make a bleach solution at home, add 1 tablespoon of bleach to 4 cups of water.

Wash laundry thoroughly

Immediately remove and wash clothes or bedding that have blood, body fluids and/or secretions or excretions on them.

Wear a surgical mask and disposable gloves while handling soiled items. Wash your hands immediately after removing gloves.

Read and follow directions on labels of laundry or clothing items and detergent. In general, wash and dry with the hottest temperatures recommended on the clothing label.

Disposing of contaminated items

Place all disposable gloves, face masks, and other contaminated items in a lines waste bin before disposing of them with other household waste. Wash your hands immediately after handling these items.

When will I be able to come out of isolation?

This will depend on a number of factors including when your symptoms cease and how well you are feeling. You may need to have further specimens collected, such as nose and throat swabs, to determine that you are no longer infectious.

A Public Health Officer will advise you of these requirements and when your isolation has finished. **You must not cease your isolation until you have been advised by the Public Health Officer that you can leave.**

If your employer, school or university requires confirmation that you are no-longer infectious, please contact the department on 1300 651 160.

Looking after your well-being during isolation

Being confined to home for an extended period of time can cause stress and conflict. Tips for looking after yourself include:

- Talk to the other members of the family about the infection. Understanding novel coronavirus will reduce anxiety.
- Reassure young children using age-appropriate language.
- Think about how you have coped with difficult situations in the past and reassure yourself that you will cope with this situation too. Remember that self-isolation won't last for long.
- Exercise regularly. Options could include exercise DVDs, dancing, floor exercises, yoga, walking around the backyard or using home exercise equipment, such as a stationary bicycle, if you have it. Exercise is a proven treatment for stress and depression.
- Keep in touch with family members and friends via telephone, email or social media.
- Keep up a normal daily routine as much as possible.
- Arrange with your employer to work from home, if possible.
- Ask your child's school to supply assignments, work sheets and homework by post or email, or if the student can join the class using online options.
- Don't rely too heavily on the television and technology. Treat self-isolation as an opportunity to do some of those things you never usually have time for, such as board games, craft, drawing and reading.
- If you are struggling to cope you call Lifeline on 13 11 14 or Beyond Blue on 1300 22 4636.

Information for caregivers and household members of a confirmed case of novel coronavirus

There should only be people in the home who are essential for providing care for the person, or who cannot find alternative accommodation.

Monitor for symptoms

If you are a caregiver or household member you should monitor yourself for symptoms of novel coronavirus. These include fever or cough or shortness. Other early signs and symptoms of infection can include chills, body aches, sore throat, headache, runny nose, muscle pain or diarrhoea.

If you develop any of the symptoms listed above:

- Call a doctor or a hospital and inform them that you are a contact of a confirmed case of novel coronavirus.
- Put on a mask if you have one.
- Keep yourself away from others (for example, in a different room).
- Do not travel on public transport and do not attend any public places.
- When you arrive at the doctor's surgery or hospital, tell them again that you are a contact of a confirmed case of novel coronavirus.

If you are experiencing severe symptoms, such as shortness of breath:

- Call 000 and request an ambulance
- Inform the ambulance officers that you have been in contact with someone with a confirmed case of novel coronavirus.

Wash your hands

Wash your hands often and thoroughly with soap and water for at least 20 seconds. You can use an alcohol-based hand sanitiser if your hands are not visibly dirty. Avoid touching your eyes, nose, and mouth with unwashed hands.

Wear a surgical face mask

Wear a surgical face mask and disposable gloves when you are in the same room as the person with confirmed of suspected infection, or when you touch or have contact with the person's blood, body fluids and/or secretions, such as sweat, saliva, sputum, nasal mucus, vomit, urine, or diarrhoea.

- Throw out disposable facemasks and disposable gloves directly into a bin after use.
- Wash your hands immediately after removing the face mask and gloves.

Where can I find out more information?

Call the Department of Health and Human Services on to discuss any questions you have. If you need a translator first call 131 450, then request the hotline on 1300 651 160.

For Victorian updates to the current incident, go to: https://www.dhhs.vic.gov.au/novelcoronavirus

For national updates: https://www.health.gov.au/news/latest-information-about-novel-coronavirus

For international updates: https://www.who.int/westernpacific/emergencies/novel-coronavirus

WHO resources https://www.who.int/health-topics/coronavirus

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Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

Coronavirus disease (COVID-19) confirmed case

What you need to know

You have been identified as having coronavirus disease (COVID-19). You must isolate yourself in your home, hotel or health care setting until Public Health authorities inform you it is safe for you to return to your usual activities. Please read this information carefully.

What is coronavirus disease (COVID-19)?

Coronaviruses are a large family of viruses which may cause illness in animals or humans. The most recently discovered coronavirus (COVID-19) is a new virus that can cause mild to severe respiratory illness in humans. An outbreak of COVID-19 has spread around the world and has been characterised as a pandemic.

What is a confirmed case?

