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Operation Soteria -Quarantine Hotels Options Analysis

24 June 2020

Purpose

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

Current Situation

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

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

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

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

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

The highest risk activities in hotel quarantine are:

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

Current Situation

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

Recommendation –

Accept Option 1

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

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

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

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

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

Additional Compliance

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

Options for improved compliance include:

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

Victoria Police

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

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

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

Option A – Optimal Model

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

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

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

This model could eliminate the need for security staff.

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

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

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

Option B – Hybrid Model

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

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

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

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

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

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

Option C – Current Staffing

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

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

Training and Induction

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

Rostering

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

Chief Health Officer Advice to Minister for Health

Advice relating to Declaration of State of Emergency

Introduction and Summary of Advice

1. Advice to the Minister for Health, from the Chief Health Officer, regarding a declaration of a state of emergency under s198 of the *Public Health and Wellbeing Act 2008* (Vic) (**the Act**) in relation to Novel Coronavirus 2019 (2019-nCov).
2. I advise that there is a serious, and potentially catastrophic, risk to public health arising from 2019-nCoV throughout the State of Victoria.
3. Arising from this, I advise the Minister
   (a) to declare a state of emergency under the Act;
   (b) to declare the state of emergency throughout the State of Victoria; and
   (c) to declare the state of emergency immediately and for a period of 4 weeks.
4. I explain my reasons for this advice below.

Background

5. Late 2019 and early 2020 saw a Novel Coronavirus, now referred to as COVID-19, originate from the city of Wuhan in the Hubei province of mainland China.
6. The formal designation of this infectious disease in Victoria is 'Novel Coronavirus 2019 (2019-nCoV)'.
7. On 21 January 2020 Australia declared 2019-nCoV as a communicable disease incident of national significance.
8. On 30 January 2020 the World Health Organisation declared 2019-nCoV a public health emergency of significant concern.
9. The Victorian Government has currently designated 2019-nCoV as a class 2 public health emergency and nominated the Department of Health and Human Services as the control agency.
10. On 27 February 2020, the Commonwealth Government announced that Australia is treating 2019-nCoV as a pandemic and that it had activated an Australian Health Sector Emergency Response Plan.
11. On 11 March 2020, the World Health Organization announced their assessment that 2019-nCoV should be characterized as a pandemic.
12. I am informed that as at 13 March 2020, there have been 38 confirmed cases of 2019-nCoV in Victoria and that as at 6 March 2020 there were 10 confirmed cases of 2019-nCoV in Victoria.

13. Projections indicate there will be approximately 170 confirmed cases of 2019-nCoV in Victoria by 20 March 2020, with approximately 1400 close contacts requiring tracing by that date.
14. On 12 March 2020 I was also informed that the first case of 2019-nCoV with no known or traceable source, had occurred in Victoria. An additional case in South Australia with no international travel history, did report travel to Victoria during the likely period of acquisition. These cases indicate there is very likely to be community transmission in Victoria at this time, with no clear link to imported cases or travel.
15. More significant and targeted action is now required to slow transmission of 2019-nCoV in Victoria.

Relevant Legislation Informing the Advice

16. Pursuant to section 198(1) of the Act, the Minister may declare a state of emergency arising out of any circumstances causing **serious risk to public health**.
17. **Serious risk to public health** is defined in section 3 of the Act to mean a material risk that substantial injury or prejudice to the health of human beings has or may occur having regard to:
    (a) the number of persons likely to be affected;
    (b) the location, immediacy and seriousness of the threat to the health of persons;
    (c) the nature, scale and effects of the harm, illness or injury that may develop; and
    (d) the availability and effectiveness of any precaution, safeguard, treatment or other measure to eliminate or reduce the risk to the health of human beings.
18. This legislative definition has framed my advice to the Minister for Health.

Approach to advice

19. In formulating my advice, I am guided by the objectives of the Act (see section 4) and I have taken an evidence based approach (section 5 of the Act) in providing advice whether there is a material risk that substantial injury or prejudice to health is or will be caused by 2019-nCoV without action, taking into account the factors outlined in the definition of serious risk to public health.
20. In formulating advice, it is based upon the best available evidence, however I note that the lack of full scientific certainty should not be used as a reason for postponing measures to prevent or control the public health risk (section 6 of the Act). The Act also provides that the prevention of disease and illness is preferable to remedial measures (section 7 of the Act)

21. In formulating my advice, I understand that decisions made under the Act should be proportionate to the public health risk in question (see section 9 of the Act). In addition, the availability and effectiveness of the measures that are proposed to prevent, manage and reduce the risk of infection of 2019-nCoV are highly relevant.
22. The primary focus of my advice is on health impacts of 2019-nCoV to the Victorian community.
23. My advice has considered the current evidence on the projection of numbers of people impacted, seriousness of the threat, how widespread the threat is throughout the Victorian community, whether action is required now, the likely outcome to human health from not taking action, how many people may be impacted from not taking action, the health and social consequences from not taking action – including to certain categories of the population including our most vulnerable, and what available effective measures may be put in place to effectively manage the health threats identified.
24. My advice has considered the steps necessary to respond to the serious risk to public health arising from 2019-nCoV, and the powers available under the Act to take those steps. In particular, I have considered the emergency powers in section 200 of the Act, which may be used in conjunction with the public health risk powers in section 190 of the Act.
25. I note that the powers under s 200:
    (a) are only available if a state of emergency has been declared;
    (b) allow a broader range of actions to be taken than under s 190, particularly in relation to imposing restrictions on the movement of groups of people; and
    (c) may be exercised in relation to the whole of the "emergency area" as declared, not only particular "premises".

