FW: FW: Cleaning specs

From: "Clare Looker (DHHS)" REDACTED
To: "StateEmergencyManagementCentre SEMC (DHHS)" <semc@health.vic.gov.au>
Cc: REDACTED (DHHS)" REDACTED @dhhs.vic.gov.au>
Date: Thu, 02 Apr 2020 17:19:53 +1100

Hi SEMC,

Has this advice been provided for the hotels? If not, there are resources on the health.gov website and

https://www.health.gov.au/sites/default/files/documents/2020/03/coronavirus-covid-19-information-for-hotels-and-hotel-staff-coronavirus-covid-19-information-for-hotels-and-hotel-staff_2.pdf

I have also included REDACTED, our REDACTED, who may know of other resources that exist that could guide facilities.

Kind regards

Clare

Dr Clare Looker
Deputy Public Health Commander COVID-19 (Operations)
Senior Medical Advisor
Health Protection Branch | Regulation, Health Protection and Emergency Management Division
Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
REDACTED
w. www.dhhs.vic.gov.au

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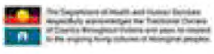

From: Simon Crouch (DHHS) REDACTED
Sent: Thursday, 2 April 2020 8:12 AM
To: Clare Looker (DHHS) REDACTED
Subject: Fwd: FW: Cleaning specs

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From: SEMC <semc@dhhs.vic.gov.au>
Sent: Thursday, April 2, 2020 7:02:22 AM
To: Simon Crouch (DHHS) REDACTED
Subject: Fwd: FW: Cleaning specs

Good morning,

Could public health please provide guidelines on cleaning requirements for response in relation to the questions below. Given this is active quarantine accommodation, there is an urgency associated with this information.

Many thanks

DHHS SDO

---------- Forwarded message ----------
From: Braedan Hogan
Date: 01/04/2020 21:49
Subject: FW: Cleaning specs
To: "StateEmergencyManagementCentre SEMC (DHHS)"

Hi SEMC – can you please seek advice from PH on this as a priority.

Braedan

Braedan Hogan

Deputy Director, Strategy and Policy

Emergency Management Branch

Regulation, Health Protection & Emergency Management Division
Department of Health and Human Services

50 Lonsdale Street Melbourne Victoria 3000
REDACTED

From: Unni Menon (DEDJTR) REDACTED
Sent: Wednesday, 1 April 2020 9:23 PM
To: Claire Febey (DEDJTR) REDACTED RE Donna Findlay (DEDJTR) REDACTED Braedan Hogan (DHHS) REDACTED
Cc: Robert Leith (DEDJTR) REDACTED >; Rob Holland (DEDJTR) REDACTED
Subject: RE: Cleaning specs

Thanks Claire and hi Braedan and Rob

My thoughts on what we require(similar to what Claire has alluded to):

1. What is the minimum acceptable standard of cleaning required at all quarantine premises
2. Any prescription details around cleaning standards expected in all common areas including corridors, hallways, reception, terraces etc
3. Should a guest vacate- what level of clean is expected for each room(COVID infected versus non infected – or is there a difference in cleaning standards)

Hope this helps

Cheers

Regards

Unni Menon

Executive Director
Department of Jobs, Precincts and Regions
Level 7, 1 Spring Street, Melbourne, 3000
REDACTED

djpr.vic.gov.au

52466801

Linkedin | Youtube | Twitter

From: Claire Febey (DEDJTR) <REDACTED
Sent: Wednesday, 1 April 2020 9:03 PM
To: Unni Menon (DEDJTR) REDACTED ; Donna Findlay (DEDJTR) REDACTED Braedan J Hogan (DHHS) REDACTED
Cc: Robert Leith (DEDJTR) REDACTED Rob Holland (DEDJTR) REDACTED
Subject: FW: Cleaning specs

Unni, Donna

Braedan is keen to understand what information we need regarding cleaning to support our negotiations with hotels.

Can you please reply all with a quick outline of what you need.

Braedan – in addition to what Unni and Donna send through, as flagged in the SCC meeting I'm keen to understand:

- What specific practices should we apply in the hotel space (e.g. cleaning after each arrival through reception, after a confirmed case is moved, after a recreation period).

This is especially important for us to understand given the health and wellbeing issues raised by DHHS staff on the call.

Thanks so much

Claire

From: Braedan Hogan (DHHS) REDACTED
Sent: Wednesday, 1 April 2020 3:36 PM
To: Claire Febey (DEDJTR) <claire.febey@ecodev.vic.gov.au>
Subject: Cleaning specs

Hi – as discussed at 1:30pm if you can send me the questions you had for us about cleaning I can see what we have available and seek further advice from Public Health if needed.

Braedan

Braedan Hogan

Deputy Director, Strategy and Policy

Emergency Management Branch

Regulation, Health Protection & Emergency Management Division
Department of Health and Human Services

50 Lonsdale Street Melbourne Victoria 3000

REDACTED

Personal Protective Equipment (PPE) advice for Hotel-Based Security Staff and Authorised Officers in contact with COVID-19 quarantined clients

Recommended PPE use according to type of activity

Setting	Activity	Security Staff	Client PPE required
Hotel Lobby **Perform hand hygiene before and after every client contact**	• Able to maintain physical distance of at least 1.5 metres	• No PPE • Hand hygiene	• No PPE
	• When accompanying clients for fresh air/exercise breaks from room to outside and able to maintain 1.5 metres • 1.5 metre physical distance is **not feasible**	• No PPE • Hand hygiene • Surgical mask • Hand hygiene	• Client to wear surgical face mask if tolerated • Hand hygiene • Advised not to touch anything on the way out/down
Hotel Lobby **When new guests are arriving for the commencement of their quarantine** **Perform hand hygiene before and after every client contact**	• Able to maintain physical distance of at least 1.5 metres	• No PPE • Hand hygiene	• Client to wear surgical face mask if tolerated • Hand hygiene • Advised not to touch anything on the way in/up
	• 1.5 metre physical distance is **not feasible**	• Surgical mask • Hand hygiene	
Hotel quarantine floor Not entering the client/s room or having direct contact with client/s. **Perform hand hygiene before and after every client contact**	No direct client contact e.g. walking room hallways or stationed in room corridors	• No PPE • Hand hygiene	• No PPE

Setting	Activity	Security Staff	Client PPE required
Doorway indirect contact by security **Perform hand hygiene before and after every client contact**	Any doorway visit: • Able to maintain physical distance of at least 1.5 metres	• No PPE • Hand hygiene	• No PPE
	Any doorway visit: • 1.5 metre physical distance is **not feasible**	• Surgical mask • Hand hygiene	• Client to wear surgical face mask if tolerated • Hand hygiene

Correct use of PPE (Mask only) and Hand Hygiene

Effective hand hygiene is the single most important strategy in preventing infection.

Gloves are NOT a substitute for hand hygiene and hands should be washed with soap and water if they are visibly soiled, otherwise hand sanitiser can be used continuously.

Gloves are NOT recommended for any security staff or AO staff member at any time.

Respiratory hygiene and cough etiquette must be applied as a standard infection control precaution at all times and perform hand hygiene each time you use a tissue or cough or sneeze into your elbow.

ALWAYS AVOID TOUCHING YOUR FACE

Hand sanitiser is NEVER applied to gloved hands.

PROCEDURE FOR PUTTING ON MASK

1. Perform hand hygiene using the hand sanitizer
2. Put on the mask handling the side tapes only
    a. If your mask has the ear loops, place them over both ears together
    b. If your mask has to be tied, tie the bottom first and then the top tie to secure on your face
    c. Ensure the mask is secured across the bridge of your nose (mold metal clip over bridge of nose) and ensure it sits snuggly under the chin
3. Perform hand hygiene
4. After mask is in place never touch the front of your mask

PROCEDURE FOR TAKING OFF MASK

1. Perform hand hygiene using the hand sanitizer
2. Do not touch the front of the mask
3. Undo the bottom tie of your mask and then the top tie, handling the mask only by the top ties, drop mask straight into the yellow bin
4. If your mask has the ear loops, remove the loops and place into bin
5. Perform hand hygiene using the hand sanitizer

NOTE

Hand hygiene should be performed when you feel that you may have contaminated your hands from touching the mask if wearing one or your face

RE: Advice for Hotel based security

From: "Merrin Bamert (DHHS)" <"/o=exchangelabs/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=638a479568194a798229202add0cc910-mbam1802">
To: "Clare Looker (DHHS)" REDACTED
Cc: "Finn Romanes (DHHS)REDACTED REDACTED REDACTED "Katherine Ong (DHHS)" REDACTED DHHSOpSoteriaEOC <dhhsopsoteriaeoc@dhhs.vic.gov.au>
Date: Fri, 29 May 2020 22:26:16 +1000

Great thanks

If they can get back to me asap we will get this actioned

Kind regards

Merrin

Merrin Bamert
Commander, Operation Soteria, Covid - 19
Director, Emergency Management, Population Health and Health Protection
South Division
Department of Health and Human Services
Level 5 / 165-169 Thomas Street, Dandenong, 3175
REDACTED

From: Clare Looker (DHHS) REDACTED
Sent: Friday, 29 May 2020 10:22 PM
To: Merrin Bamert (DHHS) REDACTED
Cc: Finn Romanes (DHHS)REDACTED REDACTED REDACTED Katherine Ong (DHHS) REDACTED
Subject: RE: Advice for Hotel based security

Hi Merrin,

We currently do not have any evidence to suggest this is not still a valid approach. However I think we should have the document formally reviewed and endorsed by REDACTED and Katherine Ong's group in light of these recent cases and the ongoing investigations, before we push it out any further.

Cheers
Clare

Dr Clare Looker
Deputy Public Health Commander COVID-19 (Case, Contact and Outbreak Management)
Senior Medical Advisor
Health Protection Branch | Regulation, Health Protection and Emergency Management Division
Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
REDACTED
w. www.dhhs.vic.gov.au

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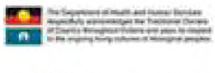


From: Merrin Bamert (DHHS) REDACTED
Sent: Friday, 29 May 2020 10:14 PM
To: Clare Looker (DHHS) REDACTED Finn Romanes (DHHS) REDACTED
Subject: FW: Advice for Hotel based security

Hi Both

Are we still comfortable with this advice as per below re PPE and activities given the latest numbers from Rydges.

If so we will send this onto all security companies and obviously we need to be pushing the hand hygiene

Regards

Merrin

Merrin Bamert
Commander, Operation Soteria, Covid - 19
Director, Emergency Management, Population Health and Health Protection
South Division
Department of Health and Human Services
Level 5 / 165-169 Thomas Street, Dandenong, 3175
REDACTED

From: Pam Williams (DHHS) REDACTED
Sent: Friday, 29 May 2020 7:54 PM
To: Merrin Bamert (DHHS) REDACTED
Subject: Fwd: Advice for Hotel based security

Once you look at this and are happy with it, please send to REDACTED
Pam
Get Outlook for iOS

From: REDACTED (DHHS) REDACTED
Sent: Friday, May 29, 2020 6:22:08 PM
To: Pam Williams (DHHS) REDACTED
Cc: REDACTED REDACTED (DHHS) REDACTED REDACTED
Subject: Advice for Hotel based security

Hi Pam,

Thank you. I've tried to locate and put together some items (videos, posters, DHHS advice) for Unified Security regarding hand hygiene and PPE. One was a reiteration of the great advice already given in the attached Word document. Somehow that message seems to have been lost but needs to be reintroduced to the staff not only on the ground at Rydges, but also upper Unified management so that there is a consistent education flow from the top down. Could you review the suggested collected advice and see if it is appropriate please? I was trying to keep it simple and work group appropriate. There is other relevant information on Safe Work Australia as well, but I thought perhaps not to overwhelm. Also attached below are the relevant management members to company as given to me by Unified Operations Manager REDACTED on 28/5/20.

I hope this is all helpful.

REDACTED
REDACTED

REDACTED
REDAC@unifiedsecurity.com.au
REDACTED
REDACTED@unifiedsecurity.com.au
REDACTED
REDACTED unifiedsecuirty.com.au

Hand hygiene

The World Health Organization has developed the following videos and posters on how to how to use alcohol-based hand-rub and how to wash your hands:

- How to hand rub (video) https://www.youtube.com/watch?v=ZnSjFr6J9HI
- How to hand rub (poster) https://www.who.int/gpsc/5may/How_To_HandRub_Poster.pdf?ua=1
- How to wash hands (video) https://www.youtube.com/watch?v=3PmVJQUCm4E
- How to wash hands (poster) https://www.who.int/gpsc/5may/How_To_HandWash_Poster.pdf?ua=1

Further Education

Although the security group may not fit exactly in the 'who it's for' training description, the security sector now finds itself providing in the hotel group used for quarantining and isolating those with Covid19. There are some who may find it useful. Just a thought…
Covid 19 Infection Control Training 30 minute video – put out by the Australian Govt.
https://www.health.gov.au/resources/apps-and-tools/covid-19-infection-control-training

Kind regards,

REDACTED
Infection Prevention & Control Outreach Team Nurse, COVID-19
IPC Outbreak Management I Legal and Executive Services Division
Department of Health and Human Services | 50 Lonsdale Street, Melbourne, Victoria, 3000
REDACTED

Incident Action Plan

Novel Coronavirus 2019/20

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

Priorities (2 February 2020)

As of 1700 on 1 February 2020,

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

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

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

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

Other relevant positions

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

Governance

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

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

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

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

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

Administration

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

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

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

Safety

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

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

Ready access to Employee Assistance Program services for staff.

Risk assessment

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

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

As of 1 February 2020,

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

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

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

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

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

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

1. Confirmed case

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

2. Suspected case

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

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

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

Risk management

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

Case management

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

Laboratory management

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

Contact management

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

Infection prevention and control

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

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

Risk communication

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

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

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

Attachments

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

FOR OFFICIAL USE ONLY

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

Situation overview

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

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

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

Epidemiology Summary	

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

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

State Response and Control Measures	

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

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

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

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

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

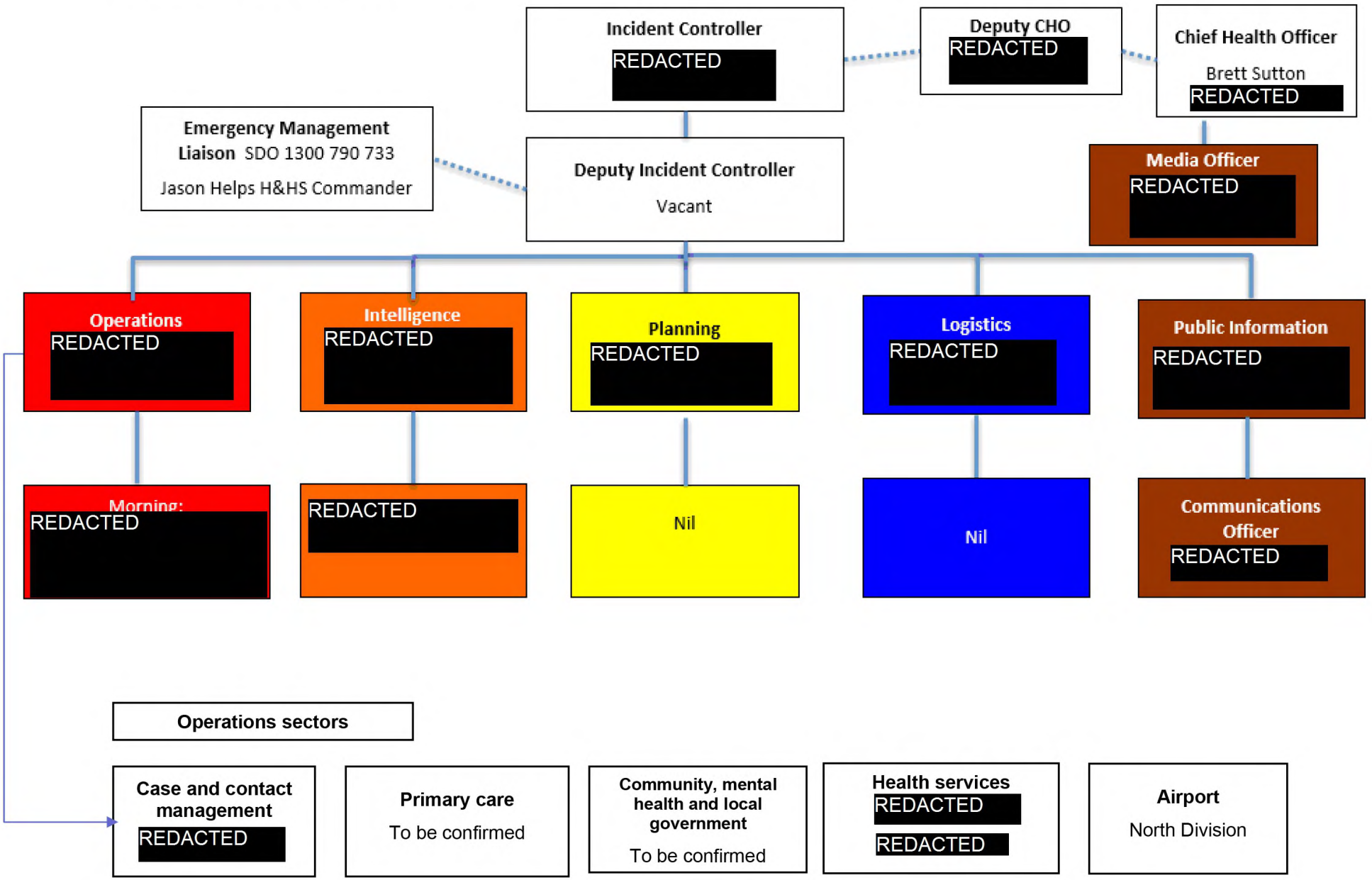
Appendix B: Action list (2 February 2020)

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

Appendix C: Log of significant policy changes

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

Appendix D: Incident Management Team



Appendix E: Communication lists

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

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

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

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

'VIP' distribution list
To be confirmed

COVID-19

Outbreak Management Plan

Version 1.0

Approved by Chief Health Officer

5 June 2020

VICTORIA State Government | Health and Human Services

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Executive Summary

Purpose

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

Context

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

Outbreak Management

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

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

Key Definitions

Outbreak of COVID-19

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

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

Linked cases

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

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

Transmission within one household does not ordinarily constitute an outbreak.