A confirmed case is someone who tests positive for COVID-19. **This means that you have been infected with the virus that causes COVID-19 and there is a risk that you could spread the virus to other people, including those you live with.** As such, it is very important that you follow the recommendations outlined in this fact sheet.

What do I need to do?

Stay at home or in your hotel room or healthcare setting

- The Isolation (Diagnosis) Direction that is currently in effect makes it compulsory for anyone with a confirmed diagnosis of COVID-19 to go into isolation for a minimum period, and to meet other compulsory conditions before being able to resume normal activities. Penalties apply to those who refuse or fail to comply with this direction.
- Isolate yourself at home or in your accommodation until you are advised by a Public Health Officer that you can return to your usual activities. If you do not isolate yourself sufficiently from people you share a house with, they are more likely to catch coronavirus and will need to start 14 days of self-quarantine from the date they last had close contact with you while you were infectious.
  - **You must not leave your house or accommodation except to seek medical attention or limited other permitted reasons, such as an emergency or if required by law.**
  - You should stay in a different room to other people. Use a separate bathroom if available.
  - Wear a surgical face mask if you cannot avoid being in the same room as another person and when seeking medical care.
  - Do not go to work, school, university, work or attend public places or events. Do not use public transport or taxi services.
  - Get others such as friends or family, who are not required to be isolated, to get food or other necessities for you.
- If you have difficulties getting food or necessities, call 1800 675 398 for support.

- If you need a translator first call 131 450, then request the hotline on 1800 675 398. More information is available on our website: https://www.dhhs.vic.gov.au/victorian-public-coronavirus-disease-covid-19

Going outside

If you live in a private house, then it is safe for you to go outside into your garden, balcony or courtyard.

If you live in an apartment it is also safe for you to go outside into the garden while wearing a surgical mask. You should, however, go quickly through any common areas on the way to the garden. Wear a surgical mask if you have to move through these areas.

Make sure you keep a distance of 1.5 metres between yourself and any other people you encounter in common areas.

Monitor your symptoms

If your illness gets worse, you should call the doctor who cared for you or the emergency department where you were assessed. If it is a medical emergency (for example, shortness of breath at rest or difficulty breathing) you should:

- Call 000 and request an ambulance
- Inform the ambulance officers that you have coronavirus disease (COVID-19).

Your doctor or treating medical team will contact you where necessary to ask about your symptoms.

How can I prevent the spread of the virus to others?

Separate yourself from others

If you share a house with others, you should stay in a different room as much as possible. Wear a surgical mask when you are in the same room as another person. Use a separate bathroom if available. Avoid shared or communal areas.

If you do not isolate yourself sufficiently from the people you share a house with (e.g. by staying in a separate room, or wearing a mask while you are in the same room), they will be at increased risk of infection and the period of time for which they are required to self-quarantine will be extended. This is because they are required to self-quarantine for a period of 14 days from the date they last had close contact with you while you were infectious. You are considered infectious until the department advises you that you can leave home isolation. Make sure you do not share a room with people who are at risk of severe disease, such as elderly people, those who have heart, lung or kidney conditions or diabetes.

Visitors who do not have an essential need to be in the home should not visit while you are in isolation.

Wash your hands and cover your coughs and sneezes

You should wash your hands regularly with soap and water for at least 20 seconds. You can use an alcohol-based hand sanitiser if your hands are not visibly dirty. Wash your hands or use a hand sanitiser before entering an area or touching items shared with others.

You should cover your coughs and sneezes with either a tissue or your elbow. Dispose of tissue into a waste bin and make sure you wash your hands afterwards.

Avoid sharing household items

You should not share dishes, drinking glasses, cups, eating utensils, towels bedding or other items with people in your house. After using these items, they should be washed thoroughly with detergent and water. A dishwasher may be used to wash crockery and utensils. Use the hottest settings possible.

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- Arrange with your employer to work from home, if possible.
- Ask your child's school to supply assignments, work sheets and homework by post or email, or if arrangements are in place for the student to join their classes using online options.
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- Do not travel on public transport and do not attend any public places.
- When you arrive at the doctor's surgery or hospital, tell them again that you are a contact of a confirmed case of coronavirus disease.

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Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

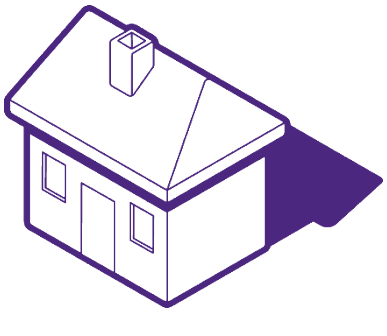
What to do if you have tested positive for coronavirus (COVID-19)

If you have tested positive for coronavirus (COVID-19)

You must isolate yourself until the Department of Health and Human Services tells you it is safe. It is important that you follow this guidance – as required by law.

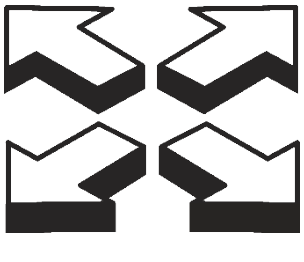
For more information, call the Coronavirus hotline on **1800 675 398** – open 24 hours,7 days.