Number of persons likely to be affected

26. 2019-nCoV is a novel coronavirus that has not been seen in humans previously.
27. 2019-nCoV may be transmitted in people in an early stage of illness where symptoms may be negligible or be unnoticed and one infected person is estimated to potentially infect 2-4 other people. This increases the potential number of persons likely to be affected.
28. Potentially, the entire Victorian population (~6.6 million) is vulnerable to infection 2019-nCoV.

29. Current modelling suggests that at the peak of a moderate severity epidemic over 120,000 infections will be occurring in the Victorian community daily, with approximately 13,000 people seeking healthcare daily, 580 requiring hospitalisation daily, and of those, 145 requiring Intensive Care Unit admission daily.
30. At the peak of a moderate severity epidemic, modelling estimates that 5,112 people will be admitted to hospital and, of these, 1,273 people will be admitted to Victoria's Intensive Care Units for 2019-nCoV cases.
31. Current modelling suggests that in a moderate scenario 3,192 people will die from 2019-nCoV in Victoria.
32. Event attendances increase the number of people in close proximity and therefore increase the number of people likely to be affected.

Location, immediacy and seriousness of the threat to the health of persons

33. There is strong evidence of sustained human to human transmission of 2019-nCoV in many countries, causing or expected to cause significant impacts on the healthcare systems in these countries. It is expected the same will occur throughout Victoria.
34. Transmission rates are significant enough to have prompted significant travel restrictions, although there remains a material, ongoing risk of imported cases into Australia.
35. The threat to Victorians and the healthcare system is immediate and serious, with the threat existing to the entire population regardless of location.

Nature, scale and effects of the harm, illness or injury that may develop

36. Disease severity of 2019-nCoV ranges from mild respiratory symptoms through to severe illness and death.
37. Elderly people and those with co-existing medical conditions are much more likely to become severely unwell. 94% of deaths have occurred in people older than 50 years old.
38. Vulnerable members of society are expected to be disproportionately impacted.

39. The current best available international evidence and modelling indicates that throughout Victoria, in a severe scenario, if the mitigating steps are not taken, in the next four months 54,939 people will require hospitalisation across the epidemic, with 12,552 in hospital at peak and 1,556 daily hospital admissions at the peak. This severe unmitigated scenario may result in 6808 people in Victoria dying from 2019-nCoV. This figure does not take account of deaths that would occur because the health system is overwhelmed and that those requiring care for other conditions will be unable to receive it.

40. Estimates from published literature and epidemiological sources indicate the case fatality rate for coronavirus disease varies and can be dependent on how high case ascertainment is. For example, in South Korea, which has a high number of case ascertainment and effective social distancing measures in place, the case fatality rate is currently estimated as 0.8% which is 8 times higher than seasonal influenza. Conversely in Italy, where there has been less initial social distancing measures, the case fatality rate is currently estimated as 6.6%, in part likely due to health services being overwhelmed. The World Health Organisation currently estimate the case mortality rate as between 2.2% and 4.3%.

41. The morbidity and mortality projections for Victoria are a serious threat to the population, create serious risks particularly for the elderly, chronically ill and vulnerable, and a significant burden will be placed on the Victorian health system to respond at a scale that has little precedent.

Availability and effectiveness of any precaution, safeguard, treatment or other measure to eliminate or reduce the risk to the health of human beings

42. There is currently no vaccination and no widely used pharmaceutical countermeasures are available for 2019-nCoV.

43. Early evidence suggests measures such as quarantine, contact tracing, infection prevention and control interventions will assist to control spread, minimise morbidity and mortality, delay and reduce the epidemic peak and preserve health resources.

44. Isolation of confirmed 2019-nCoV cases, and quarantining of close contacts, is a particularly critical public health measure to reduce transmission of the infection and potential morbidity and mortality in the Victorian community.

45. The required measures that are necessary also include social distancing, targeted closures of events/premises/business, heightened enforcement capability and timely sharing of all available information.

46. The power to regulate public gatherings is also necessary to support compliance with the new Commonwealth guideline that non-essential gatherings of more than 500 people not proceed throughout Australia from Monday 16 March 2020. A measure of this nature is important as it is aimed at slowing the transmission of 2019-nCoV.
47. Strategic management of available clinical and health resources, including facilities, workforce, medicines and other critical consumables is necessary.
48. The emergency powers under the Act are required in order to best achieve these objectives.

Advice

49. I consider that having regard to the above factors, there is a serious and potentially catastrophic risk to public health on the basis that there is a material risk that substantial injury or prejudice to the health of human beings has or may occur in Victoria related to 2019-nCoV.
50. I consider that the emergency powers (including in combination with the other powers) are necessary to manage the threat effectively and I consider the response will be much less effective in the absence of the emergency powers under section 200 of the Act.
51. I consider that it has now become necessary to exercise the emergency powers under section 200 of the Act and that it is necessary for me to grant authorisations under section 199 of the Act to exercise those emergency powers, in order to eliminate or reduce a serious risk to public health arising from 2019-nCoV.
52. Arising from this, I advise the Minister to declare a state of emergency under the Act for a period of four weeks.
53. I advise the Minister to declare the state of emergency throughout the State of Victoria given the nature of 2019-nCoV, including its transmission without apparent symptoms, such that specific measures will be required at short notice in targeted areas within Victoria and broader consistent measures across the entire State.
54. I advise the Minister to declare the state of emergency immediately in order to increase the prospects of slowing transmission of 2019-nCoV in Victoria and minimising as much as possible the serious risk to public health arising from 2019-nCoV.

Dated this 15th day of March 2020.

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Public Health and Wellbeing Act 2008

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

Interpretation:

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

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

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

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

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

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

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

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

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

This 29th day of March 2020

Time: 7pm

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