BOARD OF INQUIRY INTO THE COVID-19 HOTEL QUARANTINE PROGRAM

WITNESS STATEMENT OF Infection Control Consultant

Name: Infection Control Consultant

Address: 50 Lonsdale Street, Melbourne, Vic, 3000

Occupation: Infection Control Consultant

Date: 18 September 2020

1. I make this statement to the Board of Inquiry in response to **NTP-142**, the Notice to produce a statement in writing (**Notice**) dated 2 September 2020. This statement has been prepared with the assistance of lawyers assisting the Department of Health and Human Services (**Department**).

Roles and Responsibilities

1. Please describe your relevant professional experience and qualifications.

2. I have the following qualifications:

   (a) Certificate in Sterilisation and Infection Control, REDACTED;

   (b) Bachelor of Nursing, REDACTED;

   (c) Graduate Diploma in Education, REDACTED;

   (d) Bachelor of Applied Sciences (Medical Laboratory Science) REDACTE.

3. I am an accredited nurse immuniser and have completed a number of short courses.

4. I have co-authored papers published in the Medical Journal of Australia and Journal of Hospital Infection[1] and have presented at a number of conferences on infection control including most recently the REDACTED REDACTED

REDACTED

5. I am a member of the Infection Clinical Network Governance Committee and between October 2014 and October 2016, sat as a member on the Victorian Healthcare Associated Infection and Infection Prevention Advisory Committee. I have also been a representative on the Victorian Advisory Council on Infection Control (October 2006 to September 2010).

6. I hold professional membership with the Australasian College for Infection Prevention and Control, and was a member of the Board of Directors June 2014 to November 2017. Since 2012, I have performed the role of Co-ordinator of the ACIPC Victorian Special Interest Group.

7. My professional experience includes:

   (a) since September 2015, Infection Control Consultant at the Microbiological Diagnostic Unit Public Health Laboratory, at the Department of Microbiology and Immunology, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne. In this role, my responsibilities include developing and contributing to policies, guidelines and educational materials relating to infection prevention and control for relevant settings, and to provide IPC advice to support public health investigations, primarily in community settings, and research initiatives including to the Department;

   (b) between July 2013 to September 2015, Infection Control Manager – Nurse Consultant Grade 6 at Austin Health. In this role, I was responsible for managing the infection control team and associated matters. My responsibilities included to provide and co-ordinate an effective infection control program including ensuring standards met professional, organisational, legal and ethical requirements, and the provision of infection control education and information to staff, monitoring the effectiveness of the infection control program, initiating and participating in research, development of policies and procedures and other related matters. Prior to being a Nurse Consultant Grade 6, I was employed by Austin Health as an Infection Control nurse Consultant Grade 4 (October 2007 to January 2010) and Infection Control nurse Consultant Grade 5 (February 2010 to June 2015).

8. I was employed by Peninsula Health as an Infection Control nurse Consultant from 2002 to 2007.

9. Prior to that, I worked in a number of roles including as a registered nurse Grade 1-2 (February 1999 to April 2002) and as a medical laboratory scientist at multiple locations (May 1987 to December 1998).

2. What is your role within the Department of Health and Human Services (the Department) and what are you ordinarily responsible for?

10. REDACTED Microbiological Diagnostic Unit Public Health Laboratory, at the Department of Microbiology and Immunology, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne (**MDU**).

11. Pursuant to an arrangement with the Department, MDU provides a suitably qualified person to provide infection prevention and control expertise in both healthcare and community settings. This position acknowledges that an infection control consultant will be able to contribute particular skills and knowledge in community and healthcare settings, other than acute care, including in the context of investigation of and response to infectious disease outbreaks. I fill that position.

12. The position was primarily located at MDU, although I was located at the Department two days per week and would also attend meetings at the Department as required at other times. For example, prior to 2020, I would attend key communicable diseases meetings at the Department and work closely with Department staff. I now work on a 0.5 FTE basis within the Infection Prevention and Control Cell in the COVID-19 response division at the Department.

13. From January 2020 to mid-July 2020, I filled the role on a full time basis as the need for IPC advice in response to the COVID-19 pandemic grew.

14. My role provides a link between the public health reference laboratory at MDU and the investigation and response activities undertaken by the Department. The focus of the work is the surveillance, prevention and control of infectious diseases in healthcare (excluding acute) and community settings (such as tattooists, beauty therapists). For example, if there had been a breakdown in IPC procedures in a particular setting, I would advise on how to remedy those procedures and advise of any further follow up actions that were required such as patient/client notification.

15. My role includes:

    (a) raising awareness through proactive education and advice on infection prevention and control strategies in diverse health care and community settings, primarily among healthcare workers and other health science professionals;

    (b) developing and contributing to policies, guidelines and educational materials related to infection prevention and control for relevant settings;

(c) providing infection prevention and control advice to support public health investigations into cases of suspected infectious disease transmission, primarily in community settings, but also in healthcare settings as required;

(d) staying abreast of important developments in the science and practice of infection prevention and control, with particular reference to emerging issues relevant to public health disease prevention and control and provide practical advice on the applications of these developments;

(e) providing infection prevention and control advice to support relevant research initiatives at the Doherty Institute and the Department;

(f) providing expert advice and support to departmental committees on infection prevention and control matters as required;

(g) providing infection prevention and control advice to support inspections and investigations of both registered (for example hairdressing and tattooing) and exempt (medical and dental) premises under the *Public Health and Wellbeing Act* 2008 (**PHWA**) and the *Public Health and Wellbeing Regulations* 2009; and

(h) developing and maintaining the infection prevention and control manual for MDU Public Health Laboratory. This includes making recommendations for vaccination and serology testing of staff, administering vaccinations and maintaining the staff immunisation personnel database to ensure staff are protected against vaccine preventable laboratory acquired infections.