If you call the Coronavirus hotline, you can access an interpreter by choosing option zero (0). For any other calls, if you need an interpreter, call TIS National on **131 450** first.

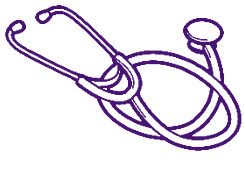


Stay at home

Wash your hands and cover coughs and sneezes



Isolate from your family and friends



If you need medical help, call your doctor or the Coronavirus hotline

Why do I need to isolate?

You have tested positive for coronavirus (COVID-19) and you must isolate because there is a high chance it will spread to other people. The best way to protect your family and the community is to stay at home and away from other people (physical distancing). Isolation can be challenging but it plays an important role in slowing the spread of coronavirus (COVID-19).

Isolation means you must not leave your home or accommodation, except for medical care or in an emergency. You cannot leave your home to exercise or to go shopping. You may be fined up to $4,957 if you leave home while required to isolate. Stay home and stay safe.

If anyone else you know has symptoms, no matter how mild, they should get tested and stay home until they get their results.

VICTORIA State Government | Health and Human Services

Where do I isolate?

You must immediately go to the place where you will isolate, without making any stops. This is usually your own home, but the department may allow you to isolate at another suitable location.

Who do I need to tell?

After you have been told about your positive test result, you must inform your employer and you can inform your close contacts. A ‘close contact’ is someone that you may have passed the virus onto, this might include the people you live with, work closely with, or were with at a social gathering.

The people you live with will need to quarantine for 14 days from the last time they had contact with you because there is a chance they will have coronavirus (COVID-19). They also need to get tested. They can leave home to get a test. This includes children.

What happens after a positive test for coronavirus (COVID-19)?

The public health team at the department will talk to you about people you have had contact with. They will contact people who are considered close contacts and will record where you are isolating and who is living with you.

The public health team will keep in touch with you regularly. You can always contact them if you need any extra help or have any other questions about keeping safe and well. You must stay in isolation until you are provided with clearance from the public health team.

When am I able to leave isolation after a positive test for coronavirus (COVID-19)?

You can leave isolation when all of the following criteria have been met:

- The department has conducted an assessment and deems that your isolation may end. They will provide you with written clearance.
- at least 10 days have passed since your symptoms began for mild illness, or 14 days for more severe illness (such as if hospitalisation was required)
- you have not had fever or respiratory symptoms from coronavirus (COVID-19) for the previous 72 hours.

Once the department, or an authorised health worker, has assessed that you meet the appropriate criteria to be cleared, you will be provided written clearance and are no longer required to isolate. You will be able to return to your normal activities, in line with the restrictions in place at your location. You must continue to isolate until you are cleared.

Will I need to be tested again?

While all people who test positive for coronavirus (COVID-19) must isolate until cleared, most people will not need to be tested again.

Current evidence suggests that generally people are no longer infectious from 10 days after their symptoms start.

The department will advise you to be tested again if you:

- are significantly immunocompromised (have a weakened immune system prone to infection) or
- have been severely ill requiring hospitalisation and have persistent symptoms.

How to stay safe

You must not leave your home or accommodation, except to seek medical attention or in an emergency.

- Separate yourself from the other people in your home by staying in a separate room.
- Wash your hands regularly and cover your coughs and sneezes.
- Wear a surgical mask when you are in the same room as other people and keep 1.5 metres apart.
- Use a separate bathroom, if possible.
- Avoid sharing household items (including plates, cups and cutlery).
- Clean household surfaces (tabletops, doors, keyboards, taps and handles).
- Wear a surgical mask and disposable gloves while handling soiled items.
- Dispose of contaminated items like gloves and masks in a lined waste bin.
- Do not have people to visit you inside your home or accommodation.
- If you live in a private house or apartment you can go into your garden or onto your balcony. You should wear a surgical mask when moving through your accommodation.

If you don't have a surgical mask, use a face covering, such as a scarf or bandana, instead.

Ask friends or family, who are not required to isolate, to get food or other necessities for you.

You may be fined up to $4,957 if you leave home while required to isolate. Stay home and stay safe.

Monitor your symptoms

If your symptoms get worse but are not serious, call your doctor. If it is a medical emergency (for example, difficulty breathing) call 000 and request an ambulance. Tell the ambulance officers that you have coronavirus (COVID-19).

Look after your wellbeing

Being in isolation can be difficult, particularly for children.

- Talk to other members of the household about your coronavirus and your experience in isolation. This can help reduce anxiety.
- Arrange with your employer to keep working from home, if you are feeling well.
- Support your child learning from home. Access online resources that are available.
- Keep in touch with family and friends via telephone, email or social media.
- Remember that isolation won't last for long.
- Access resources online – including advice on sleep, wellbeing and exercising at home. Videos are available at Wellbeing Victoria <https://www.together.vic.gov.au/wellbeing-victoria>.