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

Other immediate control response cases

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

Acronyms and abbreviations

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

Glossary

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

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

Governance

Overview

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

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

Roles and Responsibilities in an outbreak

Outbreak Management Team

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

Core members of an Outbreak Management Team

Outbreak Lead

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

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

Case and Contact Management Lead

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

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

Epidemiology Lead

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

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

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

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

DHHS Agency Commander (Representing the State Controller - Health)

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

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

State Joint Intelligence Lead (State Control Centre representative)

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

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

Communications and media lead

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

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

Outbreak Squad Coordinator

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

The Outbreak Squad Coordinator will:

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

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

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

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

Health and Wellbeing Division representative

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

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

- Commissioning Group – Metro or Regional
- Private Hospitals

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

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

Administrative Support Officer

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

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

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

Potential additional members of an Outbreak Management Team

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

Outbreak Briefings

The following meeting will take place as a regular briefing:

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

Key elements of the outbreak response

Identifying an outbreak

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

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

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

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

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

Problem Assessment Group (PAG)

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

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

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

The PAG should determine:

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

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

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

Initial Notification

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

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

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

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

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

Outbreak Management Team

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

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

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

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

An initial outbreak meeting agenda is in Appendix 4.

Outbreak Squads

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

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

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

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

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

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

Daily Activities

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

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

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

Points of Escalation

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

Tier 1

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

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

Tier 2

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

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

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

Closure of an outbreak

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

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

Outbreaks in Sensitive Settings

Sensitive Settings

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

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

The following are considered sensitive settings:

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

See Reference materials for further guidance on sensitive settings

Outbreak Briefings and Reports

Summary of outbreak briefings, plans and reports

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

Business rules for distribution of outbreak reports and data requests

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

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

Evaluation

Key Performance Indicators (KPIs)

Following the decision to establish an Outbreak Management Team:

Within 2 hours

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

Within 12 hours– 50 Lonsdale St

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

Within 24 hours –50 Lonsdale St and site visit requirements

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

Within 48 hours – on site actions

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

Closure of the outbreak

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

Reference Documents/Guidelines

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

Factsheets

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

System Requirements

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

Appendix 1 – Outbreak Control Squads

Public Health Outbreak Control Squads

Role and focus

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

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

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

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

The squads will work within each OMT.

Pre-deployment briefing

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

Roles and responsibilities

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

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

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

Informing the outbreak setting of squad deployment

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

Documentation

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

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

Appendix 2 – Use of Genomics

Use of Genomics

Microbiological Diagnostic Unit (MDU) Public Health Laboratory

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

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

MDU epidemiologists and bioinformaticians will:

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

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

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

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

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

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

- Protocol documents
- Meeting minutes

- Genomic data requests
- Genomic reports

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

Appendix 3 – Outbreak Management Plan template

Purpose

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

Governance

Outbreak Management team

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

Outbreak Management Team meeting dates

Situation

[Insert overview of the situation]

Epidemiological and clinical investigation

COVID-19 in Victoria

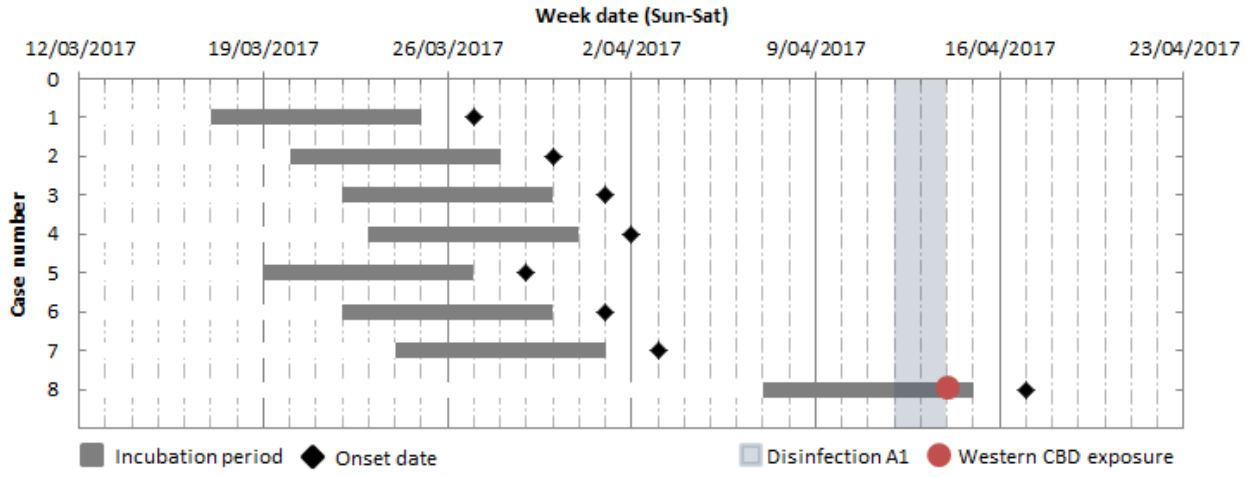
[Insert background epidemiology]

Epicurve

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

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

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



Case definitions

Current department case definition

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

Outbreak case definitions

Confirmed case – outbreak

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

Suspected case – outbreak

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

Person under investigation – outbreak

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

Rejected case

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

Case follow-up

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

Case finding

[Describe active case finding activities]

Case summary

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

Line list

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

Environmental investigation

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

Hypothesis

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

Control measures

[Describe any control measures taken]

Stakeholder mapping

[List identified stakeholders]

Risk communication

Key events

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

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

Communication with exposed settings

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

Chief Health Officer Alert

[Link to CHO alert if developed and issued]

Key messages – health professionals

[Develop and record key messages]

Key messages – general public

Develop and record key messages]

Outbreak Management Team meeting actions list

Action	Due date	Responsible person

Timeline of outbreak

Date	Action

Appendix 4 – Initial Outbreak Management Team Agenda

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

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

Appendix 5 – Health Services and Outbreaks

Health Services potential roles in outbreaks

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

Coronavirus disease 2019 (COVID-19)

Case and contact management guidelines for health services and general practitioners

5 April 2020

Version 17

VICTORIA State Government | Health and Human Services

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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 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? 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).
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. 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. 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. 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 disembarkation

OR

Paid or unpaid workers in healthcare, residential care, and disability care settings

OR

People who have worked in public facing roles in the following settings within the last 14 days:

- homelessness support
- child protection
- the police force
- firefighters who undertake emergency medical response
- childcare and early childhood education
- primary or secondary schools.

OR

Any person aged 65 years or older

OR

Aboriginal or Torres Strait Islander peoples

OR

Patients admitted to hospital where no other cause is identified

OR

Any person in other high-risk settings, including:

- 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.

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 (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
- 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 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
-

Healthcare workers and workers in aged care facilities who meet the above criteria can be released from isolation. However, these individuals must meet the following criteria before they can return to work.

Return-to-work criteria for health care workers and workers in aged care facilities

Healthcare workers and workers in aged care facilities (HCWs) must meet the following criteria before they can return to work in a healthcare setting or aged care facility:

- 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.

The department will determine when healthcare and aged care 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 empoyer, 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 result, repeat testing should be arranged. If whilst awaiting results, the healthcare worker or aged care worker meets the above release from isolation criteria, they can be released from isolation but cannot return to work until they have two consecutive negative swabs. In the event that respiratory specimens remain persistently PCR positive, a decision on return to work 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 procedures should be followed when performing return-to-work clearance testing:

- 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
- HCWs should not attempt to self-swab.
- 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 DHHS COVID-19 Response 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.

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, 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>

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 healthcare workers with fever or symptoms of acute respiratory infection should be tested for COVID-19, as per the testing criteria.

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 1: 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 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 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

24 May 2020

Version 21

VICTORIA State Government | Health and Human Services

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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 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 symptoms 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. 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. 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.

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 cases, 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 (active case finding)
- as part of department-led enhanced surveillance (to investigate how widespread COVID-19 is 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.

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.

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 a high risk setting for transmission.

Symptomatic people awaiting results of tests 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 fever.

Asymptomatic people awaiting results of tests for COVID-19 are not required to self-isolate whilst awaiting test results **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 it has been 72 hours since the last fever.

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.

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.

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

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

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 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.

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.

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 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.

Healthcare workers and workers in aged care facilities who meet the above criteria can be released from isolation. However, these individuals must meet the following additional criteria before they can return to work.

Confirmed cases who are asymptomatic

The case can be release from isolation if at least 10 days have passed since the first positive sample was taken and no symptoms have developed during this period.

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.

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.

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.

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.

Symptomatic close contacts

People without symptoms should *not* be tested except in special circumstances as directed by the department such as:

- 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 (as part of active case finding)
- 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).

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.

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 Undertaking diagnostic testing.

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 specimensAt 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). See also Undertaking diagnostic testing for PPE recommendations
  - 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.

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.

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, 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 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 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.	

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>.

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 transmission. 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

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

CONFIDENTIAL: New Outbreak - Rydges, Swanston St

From: "Simon Crouch (DHHS)" <REDACTED>

To: "Finn Romanes (DHHS)" <REDACTED>, "Brett Sutton (DHHS)" <REDACTED>

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

Date: Tue, 26 May 2020 20:10:15 +1000

Dear Finn and Brett

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

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

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

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

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

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

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

Testing of all staff who worked shifts that coincide with the case during RED acquisition period

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

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

Thanks
Simon

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

Covid positive case in Rydges on Swanston

From: Public Health Operations <publichealth.operations@dhhs.vic.gov.au>

To: DHHSOpSoteriaEOC <dhhsopsoteriaeoc@dhhs.vic.gov.au>, "Rydges Swanston (DHHS)" <rydgesswanston@dhhs.vic.gov.au>

Cc: REDACTED REDACTED, Public Health Operations <publichealth.operations@dhhs.vic.gov.au>, REDACTED (DHHS)" <REDACTED "Simon Crouch (DHHS)" REDACTED "Pam Williams (DHHS)" REDACTED REDACTED (DHHS)"REDACTED REDACTED, "Clare Looker (DHHS)"REDACTED "Sarah McGuinness (DHHS)"REDACTED

Date: Tue, 26 May 2020 20:40:42 +1000

Hi Team

As discussed, DHHS have been notified of a confirmed positive case in a staff member of Rydges on Swanston. Thank you for the information that has already been provided.

The information we have so far:
The case works at Rydges on Swanston as a REDACTED from REDACTED – each handover is roughly five minutes. The case claims to work alone and does not interact with other staff.
The case has an onset of 25 May 2020 – this means that RE infectious period is from the 23 May.
The case has worked one shift during RE infectious period and 6 shifts during RE acquisition period.

We were hoping to obtain a little more information in order for us to undertake a risk assessment and provide further advice regarding other staff at the hotel. I note that some staff have already been swabbed.

1. Can you please provide us with some background as to what duties/jobs/functions are undertaken by the REDACTED over a shift. This includes which floor RE works on predominately and which floor RE would visit during the course of RE shift.
2. What are RE interactions with other staff (all staff on site) and guests.
3. Can we please have the rosters for the following shifts: this includes all DHHS staff, hotel staff and nurses and contractors that would have worked during these times
   - 13 May 2300 - 0700 (who worked on shift with RED ACT ED in all roles, and who did RED ACT ED handover to and from)
   - 14 May 2300 – 0700 (who worked on shift with ED in all roles, and who did ED handover to and from)
   - 17 May 2300 – 0700 (who worked on shift with in all roles, and who did handover to and from)
   - 20 May 2300 – 0700 (who worked on shift with in all roles, and who did handover to and from)
   - 21 May 2300 – 0700 (who worked on shift with in all roles, and who did handover to and from)
   - 22 May 2300 – 0700 (who worked on shift with in all roles, and who did handover to and from)
   - 23 May 2300 – 0700 (who worked on shift with in all roles, and who did handover to and from)
4. What is the cleaning regime like at the hotel? A clean of all common areas, and the cases' direct work areas will need to occur.
5. A list of all staff that have been swabbed and whether any staff are symptomatic.
6. A floor plan of the hotel
7. Can you please confirm if any staff (hotel, DHHS or nurses) work at any other premises?

Any questions please let me know – I will be handing this over to an officer in the morning.

Kind Regards,

REDACTED REDACTED
Public Health Operations | Novel Coronavirus (COVID-19) Response

REDACTED
Health Protection Branch | Regulation, Health Protection and Emergency Management Division
Department of Health & Human Services | 50 Lonsdale Street, Melbourne, Victoria, 3000
REDACTED
w. www.dhhs.vic.gov.au

Summary of Rydges cases - what we know to date

From: "Sarah McGuinness (DHHS)" <REDACTED>
To: "Simon Crouch (DHHS)" <REDACTED>, "Clare Looker (DHHS)" <REDACTED>
Date: Wed, 27 May 2020 15:09:36 +1000

Hi Simon/Clare,

Below is a summary of what we know about the 2 Rydges cases to date

Case 1: 320203450603

- REDACTED
- Symptom onset date = 25th May (fever, cough, sore throat, fatigue)
- Test date = 25th May, Monash Dandenong
- Lives in REDACTED with REDACTED
- Works at Rydges on Swanston REDACTED & also does [redacted]; last shift 11pm – 7am 23rd May (overlap with case 2)
- Takes public transport to work – bus from REDACTED to REDACTED n, train from REDACTED to the city

Case 2: 320203487846

- REDACTED
- Symptom onset date = 25th May (cough, sore throat, shortness of breath)
- Test date = 26th May, Box Hill Hospital (note: worked a shift after getting tested at Box Hill as was not specifically advised of the need to isolate).
- Lives in REDACTED with REDACTED
- Case is currently isolating at home; REDACTED close contacts quarantining at home also
- Works 3 jobs:
  - REDACTED
  - [redacted]
  - [redacted]
- Drives own car to work
- Attended Coles REDACTED at ~7:30pm on Sunday 24th May (during infectious period but before symptom onset) – no prolonged face to face contact with anyone

Just getting an update from REDACTED team now.

Cheers,
Sarah

Dr Sarah McGuinness
Infectious Diseases Physician
Case, Contact and Outbreak Management | COVID-19 Surge Workforce

Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
e REDACTED

Fw: Covid positive case in Rydges on Swanston

From: "Rydges Swanston (DHHS)" <rydgesswanston@dhhs.vic.gov.au>

To: Public Health Operations <publichealth.operations@dhhs.vic.gov.au>

Cc: DHHSOpSoteriaEOC <dhhsopsoteriaeoc@dhhs.vic.gov.au>, "Rydges Swanston (DHHS)" <rydgesswanston@dhhs.vic.gov.au>, "Pam Williams (DHHS)" [redacted]

Date: Wed, 27 May 2020 14:59:46 +1000

Hi,
Please see the details requested by the hotel manager of Rydges.
Thanks
[redacted]
DHHS Team Leader

From: [redacted]
Sent: Wednesday, 27 May 2020 2:55 PM
To: Rydges Swanston (DHHS) <RydgesSwanston@dhhs.vic.gov.au>
Cc: Switch Carlton <switch_rydgesswanston@evt.com>
Subject: RE: Covid positive case in Rydges on Swanston

Sorry for the delay [redacted], Been full on….

1. Can you please provide us with some background as to what duties/jobs/functions are undertaken by the [redacted] over a shift. This includes which floor [redacted] works on predominately and which floor [redacted] would visit during the course of [redacted] shift.
   - Cleaning reception
   - Cleaning public bathrooms on ground level
   - Reconciling credit cards and back office reports
   - Vacuum lobby, bar and common areas
   - Cleaning Coffee machine
   - Cleaning Nurse room
   - Staff has advised [redacted] has not visited any guest areas in the last few days.
2. What are [redacted] interactions with other staff (all staff on site) and guests.
   - Very limited
   - under 10 minutes handover before and after [redacted] shift
   - little to no interaction with Nurses and Security
3. Can we please have the rosters for the following shifts: this includes all DHHS staff, hotel staff and nurses and contractors that would have worked during these times
   - 13 May [redacted] (who worked on shift with [redacted] in all roles, and who did [redacted] handover to and from)
     - Before: [redacted]
     - Later: [redacted]
   - 14 May [redacted] (who worked on shift with [redacted] in all roles, and who did [redacted] handover to and from)
     - Before: [redacted]
     - Later: [redacted]
   - 15 May [redacted] (who worked on shift with [redacted] in all roles, and who did [redacted] handover to and from)

- Before: REDACTED
- Later: REDACTED

- 17 May REDACTED (who worked on shift with RED in all roles, and who did RED handover to and from)
  - NO shift
- 20 May REDACTED who worked on shift with RE DA in all roles, and who did RE DA handover to and from)
  - Before: REDACTED
  - Later: REDACTED
- 21 May REDACTED (who worked on shift with RE DA in all roles, and who did RED ACT handover to and from)
  - Before: REDACTED
  - Later: REDACTED
- 22 May REDACTED (who worked on shift with RED ACT in all roles, and who did R E handover to and from)
  - Before: REDACTED
  - Later: REDACTED
- 23 May REDACTED (who worked on shift with RE DA in all roles, and who did RE DA handover to and from)
  - Before: REDACTED
  - Later: REDACTED

4. What is the cleaning regime like at the hotel? A clean of all common areas, and the cases' direct work areas will need to occur.
   - Common areas cleaned every 3/4 hours. Reception (primary work place) disinfected every few hours.
   - Lifts
   - Vacuuming, mopping done nightly
   - Bathrooms cleaned at different times of day when possible.