16. From January 2020, I began to offer IPC advice specifically in relation to COVID-19. As I describe below, this took the form of drafting or providing input into documents and providing email advice in response to questions. This advice was provided state-wide.

17. There was a considerable need for IPC advice with the emerging threat of COVID-19 in Victoria. From January 2020 to end of March 2020, I was the only person within the Department providing IPC advice and the demand for my advice was great. I received an enormous number of emails and phone calls asking for advice on a wide range of IPC issues from many different clinical and non-clinical settings. This included advice on personal protective equipment (**PPE**) selection and use, cleaning and disinfection requirements and hand hygiene products. I was also required to review or contribute to numerous documents for the Department and external organisations, such as Ambulance Victoria and the Department of Education and Training, that required specific IPC input.

The IPC Cell

18. On 27 March 2020, I received an email from the Deputy Chief Health Office (**DCHO**), Dr van Diemen, advising that she had determined to establish an IPC cell to provide expert guidance on IPC and PPE and coordinate and consolidate work relating to IPC and PPE usage.[2] This was part of the state's COVID-19 response such that the Department would make IPC and PPE advice available, online or in response to queries, that could be used by Victorian settings and workplaces and government departments.

19. Dr Katherine Ong was appointed as Deputy Public Health Commander, Pathology and IPC and I reported to Dr Ong.

20. The IPC Cell commenced in early April 2020 with myself, two part-time IPC consultants and a full-time administrative staff member. Both consultants were experienced IPC consultants. One was from Safer Care Victoria and was the project lead for the Infection Clinical Network at SCV. The other consultant was from the Victorian Hospital Acquired Infection Surveillance System (**VICNISS**) Coordinating Centre and, within the Department's IPC Cell, was tasked with providing COVID-19 IPC preparedness advice for Victorian aged care facilities. They both continued to have responsibilities with their other roles. I continued to be the primary lead (Operations) Monday-Friday and was also frequently the Strategy, Policy and Planning Lead for the IPC Cell simultaneously. The role included on-call weekend working which was covered by the IPC consultants of the cell on a rostered basis.

21. Dr REDACTED joined shortly afterwards and filled the role of IPC Cell Strategy, Policy & Planning Lead approximately 2 days per week and filling in for Dr Ong as well when required.

22. In mid-April 2020, two more part-time IPC consultants from VICNISS (providing, together, 1 EFT) and a resource development officer joined the Cell to help provide advice and/or development of documentation and resources.

23. In mid-May 2020, a further part-time IPC consultant was added and the resource development officer left. In early July 2020 two part-time IPC consultants went full-time and an additional part-time IPC consultant was added. In mid-July, I went part-time and a part-time education officer was added. In mid-September 2020, a full-time education officer and a full-time IPC consultant were added. These appointments and this growth has responded to our attempts, since April to continue to try to grow the cell to meet demand, by advertising and filling positions when we have been able to. State-wide, there has been a shortage of available IPC expertise given the demand.

[2] Email from DCHO, 27 March 2020, DHS.5000.0122.0601.

24. Within the first few weeks of the IPC Cell being established, a generic email address was set up to receive queries. These queries were triaged within the IPC Cell team and addressed as soon as work-load permitted. Often, one of us would work on a query, we would discuss the advice with the IPC Cell group and then finalise our advice.

25. The range of matters I was called upon to advise on a day-by-day basis was diverse as to setting, topic and geography. In any given day, I might have been required to advise a local council on PPE for their employees or what hand hygiene products were suitable for use, provide cleaning guidance for public spaces such as public toilets or playgrounds, advise about preventing COVID transmission risk in construction or retail shops, advising about PPE standards in aged care, such as what should be worn when assisting residents to shower, and endorsing and reviewing content of internally and externally prepared documents including to other Government departments and regulators. The volume of email and telephone queries has been considerable.

3. What role did you play in the Hotel Quarantine Program and for what were you responsible? Please specify the time period in which you performed your role(s).

26. I had no formal role in hotel quarantine and was not directly involved in the hotel quarantine program.

27. I interacted with the program through my role as an IPC consultant for the Department to answer questions received by the IPC Cell from those working in the hotel quarantine program, and to provide advice and guidance from time to time in answer to requests. Often this advice was also provided as state-wide advice, that was then available to those managing the hotel quarantine program.

28. I was involved in developing documents that I am aware were used in hotel quarantine, but, as I indicate above, I was not involved in the implementation of the procedures and so cannot comment on their effectiveness.