If you are not coping, talk to your doctor or contact:

- **Lifeline Australia** <https://www.lifeline.org.au/>, phone: **13 11 14**
  A crisis support service that provides support at any time.
- **Beyond Blue** <https://www.beyondblue.org.au/>, phone: **1300 22 4636**
  They are providing specialist help for people in isolation.
- **Kids Helpline** <https://www.kidshelpline.com.au/>, phone: **1800 551800**
  A free and confidential counselling service for young people.

Support is available

A one-off $1,500 payment is available to support eligible Victorian workers who have coronavirus (COVID-19) or are a close contact of a confirmed case. For information visit Pandemic Leave Disaster Payment <https://www.servicesaustralia.gov.au/individuals/services/centrelink/pandemic-leave-disaster-payment>.

Emergency relief packages with food and personal items are available if you cannot get help from friends or family.

For information on support and emergency relief packages or help getting groceries, visit Quarantine and isolation <https://www.dhhs.vic.gov.au/self-quarantine-coronavirus-covid-19> or call the Coronavirus hotline on **1800 675 398** – open 24 hours, 7 days.

Information for caregivers and other household members

If you are looking after a family member who has coronavirus (COVID-19) there are some important things you should do to keep everyone in your home safe:

- Ensure the person remains in one room, away from other people.
- Keep their door closed and windows open, where possible.
- Keep the number of carers to a minimum.
- Always wash your hands with soap and water or use a hand sanitiser before and after entering the room.
- Keep the sick person's crockery and utensils separate from the rest of the household.
- If available, wear a surgical mask (single-use face mask) when you are in the sick person's room. If you don’t have a surgical mask, use a face covering, such as a scarf or bandana, instead.
- Regularly clean and disinfect high-touch surfaces such as tabletops, doors, keyboards, taps and handles.
- Dispose of tissues and masks in a sealed plastic bag.
- Wear a mask and gloves when handling laundry and wash at the highest heat setting.
- Do not have visitors.

If the person starts to feel worse, call the Coronavirus hotline on **1800 675 398** – open 24 hours, 7 days for advice. If you need to visit your doctor, call ahead so they can prepare.

Monitor symptoms

If the person you are caring for develops serious symptoms, such as difficulty breathing, call **triple zero (000)** and ask for an ambulance.

If anyone else has any symptoms they should get tested and stay home.

Get tested if you have any of these symptoms: fever, chills or sweats, cough or sore throat, shortness of breath, runny nose, loss of sense of smell or taste.

To find out more information about coronavirus and how to stay safe visit
DHHS.vic – coronavirus disease (COVID-19)
<https://www.dhhs.vic.gov.au/coronavirus>

If you need an interpreter, call TIS National on 131 450

For information in other languages, scan the QR code or visit
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For any questions
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Please keep Triple Zero (000) for emergencies only

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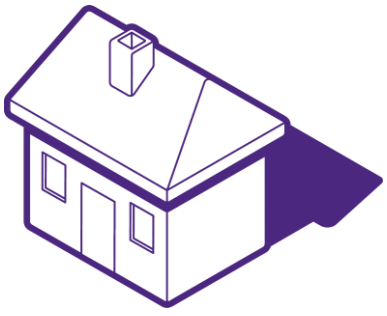

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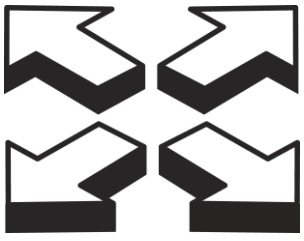

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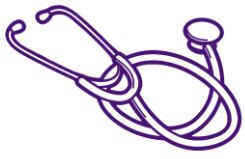

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The people you live with will need to quarantine for 14 days from the last time they had contact with you because there is a chance they will have coronavirus (COVID-19). They also need to get tested. They can leave home to get a test. This includes children.

What happens after a positive test for coronavirus (COVID-19)?

The public health team at the department will talk to you about people you have had contact with. They will contact people who are considered close contacts and will record where you are isolating and who is living with you.

The public health team will keep in touch with you regularly. You can always contact them if you need any extra help or have any other questions about keeping safe and well. You must stay in isolation until you are provided with clearance from the public health team.

When am I able to leave isolation after a positive test for coronavirus (COVID-19)?

You can leave isolation when all of the following criteria have been met:

- The department has conducted an assessment and deems that your isolation may end. They will provide you with written clearance.
- at least 10 days have passed since your symptoms began for mild illness, or 14 days for more severe illness (such as if hospitalisation was required)
- you have not had fever or respiratory symptoms from coronavirus (COVID-19) for the previous 72 hours.

Once the department, or an authorised health worker, has assessed that you meet the appropriate criteria to be cleared, you will be provided written clearance and are no longer required to isolate. You will be able to return to your normal activities, in line with the restrictions in place at your location. You must continue to isolate until you are cleared.

Will I need to be tested again?

While all people who test positive for coronavirus (COVID-19) must isolate until cleared, most people will not need to be tested again.

Current evidence suggests that generally people are no longer infectious from 10 days after their symptoms start.