5. A list of all staff that have been swabbed and whether any staff are symptomatic. (DHHS & Nursing staff)
   - REDACTED no symptoms
   - REDACTED – No Symptoms
   - REDACTED – No Symptoms
   - REDACTED – No Symptoms
   - REDACTED – Cough and cold – Tested at Monash Clinic Clayton

6. A floor plan of the hotel

7. Can you please confirm if any staff (hotel, DHHS or nurses) work at any other premises?
   - All hotel staff work at the location

Thanks,
REDA

From: Rydges Swanston (DHHS) <RydgesSwanston@dhhs.vic.gov.au>
Sent: Wednesday, 27 May 2020 9:02 AM
To: REDACTED
Cc: Switch Carlton <switch_rydgesswanston@evt.com>
Subject: Fw: Covid positive case in Rydges on Swanston

Hi REDA
Apologies for disturbing you on your day off but this issue of the staff member is gathering pace. Public health have some questions below I was wondering if you could type out some answers to the questions in green
thanks
REDACTED

From: REDACTED (DHHS) <REDACTED@dhhs.vic.gov.au>
Sent: Tuesday, 26 May 2020 9:08 PM
To: Rydges Swanston (DHHS) <RydgesSwanston@dhhs.vic.gov.au>
Cc: Pam Williams (DHHS) <REDACTED.gov.au>; REDACTED (DHHS) REDACTED@dhhs.vic.gov.au>; DHHSOpSoteriaEOC <DHHSOpSoteriaEOC@dhhs.vic.gov.au>
Subject: RE: Covid positive case in Rydges on Swanston

Hi Rydges Team,

I have highlighted the queries below that DHHS will respond too. Please call me if you require any assistance with the areas specific to hotel operations.

4. Can you please provide us with some background as to what duties/jobs/functions are undertaken by the REDACTED over a shift. This includes which floor RE works on predominately and which floor RE would visit during the course of RE shift.
5. What are RE interactions with other staff (all staff on site) and guests.
6. Can we please have the rosters for the following shifts: this includes all DHHS staff, hotel staff and nurses and contractors that would have worked during these times
   - 13 May REDACTED who worked on shift with RE in all roles, and who did RE handover to and from)
   - 14 May REDACTED (who worked on shift with RED in all roles, and who did R handover to and from)
   - 17 May REDACTED who worked on shift with RED in all roles, and who did RE handover to and from)
   - 20 May REDACTED (who worked on shift with RED in all roles, and who did RE handover to and from)
   - 21 May REDACTED (who worked on shift with RED in all roles, and who did R handover to and from)
   - 22 May REDACTED who worked on shift with RED in all roles, and who did RE handover to and from)
   - 23 May REDACTED (who worked on shift with RED in all roles, and who did RED handover to and from)
8. What is the cleaning regime like at the hotel? A clean of all common areas, and the cases' direct work areas will need to occur.
9. A list of all staff that have been swabbed and whether any staff are symptomatic. (DHHS & Nursing staff)
10. A floor plan of the hotel
11. Can you please confirm if any staff (hotel, DHHS or nurses) work at any other premises?

Regards

From: Public Health Operations <publichealth.operations@dhhs.vic.gov.au>
Sent: Tuesday, 26 May 2020 8:41 PM
To: DHHSOpSoteriaEOC <DHHSOpSoteriaEOC@dhhs.vic.gov.au>; Rydges Swanston (DHHS) <RydgesSwanston@dhhs.vic.gov.au>
Cc: REDACTED (DHHS) <REDACTED@dhhs.vic.gov.au>; Public Health Operations <publichealth.operations@dhhs.vic.gov.au>; REDACTED (DHHS) <REDACTED@dhhs.vic.gov.au>; REDACTED hs.vic.gov.au>; Pam Williams (DHHS) REDACTED s.vic.gov.au>; REDACTED REDACTED hhs.vic.gov.au>; Clare REDAC (DHHS) <REDACTED@dhhs.vic.gov.au>; REDACTED (DHHS) <REDACTED ov.au>
Subject: Covid positive case in Rydges on Swanston

Hi Team

As discussed, DHHS have been notified of a confirmed positive case in a staff member of Rydges on Swanston. Thank you for the information that has already been provided.

The information we have so far:
The case works at Rydges on Swanston as REDACTED – each handover

is roughly five minutes. The case claims to work alone and does not interact with other staff. The case has an onset of [redacted] May 2020 – this means that [redacted] infectious period is from the [redacted] May. The case has worked one shift during [redacted] infectious period and 6 shifts during [redacted] acquisition period.

We were hoping to obtain a little more information in order for us to undertake a risk assessment and provide further advice regarding other staff at the hotel. I note that some staff have already been swabbed.

1. Can you please provide us with some background as to what duties/jobs/functions are undertaken by the [redacted] over a shift. This includes which floor [redacted] works on predominately and which floor [redacted] would visit during the course of [redacted] shift.
2. What are [redacted] interactions with other staff (all staff on site) and guests.
3. Can we please have the rosters for the following shifts: this includes all DHHS staff, hotel staff and nurses and contractors that would have worked during these times
   - 13 May [redacted] (who worked on shift with [redacted] in all roles, and who did [redacted] handover to and from)
   - 14 May [redacted] (who worked on shift with [redacted] in all roles, and who did [redacted] handover to and from)
   - 17 May [redacted] (who worked on shift with [redacted] in all roles, and who did [redacted] handover to and from)
   - 20 May [redacted] (who worked on shift with [redacted] in all roles, and who did [redacted] handover to and from)
   - 21 May [redacted] (who worked on shift with [redacted] in all roles, and who did [redacted] handover to and from)
   - 22 May [redacted] (who worked on shift with [redacted] in all roles, and who did [redacted] handover to and from)
   - 23 May [redacted] (who worked on shift with [redacted] in all roles, and who did [redacted] handover to and from)
4. What is the cleaning regime like at the hotel? A clean of all common areas, and the cases' direct work areas will need to occur.
5. A list of all staff that have been swabbed and whether any staff are symptomatic.
6. A floor plan of the hotel
7. Can you please confirm if any staff (hotel, DHHS or nurses) work at any other premises?

Any questions please let me know – I will be handing this over to an officer in the morning.

Kind Regards,

[redacted] – Case and Contact Management Lead
Public Health Operations | Novel Coronavirus (COVID-19) Response
[redacted]
Health Protection Branch | Regulation, Health Protection and Emergency Management Division
Department of Health & Human Services | 50 Lonsdale Street, Melbourne, Victoria, 3000
t [redacted] f. 1300 651 170 | e. publichealth.operations@dhhs.vic.gov.au
w. www.dhhs.vic.gov.au

Outbreak summaries - 27 May

From: "Simon Crouch (DHHS)" REDACTED

To: "Finn Romanes (DHHS)" REDACTED "Brett Sutton (DHHS)" REDACTED

Cc: "Jacinda de Witts (DHHS)" REDACTED "Annalise Bamford (DHHS)" REDACTED "Kym Peake (DHHS)" REDACTED "Kira Leeb (DHHS)" REDACTED "Jackie Kearney (DHHS)" REDACTED "Terry Symonds (DHHS)" REDACTED sccvic.stateintelmgr@scc.vic.gov.au, "Jason Helps (DHHS)" REDACTED "Andrea Spiteri (DHHS)" REDACTED "Clare Looker (DHHS)" <clare.looker@dhhs.vic.gov.au>, REDACTED

Date: Wed, 27 May 2020 23:27:27 +1000

Dear Finn and Brett

Please see today's update of outbreaks – apologies that it is late today.

There is one new outbreak since yesterday's update which includes 2 cases.

REDACTED

- There are two confirmed cases in residents of this aged care facility. Case 1 – symptom onset 17 May; case 2 – asymptomatic.
- All staff at the site have undergone initial testing – all returning negative results. Further testing of staff who work in the same residence of case 2 took place on 26 and 27 May through Alfred Health.
- All but one of the residents have been tested. The resident who has not been tested has dementia and has consistently refused testing. Both cases live in separate areas of the facility. The resident who has not been tested lives in a separate area of the facility to both cases.
- Following an infection control assessment by Alfred Health, case 2 has been moved back into their residence. There had been concerns regarding her mental health and wellbeing REDACTED The department has outlined specific requirements for case 2 to be safely isolated REDACTED
- Release from isolation testing for the first case will be conducted this week
- Further testing was planned for close contacts of case 1 on 28 May. Following notification of the second case, this has been expanded to include all staff and residents. Resident close contacts of case 2 were tested on 26 May
- Staffing support is being provided by the Commonwealth
- This outbreak is active and under investigation. There is no projected closure date

REDACTED

- There is a single confirmed case in a resident of this aged care facility. Symptom onset for the case was 13 May. The case has been isolated since that time.
- All residents (bar one) have been tested and received negative results. The resident who has not been tested has severe dementia and lives in a separate area of the facility to the case.
- All staff have been tested and have returned negative results.
- A member of the department's outbreak control squad has visited the site and performed an assessment. Appropriate infection prevention and control measures are being implemented. A second visit was conducted on 22 May. Some concerns about IPC procedures have been raised that will be discussed further tomorrow.
- PPE training was conducted by outbreak squads on 21 May
- A second round of testing for close contacts (38 residents, 8 staff) was conducted on Monday 25 May. The department has been verbally advised that all tests are negative. Formal results are pending.
- Some staff who have been released from isolation by DHHS have started to return to work
- The department has commenced discussions with the facility regarding relaxing restrictions. The 14 day period of isolation for close contact residents will end on Friday.

- This outbreak is active and under investigation. There is no projected closure date.

REDACTED

- Three confirmed case have been linked to this outbreak in an aged care facility (resident), including 2 new cases today.
- Symptom onset for case 1 was 16 May. The case was admitted to the REDACTED on 17 May following a fall. They have met clearance criteria. They will remain at the REDAC in a sub-acute ward until the outbreak has been closed.
- The facility advised that a resident with symptoms of a respiratory illness died on the 11 May. This was considered a suspected case as testing was not performed and the body has since been cremated. Their family contacts were placed in quarantine but have now all tested negative.
- As of 20 May, all residents in the same wing as the case (17), and staff that worked in that wing from 14 to 17 May (21) are considered close contacts and are being quarantined. The department has also identified 7 other close contacts including 5 family members and 2 healthcare workers.
- To date, all 87 residents and 103 staff have received negative results from initial testing.
- Testing was arranged for a further 7 staff members. Of these staff members, two have returned positive results. Both are asymptomatic. Case interviews have been completed and contact tracing is ongoing. The department is working closely with the facility to ensure appropriate measures are being put in place. Including quarantine of all residents.
- Testing for all staff and residents is being undertaken on 26 and 27 May. Results are pending.
- PPE training was conducted on 21 May by outbreak squads.
- This outbreak is active and under investigation. There is no projected closure date.

REDACTED

- Three cases have been linked to this rural health service (an acute care and aged care facility) – all are healthcare workers.
- The first case had symptom onset on 7 May and was notified 9 May. Close contacts were tested and isolated. This case has an unknown source of acquisition.
- The two other cases are HCWs. Both were tested along with other staff members on 18 May and are isolating at home. Both are asymptomatic. One was already in isolation as a close contact of the first case. The remaining case has not worked at the facility since 4 May due to annual leave but had casual contact with 2 other HCWs during this period – both are being tested. Contact tracing is under way.
- On 18 May, 66 healthcare workers, 7 residents and 2 VMOs were tested as part of the testing blitz
- A meeting was held with the service CEO, department's rural health director and other stakeholders to discuss testing and other issues on 20 May. The department has recommended that all staff from the district health service who were not tested as part of the testing blitz on 18 May be re-tested.
- Because neither of the two new cases have been on-site since 9 May, there is no plan to test aged care residents or acute care patients, although this decision will be re-evaluated once results of staff testing are known.
- An REDACTED from Bendigo & an IPC nurse visited the service on 21 May and no IPC issues were identified
- On 22nd May 196 staff were tested. 195 results negative, with one test pending.
- This outbreak is active and under investigation. There is no projected closure date.

REDACTED **Fawkner and Craigieburn**

- 12 cases have been detected to date, including 4 employees at REDACTED Fawkner, 7 members of an extended family group who live across two households and a delivery driver.
- The employee at REDACTED Craigieburn is part of the extended family group and appears to have been infected by a household contact
- REDACTED Fawkner closed on 8 May and re-opened on 13 May after a commercial clean. 53 of 56 staff who required return to work testing (employees who are close contacts) have had this done through the Northern Hospital, and staff started to return to work from Sunday 24 May. Further results are currently being chased
- REDACTED Craigieburn closed on 15 May and re-opened on 16 May after a commercial clean. Return to work testing has been requested for staff who are close contacts. 4 staff are yet to test. 6 test results are pending and a further staff member has resigned and will not return to work.

- Staff members at REDACTED Craigieburn who are not close contacts (have not worked an overlapping shift with a case while potentially infectious) and are asymptomatic are allowed to return to work; however, if they have had a COVID-19 test, this must return negative before they return to work.
- 12 additional REDACTED stores were visited by a delivery driver who is a confirmed case. This delivery driver appears to have acquired COVID at the Craigieburn store.
- 28 REDACTED staff from across these 12 stores have been identified as close contacts have been quarantined and will undergo return-to-work testing at various sites this week.
- 21 staff at the distribution centre that the delivery driver works at have been isolated as close contacts. They are undergoing return to work testing, before being able to return to work after their quarantine.
- This outbreak is active and under investigation. There is no projected closure date yet.

Cedar Meats

- 111 cases have been linked to this outbreak – 67 staff and 44 external to the outbreak site.
- Three of the latest cases are asymptomatic employees.
- Cases include a HCW associated with Sunshine Hospital, and a PCA who works at Doutta Galla aged care facility
- The meatworks closed on 1 May for a period of 14 days.
- A number of close contacts reached the end of their 14 day quarantine period on 15 May. Correspondence was sent out, in a number of different languages, advising of the need for a negative swab prior to return to work (for meat industry and health care workers).
- Facility management met with the department, including the Chief Health Officer on 18 May to discuss re-opening plans. The department advised regarding staffing, cleaning and dis-infection and physical distancing measures which should be implemented.
- An Environmental Health Officer visited the site on 19 May to conduct an assessment and make recommendations for re-opening safely.
- The facility is working closely with WorkSafe and the department towards a safe, staged re-opening of the site.
- During the week of 18 May, loadout operations re-commenced using staff who were not onsite during the period of interest (21 March – 1 May) and confirmed cases who had been clinically cleared and provided evidence of a negative swab were allowed to return to the site.
- Close contacts who have completed their quarantine period and provided evidence of a negative swab will be allowed to return to the site this week, starting with management staff.
- It is anticipated that the facility will return to full functioning later this week.
- This outbreak is active and under investigation. There is no projected closure date.

Rydges

- 2 cases have been linked to this outbreak – both are staff who work REDACTE at Rydges on Swanston.
- The symptom onset date for both cases is 25 May. Each case worked one shift at Rydges on Swanston during their infectious period (before symptom onset).
- No close contacts have been identified at Rydges on Swanston to date, but both cases have household contacts (and one case has an additional close contact from another job) who have been contacted by the department and advised to quarantine.
- Testing has been recommended for all staff who attended Rydges on Swanston for 30 minutes or more on or after the 11 May. This testing commenced today.
- A commercial clean of relevant areas of the hotel has been arranged.
- This outbreak is active and under investigation. There is no projected closure date.

Thanks
Simon

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

OFFICIAL: RE: Rydges on Swanston OMT

From: "REDACTED (DHHS)" <REDACTED>

To: Public Health Operations <publichealth.operations@dhhs.vic.gov.au>, "Clare Looker (DHHS)" REDACTED <REDACTED (DHHS)" <REDACTED (DHHS)" <REDACTED>, Public Health Intelligence <publichealth.intelligence@dhhs.vic.gov.au>, "DHHS EmergencyCommunications (DHHS)" <em.comms@dhhs.vic.gov.au>, "Jason Helps (DHHS)" <REDACTED>, "Pam Williams (DHHS)" <REDACTED>, "REDACTED (DHHS)" <REDACTED>, sccvic.stateintelmgr@scc.vic.gov.au

Cc: "REDACTED (DHHS)" <REDACTED>, "REDACTED <REDACTED>, "Sarah McGuinness (DHHS)" <REDACTED>, "REDACTED (DHHS)" <REDACTED>, "Braedan Hogan (DHHS)" <REDACTED>

Date: Thu, 28 May 2020 13:19:34 +1000

Hi all,

Please find below actions/key outcomes from today's Rydges OMT.