29. As I explain in this statement, the demand for IPC remained considerable and with time, both an independent consultancy, Infection Prevention Australia (engaged in early April, as I discuss further below) and a health service, Alfred Health, became involved. Towards the end of the program, on 20 June 2020, Dr Ong, the Deputy Public Health Commander, Pathology and IPC clarified the roles and responsibilities of all involved at that stage as follows:[3]

[3] Email from Dr Ong, 20 June 2020, DHS.5000.0099.6387.

- *Operation Soteria – overarching responsibility for health and wellbeing issues including IPC issues at hotels (coordinated by the soon to start Clinical lead)*
- *IPC Cell – departmental IPC policy including input into hotels policy and plans – but this requires IPC support from on the ground to provide contextual input*
- *IPCON team – on the ground IPC support and advice to feed back to the Operation Soteria team as well as providing context to inform IPC Cell policy*
- *Alfred Health – implementation of health and wellbeing policy at hotels including education and training (but not operational yet across all hotels).*

30. The IPC Cell's responsibility throughout the program remained creating departmental IPC policy advice for state-wide settings, including hotels.

31. As explained later in this statement, the documents I was involved in preparing or, if noted, was requested to review, that I am now aware were used in quarantine hotels as part of the program include:

CCOM Guidelines

(a) "Coronavirus disease 2019 (COVID-19) Case and contact management guidelines for health services and general practitioners" dated 5 April 2020 (**CCOM Guidelines**). A copy is available at DHS.0001.0095.0001.

Cleaning

(b) "Cleaning and disinfecting to reduce COVID-19 transmission: Tips for non-healthcare settings" dated 20 March 2020. A copy of it is available at DHS.0001.0015.0323.

(c) "Cleaning and disinfecting to reduce COVID-19 transmission: Building and construction sites" dated 4 April 2020. I was asked to and did review this document but did not prepare it. A copy of it is available at DHS.5000.0105.5942.

(d) "Hotel Quarantine Response – Advice for cleaning requirements for hotels who are accommodating quarantined, close contacts and confirmed COVID-19 guests updated" issued 16 June 2020. I was asked to and did review this document but did not prepare it. A copy of that advice is at DHS.5000.0003.1597.

PPE

(e) "PPE Advice for Hotel-based Healthcare Workers Contact with COVID-19 Quarantined Clients" approved 1 May 2020. A copy of this advice is at

DHS.0001.0001.1358. I was asked to and did review this document but did not prepare it.

(f) "PPE Advice for Hotel-Based Security Staff & AOs in Contact with Quarantined Clients" approved 5 May 2020. I was asked to and did review this document but did not prepare it. A copy of the advice is at DHS.5000.0023.1373

(g) "PPE Advice for Hotel-Based Security Staff & AOs in Contact with Quarantined Clients" approved 8 June 2020. I was asked to and did review this document but did not prepare it. A copy of that advice is at DHS.5000.0001.8212.

CCOM Guidelines

32. The CCOM Guidelines are guidelines published by the Department on its website and are aimed at health services and general practitioners. The content of the document includes a range of topics, including infection prevention and control. I was involved in preparing content for that section, which was based on evidence-based literature, international guidelines from the World Health Organization titled *Infection prevention and control during health care when novel coronavirus (nCoV) infection is suspected: Interim guidance January 2020*[4] and national guidelines released by the Communicable Diseases Network Australia called the *Series of National Guidelines – Coronavirus Disease 2019 (COVID-19) guideline*.[5] I was also involved in preparing content for the Environmental management section, which addressed cleaning and disinfection.

33. I am aware that Dr Romanes as Deputy Public Health Commander – Planning oversaw preparation of the CCOM Guidelines and it was endorsed by the Public Health Commander and DCHO. The guideline is updated from time to time and published on the Department's website.

Cleaning

34. From early 2020, I understood that evidence suggested that COVID-19 could spread through close contact with an infected person and is typically transmitted via respiratory droplets (produced when an infected person coughs or sneezes). Further, that it was and is possible for a person to acquire COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose or eyes. There was a concern also that the virus may remain viable on surfaces for some time, depending on the nature of the surface and the amount of fluid deposited.

[4] World Health Organization titled Infection prevention and control during health care when novel coronavirus (nCoV) infection is suspected: Interim guidance January 2020, DHS.0001.0112.0001.

[5] Coronavirus Disease 2019 (COVID-19), CDNA National Guidelines for Public Health Units, version 2.4, 25 March 2020, DHS.5000.0125.9849.

35. Cleaning and disinfection are therefore important infection prevention and control strategies to reduce the risk of transmission from potentially contaminated environmental surfaces. Cleaning physically removes organic matter, dirt and some micro-organisms. Disinfection with chemicals is often used after cleaning to kill most remaining micro-organisms.

36. For this reason, in mid-March 2020, I wrote some advice for cleaning and disinfection, "*Cleaning and disinfecting to reduce COVID-19 transmission: Tips for non-healthcare settings*" dated 20 March 2020 (**Cleaning Advice**).[6] Dr Romanes, Deputy Public Health Commander – Strategy and Policy endorsed the document.

37. The information in the Cleaning Advice was prepared for use in non-clinical settings, across Victoria and were placed on the Department's website so that, as I understood it, it would be available to the public, including businesses and other settings to use. The information was not developed specifically for hotels, although they were intended to address a range of situations including those where a suspected or confirmed case is in a facility that houses people overnight, for example, a hotel.