The department will advise you to be tested again if you:

- are significantly immunocompromised (have a weakened immune system prone to infection) or
- have been severely ill requiring hospitalisation and have persistent symptoms.

How to stay safe

You must not leave your home or accommodation, except to seek medical attention or in an emergency.

- Separate yourself from the other people in your home by staying in a separate room.
- Wash your hands regularly and cover your coughs and sneezes.
- Wear a surgical mask when you are in the same room as other people and keep 1.5 metres apart.
- Use a separate bathroom, if possible.
- Avoid sharing household items (including plates, cups and cutlery).
- Clean household surfaces (tabletops, doors, keyboards, taps and handles).
- Wear a surgical mask and disposable gloves while handling soiled items.
- Dispose of contaminated items like gloves and masks in a lined waste bin.
- Do not have people to visit you inside your home or accommodation.
- If you live in a private house or apartment you can go into your garden or onto your balcony. You should wear a surgical mask when moving through your accommodation.

If you don't have a surgical mask, use a face covering, such as a scarf or bandana, instead.

Ask friends or family, who are not required to isolate, to get food or other necessities for you.

You may be fined up to $4,957 if you leave home while required to isolate. Stay home and stay safe.

Monitor your symptoms

If your symptoms get worse but are not serious, call your doctor. If it is a medical emergency (for example, difficulty breathing) call 000 and request an ambulance. Tell the ambulance officers that you have coronavirus (COVID-19).

Look after your wellbeing

Being in isolation can be difficult, particularly for children.

- Talk to other members of the household about your coronavirus and your experience in isolation. This can help reduce anxiety.
- Arrange with your employer to keep working from home, if you are feeling well.
- Support your child learning from home. Access online resources that are available.
- Keep in touch with family and friends via telephone, email or social media.
- Remember that isolation won't last for long.
- Access resources online – including advice on sleep, wellbeing and exercising at home. Videos are available at Wellbeing Victoria <https://www.together.vic.gov.au/wellbeing-victoria>.

If you are not coping, talk to your doctor or contact:

- **Lifeline Australia** <https://www.lifeline.org.au/>, phone: **13 11 14**
  A crisis support service that provides support at any time.
- **Beyond Blue** <https://www.beyondblue.org.au/>, phone: **1300 22 4636**
  They are providing specialist help for people in isolation.
- **Kids Helpline** <https://www.kidshelpline.com.au/>, phone: **1800 551800**
  A free and confidential counselling service for young people.

Support is available

A one-off $1,500 payment is available to support eligible Victorian workers who have coronavirus (COVID-19) or are a close contact of a confirmed case. For information visit Pandemic Leave Disaster Payment <https://www.servicesaustralia.gov.au/individuals/services/centrelink/pandemic-leave-disaster-payment>.

Emergency relief packages with food and personal items are available if you cannot get help from friends or family.

For information on support and emergency relief packages or help getting groceries, visit Quarantine and isolation <https://www.dhhs.vic.gov.au/self-quarantine-coronavirus-covid-19> or call the Coronavirus hotline on **1800 675 398** – open 24 hours, 7 days.

Information for caregivers and other household members

If you are looking after a family member who has coronavirus (COVID-19) there are some important things you should do to keep everyone in your home safe:

- Ensure the person remains in one room, away from other people.
- Keep their door closed and windows open, where possible.
- Keep the number of carers to a minimum.
- Always wash your hands with soap and water or use a hand sanitiser before and after entering the room.
- Keep the sick person's crockery and utensils separate from the rest of the household.
- If available, wear a surgical mask (single-use face mask) when you are in the sick person's room. If you don't have a surgical mask, use a face covering, such as a scarf or bandana, instead.
- Regularly clean and disinfect high-touch surfaces such as tabletops, doors, keyboards, taps and handles.
- Dispose of tissues and masks in a sealed plastic bag.
- Wear a mask and gloves when handling laundry and wash at the highest heat setting.
- Do not have visitors.

If the person starts to feel worse, call the Coronavirus hotline on **1800 675 398** – open 24 hours, 7 days for advice. If you need to visit your doctor, call ahead so they can prepare.

Monitor symptoms

If the person you are caring for develops serious symptoms, such as difficulty breathing, call **triple zero (000)** and ask for an ambulance.

If anyone else has any symptoms they should get tested and stay home.

Get tested if you have any of these symptoms: fever, chills or sweats, cough or sore throat, shortness of breath, runny nose, loss of sense of smell or taste.

To find out more information about coronavirus and how to stay safe visit DHHS.vic – coronavirus disease (COVID-19) <https://www.dhhs.vic.gov.au/coronavirus>

If you need an interpreter, call TIS National on 131 450

For information in other languages, scan the QR code or visit DHHS.vic –Translated resources - coronavirus (COVID-19) <https://www.dhhs.vic.gov.au/translated-resources-coronavirus-disease-covid-19>

For any questions

Coronavirus hotline 1800 675 398 (24 hours)

Please keep Triple Zero (000) for emergencies only

To receive this document in another format phone 1300 651 160 using the National Relay Service 13 36 77 if required, or Public Health branch <public.health@dhhs.vic.gov.au>.