Actions

1. REDACT **/Outbreak Squad team** to prepare materials (video and written) on proper hygiene and use of PPE, to be distributed to staffing agency leadership (both health services and security guards) via Pam Williams
2. REDACT to liaise with Katherine Ong and intelligence leads to determine best practice use of PPE face shields when taking swabs, and discuss next steps with OMT group
3. REDACT to discuss potential support for procuring contact details and complete rosters of all staff in the hotel with REDA
4. **Sarah M** to coordinate distribution of negative test results to staff
5. REDACT to provide stakeholder contact details to REDA and Sarah; REDA to ensure second letter (and subsequent advice) is sent to appropriate stakeholders (CC'ing in REDA and REDACT)
6. **Sarah M** to confirm with REDAC that commercial cleaning is underway
7. **Sarah M** to chase status of genomics

Key outcomes/agreements

1. Opportunity to think of innovative ways to more broadly engage with OH&S, Worksafe, and other key industrial bodies to instruct on proper and appropriate use of PPE and related prevention education
2. No change to definition of close contacts until initial test results have been received, and further information/assessment from the site occurs

Cheers,

REDA

REDACTED
REDACTED
Department of Health and Human Services
Level 5, 2 Lonsdale St, Melbourne VIC 3000
m REDACTED

Outbreak summaries

From: "Sarah McGuinness (DHHS)" REDACTED
To: "Clare Looker (DHHS)" REDACTED
Date: Thu, 28 May 2020 19:32:22 +1000

Hi Clare,

Apologies for the delay in getting this to you.

Updated outbreak summaries provided below. The only one I haven't done is the extended family.

Cheers,
Sarah

REDACTED

- Three confirmed cases have been linked to this outbreak in an aged care facility (resident)
- Symptom onset for case 1 was 16 May. The case was admitted to the REDACTED on 17 May following a fall. They have met clearance criteria. They will remain at the REDACT in a sub-acute ward until the outbreak has been closed
- The facility advised that a resident with symptoms of a respiratory illness died on the 11 May. This was considered a suspected case as testing was not performed and the body has since been cremated. Their family contacts were placed in quarantine but have now all tested negative.
- As of 20 May, all residents in the same wing as the case (17), and staff that worked in that wing from 14 to 17 May (21) are considered close contacts and are being quarantined. The department has also identified 7 other close contacts including 5 family members and 2 healthcare workers.
- To date, all 87 residents and 103 staff have received negative results from initial testing.
- Testing was arranged for a further 7 staff members. Of these staff members, two have returned positive results (cases 2 and 3), both are asymptomatic. Case interviews have been completed and contact tracing is ongoing. The department is working closely with the facility to ensure appropriate measures are being put in place. Including quarantine of all residents.
- Testing for all staff and residents is being undertaken from the 25th until the 29th May. Results are pending.
- PPE training was conducted on 21 May by outbreak squads.
- This outbreak is active and under investigation. There is no projected closure date.

REDACTED

- There are two confirmed cases in residents of this aged care facility. Case 1 – symptom onset 17 May; case 2 – asymptomatic.
- All but one of the residents at the facility have been tested. The resident who has not been tested has dementia and has consistently refused testing. Both cases live in separate areas of the facility. The resident who has not been tested lives in a separate area of the facility to both cases.
- All staff at the site have undergone initial testing with all results negative.
- Further testing of staff who work in REDACTED (residence of case 2) took place on 26 and 27 May through Alfred Health. All results received for staff are negative to date, but some results are still pending.
- Following an infection control assessment by Alfred Health, case 2 has been moved back into REDACTED There had been concerns regarding her mental health and wellbeing while isolating i REDACTED The department has outlined specific requirements for case 2 to be safely isolated REDACTED
- Release from isolation testing for the first case has commenced
- A testing Blitz took place on 28th May, which involved testing of all staff and residents in the cottages (except those tested earlier in the week). This included re-testing of staff and residents who
- Staffing support is being provided by Commonwealth
- This outbreak is active and under investigation. There is no projected closure date

REDACTED

- There is a single confirmed case in a resident of this aged care facility. Symptom onset for the case was 13 May. The case has been isolated since that time.
- All residents (bar one) have been tested and received negative results. The resident who has not been tested has severe dementia and lives in a separate area of the facility to the case. An additional resident that has not been tested was identified today, and a test has been organised.
- All staff have been tested and have returned negative results.
- A member of the department's outbreak control squad has visited the site and performed an assessment. Appropriate infection prevention and control measures are being implemented. A second visit was conducted on 22 May. Some concerns about IPC procedures have been raise. The facility has engaged and internal IPC consultant who will attend the site tomorrow.
- PPE training was conducted by outbreak squads on 21 May
- A second round of testing for close contacts (38 residents, 8 staff) was conducted on Monday 25 May. All results are negative.
- Some staff who have been released from isolation by DHHS have started to return to work. All staff that are isolating are aware when they are able to return to work and have been provided with this in writing.
- A plan towards the removal of isolation restrictions for the 38 close contact residents has been developed today, and will be provided to the facility tomorrow. The plan includes recording symptom checks on residents and providing them to DHHS daily, ensuring a negative test on the remaining resident and the facility engaging with an IPC consultant. The current aim is to review the need to isolation for these 38 residents on Monday the 1st of June.
- This outbreak is active and under investigation. There is no projected closure date.

REDACTED

- Three cases have been linked to this rural health service (an acute care and aged care facility) – all are healthcare workers.
- The first case had symptom onset on 7 May and was notified 9 May. Close contacts were tested and isolated. This case has an unknown source of acquisition.
- The two other cases are HCWs. Both were tested along with other staff members on 18 May and are isolating at home. Both are asymptomatic. One was already in isolation as a close contact of the first case. The remaining case has not worked at the facility since 4 May due to annual leave but had casual contact with 2 other HCWs during this period – both are being tested. Contact tracing is under way.
- On 18 May, 66 healthcare workers, 7 residents and 2 VMOs were tested as part of the testing blitz
- A meeting was held with the service CEO, department's rural health director and other stakeholders to discuss testing and other issues on 20 May. The department has recommended that all staff from the district health service who were not tested as part of the testing blitz on 18 May be re-tested.
- Because neither of the two new cases have been on-site since 9 May, there is no plan to test aged care residents or acute care patients, although this decision will be re-evaluated once results of staff testing are known.
- An REDACTED from Bendigo & an IPC nurse visited the service on 21 May and no IPC issues were identified
- On 22nd May 196 staff were tested. 195 results negative, with one test pending.
- This outbreak is active and under investigation. There is no projected closure date.

REDACTED **Fawkner and Craigieburn**

- 12 cases have been detected to date, including 4 employees at REDACTED Fawkner, 7 members of an extended family group who live across two households and a delivery driver.
- The employee at REDACTED Craigieburn is part of the extended family group and appears to have been infected by a household contact
- REDACTED Fawkner closed on 8 May and re-opened on 13 May after a commercial clean. Staff who required return to work testing (employees who are close contacts) have had this done through the Northern Hospital, and staff started to return to work from Sunday 24 May. All results from Fawkner have been provided to REDACTED and are reported as negative.
- REDACTED Craigieburn closed on 15 May and re-opened on 16 May after a commercial clean. Return to work testing has been requested for staff who are close contacts. 6 test results are pending and a further staff member has resigned and will not return to work.
- Staff members at REDACTED Craigieburn who are not close contacts (have not worked an

overlapping shift with a case while potentially infectious) and are asymptomatic are allowed to return to work; however, if they have had a COVID-19 test, this must return negative before they return to work.
- 12 additional REDACTED stores were visited by a delivery driver who is a confirmed case. This delivery driver appears to have acquired COVID at the Craigieburn store.
- 28 REDACTED staff from across these 12 stores have been identified as close contacts have been quarantined. All of these staff have undergone a return to work test.
- 21 staff at the distribution centre that the delivery driver works at have been isolated as close contacts. All of these staff have undergone return to work testing.
- This outbreak is active and under investigation. There is no projected closure date yet.

Cedar Meats
- 111 cases have been linked to this outbreak – 67 staff and 44 external to the outbreak site. 11 of these cases remain active; 100 cases have been cleared by the department.
- The last symptomatic staff member to be identified had onset of symptoms on 8th May.
- Cases include a HCW associated with Sunshine Hospital, and a PCA who works at Doutta Galla aged care facility
- The meatworks closed on 1 May for a period of 14 days.
- A number of close contacts reached the end of their 14 day quarantine period on 15 May. Correspondence was sent out, in a number of different languages, advising of the need for a negative swab prior to return to work (for meat industry and health care workers).
- Facility management met with the department, including the Chief Health Officer on 18 May to discuss re-opening plans. The department advised regarding staffing, cleaning and dis-infection and physical distancing measures which should be implemented.
- An Environmental Health Officer visited the site on 19 May to conduct an assessment and make recommendations for re-opening safely.
- The facility has followed the staged re-opening plan outlined by WorkSafe and the department, and returned to full operations today (28/05/2020) with staff cleared by DHHS.
- This outbreak is active and under investigation. There is no projected closure date.

Rydges
- 2 cases have been linked to this outbreak – both are staff who work REDACTED at Rydges on Swanston.
- The symptom onset date for both cases is 25 May. Each case worked one shift at Rydges on Swanston during their infectious period (before symptom onset).
- No close contacts have been identified at Rydges on Swanston to date, but both cases have household contacts (and one case has an additional close contact from another job) who have been contacted by the department and advised to quarantine.
- Testing has been recommended for all staff who attended Rydges on Swanston for 30 minutes or more on or after 11 May and commenced on 27 May. To date, the department has received negative results for 78 staff; further test results are pending.
- A full commercial bioclean of relevant areas of the hotel was performed on 28 May.
- This outbreak is active and under investigation. There is no projected closure date.

Dr Sarah McGuinness
Infectious Diseases Physician
Case, Contact and Outbreak Management | COVID-19 Surge Workforce
Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
REDACTED

OFFICIAL: RE: OMT Rydges on Swanston

From: REDACTED REDACTED

To: REDACTED REDACTED>, "Sarah McGuinness (DHHS)" <REDACTED>, Public Health Intelligence <publichealth.intelligence@dhhs.vic.gov.au>, REDACTED, REDACTED>, "Jason Helps (DHHS)" <REDACTED>, REDACTED REDACTED (DHHS)" <REDACTED REDACTED>, "DHHS EmergencyCommunications (DHHS)" <em.comms@dhhs.vic.gov.au>, "press (DHHS)" <press@dhhs.vic.gov.au>, REDACTED, REDACTED, REDACTED, REDACTED, REDACTED DHHS)" <REDACTED>, REDACTED (DHHS)" <REDACTED>

Cc: REDACTED DHHS)" <REDACTED>, "Merrin Bamert (DHHS)" <REDACTED>, "Pam Williams (DHHS)" <REDACTED>

Date: Fri, 29 May 2020 12:10:33 +1000

Hi all,

Below are key actions/outcomes from the Rydges OMT on 29 May.

Actions:

1. REDAC to contact REDA offline to assist with procuring Rydges staff contact details
2. REDA to organise case and contact interview with potential case 3, and report back details to the team ASAP
3. R ED to investigate standard cleaning arrangements at the hotel and report back to team
4. REDACTE to ensure that people tested through Rydges receive negative results

Key updates:

1. Bio clean was completed yesterday, and report from ICON saved in the OMT folder
2. Discussion re: review of PPE equipment for nursing administering tests to be resumed at IPC/CCOM/Outbreak Squad joint meeting later today at 4pm. Agreements/recommendations to be fed back into existing guidelines as appropriate
3. Hygiene & PPE education provided by to hotel staff and security guards. Further educational opportunities to be organised and provided to security firm management by IPC
4. Discussion re: policy for staff coming back into DHHS post field-visits to occur offline
5. Working hypothesis to be re-considered following case and contact investigation with case 3, and confirmed with team pending updates
6. Case 1 and 2 only worked at the Rydges Swanston hotel (no other Rydges).

Cheers,

REDACTED
Program Manager, Public Health Command COVID-19
Department of Health and Human Services
Level 5, 2 Lonsdale St, Melbourne VIC 3000
REDACTED

RE: Briefing for Finn

From: REDACTED (DHHS)"REDACTED
To: "Sarah McGuinness (DHHS)"REDACTED "Clare Looker (DHHS)" REDACTED
Date: Fri, 29 May 2020 16:17:56 +1000

Just also wanted to highlight the email I got from Nigel at the security company

*Last time three positive guards worked together was on Saturday **23/05/2020**- 1800 to 0600. But they all worked on different levels.*

REDACTED

I now also have the rosters since the 11th May – on this is does not however note which floor people worked on

Thanks

REDACTED

Public Health Operations (Case, Contact & Outbreak management)| Novel Coronavirus (COVID-19) Response

Health Protection Branch | Regulation, Health Protection and Emergency Management Division
Department of Health & Human Services | 50 Lonsdale Street, Melbourne, Victoria, 3000
REDACTED
w. www.dhhs.vic.gov.au

From: Sarah McGuinness (DHHS) REDACTED
Sent: Friday, 29 May 2020 3:59 PM
To: Clare Looker (DHHS)REDACTED
Cc: REDACTED
Subject: Briefing for Finn

Hi Clare,

Brief summary of the 4 Rydges cases is provided here:

	Case 1	Case 2	Case 3	Case 4
PHESS ID	REDACTED			
Age/gender	REDACTED			

Symptoms?	Yes	Yes	No	No
Symptom onset date	25/05/2020	25/05/2020	Asymptomatic	Asymptomatic
Current location	Isolating at Rydges hotel	Isolating at home	Hotel accommodation arrangements in process	Isolating at home
Work role	REDACTED			
Last worked at Rydges	REDACTED			
Swab date	25th May	26th May	27th May	27th May
Testing location	Monash Dandenong / Southern Cross Pathology	Box Hill Hospital / Eastern Health Pathology	GP / ACL	Epping Drive Through
Notification date	26th May	27th May	29th May	29th May

As discussed, we are in contact with the security company to get rosters for the above workers.

REDACTED

All deny close contact with other workers during their shifts.

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

- REDACTED nvolvement in cleaning duties, including the lift used to transport positive patients
- Use of masks and gloves that are non-standard (e.g. porous gloves) and lack of training in hand hygiene and PPE use
- Lack of routine cleaning & disinfection with agents that have antiviral activity in areas of hotel where staff work (cleaning products used in common areas & lifts are household variety products)
- No reported contact with confirmed cases.

Thus far, we have advised that everyone who has been on-site for 30 minutes or more since 11th May undergo testing for COVID. No staff have been identified as close contacts to date. We started providing advice this afternoon that staff who have worked at Rydges on Swanston since the 11th May (14 days before symptom onset in the first case) do not work elsewhere, unless they have not been on site in the past 14 days (i.e. since 15th May) AND have had a negative swab.

As discussed, there are probably four stages of action that we could consider in such a setting:
Stage 1 – active monitoring only
Stage 2 – test everyone but do not enforce restrictions
Stage 3 – testing PLUS cohorting of staff (i.e. say they can't work elsewhere for now) +/- designate certain people (e.g. overlapping shifts with a case during their infectious period) as close contacts
Stage 4 – designate everyone as close contacts and get in an entirely new workforce.

My current feeling is that we should go with Stage 3.

Kind regards,
Sarah

Dr Sarah McGuinness
Infectious Diseases Physician
Case, Contact and Outbreak Management | COVID-19 Surge Workforce

Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
REDACTED

Briefing for Finn

From: "Sarah McGuinness (DHHS)" REDACTED
To: REDACTED
Cc:
Date: Fri, 29 May 2020 15:58:55 +1000

Hi REDACTED,

Brief summary of the 4 Rydges cases is provided here:

	Case 1	Case 2	Case 3	Case 4
PHESS ID	320203450603	320203487846	320203509872	320203513656
Age/gender	REDACTED			
Symptoms?	Yes	Yes	No	No
Symptom onset date	25/05/2020	25/05/2020	Asymptomatic	Asymptomatic
Current location	Isolating at Rydges hotel	Isolating at home	Hotel accommodation arrangements in process	Isolating at home
Work role	REDACTED	Security	Security	Security
Last worked at Rydges	Night shift starting 23rd May	Night shift starting 23rd May	Night shift starting 26th May	Night shift starting 25th May
Swab date	25th May	26th May	27th May	27th May
Testing location	Monash Dandenong / Southern Cross Pathology	Box Hill Hospital / Eastern Health Pathology	GP / ACL	Epping Drive Through
Notification date	26th May	27th May	29th May	29th May

As discussed, we are in contact with the security company to get rosters for the above workers.
Case 1 works as REDACTED in lobby
Case 2 works on the floors of the hotel
Case 3 works on both the floors and in the lobby
Case 4 works on the floors of the hotel

All deny close contact with other workers during their shifts.

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

- REDACTED 's involvement in cleaning duties, including the lift used to transport positive patients
- Use of masks and gloves that are non-standard (e.g. porous gloves) and lack of training in hand hygiene and PPE use
- Lack of routine cleaning & disinfection with agents that have antiviral activity in areas of hotel where staff work (cleaning products used in common areas & lifts are household variety products)
- No reported contact with confirmed cases.