38. I prepared the information contained in the advice having regard to the AHPPC information for routine cleaning and disinfection in the community and information from the Department Guidelines for the investigation of gastroenteritis to determine appropriate bleach dilutions and steam cleaning information.[7] I also looked at the US Centers for Disease Control and Prevention (**CDC**) website. It had specific webpages on cleaning that I remember considering when I drafted the advice.[8]

39. On 2 April 2020, I sent an email to the State Emergency Management Centre (**SEMC**) following an email sent by Dr Looker who is the Deputy Public Health Commander of Case, Contact and Outbreak Management. My email provided the SEMC with a link to the Cleaning Advice, available online, in answer to an email from Mr Menon, from DJPR, asking for information about the cleaning standard required at all quarantine premises, details about standards for common areas and cleaning standard for hotel rooms.[9]

40. I am aware that in June, further cleaning advice was prepared for hotel quarantine, "*Hotel Quarantine Response – Advice for cleaning requirements for hotels who are accommodating quarantined, close contacts and confirmed COVID-19 guests updated*" issued 16 June 2020

[6] "Cleaning and disinfecting to reduce COVID-19 transmission: Tips for non-healthcare settings" dated 20 March 2020, DHS.0001.0015.0323.

[7] Published at https://www2.health.vic.gov.au/public-health/infectious-diseases/infection-control-guidelines/gastrointestinal-illness-investigation-guidelines.

[8] Published at https://www.cdc.gov/coronavirus/2019-ncov/community/clean-disinfect/index.html, as at 18 September 2020 (updated from time to time).

[9] Email from me, 2 April 2020, DHS.5000.0054.2681.

(**Hotel Cleaning Advice**). While I did not prepare the document it adopted the substance of the March Cleaning Advice and I reviewed a draft copy of it on 16 June 2020 and agreed with and did not change the substance of the advice it contained.[10] It contains more specific information that is relevant to hotels than the Cleaning Advice but the essential substance of the advice is the same in both documents.

PPE

41. The use of PPE is another important IPC measure. In advising on PPE or drafting PPE guidelines, it was and is my practice to have regard to and adopt where appropriate relevant national and international guidelines on evidence-based best practice and a review of evidence through literature search. This includes reference to World Health Organisation, Communicable Disease Network of Australia, the USA Centers for Disease Control and Prevention and the Australian National Health and Medical Research Council Australian Guidelines for the Prevention and Control of Infection in Healthcare.[11] I will generally always follow such guidance. The only example I can think of where I have not, was very recently when Victorian PPE guidance has differed from National guidance with respect to use of P2 respirators instead of surgical masks for the care of patients with suspected or confirmed COVID-19 infection in certain circumstances. This was in response to the PPE taskforce's[12] guidance and was not a decision that the IPC Cell made.

42. I was asked to review an earlier version of the PPE Advice titled "PPE Advice for Hotel-based Healthcare Workers Contact with COVID-19 Quarantined Clients" that was later dated 1 May 2020, DHS.0001.0001.1358 (**PPE for Hotel HCWs**).

43. On 15 April 2020, I was party to an email chain between the State Control Centre and Merrin Bamert relating to PPE guidance for hotel sites. The email chain started with an email to me from State Control asking me to advise on whether PPE guidelines had been provided. Ms Bamert responded to that email and it concluded with the SCC advising that REDACTED "will be writing some clear guidelines and FAQ's regarding P2/surgical mask use, PPE use and specific information for Security staff…".[13]

44. The Department had engaged REDACTED and Infection Prevention Australia (**IPA**) on my suggestion after I had been asked to provide IPC advice specifically to Rydges in early April

[10] Email from me, 16 June 2020, DHS.5000.0103.8651 attaching Procedure for cleaning quarantine and quarantine red hotels 16162020, DHS.5000.0103.8653.

[11] Australian National Health and Medical Research Council Australian Guidelines for the Prevention and Control of Infection in Healthcare, DHS.0001.0112.0006, published at https://www.nhmrc.gov.au/about-us/publications/australian-guidelines-prevention-and-control-infection-healthcare-2019#block-views-block-file-attachments-content-block-1.

[12] The PPE Taskforce was established in early April 2020 by Safer Care Victoria and is chaired by the Chief Medical Officer to provide standardised PPE advice to healthcare services and GPs, and to manage PPE stock.

[13] Email copied to me, 15 April 2020, DHS.5000.0052.7822.

and I did not have capacity to attend the hotel as requested. I discuss this in more detail below in response to question 9. IPA were then engaged to assist in providing training and advice to Rydges and '*support infection control procedures for the broader hotel arrangements'* and, among other things, undertake an assessment of other agency PPE arrangements for the purposes of supporting the wellbeing of other agencies' staff in order to reduce the risk of contamination[14]. REDACT occasionally consulted with me on some issues, for example, the use of P2 respirators by nurses. I am aware that IPA also did an IPC audit of a number of hotels. I provided input for one document for REDACT, being the PPE for Hotel HCWs, as I explain in paragraph 46 below.