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

Available at DHHS.vic –Translated resources - coronavirus (COVID-19) <https://www.dhhs.vic.gov.au/translated-resources-coronavirus-disease-covid-19>

Coronavirus disease (COVID-19) - close contact

What you need to know

You have been identified as having had close contact with someone diagnosed with coronavirus disease (COVID-19). Please read this information carefully.

What is novel coronavirus?s

Coronaviruses are a large family of viruses which may cause illness in animals or humans. The most recently discovered coronavirus (COVID-19) is a new virus that can cause infection in humans, including severe respiratory illness. An outbreak of COVID-19 has spread around the world and has been characterised as a pandemic.

What is a close contact?

A close contact is someone who has been face to face for at least 15 minutes with someone who has tested positive for COVID-19 or been in the same closed space for at least 2 hours, when that person was potentially infectious. Being a close contact means there is a significant risk of becoming infected with novel coronavirus.

What do I need to do?

Stay at home or in your hotel room

- Quarantine yourself at home until 14 days after you were last exposed to the infectious person.
  - You should not leave your house except to seek medical attention.
  - You should stay in a different room to other people as much as possible. Use a separate bathroom if available.
  - Do not go to work, school, university, work or attend public places or events. Do not use public transport or taxi services.
  - Where possible, get others such as friends or family, who are not required to be quarantined, to get food or other necessities for you.
- If you have difficulties getting food or necessities, call 1800 675 398 for support.
- If you need a translator first call 131 450, then request the hotline on 1800 675 398. More information is available on our website: dhhs.vic.gov.au/novelcoronavirus
- Please keep Triple Zero (000) for emergencies only.

Going outside

If you live in a private house, then it is safe for you to go outside into your garden, balcony or courtyard.

If you live in an apartment it is also safe for you to go outside into the garden while wearing a surgical mask. You should, however, go quickly through any common areas on the way to the garden. Wear a surgical mask if you have to move through these areas.

Monitor your symptoms

- Monitor your health until 14 days after you were last exposed to the infectious person.
- Watch for any of these signs and symptoms:
  - fever
  - cough
  - shortness of breath
- Other early symptoms can include chills, body aches, sore throat, headache, runny nose, muscle pain or diarrhoea.

You will be contacted regularly by the Department of Health and Human Services to check whether you have had symptoms.

What if I develop symptoms?

If you develop any of the symptoms listed above:

- Call a doctor or coronavirus assessment centre and inform them that you have had contact with a confirmed case of COVID-19 and you have symptoms.
- Put on a mask if you have one.
- Keep yourself away from others (for example, in a different room).
- Do not go to work, school, university, work or attend public places or events. Do not use public transport or taxi services.
- When you arrive at the general practice or hospital, tell them again that you are a contact of a confirmed case of novel coronavirus.

Your doctor or staff at the hospital emergency department will ensure you are wearing a mask and take you through to a room away from others.

The doctor will contact our department on 1300 651 160. They may organise to take nose and throat swabs to send for testing for the novel coronavirus.

If you are experiencing severe symptoms, such as shortness of breath:

- Call 000 and request an ambulance.
- Inform the ambulance officers that you have been in close contact with a confirmed case of novel coronavirus.

How can I prevent the spread of the virus?

Practising good hand and sneeze/cough hygiene is the best defence:

- Wash your hands often with soap and water before and after eating as well as after attending the toilet.
- Avoid all contact with others.
- Cough and sneeze into your elbow.

Should I wear a face mask?

Face masks are not recommended if you do not have symptoms. A facemask will not protect you against becoming infected.

If you are ill, you should put on a mask if you have one to prevent spreading the infection to others. You will be given a mask to wear by your doctor.

Looking after your well-being during quarantine

Being confined to home for an extended period of time can cause stress and conflict. Tips for looking after yourself include:

- Talk to the other members of the family about the infection. Understanding novel coronavirus will reduce anxiety.
- Reassure young children using age-appropriate language.
- Think about how you have coped with difficult situations in the past and reassure yourself that you will cope with this situation too. Remember that self-quarantine won't last for long.
- Exercise regularly. Options could include exercise DVDs, dancing, floor exercises, yoga, walking around the backyard or using home exercise equipment, such as a stationary bicycle, if you have it. Exercise is a proven treatment for stress.
- Keep in touch with family members and friends via telephone, email or social media.
- Keep up a normal daily routine as much as possible.
- Arrange with your employer to work from home, if possible.
- Ask your child's school to supply assignments, work sheets and homework by post or email, or if the student can join the class using online options.
- Don't rely too heavily on the television and technology. Treat self-quarantine as an opportunity to do some of those things you never usually have time for, such as board games, craft, drawing and reading.
- If you are struggling to cope you call Lifeline on 13 11 14 or Beyond Blue on 1300 22 4636.

What does this mean for my family, friends and co-workers?

If you are in quarantine because you have been in close contact with someone who is a confirmed case of COVID-19, your family members and other people you have been in contact with **DO NOT need to be quarantined**.