Thus far, we have advised that everyone who has been on-site for 30 minutes or more since 11th May undergo testing for COVID. No staff have been identified as close contacts to date. We started providing advice this afternoon that staff who have worked at Rydges on Swanston since the 11th May (14 days before symptom onset in the first case) do not work elsewhere, unless they have not been on site in the past 14 days (i.e. since 15th May) AND have had a negative swab.

As discussed, there are probably four stages of action that we could consider in such a setting:
Stage 1 – active monitoring only
Stage 2 – test everyone but do not enforce restrictions
Stage 3 – testing PLUS cohorting of staff (i.e. say they can't work elsewhere for now) +/- designate certain people (e.g. overlapping shifts with a case during their infectious period) as close contacts
Stage 4 – designate everyone as close contacts and get in an entirely new workforce.

My current feeling is that we should go with Stage 3.

Kind regards,
Sarah

Dr Sarah McGuinness
Infectious Diseases Physician
Case, Contact and Outbreak Management | COVID-19 Surge Workforce
Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
REDACTED

Rydges hotel - Two new COVID-19 cases

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

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

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

Dear colleagues,

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

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

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

All deny close contact with other workers during their shifts.

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

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

variety products)
- No reported contact with confirmed cases.

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

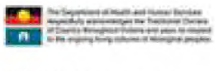
Following discussion with the Public Health Commander and Chief Health Officer,
Additional next steps
- Cohorting of staff - all staff who have worked at the hotel from 11th May will be asked not to work at other sites
- Any security staff member who has had an overlapping shift with any of the cases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

Kind regards

REDACTED

REDACTED
Deputy Public Health Commander COVID-19 (Case, Contact and Outbreak Management)
Senior Medical Advisor
Health Protection Branch | Regulation, Health Protection and Emergency Management Division
Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
REDACTED REDACTED
w. www.dhhs.vic.gov.au

Follow the Chief Health Officer on Twitter @VictorianCHO



Updated actions Rydges Hotel

From: "Clare Looker (DHHS)"REDACTED

To: "Merrin Bamert (DHHS)"REDACTED "Pam Williams (DHHS)" REDACTED , "Nick Chiam (DHHS)"REDACTED "Meena Naidu (DHHS)" REDACTED DHHSOpSoteriaEOC <dhhsopsoteriaeoc@dhhs.vic.gov.au>, "Melody Bush (DHHS)" REDACTED

Cc: "Sarah McGuinness (DHHS)"REDACTED REDACTED (DHHS)" REDACTED REDACTED (DHHS)" REDACTED "Annalise Bamford (DHHS)" REDACTED , "Finn Romanes (DHHS)" REDACTED

Date: Fri, 29 May 2020 22:18:16 +1000

Hi Merrin,

As discussed, late this evening we have been notified of two further cases in staff members at Rydges Hotel. The total number of cases now being **six.**

The interview for Case 5 is underway and I understand he is a security guard who worked REDA REDA Further details pending.

Case 6 is a mental health nurse from REDACTED We are yet to successfully reach this case, but will continue to try until 10.30pm before resuming efforts in the morning. As I mentioned, there is a suggestion this case may also have worked at the Mariott but we currently have no details about symptoms, timelines, infectious periods etc.

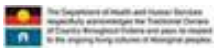
A fuller risk assessment will be undertaken tomorrow once all these details are available, however there are a number of **immediate steps** that we should instigate tonight:

- **No new admissions to the hotel.**
- **Minimising all movement of residents outside their rooms (except for emergency care).**
  - **No walks, smoking, non-critical mental health breaks**
- **No movement of staff between sites/cohorting. Any staff member who has worked at Rydges from 11th May should not work at any other sites.**
  - **Including all heath staff, AOs, team leaders, support staff, DJPR team leaders, security and hotel staff.**
  - **At the moment, these staff can continue to work at Rydges.**
  - **Time frame for the limitation is not yet clear (will depend on the timelines for un-interviewed cases and any other cases)**
  - **A larger group of staff may need to be fully quarantined depending on the outcomes of the investigation**
- **Cleaning – I understand a full deep clean has occurred and regular commercial cleaning will commence with a particular focus on common areas and high touch surfaces**
- **Reactive media lines have been drafted, however these will likely need tweaking in the morning.**

Sarah has scheduled an outbreak management team meeting for 10am tomorrow. Please feel free to forward that invitation to anyone cover weekend roles or who may have been missed.

Kind regards
Clare

Dr Clare Looker
Deputy Public Health Commander COVID-19 (Case, Contact and Outbreak Management)
Senior Medical Advisor
Health Protection Branch | Regulation, Health Protection and Emergency Management Division
Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
REDACTED
w. www.dhhs.vic.gov.au



Outbreak Management Plan – Rydges Swanston

Updated 14 June 2020 at 20:10h (S. McGuinness)

Epi update 13 July 15:00

Purpose

The purpose of this document is to provide an update on the current status of the Rydges on Swanston Street Outbreak.

Governance

Outbreak Management team

Functional role	Name:	Mobile No:	Email:
Outbreak Lead	Simon Crouch Sarah McGuinness Ramona Muttucumaru Naveen Tenneti	REDACTED	REDACTED
Case and Contact Lead	REDACTED		
Epidemiology Lead	REDACTED		publichealth.intelligence@dhhs.vic.gov.au
DHHS Command	Jason Helps		
Joint Intelligence Lead	REDACTED		
Communications and Media Lead	REDACTED		
Outbreak Squad Coordinator	REDACTED		
Administrative Support Officer			

Outbreak Management Team meeting dates

First meeting – 1830 on Tuesday 26 May 2020.

Second meeting – 1130 on Wednesday 27 May 2020

Third meeting – 1000 on Thursday 28 May 2020

Fourth meeting – 1000 on Friday 29 May 2020

Fifth meeting – 1000 on Saturday 30 May 2020

Sixth meeting – 1000 on Sunday 31 May 2020

Seventh meeting – 1230 on Monday 1 June 2020

Eighth meeting – 1300 on Tuesday 2 June

Ninth meeting – 1300 on Wednesday 3 June

Tenth meeting – 1300 on Thursday 4 June

Eleventh meeting – 1300 on Friday 5 June

Twelfth meeting – 1300 on Saturday 6 June

Thirteenth meeting – 1300 on Monday 8 June

Fourteenth meeting – 1200 on Thursday 11 June

Fifteenth meeting – 1300 on Friday 12 June

Outbreak summary (Epi)

A total of **17** cases of COVID-19 epidemiologically associated with the Rydges Hotel on Swanston Street. have been notified to the department in Victoria (an additional case notified in QLD brings the total to 18). One is REDACTED the Rydges Hotel; six are security guards working at the hotel, one is a REDACTED (HCW) working at the hotel, nine are household close contacts of a staff member (secondary contacts – this includes one QLD notification) and one is a close contact of a household contact of a staff member. The first case was notified on 26 May 2020. Rydges Swanston Street was being used for hotel quarantine of returned travellers, specifically positive COVID-19 cases. All staff cases were in those that worked night shift. The first seven staff cases worked overlapping shifts on R E May, and it is hypothesised that there may have been a common exposure on this date. However, the 8th staff case only worked at the hotel from 24-27 May inclusive.

A case (REDACTED) was notified in Queensland on 5 June, symptom onset 1 June 2020. **This case is included in the epi curve but is NOT counted in Victoria case numbers as was diagnosed in Queensland**. This case had six close contacts in Victoria that were investigated by the department. (COVID-net ID - Rydges outbreak REDACTED). The most recent staff case (notified on 9 June 2020) was detected on return-to-work testing, but reported an onset date of 4 June 2020, which is eight days after the end of RE last shift. The case was in isolation during their infectious period (last date of work was 27 May 2020). A new case was notified on 10 June 2020 in a household contact of the most recently notified staff member, who until 27 May 2020 was sharing a room with the staff member.

As of 10 June 2020, five cases show genomic link to a single detainee family. As of the 12 of June 2020,120 close contacts have been identified and all close contacts have been tested. All results so far have been negative; 3 close contacts have pending results for day 11 testing and one is yet to be tested. Rydges is now planned to re-open as a quarantine hotel, but not for positive cases.

On 12 June a new case was notified to the department in a previously known household close contact REDACTED of three confirmed cases (one of whom is a security guard staff member) following a positive day 11 swab while in home isolation.

On 18 June a case was notified to the department in a contact of the case notified in QLD. This case, residing in Victoria, had been identified as a close contact and commenced home isolation on 6 June. The case developed symptoms 11 June and went for testing on 17 June.

Total Confirmed cases	17 (18 including the case diagnosed in QLD)
Total active cases	0
Relationship to exposure site	Household: 8
	Staff: 8
	Social: 1
Sex distribution	Female: Male:
Age (median (range))	25
Indigenous	Indigenous: Non-Indigenous: Unknown:
Date of first diagnosis	26 May 2020
Date of first symptom onset	25 May 2020
Date of most recent symptom onset	11 June 2020
Total hospitalisations	1
Current hospitalisations	0
Total ICU admissions	1
Current ICU admissions	0
Deaths	0
Presumptive first case	– first case notified) preliminary genomics have suggested links with sequences from a family of overseas returnees from in hotel detention at
Close contacts (active)	144 (4)
Casual contacts (active)	46 (38)
Actions (high level)	-

*QLD case not included in the above summary table

Situation

The Rydges on Swanston Hotel currently operates as a mandatory quarantine hotel accommodating people who test positive to COVID-19 during mandatory quarantine and a number of close contacts.

The proposed index case with symptom onset 25 May, tested same day. The case worked the night of May, having travelled by bus from and then by train. He lives in a

Case 2 works as a security guard. Symptom onset 25 May, tested 26 May. The case worked the night of May (drove in by private car). Household contacts include housemates (all of whom work in security) in a house (all are close contacts), none have been confirmed as cases.

Case 3 works as a security guard. reported being asymptomatic and was tested at the request of employer following notification of the first case. Four close contacts were identified within a household. and housemate have since tested positive.

Case 4 works as a security guard. reported being asymptomatic and was tested at the request of employer following notification of the first case. Two close contacts were identified. Case 4 also worked as and lives in a housemates is currently isolating at home. shift schedule is unclear.

Case 5 (RED ACT) works as a security guard. RE reported symptom onset on 27 May. RE was tested at the request of RE employer following notification of the first case. Two household close contacts were identified, both were tested.

Case 6 REDA is a REDACTED nurse whose symptom onset was 29 May (swabbed same day). RE last worked at Rydges on Swanston on RE May. RE also worked at the Marriott Hotel on REDACT May (not during infectious period). RE presented to the Marriott Hotel for a shift on R May, but was turned away by the manager on the basis of RE recent work at the Rydges (as by then, the first 2 cases had been publicly reported). This interaction is currently being investigated to determine if it meets criteria for close contact. R did not work at another health care facility during RED infectious period. RE lives in a REDACTED (deemed a close contact) and was isolating at home until 4 June, at which time RE was transferred to RED by ambulance due to worsening symptoms. RE was admitted to ICU on R June, transferred to ward on R June and granted clinical clearance from the department on 17 June.

Case 7 REDA is a security guard whose symptom onset was 25 May. RE lives in a REDACTED house with REDACTED (all of whom were deemed close contacts) and is currently isolating in emergency accommodation at the REDA hotel. RED housemates have subsequently tested positive.

Four more cases (Cases 8, 9. 11 and 12) are housemates of REDA and had symptom onset 31 May and 1 June. One is a REDACTE with REDAC who worked between RED May.

Two more cases (Cases 10 and 13) are REDA and housemate of RED. One is asymptomatic and was in isolation prior to testing positive.

All staff who attended the site between 11-28 May were asked to seek testing for COVID-19. The majority of staff were tested on-site (swabs taken by on-site nurses, couriered to VIDRL). To date, results received from VIDRL include 127 negative and 2 positive results (cases 5 & 6). Some staff sought testing elsewhere – this includes 19 Alfred health nurses who all tested negative. The highest attack rate is seen amongst security guards, with 5/42 testing positive (remaining security guards have tested negative).

One staff member (REDACTED) was transferred from their home and presented to REDACTED emergency with ongoing fevers, shortness of breath and productive cough. They were admitted to REDACTED ICU late on R June on oxygen, not ventilated.

A housemate of the HCW, who was not mentioned to the department as a close contact, had moved to RE the day after the case was interviewed, has since tested positive in Qld. This case will not be counted in Victoria numbers (as diagnosed in Qld). RE had six close contacts in Victoria who are being followed up. During infectious period, this case took the Skybus (22min journey) to Tullamarine airport and flew to REDACTED A review of the CCTV footage by Skybus management has not revealed any close contacts that have resulted from this exposure. The Melbourne to REDACTED flight has been traced by the REDACTE Public Health Unit.

Case 14 is a staff member previously identified as a close contact of the Rydges exposure site (i.e. who worked there during the period 18-28 May but had no identified contact with a confirmed case). This case was notified to the department and interviewed on 9 June and has a symptom onset date of 4 June. The case was in isolation during their infectious period and does not report having close contact with anyone during this time.

Case 15 is a household contact of case 14 (not previously disclosed / identified) with symptom onset 7-June, diagnosed 10-June. This case is REDACTED however, did not work during their infectious period. This case was not in isolation during their infectious period, and visited a butchers, a chemist, and a friend.

Case 16, symptom onset 7 June, diagnosed 12 June, is a household contact of Cases 12 and 13. Case 16 had been isolating at home for four days with Case 12 before they moved to hotel

accommodation. Case 13 (asymptomatic) had been isolating at the same home in a bedroom with ensuite.

Case 17, symptom onset 11 June, diagnosed 18 June, is a close contact of the RED notified case. They were identified as a close contact and commenced isolation on 6 June.

Epidemiological and clinical investigation

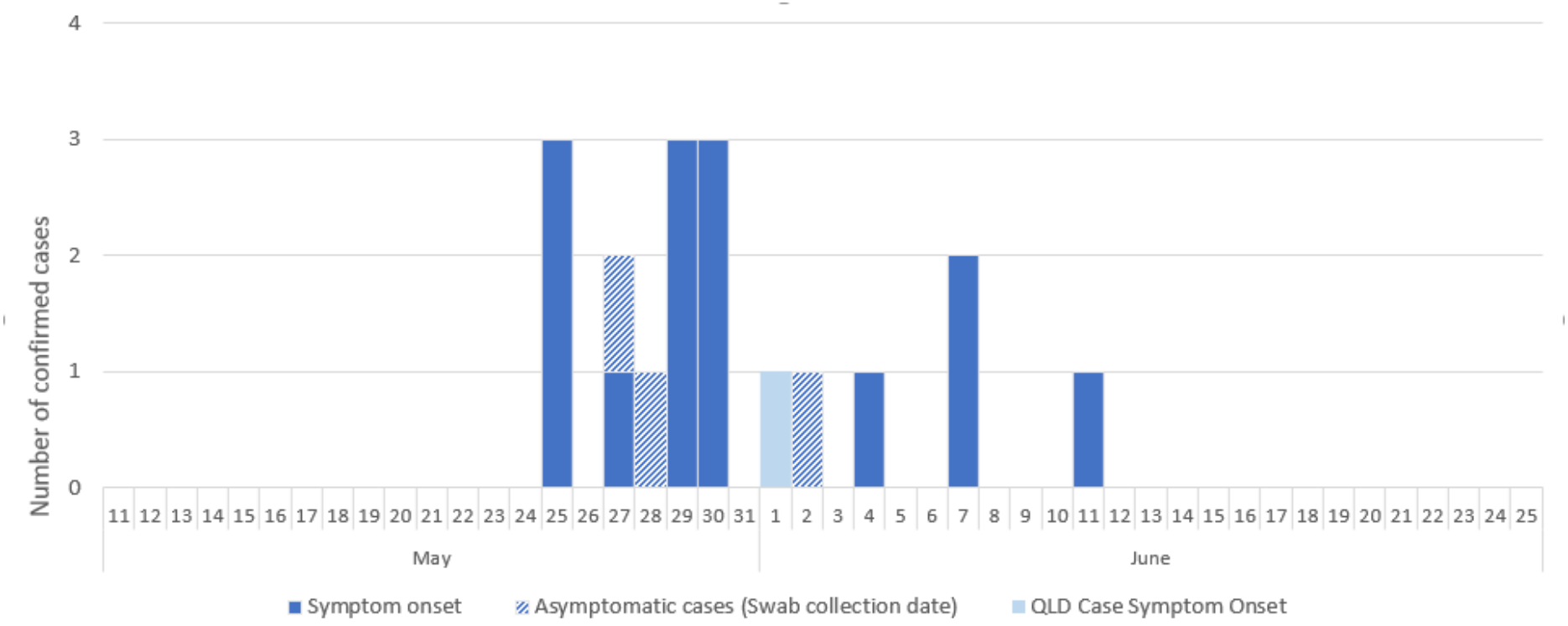


Figure 1: Epidemic curve for Rydges on Swanston Outbreak, by date of calculated symptom onset, including QLD case

*for asymptomatic cases symptom onset is estimated as first positive specimen collection date