45. This came about because on 17 April 2020, I was copied on an email sent by the Manager, Emergency Operations to engage a private consultant to support infection control procedures at hotels namely, to review IPC practices by clinical staff, training, procedure development and review, and assessment of other agency PPE arrangements.[15]

46. Shortly after, I was requested to review a document provided by REDACTED concerning PPE for healthcare workers undertaking nasopharyngeal swabbing. I reviewed her draft and passed on my comments to the Deputy Public Health Commander for Pathology and IPC, Dr Ong who subsequently provided my comments to the Public Health Commander, Dr Romanes who agreed with them.[16]

47. On 21 April 2020, I provided IPA with our suggested amendments to their draft.[17] This draft was subsequently finalised by IPA.[18] Later, on 21 April 2020, I was copied to an email sent from REDACTED to Merrin Bamert attaching the PPE for Hotel HCWs "to be sent to hotel team leaders".[19] This is an example of one of the ways I indirectly facilitated the giving of IPC or PPE advice that was to be applied in the hotel quarantine program.

48. I was also involved in providing observations and input into the document titled “PPE Advice for Hotel-Based Security Staff & AOs in Contact with Quarantined Clients” issued 5 May 2020 (**PPE for Security Staff and AOs**). A copy of the advice is at DHS.5000.0023.1373.

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[14] Email copied to me, 17 April 2020, DHS.5000.0053.1869.

[15] Ibid.

[16] Email from Dr Romanes, 18 April 2020, DHS.5000.0111.2138 attaching DHS.5000.0111.2148. Subsequently, I was copied to an email from Dr Ong about this document, 18 April 2020, DHS.5000.0128.7691.

[17] Email from me, 21 April 2020, DHS.5000.0087.2463 attaching draft COVID Hotel HCW quarantine PPE advice, DHS.5000.0087.2467.

[18] Email to me, 21 April 2020, DHS.5000.0104.0984 attaching DHS.5000.0104.0989.

[19] Email, 21 April 2020, DHS.5000.0010.1858 attaching PPE Advice for hotel HCWs, DHS.5000.0010.1863.

49. This was developed in the following way. On 27 April 2020, I was copied into a series of emails exchanged with IPA's consultant and REDACTED relating to PPE for security guards. I contributed to the discussion by advising that there had been updates to the National PPE guidance… "… for hospitals which states that airborne/contact precautions are not required for patients with severe coughing (a withdrawal of previous advice)" and I observed that this may "…provide reassurance for the nurses who are taking swabs that P2 respirators are not required when taking swabs from suspected cases, even if they cough."[20]

50. On 27 April 2020, REDACTED emailed me and others noting issues with non-compliance (specifically, over wearing masks and gloves).[21] In response, we made changes to the PPE for security staff and authorised officer (**OA**) advice noting that PPE should not be worn by security or AOs when not required.[22] I advised that advice endorsed by the Deputy Public Health Commander, Planning was that staff accompanying people downstairs for breaks did not require gloves but that they, and the people leaving the room, required hand hygiene and that the person leaving the room also should be advised not to touch anything and that AOs or security should touch lift buttons, open doors etc to lessen contamination risk.

51. I was then provided with a draft of the PPE Advice for Security and AOs, which I reviewed and made minor amendments including to information about how to don and doff a mask.[23]

52. I am aware that on 30 May 2020, that my colleagues in the IPC cell updated the PPE advice for hotel security.[24]

53. On 10 June 2020, I was party to an email chain about a review of the PPE for Security Staff and AOs, and contributed to this exchange by noting that the advice was not required to be approved by the PPE Taskforce.[25]

54. The information contained in both these PPE documents was based on evidence at that time that COVID-19 was transmitted primarily via droplet and contact and the then current WHO guidance[26] and the National Guidance which required a mask to be worn if a person was

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[20] See email chain, 28 April 2020, DHS.5000.0087.2413.

[21] Email chain, 27 April 2020, DHS.5000.0087.2121.

[22] Ibid.

[23] Email from me, 28 April 2020, DHS.5000.0087.2413 attaching DHS.5000.0087.2420.

[24] Email copied to me, 30 May 2020, DHS.5000.0019.3535. An earlier email chain containing updated advice is DHS.5000.0098.2715 attaching PPE Advice for hotel Security_Update 30 May 2020, DHS.5000.0098.2721.

[25] Email chain, 10 June 2020, DHS.5000.0103.8676.

[26] WHO guidance, 27 February 2020, Rational use of PPE, DHS.0001.0106.0134; WHO Guidance, 6 April 2020, Rational use of personal protective equipment for coronavirus disease (COVID-19) and considerations during severe shortages, DHS.0001.0108.0001.

within 1.5m of suspected/confirmed cases, a mask would not be required if physical distancing could be maintained.

55. I also recall that I had been informed in a conversation around this time that the role of security guards was to 'crowd control' only when guests arrived and to escort guests to and from their rooms for fresh air breaks. I was not aware of any other duties being performed by them. I also understood that they were not required to touch returned travellers as part of their duties (as might otherwise be an expected possibility for security guards in another setting).

56. The advice directed at security and AOs used lay language because I understood that security guards, and also AOs were not a health workforce and would not be as familiar with use of masks or other PPE as health care workers would be.