However, you should minimise contact with other people, including your family. Wherever possible, remain in a separate room in the house. If you do have to be in the same room, wear a mask and maintain 1.5 metres distance between yourself and others. Wash your hands regularly and disinfect surfaces you have touched with a common household disinfectant.

Do I need to inform people I have been in contact with?

If you are a close contact of someone with COVID-19 and have not experienced any symptoms you do not need to inform other people you have had contact with that you're a contact of a case.

However, if you do develop symptoms while you are in quarantine, and test positive for the virus, your close contacts will need to be informed. In this situation a Public Health Officer from the Department of Health and Human Services will contact you to determine who your close contacts are. The Public Health Officer will then contact those people and explain what they need to do.

For example, co-workers may not be ***close*** contacts – it depends how closely you have worked together and for how long. The Public Health Officer will determine if they need to be contacted or not. For more information on close contacts, see https://www.dhhs.vic.gov.au/victorian-public-coronavirus-disease-covid-19#how-do-you-define-close-contact

What happens at the end of my quarantine period?

You will need to remain in quarantine for 14 days after the last time you had close contact with the infected person.

You will be informed when you will be able to leave self-quarantine.

Medical clearance or testing is not required if you have not had any symptoms of coronavirus during your 14 days of self-quarantine.

If you develop symptoms while in quarantine, you will need to be tested for the virus. Please refer to the section "What if I develop symptoms" above.

Where can I find out more information?

Call the Department of Health and Human Services on to discuss any questions you have. If you need a translator first call 131 450, then request the to be put through to the department on 1300 651 160.

For Victorian updates to the current incident, go to: https://www.dhhs.vic.gov.au/novelcoronavirus

For national updates: https://www.health.gov.au/news/latest-information-about-novel-coronavirus

For international updates: https://www.who.int/westernpacific/emergencies/novel-coronavirus

WHO resources https://www.who.int/health-topics/coronavirus

To receive this publication in an accessible format phone 1300 651 160, using the National Relay Service 131 450 if required, or email Public Health branch <public.health@dhhs.vic.gov.au>.

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

What to do if you have been in close contact with someone with coronavirus (COVID-19)

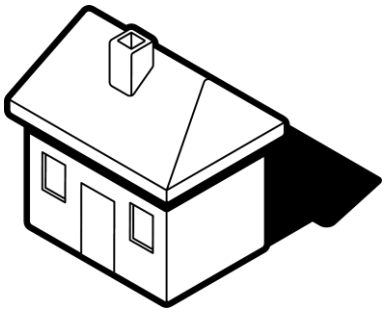
What to do if you have been in close contact with someone with coronavirus (COVID-19)

You have had close contact with someone with coronavirus (COVID-19)

You must quarantine yourself in your home or other accommodation for 14 days after you last had contact with this person.

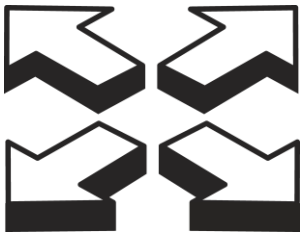
Please read this carefully. For more information, contact the coronavirus hotline on **1800 675 398** (24 hours, 7 days a week).

If you call the coronavirus hotline, you can access an interpreter by choosing option zero (0). For any other calls, if you need an interpreter, call TIS National on **131 450** first.

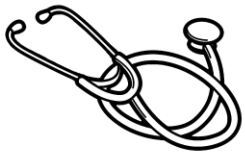


Stay at home

Wash your hands and cover coughs and sneezes



Isolate from your family and friends



If you need medical help, call your doctor or the hotline

Who is a close contact?

If you have had face-to-face contact for more than 15 minutes or spent more than two hours in a closed space with someone who has tested positive for coronavirus when they were infectious, you are a close contact.

Close contact can happen in many ways, such as living in the same household or working in the same workplace. The Department of Health and Human Services (DHHS) will tell someone if they are a close contact.

Why do I need to quarantine?

Quarantine means you cannot leave your home or accommodation for any reason, except for medical care or in an emergency. Anyone who is a close contact must quarantine as there is a high chance coronavirus will spread to other people. The best way to protect your family and community is to stay at home and away from other people (physical distancing).

VICTORIA State Government | Health and Human Services

You cannot leave your home to exercise. You may be fined up to $4,957 if you leave home while required to quarantine. Stay home and stay safe.

Where do I quarantine?

You must immediately go to the place where you will quarantine, without making any stops. This is usually your own home, but if you can't do this at home then accommodation will be arranged for you.

Who do I need to tell?

After you have been told that you are a close contact, you must tell your employer. You should tell the people you live with that you are a close contact.

How do I stay safe?

You must not leave your home or accommodation, except to seek medical attention or in an emergency.