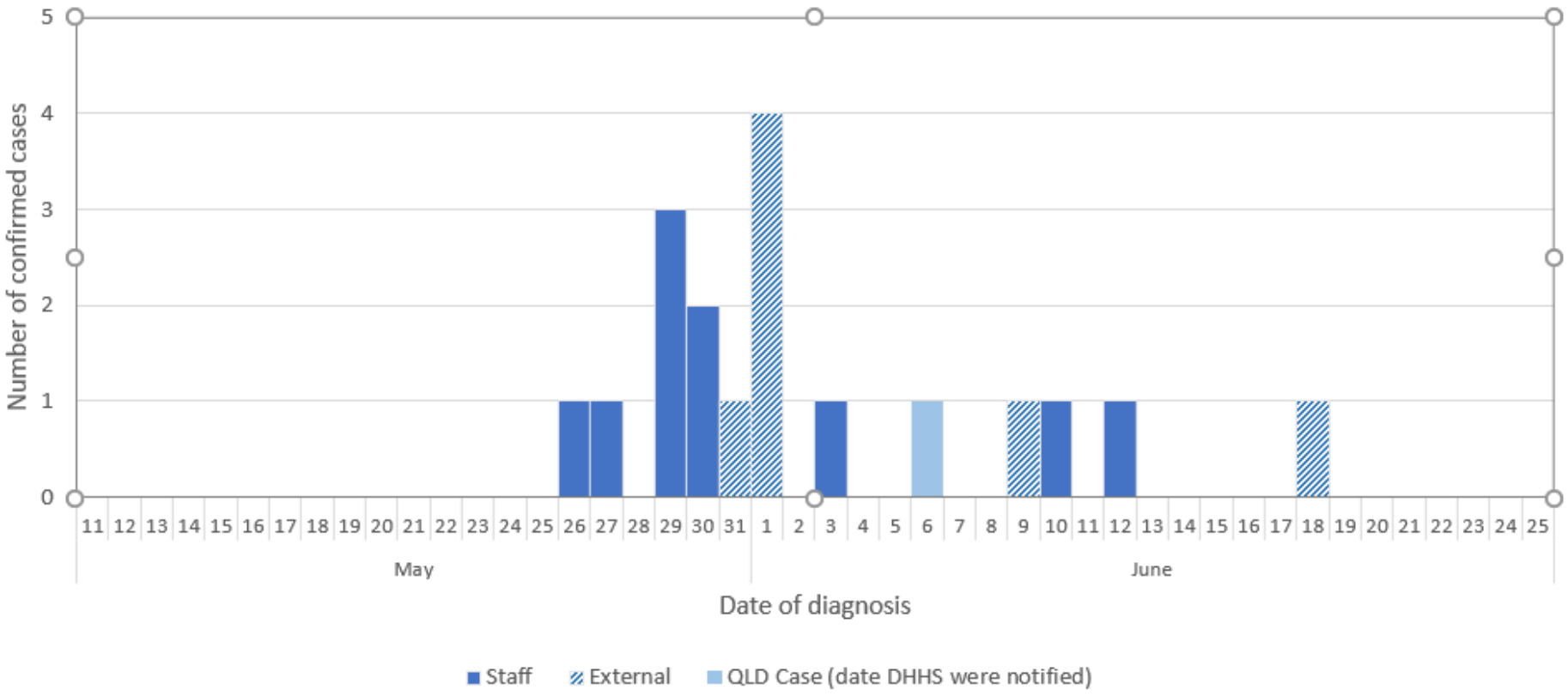


Figure 2: Epidemic curve for Rydges on Swanston Outbreak, by date of diagnosis, including QLD case

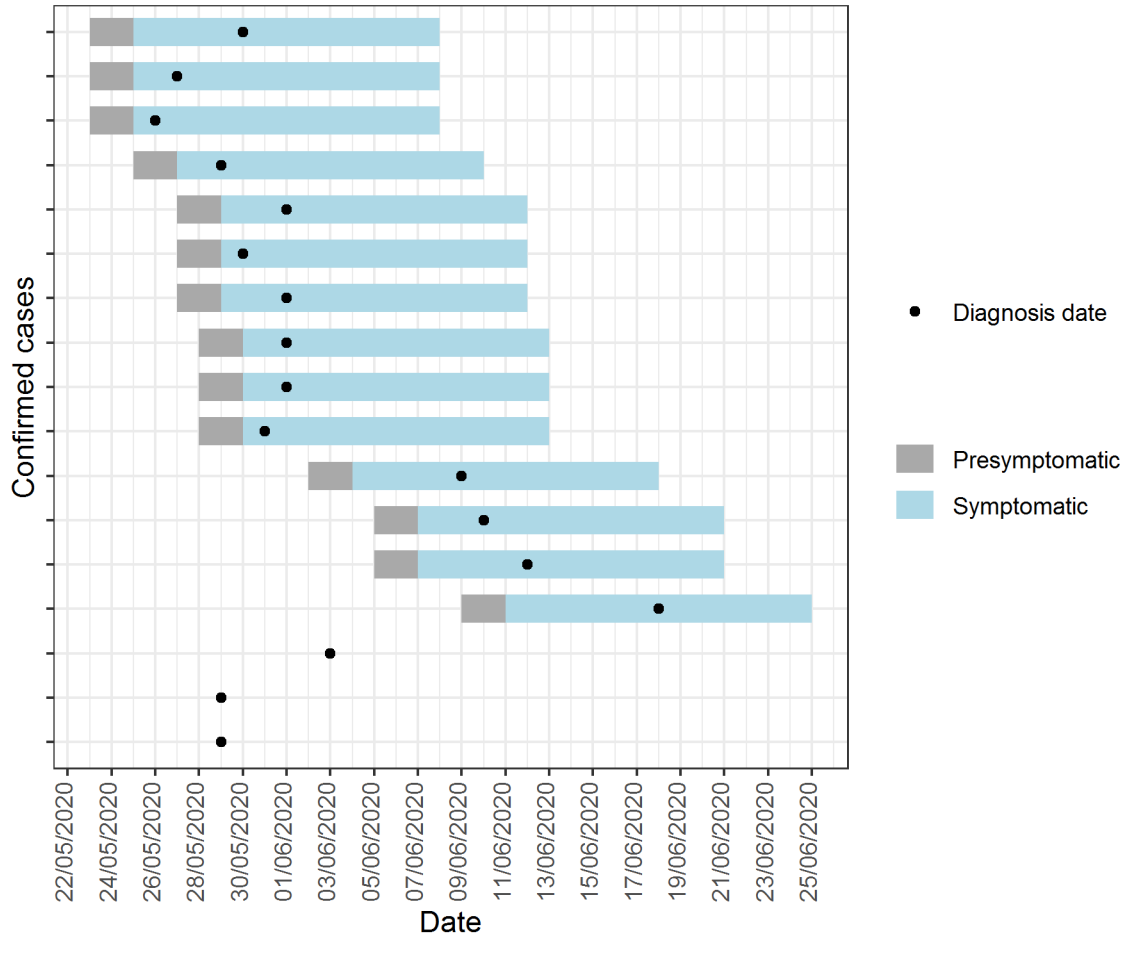


Figure 3: Onset date and incubation period for confirmed cases, Rydges on Swanston

Note: The timeline cascade will not include the case diagnosed in Queensland

Case definitions

Current COVID-19 case definition (as of 2 June 2020)

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

Outbreak case definitions

Confirmed case:

A person tested positive for COVID-19 with an epidemiological link to the Rydges on Swanston Outbreak whose symptoms began on or after 11 May 2020.

Note: travellers who are in detention at Rydges on Swanston will be consider as a potential outbreak case if they have had direct contact with another confirmed outbreak case or if they are linked by genomic analysis.

Close Contact:

Any person who has had exposure of 15 minutes face to face or two hours in the same enclosed space to a confirmed outbreak case.

Casual Contact:

A person who has had any contact with, or worked a parallel shift with, a confirmed outbreak case.

Acquisition period:

11 May – 25 May 2020 (14 days prior to symptom onset in a case). All staff who spent 30 minutes or more at Rydges during this period have been asked to be tested.

Case follow-up

All cases are well having completed isolation.

Close Contact Follow up

Case 1 has 5 household contacts who have been designated as close contacts.

Case 2 has 3 household contacts who have been designated as close contacts. A work contact from another security job was initially designated as a close contact, but on review of the situation this person had <=5 minutes contact with the case while maintaining physical distancing and therefore does not meet the close contact criteria.

Case 3 has three household contacts who have been designated as close contacts – two have subsequently been confirmed as cases.

Case 4 has 2 household contacts who have been designated as close contacts.

Case 5 has 5 household contacts who have been designated as close contacts – four have subsequently been confirmed as cases.

Case 6 has 1 household contact who has been designated as a close contacts.

Case 7 has 3 household contacts who have been designated as close contacts.

Cases 8-14 are all household contacts of the above staff cases.

On 5 May, Queensland health notified us of a previously unrecognised household close contact of case 6 who reported moved out of the house (to Queensland) on 31 May 2020. This person has subsequently tested positive.

As of 30 May, any staff member who attended the Rydges on Swanston Hotel for 30 minutes or more during the period 18 May to midday on 28 May inclusive is now considered a close contact and is being asked to self-quarantine for 14 days since their last visit to the hotel. This includes:

- Medi7 GPs
- Alfred health nurses
- Unified Security staff
- YNA nurses
- Hotel staff
- SwingShift nurses
- Outbreak Squad nurses
- DHHS staff (AOs and team leaders)
- DJPR staff member

Environmental investigation

The hotel is located at 701 Swanston Street, Carlton.

A visit was made to the site by an IPC outbreak squad nurse on 27 May. Photographs and a report have been uploaded to PHESS. Key findings included:

- The hotel has no dedicated cleaning staff. Cleaning of common areas (including the lift used to transport positive cases) is currently performed by hotel staff (including the night manager), using a range of products that are unlikely to be effective against SARS-CoV-2 (e.g. PineOCleen, Glen20, home variety wipes and chux). Terminal cleaning of hotel rooms (following exit of a case) is contracted out to a cleaning company called Ikon.
- A 'deep clean' involving cleaning and disinfection using agents with antiviral activity is yet to be performed in the areas where the two infectious staff members worked
- Security staff are wearing vinyl gloves and non-approved masks for their shifts
- Education around PPE usage and separation of "clean" and "dirty" tasks is needed

Discussion with hotel management over processes for garbage disposal and linen changes:

- The hotel provides linen and ask guests to change their own linen
- Soiled linen is to be placed in double bags and placed outside rooms
- Soiled linen is then collected by people wearing full PPE including gown.

Discussion with nurses who cleaned room REDACTED and changed linen:

-

Information provided by hotel management and AO notes re: contact of guests from room REDACTED (the REDACTED genomically linked with staff cases) with environment & staff:

- The guests arrived on RED May and departed RE May
- The room was very messy and the kids drew on the walls
- Two nurses provided assistance in cleaning and changing bedlinen on RE May as the REDACTED REDAC was very flustered managing REDACTE
- The REDA is reported to have been taken for a walk on 18th May, accompanied by 4 security guards (wearing masks and gloves) and two nurses (wearing full PPE) – we are awaiting CCTV footage to confirm this and glean more information about environmental contact
- The area where guests are taken for a break is an empty room. Guests are advised not to touch anything. The nurses call the lift and open doors for guests when needed. This info is to the best of my knowledge and what I am informed

Genomic Investigation

Request:

Request for expedited genomic testing. Preliminary genomic analysis has identified that the first case and second case cluster genomically with sequences from a family REDACTED that are overseas returnees from REDACTE Based on PHESS notes, they appear to have been moved into the Rydges on R May from the Crowne Promenade hotel. Symptom onset dates range from 9-15 May.

Details of these genomic findings are at REDACTED

Results

As of 13 July, MDU has provided information on the genomic analysis of sequences associated with The Rydges on Swanston Outbreak. The onwards transmission from cases associated with the original Rydges outbreak has seeded five clusters that are distinct and well-supported clusters

associated with the main Rydges Parent Cluster. These clusters are examples of local transmission and diversification, the groups are all very closely related, and the availability of more sequences could allow for the merging or splitting of these clusters.

The main parent cluster contains sequences from RED The earliest identification of this cluster was in sequences from security staff at the Rydges Hotel which cluster with a family of RE overseas returnees from REDACTE that were in hotel isolation at the Rydges. This parent cluster also includes sequences from cases associated with REDA (previously REDACTE), REDACTED Family Outbreak, REDACTED REDACTED REDACTED REDACTED REDACTED REDACTED sequences from five different public housing towers, a single case from REDACTED REDACTED and several other complex cases. There were 34 additional cases genomically linked that are not known to be epidemiologically linked to an outbreak.

The first of the seeded clusters from the main parent cluster includes sequences from three cases, all of these were associated with the REDACTED

The second of the seeded clusters contains sequences from 15 cases. This includes 11 cases epidemiologically linked to the REDACTED Outbreak, one associated with Ilim REDACTED REDAC Outbreak and three not linked to clusters that all live in REDACTED One of these is a REDACTE two others are spouses.

The third seeded cluster contains sequences from 38 cases. This includes those from the REDACTE REDACTED REDACTED and two cases associated with complex cases in REDACTE and a single case from REDACTED This also includes three cases that are still under investigation, four cases not linked to a cluster with an unknown source of acquisition and another case that reported recent overseas travel and commenced hotel detention R June at Crown Metropol and subsequently tested positive and was moved to the Brady Hotel.

The fourth seeded cluster contains sequences from 45 cases. This includes 14 from the REDA REDACTED , six from cases that attended the REDACTED , two cases associated with separate public housing towers and a case from REDACTED It also includes cases associated with several ELC (REDACTED) and workplaces (RED). Ten of the cases genomically linked were not known to be associated with an outbreak.

The fifth seeded cluster contains sequences from 32 cases. This contains 19 sequences from cases associated with REDACTED Outbreak and five from REDACTED Eight additional cases were not known to be associated with an outbreak and three of these have been identified as an unknown source of acquisition.

As at 10 July 2020, there are 274 cases that are genomically linked to the REDAC Parent Cluster. Due to travel restrictions, there are less travel associated importations of COVID-19 and more local transmission occurring. This means sequences from cases are very similar to one another and therefore, it is harder to distinguish and determine relatedness between them. A sequence from an outbreak may be genomically linked to a different cluster than another sequence from that same outbreak, however please note this does not definitively mean the outbreak has multiple sources of infection as these cluster groups are very closely related and constantly changing with availability of more sequence data.

Hypothesis

Transmission of SARS-CoV-2 has occurred at the workplace from a COVID case in quarantine (either directly, via fomites or through contact with an unidentified intermediary staff case).

Control measures

Case 1, 3 and 5 were originally isolated at the Rydges, but were moved to the Novotel with other cases (due to staffing concerns at Rydges).

Identified close contacts have been quarantined.

Cleaning of work areas to be undertaken (commercial deep clean completed on 28 May).

Testing of all contacts from the acquisition period (from 11 May 2020) to be conducted at the workplace on 27 and 28 May (nurses from YNA to collect swabs; sent to VIDRL for testing).

All staff members who attended the Rydges on Swanston Hotel for 30 minutes or more during the period 18 May to midday on 28 May inclusive are considered close contacts. Rationale for this period is that it extends from 7 days prior to symptom onset in first case (and a date which is almost 14d ago), until the date on which a full clean and disinfection of the site was undertaken (28th May).

Staff who only attended the site between 11 and 17 May inclusive AND who have had a negative test have been advised that they can continue their usual activities.

Staff who have only attended the site since 28 May have been asked to only work at Rydges while an investigation is underway.

Stakeholder mapping

Rydges Hotel Management:

- Key contact: Rosswyn Menezes – General Manager, REDACTED @evt.com, hotel: REDACTED mobile: REDACTED

Your Nursing Agency (YNA)

SwingShift (mental health nurses):

- Eric Smith – Managing Director; RED @swingshift.com.au, phone: REDACTED

Alfred Hospital (nursing staff)

- REDACTED

Unified Security

- Key contact: Nigel Coppick – National Operations Manager (Victoria Office), REDA @unifiedsecurity.com.au, mobile: REDACTED phone: REDACTED

Medi7 GPs:

- Key contact: Stuart Garrow – Clinical Lead, Melbourne Quarantine Hotel Doctor Team, REDACTED @gmail.com, REDACTED

DJPR:

- Key contact: Rachaele May – DJPR Hotel Quarantine Agency Commander, REDACTED @agriculture.vic.gov.au, djprcovidaccom-lead@ecodev.vic.gov.au, mobile: REDACTED

Operation Soteria (Pam Williams, Merrin Bamert)

Issues/risks:

There is a high risk of transmission from COVID positive cases being detained in the hotel to the staff members working at the hotel. This is due to the inadequate education and cleaning procedures that are currently in place. The cleaning duties of communal areas were the responsibility of the security staff; specifically, for the elevators used to transport COVID positive cases. Because of this, there is a

high likelihood of fomite spread from poor cleaning products being utilised, poor PPE used by security staff, and a lack of education surrounding cleaning practices. At risk populations include staff members from the hotel, DHHS staff, nurses, and various other HCWs that were onsite to attend to the people in hotel detention. Outside of the hotel, there has been onward household transmission to partners and housemates.

Risk communication

Key events

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

Escalation point	Date of escalation
Deputy Public Health Commander CCOM	17:00, 26 May 2020
Public Health Commander	17:48, 26 May 2020
Chief Health Officer	20:10, 26 May 2020
Minister's Office	20:10, 26 May 2020

Communication with exposed settings

Initial request for information from the Rydges on the evening of 26 May 2020.

Key messages – general public

Approved media holding lines as of 26 May 2020

Statement

The department has been notified of a COVID-19 case in a staff member at Rydges on Swanston, Melbourne.