57. The emphasis was to try and maintain physical distancing at all times. Masks can provide a false sense of security and create an infection risk for those inexperienced in use of PPE. Use of masks in these circumstances, without adequate training, can increase instances of staff touching their face and thereby increase risk of contamination and transmission. Masks are also better for source control, to stop infected persons from spreading droplets, rather than protecting wearers from infection.

58. The advice recommended hand hygiene rather than use of gloves. This is because glove use can lead to poor hand hygiene compliance particularly with untrained workers who may feel that they are protected by gloves and then touch lots of surfaces with gloved hands, potentially contaminating them. It is preferable to sanitise hands regularly by washing with soap and water or using an alcohol-based hand rub between touching different surfaces.

59. An assessment needs to be undertaken for any advice that is given based on the best available evidence at that time as I set out in paragraphs 56 to 58. In my view, the PPE for Security and AOs was an appropriate balance having regard to these considerations.

<u>General *ad hoc* advice</u>

60. In my general role as the Department's IPC consultant, I also responded to *ad hoc* advice requests from those operating the hotel quarantine program. In addition to those matters discussed above and below, I recall receiving a query about whether vacuum cleaners needed to be wiped down between being used in different rooms. I advised that they did and that HEPA filtered vacuum cleaners should be used.[27] On 1 May 2020, I provided advice relating to PPE requirements for hotel day 11 testing[28]

[27] Email from me, 26 May 2020, DHS.5000.0015.3997.

[28] Email, 1 May 2020, DHS.5000.0103.9010.

Personal Protective Equipment (PPE)

4. In your view, was the PPE provided to people working at quarantine hotels adequate? Why or why not?

61. I am not aware of the actual PPE that was provided to people working at quarantine hotels.

62. My views about what, when and how to appropriately use PPE in quarantine hotels, and the reasons for my views, is stated in my answer to question 3 and in the PPE charts to which I refer.

63. I also give evidence about the use of surgical or N95 masks below, in answer to question 5.

5. In the context of the Hotel Quarantine Program, did any person raise concerns or complaints with you in relation to PPE? If so, please provide details, including details about what action (if any) you took in relation to the matter that was the subject of the complaint or concern.

Please provide any relevant documents.

64. The only concern I am aware of in relation to PPE at hotels quarantine was an issue raised with me by REDACTED by email dated 16 May 2020. REDACTE also sent RE email to IPA's consultant.[29] REDACTE was concerned that donning and doffing videos from Melbourne Health provided as part of a Department online training program were not consistent with the PPE for HCWs. REDACTE concern related to the advice in that document, at the time, that swabbing did not require an N95 mask and a surgical mask could be worn.

65. IPA's consultant responded to this email on 16 May 2020 stating that, at the time, swabbing was not regarded as an aerosol generating procedure and so a surgical mask was sufficient. I responded advising that surgical masks could be worn for up to 4 hours and that "(s)taff in hotels do not need to wear P2/N95 respirators as they are not undertaking any aerosol generating procedures (AGPs). Taking a nose or throat swab, even if it causes coughing is not an AGP and therefore a surgical mask is sufficient." This was consistent with the use of masks by nurses in emergency departments and respiratory testing clinics at the time (that they were wearing surgical masks and not P2/N95 respirators). This advice has not changed. P2/N95 respirators are now used in certain settings when caring for suspected or

[29] Email to me, 16 May 2020, DHS.5000.0101.7085.

confirmed COVID-19 cases for prolonged periods and this change in PPE use has really only been relevant to Victoria.

66. My response was informed by the current WHO, National/AHPPC guidance and Victorian policy/guidance, which has remained unchanged and is now expressed in the "*COVID-19 –A Guide to the conventional use of PPE*".[30]

67. On 28 May 2020, I was copied to an email from Dr Ong to REDACTED and others about current PPE recommendations in relation to swabbing. This advice referred REDACTED to the DHHS website and was responsive to issues identified by the Outbreak nurses that nursing staff wanted to use P2/N95 respirators when taking swabs.[31]

68. I am also aware that in the context of the outbreak response at Rydges, Outbreak Squad nurses made observations about the use of PPE by security and nurses. I was not involved in the Outbreak Squad and they did not report to the IPC Cell. My interactions with the Outbreak Squad were on an as needs basis. For example, from time to time they might ask for advice about how to address a particular IPC issue and I or some other member of the IPC cell would provide the required advice.

69. On 19 June 2020, I had a conversation with REDACTED and in that call she raised a number of issues with me. I sent an email to Dr Ong following this call reporting those matters, including how concerns raised by IPCON nurses could be addressed going forward, noting that two nurses were going to be working with Operation Soteria from the following week and so that would help resolve some issues.[32]

Training

6. What training or instructions did you (or, to the extent that you are aware, others) provide to people (including nursing staff, hotel staff, private security staff and employees of the Victorian Public Service) working at quarantine hotels about:

(a) use of PPE;

(b) cleaning; or

(c) any other aspects of infection control.

If your answer differs for different locations or different time periods, please specify.

Please provide relevant documents.

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[30] As at 24 April 2020, DHS.5000.0129.4584. This document has been updated from time to time. Current version published at https://www.dhhs.vic.gov.au/coronavirus-covid-19-guide-conventional-use-personal-protective-equipment-ppe.

[31] Email copied to me, 28 May 2020, DHS.5000.0099.6606.