- Separate yourself from other people by staying in a separate room.
- Wash your hands regularly and cover your coughs and sneezes.
- Wear a surgical mask when you are in the same room as other people and keep 1.5 metres apart.
- Use a separate bathroom, if possible.
- Avoid sharing household items (including plates, cups and cutlery).
- Clean household surfaces (tabletops, doors, keyboards, taps and handles) and wash laundry often.
- If you have any, wear disposable gloves while handling soiled items and always wash your hands.
- Dispose of contaminated items like gloves and masks in a lined waste bin.
- Do not have people to visit you inside your home or accommodation.
- If you live in a private house or apartment you can go into your garden or onto your balcony. You should wear a surgical mask when moving through your accommodation.

Ask friends or family, who do not need to quarantine, to get food or other necessities for you.

You may be fined up to $4,957 if you leave home while required to quarantine. Stay home and stay safe.

Monitor your symptoms

While you are in quarantine, you should watch for symptoms of coronavirus:

- fever
- chills or sweats
- cough
- sore throat
- shortness of breath
- runny nose
- loss of sense of smell or taste.

If you have any of the symptoms of coronavirus you should get tested and then return home immediately.

Do I need to get tested when I am a close contact?

If you have any of the symptoms of coronavirus, you should seek advice and get tested.

Call your doctor or contact the coronavirus hotline on **1800 675 398** (24 hours, 7 days a week).

If you are feeling well and have no symptoms, you will be asked to get tested around day 11 of your quarantine.

You must wear a face covering if you leave home to get tested. Avoid using public transport, taxi or rideshare services. After you have been tested, you must immediately go back to the place where you are in quarantine.

The coronavirus test is free for everyone. This includes people without a Medicare card, such as visitors from overseas, migrant workers and asylum seekers.

How long do I need to quarantine for?

The Department of Health and Human Services will let you know how long you need to quarantine for. Quarantine is usually for 14 days, unless you begin to develop symptoms and/or test positive for coronavirus.

If you are still feeling well and have no symptoms, you will be asked to get tested around day 11 of your quarantine. Even if you feel well, while you are waiting for your test result you **cannot finish your quarantine until you been told it is safe to do so**.

Look after your well-being

Being in quarantine can be difficult, particularly for children.

- Talk to other members of the household. Understanding information about coronavirus will reduce anxiety.
- Arrange with your employer to work from home, if possible.
- Support your child learning from home. Access online resources that are available.
- Keep in touch with family and friends via telephone, email or social media.
- Remember that quarantine won't last for long.

Access resources online – including advice on sleep, wellbeing and exercising at home. Videos are available at Wellbeing Victoria <https://www.together.vic.gov.au/wellbeing-victoria>.

If you are not coping, talk to your doctor or contact:

- **Lifeline Australia** <https://www.lifeline.org.au/>, phone: **13 11 14**
  A crisis support service that provides support at any time.
- **Beyond Blue** <https://www.beyondblue.org.au/>, phone: **1300 22 4636**
  They are providing specialist help for people in isolation.
- **Kids Helpline** <https://www.kidshelpline.com.au/>, phone: **1800 551800**
  A free and confidential counselling service for young people.

Support packages are available

A one-off $1,500 payment is available to support eligible Victorian workers who have been diagnosed with coronavirus or are a close contact of a confirmed case. See Pandemic Leave Disaster Payment <https://www.servicesaustralia.gov.au/individuals/services/centrelink/pandemic-leave-disaster-payment>.

If you need assistance due to your age, disability or a chronic health condition then a service provider, carer, family member or friend can help. You should tell them that you are in quarantine before they visit.

Emergency relief packages with food and personal items are available if you cannot get help from friends or family.

For information on support and emergency relief packages or help getting groceries, visit DHHS.vic. – Quarantine and isolation <https://www.dhhs.vic.gov.au/self-quarantine-coronavirus-covid-19> or call the Coronavirus hotline on **1800 675 398**.

Information for caregivers and other household members

If you are looking after a family member there are some important things you should do to keep everyone in your home safe:

- Ensure the quarantined person remains in one room, away from other people.
- Keep their door closed and windows open, where possible.
- Keep the number of carers to a minimum.
- Always wash your hands with soap and water or use a hand sanitiser before and after entering the room.
- Keep the quarantined person's crockery and utensils separate from the rest of the household.
- If available, wear a surgical mask when you are in the quarantined person's room. If you don't have a surgical mask, use a face covering, such as a scarf or bandana, instead.
- Wear a mask and gloves when handling laundry and wash at the highest heat setting.
- Clean household surfaces (tabletops, doors, keyboards, taps and handles) often.
- Dispose of tissues and masks in a sealed plastic bag.
- Do not have visitors.

If the person starts to feel unwell, call the coronavirus hotline on **1800 675 398** for advice. If you need to visit your doctor, call ahead so they can prepare.

Monitor symptoms

If the person you are caring for develops serious symptoms, such as difficulty breathing, call triple zero (000) and ask for an ambulance.

If anyone else has any symptoms they should get tested and return immediately home.

To find out more information about coronavirus and how to stay safe visit
DHHS.vic – coronavirus disease (COVID-19) **<https://www.dhhs.vic.gov.au/coronavirus>**

If you need an interpreter, call TIS National on 131 450

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