The source of acquisition for this case is under investigation and all potential sources of transmission will be explored.

All identified close contacts of the staff member have been contacted and placed into quarantine.

Any staff who are classified as close contacts of the case will be tested.

Thorough cleaning of relevant parts of the hotel is being undertaken, alongside other appropriate public health actions including contact tracing, isolation and quarantine where required.

Background

The hotel is not currently open to the public.

There are some returned overseas travellers observing their quarantine at the hotel.

The cause of the infection is under investigation.

Timeline of outbreak

Date	Action
26/05/2020	Case 1 notified to DHHS – REDACTED interview completed Emergency accommodation arrangements made for Case 1
26/05/2020	Worksafe informed
26/05/2020	Email sent to Operation Soteria team & Rydges Swanston with the following directions: - Request to provide background as to duties/jobs/functions undertaken by the REDACTED and RE[illegible] interactions with other staff and guests - Request for rosters for shifts worked by manager since 11th May REDACTED - Request for floor plan of hotel - Request for list of staff that had been swabbed and whether any staff are symptomatic - Instruction that 'A clean of all common areas, and the cases' direct work areas will need to occur'
27/05/2020	On-site visit by IPC nurse from outbreak squad (report in TRIM) - Noted that a 'deep clean' involving application of a disinfectant with antiviral properties had not yet been carried out - Noted inconsistencies in staff use of PPE and issues with inappropriate use of PPE (masks not applied correctly, incorrect use of gloves) - Noted that the REDACTED 's duties include cleaning of common areas and the lift used to transport COVID-19 cases
27/05/2020	Case 2 notified to DHHS – security guard REDACTED
27/05/2020	Request made to DJPR to arrange a commercial 'deep clean' of all common areas / areas visited by two
27/05/2020	Decision made to ask all staff who have been on-site for 30 minutes or more from 11 May 2020 (14 days prior to symptom onset date for Cases 1 and 2) to undergo testing for COVID-19
27/05/2020	Contact made with Stuart Garrow (RED ACTED GP providing on-site services) - Confirmed that 3 x medical staff who have been on-site since 11th May attended Rydges on 27/5/2020 for sample collection - Confirmed that RE[illegible] is happy to contact any staff members with positive results through any positive results in staff
28/05/2020	Contact made with Alfred Hospital re: Alfred staff who attended site between 11-27 May (19 staff). Spreadsheet received from infection prevention and control team.

28/05/2020	Full commercial bioclean of common/affected areas conducted by Ikon cleaning – documentation received and filed in TRIM folder
28/05/2020	On-site visit by outbreak squad nurses to provide IPC education
29/05/2020	Notification of Case 3 by ACL at ~1000h; case interview completed Emergency accommodation arrangements made for Case 3 Notification of Case 4 by Doctor at ~1200h; case interview completed Notification of Case 5 by VIDRL at ~1800h; case interview completed Notification of Case 6 by VIDRL at ~2000h; unable to contact case
29/05/2020	Following notification of cases 3 and 4, decisions made that: • Any staff who have worked at Rydges on Swanston since the 11th May (14 days before symptom onset in Case 1 & 2) should not work elsewhere, unless they have not been on site in the past 14 days AND have had a negative swab. Information relayed to relevant agencies (including Swing Shift, YNA, Unified Security, Alfred Health, Rydges, DHHS) • Directive to implement at least daily commercial cleaning (using disinfectant with antiviral activity) with a particular focus on common areas and high touch surfaces Following notification of cases 5 and 6 decision made to limit movement of staff and patients in and out of premises effective immediately: • No new admissions to hotel • Minimising all movement of residents outside their rooms (except for emergency care) • No movement of staff between hotel sites, including all health staff, AOs, team leaders, support staff, DJPR team leaders, security and hotel staff (time frame currently unclear)
30/05/2020	Actions from OMT #5: • At least once daily cleaning & disinfection of all common areas and frequently touched surfaces to commence • Ongoing education and PPE training for staff • Explore option of embed IPC lead from a health service • Quarantine staff who attended for 30 min or more between 18 May and midday on 28 May for 14 days since last exposure • Emergency accommodation for cases 3 & 5 • Communications to staff
3/06/2020	Late on 3 June, PHU staff became aware that a close contact of the exposure site worked two shifts at a correctional facility when they were supposed to be in quarantine. The close contact is asymptomatic and has received one negative test; a second test is pending. Although the public health risk is considered low, the correctional facility, Justice Health and Corrections Victoria have been advised of this situation.

4/06/2020	PHU staff arranged for an ambulance to transport one of the staff cases REDACTED from home to hospital after their symptoms deteriorated. The case is currently under close observation in ICU.
4/06/2020	Due to difficulties in staffing the Rydges, alternative accommodation was sought. Residents have been moved today to a different hotel in the CBD. Department outbreak control squad nurses have visited this hotel and are providing training and support to enable the lifting of restrictions. It is expected that following training of security staff today (3 June) that restrictions can be lifted tomorrow (4 June)
5/06/2020	Notified by Queensland health of an additional close contact – housemate of case REDACTED who moved out on REDACTED May 2020 (during cases' infectious period). Now symptomatic and has sought testing in QLD
5/06/2020	Request made to Operation Soteria for CCTV footage and documentation of movements of staff and family in hotel. AO handover notes provided (scanned PDF placed in TRIM)
08/06/2020	Household contacts associated with outbreak called and provided verbal and written advise to seek testing prior to end of quarantine (day 11 advised).
9/06/2020	All close contacts associated with outbreak being called and provided provided verbal and written advise to seek testing prior to end of quarantine (day 11 advised).
9/06/2020	Notification of Case 14 (in Victoria) Case 14 interviewed – security guard identified as close contact of exposure site; has been in quarantine since 27/5
10/06/2020	Notification of Case 15 (in Victoria) Case 15 interviewed – household close contact of case 14; had not been in quarantine as case 14 had advised R had been quarantining separately from rest of household (in studio)
12/06/2020	Notification of Case 16 (in Victoria)
14/06/2020	Awaiting results on 2 close contacts for day 11 testing. Outbreak control squad visited site on 13 June and advised that Rydges site was not ready for opening and that an effective terminal clean needed to be undertaken and correct signage put up.
17 June 2020	Preliminary information from MDU linking the case associated with Embracia Aged Care genomically to cases from Rydges on Swanston St Outbreak.
18 June 2020	Department notified of Case 17.

OMT meeting actions list

Outbreak Meeting 1 – 26th May

Action	Due date	Responsible person
Request further information from Rydges on: - Interactions with guests - Rosters - Floor plan - Duties of case	27 May 2020	REDACTED
Test all staff who have worked the same shift (including staff handed over to and from) as the case	27 May 2020	Simon Crouch
Confirm staff not working across different hotels	27 May 2020	Jason Helps
Clean areas case has worked	27 May 2020	REDACTED
Outbreak squad visit	27 May 2020	REDACTED
Media holding lines	26 May 2020	

Outbreak Meeting 2 – 27th May

Action	Due date	Responsible person
Document and map staff interactions and contacts with case 1 and case 2 across hotel to provide comprehensive mapping of potential contact points	28 May 2020	Pam
Coordinate testing for those who had overlapping shifts with cases as a priority	27 May 2020	REDACTED
Work with team to procure hotel floor plans and staff rosters	28 May 2020	REDACTED
Draft lines for staff testing +/- letter	27 May 2020	Sarah
Complete on-site visit and provide report	27 May 2020	REDACTED
Interview case 2	27 May 2020	
Escalate outbreak brief to Brett via Finn	27 May 2020	Simon
Facilitate expedited genomics analysis	28 May 2020	REDACTED
Ensure pathology slips are labelled as URGENT: priority 1 – outbreak (Rydges) to ensure quick turnaround of results by VIDRL	27 May 2020	

Outbreak Meeting 3 – 28th May

Action	Due date	Responsible person
Prepare materials (video and written) on proper hygiene and use of PPE, to be distributed to staffing agency leadership (both health services and security guards) via Pam Williams	30/05/2020	Outbreak Squad REDACTED
Liaise with Katherine Ong and intelligence leads to determine current knowledge about eye protection vs face shields for PPE when collecting deep nasal and oropharyngeal swabs	29/05/2020	REDACTED
Discuss potential support for procuring contact details and complete rosters of all staff in the hotel from the Public Health OMT (via RED)	28/05/2020	REDACTED
Liaise with VIDRL and REDACTED re: coordination of collection & testing of samples from Rydges hotel staff	28/05/2020	Sarah M
Coordinate distribution of negative test results to staff	28/05/2020	Sarah M REDACT
Confirm with DJPR that commercial cleaning is underway	28/05/2020	Sarah M
Follow up status on genomics	28/05/2020	Sarah M

Outbreak Meeting 4 – 29th May

Action	Due date	Responsible person
Procure staff contact details for Rydges staff	29/05/2020	REDACTED
Conduct interview & contact tracing for case 3	29/05/2020	
Investigate standard cleaning arrangement at the hotel and report back to team	29/05/2020	
Ensure that negative results received from VIDRL are sent via SMS to staff	29/05/2020	

Outbreak Meeting 5 – 30th May

Action	Due date	Responsible person
Complete interview of Case 6 and assess potential close contacts at Marriott hotel	30/05/2020	CCOM
Chase genomics over the coming week		Intelligence
Arrange at least daily cleaning and disinfection of all common areas & frequently touched surfaces	30/05/2020	Operation Soteria (Merrin)
Continue education regarding PPE, hand hygiene and discuss these with security company management	30/05/2020	Outbreak squad
Embed IPC lead from a health service		Operation Soteria (Merrin)

Limit movement of guests today only, until full environmental clean		Operation Soteria
Maintain block on new admissions of well people until full clean today		Operation Soteria
Quarantine staff who attended for 30 min or more between 18 May and midday on 28 May inclusive for 14 days from last exposure		REDACTED
Arrange emergency accommodation for Case 5		DHHS commander
Liaise with WorkSafe		CCOM
Communicate to various work groups / agencies who have been on-site		Merrin (Operation Soteria) REDACTED CCOM (DJPR, YNA, Swingshift, Medi7, Alfred, Unified Security, outbreak squads)

Outbreak Meeting 11 – 8 June

Action	Due date	Responsible person
Follow up cleaning practices at the hotel prior to 4/06/2020	5/06/2020	REDACTED
Share any updates regarding the nurse who worked at REDACT with the OMT team	5/06/2020	
Sarah to collate questions for finding details about the genomically linked family, REDAC to summarise info known so far; both to escalate concerns about the family's movement within the hotel to Pam Williams	5/06/2020	SarahREDACT
Schedule OMT meetings for Saturday and Monday	5/06/2020	Sarah
Clarify plan to move COVID-19 cases back Rydges Swanston St with Merrim Bamert from Operation Soteria	09/06/20	REDACTED
Advise all close contacts of the requirement for day 11 clearance testing	09/06/20	REDAC and CCOM team
Provide IPC advice given to hotel security staff and AOs	09/06/20	REDACTEand Outbreak Squad team

Outbreak Meeting 14 – 11 June

Action	Due date	Responsible person
ContacREDACTED Outbreak squads to arrange site visit to Rydges	12/06/2020	Sarah

Chase CCTV footage from Rydges	12/06/2020	Sarah
Ensure that emergency accommodation arrangements are underway for two most recently reported cases	12/06/2020	REDACTED
Provide an update to DJPR and Operation Soteria	12/06/2020	Sarah
Follow up results of close contact day 11 testing	12/06/2020	CCOMREDACTED
Escalate discussion of whether staff working at the COVID-19 positive hotel can work elsewhere to Deputy PHC	12/06/2020	Sarah

Line list

List does not include the QLD notified case.

Case	PHESS ID	Age Group	Sex	Onset Date	Diagnosis Date	Clinical Status	Cluster Link
17	320203567743	REDACTED	RED)AC ACT) ED	2020-06-11	2020-06-18	Well, isolation complete	Social
16	320203518386			2020-06-07	2020-06-12	Well, isolation complete	Household
15	320203585777			2020-06-07	2020-06-10	Well, isolation complete	Household
14	320203506661			2020-06-04	2020-06-09	Well, isolation complete	Staff
13	320203514855			NA	2020-06-03	Well, isolation complete	Household
12	320203514833			2020-05-29	2020-06-01	Well, isolation complete	Household
11	320203515292			2020-05-29	2020-06-01	Well, isolation complete	Household
10	320203515305			2020-05-30	2020-06-01	Well, isolation complete	Household
9	320203515315			2020-05-30	2020-06-01	Well, isolation complete	Household
8	320203515304			2020-05-30	2020-05-31	Well, isolation complete	Household
7	320203514863			2020-05-25	2020-05-30	Well, isolation complete	Staff
6	320203514969			2020-05-29	2020-05-30	Well, isolation complete	Staff
5	320203509872			NA	2020-05-29	Well, isolation complete	Staff
4	320203511748			NA	2020-05-29	Well, isolation complete	Staff
3	320203513656			2020-05-27	2020-05-29	Well, isolation complete	Staff
2	320203487846			2020-05-25	2020-05-27	Well, isolation complete	Staff
1	320203450603			2020-05-25	2020-05-26	Well, isolation complete	Staff

Outbreak demographic summary

Includes Victorian notified cases only.

		N	Perc %
Total		**17**	**100**
Sex	Female	4	23.5
	Male	13	76.5
	Unknown	0	0
Age group	0-9	0	0
	10-19	2	11.8
	20-29	11	64.7
	30-39	2	11.8
	40-49	1	5.9
	50-59	1	5.9
	60-69	0	0
	70-79	0	0
	80-89	0	0
	90+	0	0
Indigenous status	Indigenous	0	0
	Non-Indigenous	16	94.1
	Unknown	1	5.9
Clinical status	Admitted, not known to be in ICU	0	0
	Admitted to ICU	0	0
	Home isolation	0	0
	Hospital in the home	0	0
	Deceased	0	0
	Well, isolation complete	17	100
	Not recorded	0	0

Shifts worked by staff cases at Rydges

Date	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6	Case 7	Case 8
Details	REDACTED 320203450603 REDACTED	320203487846	320203509872	320203513656	320203514863	320203514969	320203511748	320203506661
Role	REDACTED	REDACTED	REDACT	REDAC	REDACTE D	REDACT EDA REDA	REDACTED	REDACTE D
Sx onset	25/05/2020	25/05/2020	Asymptomatic	27/05/2020	25/05/2020	29/05/2020	Asymptomatic	04/06/2020
11 May	REDACTED							
12 May								
13 May								
14 May								
15 May								
16 May								
17 May								
19 May								
20 May								
21 May								
22 May								
23 May								

			REDACTED			REDACTE		
24 May								
25 May								
26 May								
27 May								
28 May								

*text in red denotes shifts worked during infectious period

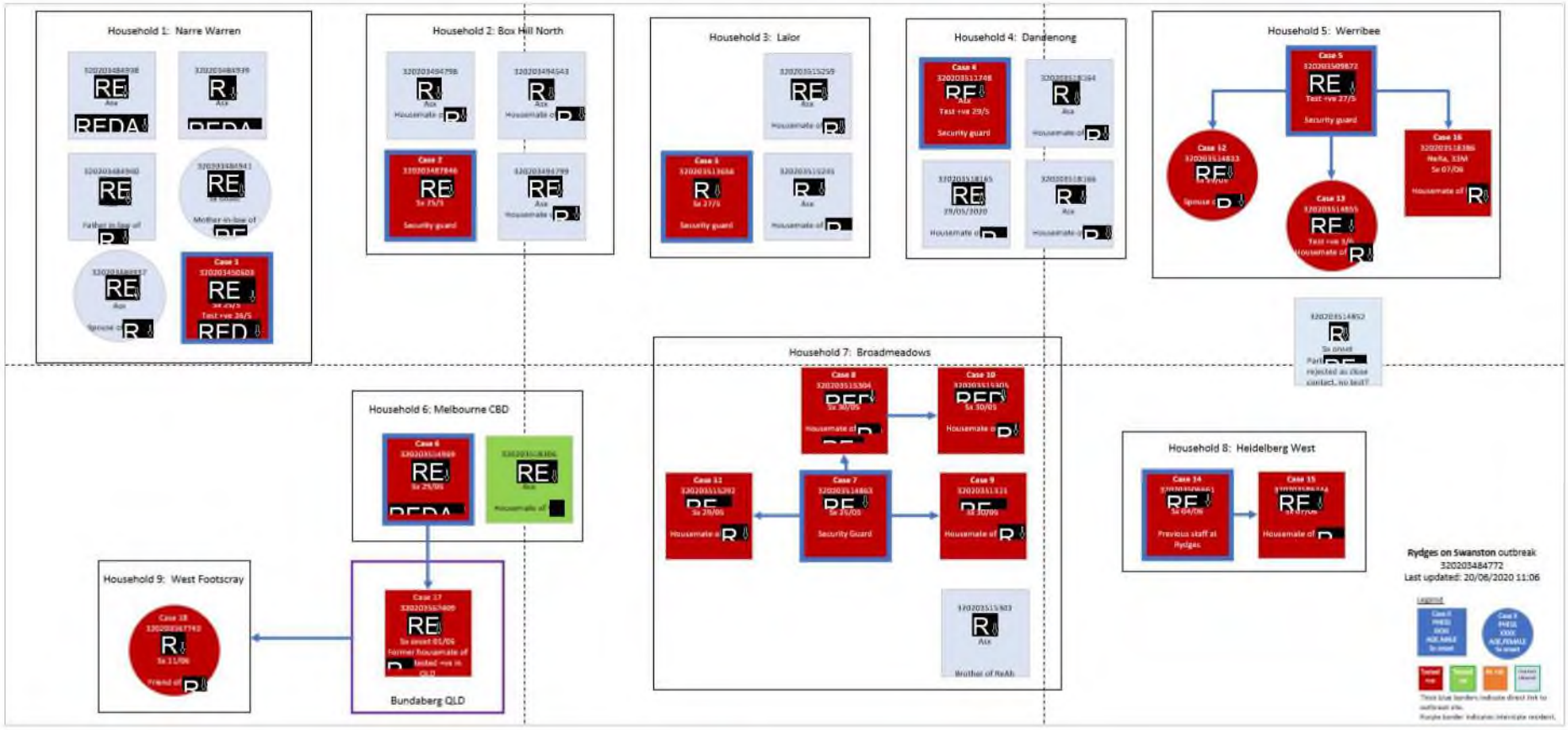


Figure 4: Visio transmission diagram, Rydges Swanston, Updated 21 June 2020, 15:00

Outbreak Management Plan – Stamford Plaza

PHESS ID: 320203632182

OMT Lead updated 25 June 23:20

Epi updated 19 July 10:30

Purpose

The purpose of this document is to provide an update on the current status and public health actions relating to the Stamford Plaza Outbreak.