[32] Email from me, 19 June 2020, DHS.5000.0120.7619 attaching DHS.5000.0120.7621. I was copied to a subsequent email from referring to my discussion, 20 June 2020, DHS.5000.0081.9249.

70. I did not provide training at hotels about PPE, cleaning or other aspects of IPC, other than as I describe above, by making available relevant guidance and material and reviewing training material.

71. I am aware that the Department's emergency operations team engaged IPA to provide support regarding training on or about 18 April 2020 as I discuss below in my answer to question 9[33] and on or about 17 May 2020.[34]

72. I am aware that my colleagues in the IPC Cell were also involved in organising training or education. On 10 June 2020, I sent an email to REDACTED and others advising that I understood that REDACTED, my colleague in the IPC Cell would be organising some education for security guards.[35] I recall that training was to be provided by an independent consultant and I understand that was subsequently provided.[36] I was involved on or about 18 June 2020 to review some information relating to the role of security.[37] I was also copied to an email on 20 June 2020 which noted that at that date one of my colleagues would be progressing IPC training program for security staff.[38] Subsequently, on 26 June 2020, I was copied to an email sent by my colleague attaching training materials.[39]

73. I am also aware that between 8 June 2020 and 15 June 2020, REDACTE provided Dr Stuart Garrow, of Onsite Doctors Pty Ltd which had been engaged by the Department in connection with the hotel quarantine program, with the PPE for HCWs. Dr Garrow subsequently emailed me and proposed that a member of the IPC Cell join in a daily zoom call to discuss IPC issues.[40] I think I sought more information about the program and do not think that I received a response.

74. While I did not directly provide any instructions, I was involved in providing DHHS information for use at hotels as I have explained in answer to question 3. I have not repeated the contents of question 3 in this answer.

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[33] Email copied to me, 18 April 2020, DHS.5000.0052.5490.

[34] Email copied to me, 17 May 2020, DHS.5000.0022.7699.

[35] Email chain, 10 June 2020, DHS.5000.0103.8520. Also see email copied to me, 19 June 2020, DHS.5000.0099.6460.

[36] Email from me, 29 June 2020, DHS.5000.0103.8282.

[37] Email copied to me, 19 June 2020, DHS.5000.0099.6460.

[38] Email copied to me, 20 June 2020, DHS.5000.0099.6387.

[39] Email copied to me, 26 June 2020, DHS.5000.0095.6924 attaching DHS.5000.0095.6927, DHS.5000.0095.6929, DHS.5000.0095.6931, DHS.5000.0095.6935 and DHS.5000.0095.6951.

[40] Email chain, 15 June 2020, DHS.5000.0108.1502.

PPE

75. On one occasion in late April or early May I provided advice to a doctor working in the public health team in the Department about setting up day 11 testing and the PPE to be used when testing.[41]

Cleaning

76. On 13 April 2020, I was copied to an email from Dr Ong to Rachaele May, the DJPR COVID Accommodation lead providing advice relating to hotel cleaning for rooms occupied by non-symptomatic guests. Dr Ong provided that advice on behalf of the IPC Cell.[42]

77. On 1 June 2020, we received a request to provide advice to Rachaele May, DJPR Hotel Quarantine Agency Commander regarding cleaning standards at Rydges and Novotel South Wharf hotels. The query came to me but we were unable to answer it without further information. The same day the query was received, I responded to Ms May and requested further information to enable the query to be answered.[43] I was not aware whether this request was made in the context of the Rydges outbreak.

78. Subsequently, on 2 June 2020, I received a request to review a document titled 'Advice for cleaning COVID positive hotels' (which came to be the Hotel Cleaning Advice). The Hotel Cleaning Advice was substantially based on the Cleaning Advice, which had been prepared in March. I reviewed that advice and provided my preliminary comments in response noting that I wished to discuss the document with the IPC cell before it was finalised.[44]

79. On 6 June 2020, I received an email from the DJPR Project Officer - Accommodation Support in relation to cleaning information for the Novotel South Wharf.[45] On behalf of the IPC Cell, I responded on 12 June 2020 advising that there should be daily cleaning of guest rooms and that fogging was not recommended. I also asked DJPR to confirm the products being used to disinfect and their cleaning schedule and whether the cleaners are trained to use it, along with being appropriately trained to use appropriate PPE for daily and discharge cleaning. In my view, this information was able to be discerned from the Cleaning Advice published in March.

[41] Email, 17 May 2020, DHS.5000.0103.8980.

[42] Email copied to me, 13 April 2020, DHS.0001.0011.0442.

[43] Email chain, 2 June 2020, DHS.5000.0101.6315.

[44] Email from me, 3 June 2020, DHS.5000.0087.3347 attaching DHS.5000.0087.3349.

[45] Email, 6 June 2020, DHS.5000.0014.7986 attaching DHS.5000.0014.7990, DHS.5000.0014.7996 and DHS.5000.0014.8009.

80. Subsequently, on 14 June 2020, another IPC Cell colleague updated the Hotel Cleaning Advice.[46]

IPC

81. On 16 June 2020, I sent an email to Merrin Bamert in response to an email she had sent through to the IPC Cell. That email provided instructions to direct all questions about IPC for hotels to the IPC Cell's generic email address. My email to Ms Bamert also referred her to the COVID-19 Infection Prevention and Control guideline and website link to it and noted that all advice provided by the IPC Cell was in line with this Guideline.[47]

82. On 16 June 2020, I provided advice in response to a query relating to hotel laundry at the Brady Hotel.[48]

7. In your view, was the training provided to people (including nursing staff, hotel staff, private security staff and employees of the Victorian Public Service) working at quarantine hotels about:

(a) Use of PPE;

(b) Cleaning; and

(c) Other aspects of infection control,

appropriate and adequate? Why or why not?

83. Beyond those matters I discuss above in answer to question 6, I am not aware of what training was provided to people working at quarantine hotels in relation to the use of PPE, cleaning and other aspects of IPC.

84. To the extent that I or my colleagues in the IPC Cell were involved in providing information or reviewing training material, it is my view that the advice the IPC Cell provided was at all times current and based on the prevailing international and national guidelines and evidence available in the literature in place at the relevant time and that it was both appropriate and adequate.

[46] Email copied to me, 14 June 2020, DHS.5000.0099.6476 attaching DHS.5000.0099.6482 and DHS.5000.0099.6488.

[47] Email from me, 16 June 2020, DHS.5000.0095.3692.

[48] Email from me, 16 June 2020, DHS.5000.0108.0852.

8. In the context of the Hotel Quarantine Program, did any person raise concerns or complaints with you in relation to training about use of PPE, cleaning or any other aspect of infection control? If so, please provide details, including details about what action (if any) you took in relation to the matter that was the subject of the complaint or concern.

Please provide any relevant documents.

85. I do not recall any particular complaints or concerns being raised with me relating to training about PPE, cleaning or other aspects of IPC. I otherwise refer to my answer to question 5.

Rydges Hotel in Carlton

9. In your opinion, how would you assess the adequacy of infection control practices and procedures at the Rydges Hotel in Carlton?

86. I am unable to express an opinion about the adequacy of the application and implementation of IPC practices and procedures at the Rydges Hotel in Carlton. I do not know how IPC practices and procedures were implemented and never visited that hotel.

87. In my view, the documents I describe above set out appropriate IPC practices and procedures for a range of settings if properly applied and implemented.

88. My understanding of what was in place at the Rydges is limited to snippets of information I received from time to time.

89. On 10 April 2020, the Deputy Manager, Emergency Operations, Emergency Management Branch[49] emailed to the IPC Cell inbox in the context of Rydges being designated as a COVID-positive site and sought our assistance with arranging an IPC briefing and training GPs and nurses. As discussed above, I did not have capacity at the time and so provided contact information for a private IPC consultant I recommended who could assist.[50] I was subsequently informed that a site walk through had been arranged to flag any issues that required attention and that the topic of training was raised with the consultant.[51]

90. On 11 April 2020, I received a copy of the IPC consultant's assessment and recommendation following her site visit to the Rydges. It contained recommendations about the manner in

[49] Email, 10 April 2020, DHS.5000.0087.4479.

[50] Email from me, 10 April 2020, DHS.5000.0102.1214.

[51] Email to me, 11 April 2020, DHS.5000.0087.8605.

which guests should be triaged and some observations about PPE availability and other matters. I circulated that email to the IPC Cell for information purposes.[52]

91. Subsequently, I was informed by email the Manager, Emergency Operations that the consultant had been of "great assistance in supporting the operationalising of a COVID +ve hotel" and that emergency operations would like to engage RE for further support at hotels. In response, I provided the consultant's contact details again.[53] I am aware that contact was subsequently made with the consultant to discuss arrangements with the consultant but do not know the outcome of those discussions.[54]

92. On the assumption that those IPC procedures and practices reflected the recommended standards contained in the information provided by the IPC Cell, I understand it would have been current advice based on the prevailing international and national guidelines in place at the time and that this was both appropriate and adequate.

10. In your view, was there any difference between infection control practices and procedures at the Rydges Hotel Carlton and any other quarantine hotel? Please provide details. If your answer differs for different locations or different time periods, please specify.

93. I am not familiar with the IPC practices and procedures at quarantine hotels, including the Rydges and do not know whether there were differences in IPC practices and procedures at the Rydges and other quarantine hotels.

94. It is my expectation that the practices and procedures would not be different because even at a quarantine hotel there is a possibility that a returned traveller may be COVID-19 positive and at risk of transmitting it unknowingly to others.

Complaints and issues

11. Did you have concerns, or raise any issues, about any aspect of the Hotel Quarantine Program, or the way that the program was being delivered? If so, in relation to each, please:

(a) provide the details of each concern or issue;

(b) explain how the concern or issue was dealt with, including any persons to whom it was relayed; and

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[52] Email, 11 April 2020, DHS.5000.0128.7672.
[53] Email chain, 15 April 2020, DHS.5000.0088.8925.

[54] Email copied to me, 18 April 2020, DHS.5000.0052.5490.

(c) describe what outcome, if any, was achieved in relation to the concern or issue.

95. I did not have a real insight into how the program was operating to form a view on this issue.

Further Information

12. If you wish to include any additional information in your witness statement, please set it out below.

96. No.

Signed at Melbourne

in the State of Victoria

on 18 September 2020

REDACTED

Infection Control Consultant