Governance

Outbreak Management team

Functional role	Name:	Mobile No:	Email:
Outbreak Lead	Sarah McGuinness/REDACTED	REDACTED	REDACTED
Case and Contact Lead	REDACTED		
Epidemiology Lead			publichealth.intelligence@dhhs.vic.gov.au
Joint Intelligence Lead			
Communications and Media Lead			
Outbreak Squad Coordinator	REDACTED		
Administrative Support Officer	REDACTED		

Outbreak Management Team meeting dates

Tuesday 16 June (OMT Lead: Simon Crouch)

Wednesday 17 June at 2pm (OMT Lead: Sarah McGuinness)

Thursday 18 June at 2pm (OMT Lead: Sarah McGuinness)

Friday 19 June at 2pm (OMT Lead: Sarah McGuinness)

Saturday 20 June at 2pm (OMT Lead: Sarah McGuinness)

Sunday 21 June at 2:30pm (OMT Lead: REDACTED)

Monday 22 June at 2:30pm (OMT Lead: REDACTED)

Wednesday 24 June at 1:00pm (OMT Lead: REDACTED)

Thursday 25 June at 3:00pm (OMT Lead: REDACTED)

Friday 26 June at 3:00 pm (OMT Lead: Sarah McGuinness)

Sunday 28 June at 2:30pm (OMT Lead)

Wednesday 1 July at 1:00pm (OMT Lead REDACTED

Outbreak summary (Epi)

A total of **48** cases of COVID-19 have been notified to the department, 26 are in security guards at the hotel, one is a REDACT worker that works in the hotel, one is in a workplace close contact (interview pending, 19 are household contacts, one is an individual who completed their hotel quarantine and subsequently tested positive, and one is REDACTED who was exposed to this person. One case is linked to the REDAC Family Outbreak REDACTED and one case is likely household transmission (housemate of staff members). The first case notified to the department had a symptom onset of 15 June and this was identified by the department as a complex case on 16 June; this was upgraded to an outbreak on 18 June. A case notified to the department prior to Case 1, as part of the REDA Family Outbreak, was retrospectively linked to this outbreak following investigation REDACTED – and this is the only case included in both outbreaks as per discussions with OMT 16/7/2020. One case was admitted to ICU in REDACTE Hospital RE June but has since been discharged. The index case and RE family spent the night at the REDACTED and were discharged on 21 June (index case required rehydration). The cases related to the outbreak are currently isolating in hotel accommodation. There have been five cases admitted to hospital.

A total of 21 households are included in the outbreak. One case initiated a further outbreak at REDACT Aged Care REDACTED Two cases in Household 1 had links to the REDA Family Outbreak, one was linked to Stamford on July 4.

Variable	Value
Total Confirmed cases	48
Total active cases	6
Relationship to exposure site	Staff: 26
	Household: 18
	Other: 2
	Resident: 1
	Unknown: 1
Sex distribution	Female: 12; Male: 36
Age (median (range))	26.5 RED
Indigenous	Indigenous: 1; Non-Indigenous: 46; Unknown: 1
Date of first diagnosis	14 June 2020
Date of first symptom onset	10 June 2020
Date of most recent symptom onset	04 July 2020
Total hospitalisations	4
Current hospitalisations	0
Total ICU admissions	1
Current ICU admissions	0
Deaths	0
Presumptive first case	-
Close contacts (active)	572 (49)
Casual contacts (active)	90 (79)
Actions (high level)	-

Situation

The Stamford Plaza was operating as a mandatory quarantine hotel and is closed to the public. The index case[redacted] was notified to the department on 16 June in a contracted staff member (security guard) who worked at the Stamford Plaza hotel on Little Collins Street. The case did not attend work whilst symptomatic and was tested when they developed symptoms on 15 June. However, the case worked two shifts at the hotel during their infectious period on[redacted] June [redacted] The source of acquisition for this case is unknown.

The case lives with[redacted]. Their home situation is[redacted] children are [redacted] – they are well known to the DHHS child protection team. The primary carer is [redacted] and t[redacted] to have supervised contact. The[redacted] [redacted] attend childcare full time. They have no other family support available. The [redacted]. The parents are [redacted] require an interpreter.

Department outbreak control squad nurses visited the hotel site to assess the situation. They have advised that the hotel and security staff are not adequately educated in hand hygiene and PPE and their work is not visibly zoned for safe containment of COVID19 cases, suspected cases and quarantined close contacts. There is therefore a risk of fomite and person-to-person cross contamination. Face-to-face education to staff was provided.

Further cases were notified between 13 June and 18 July. The hotel remains closed.

Epidemiological and clinical investigation

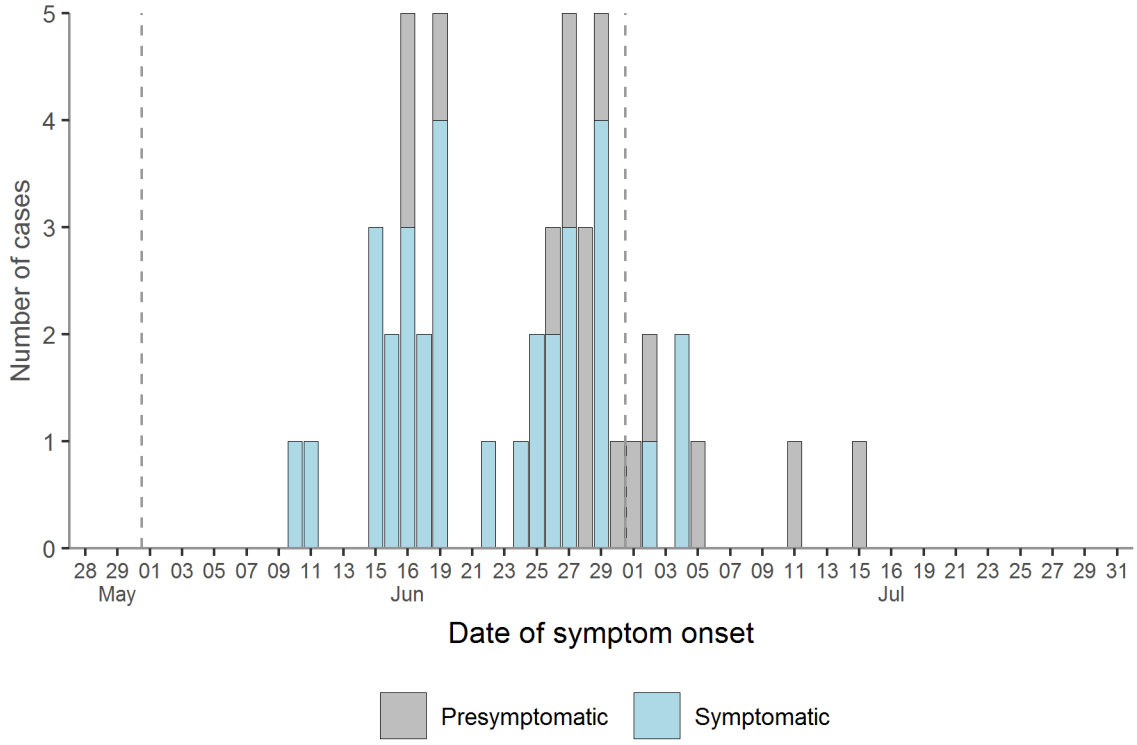


Figure 1: Epidemic curve for Stamford Plaza Outbreak by date of symptom onset* as of 17 July 2020

*for asymptomatic cases, calculated symptom onset date is used

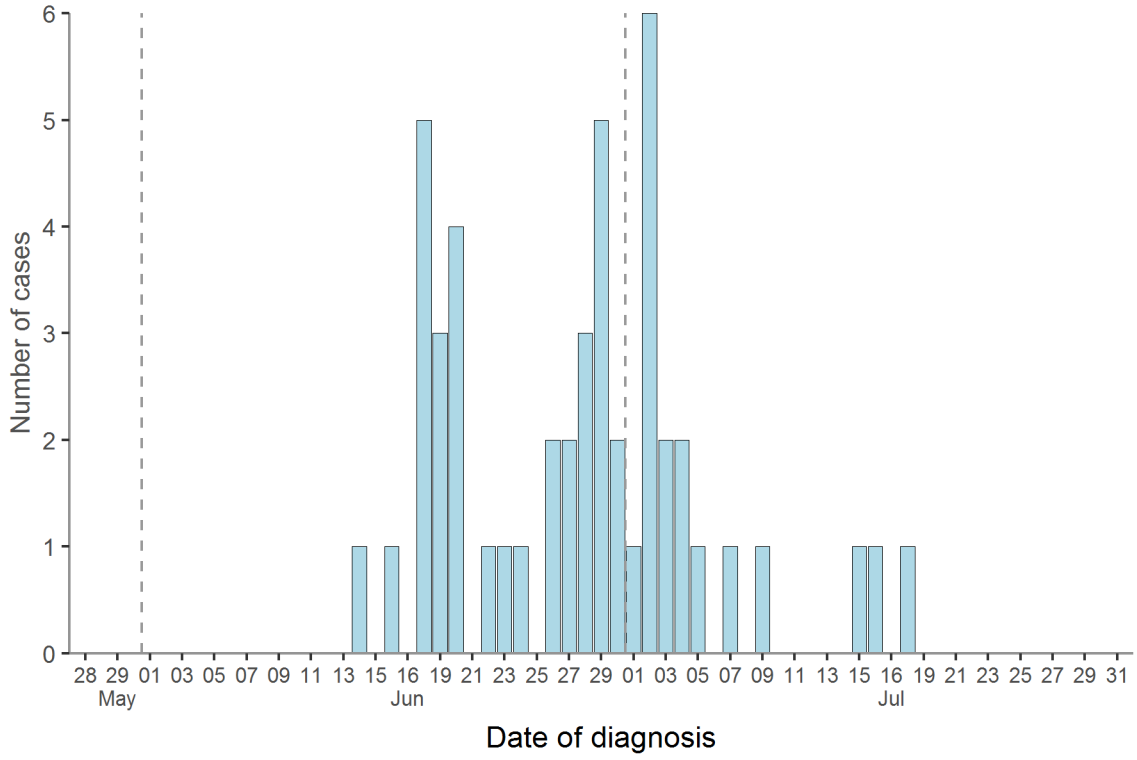
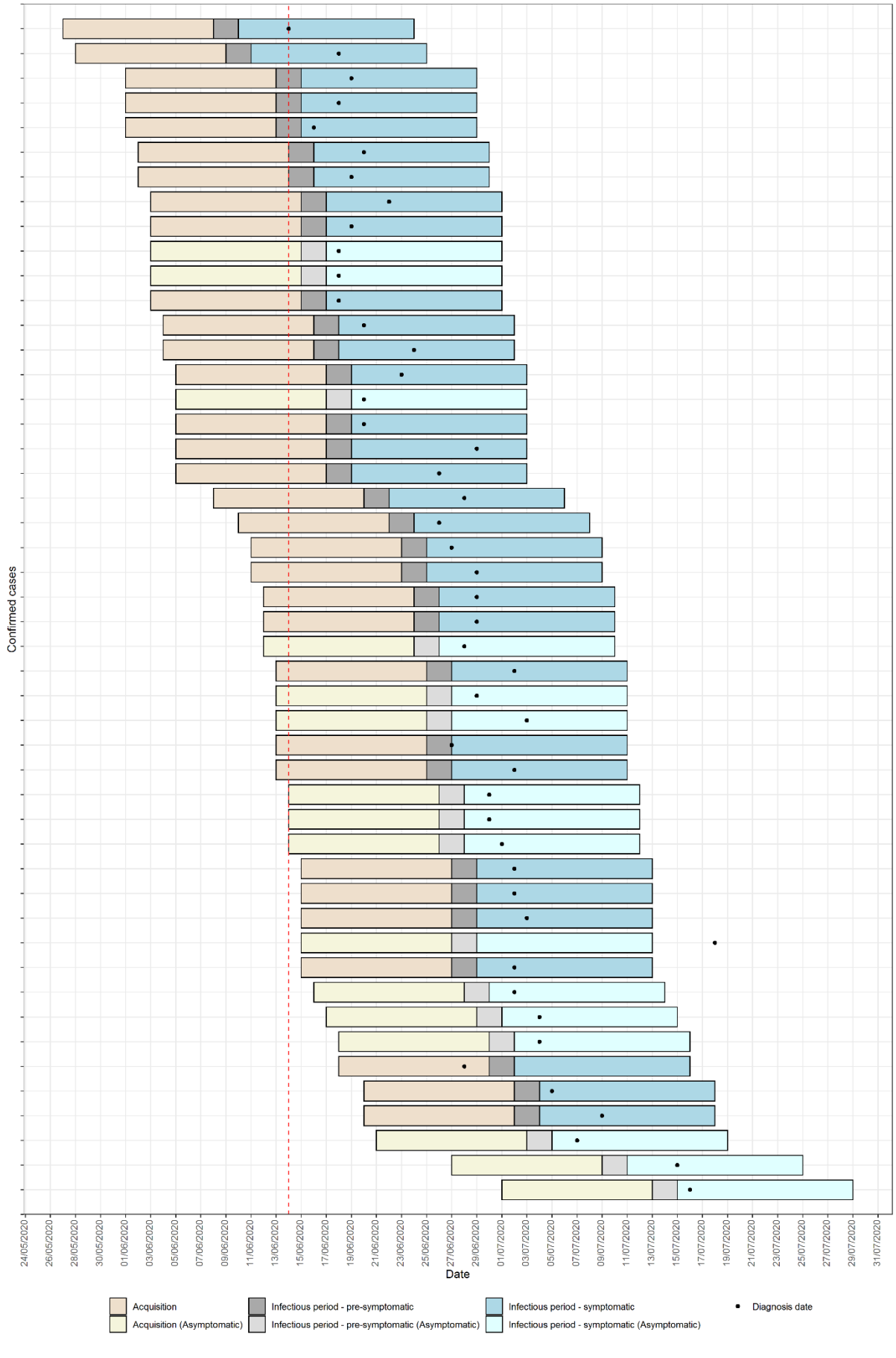


Figure 2: Epidemic curve for Stamford Plaza Outbreak by date of diagnosis as of 17 July


Confirmed cases
24/05/2020
26/05/2020
28/05/2020
30/05/2020
01/06/2020
03/06/2020
05/06/2020
07/06/2020
09/06/2020
11/06/2020
13/06/2020
15/06/2020
17/06/2020
19/06/2020
21/06/2020
23/06/2020
25/06/2020
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09/07/2020
11/07/2020
13/07/2020
15/07/2020
17/07/2020
19/07/2020
21/07/2020
23/07/2020
25/07/2020
27/07/2020
29/07/2020
31/07/2020
Date
Acquisition
Acquisition (Asymptomatic)
Infectious period - pre-symptomatic
Infectious period - pre-symptomatic (Asymptomatic)
Infectious period - symptomatic
Infectious period - symptomatic (Asymptomatic)
Diagnosis date

Figure 3: Onset date and incubation period for confirmed cases, Stamford Plaza Outbreak

Case definitions

Current COVID-19 case definition

A confirmed case who has attended the Stamford Hotel on or after 1 June 2020 or is linked to this site through known exposure to a confirmed case who has attended this site.

Outbreak case definitions

Confirmed case: A person tested positive for COVID-19 with an epidemiological link to Stamford Plaza or a confirmed case of this outbreak, with symptom onset (or infectious period) on or after 1 June 2020 (14 days prior to symptom onset of earliest confirmed case).

Close Contact: A person with 15 minutes (cumulative) face-to-face contact, or two hours in an enclosed area with a confirmed case of the Stamford Plaza outbreak on or after 13 June 2020 (two days before symptom onset in the primary case).

In this setting close contacts at risk of infection include

- All staff members and contractors who spent 30 minutes or more at the Stamford Plaza Hotel from Monday 8 June to Wednesday 17 June inclusive are considered close contacts and are being advised to quarantine for a period of 14 days.
- External (non-work, e.g. household, family) close contacts of confirmed cases.

Casual Contact: A person who does not meet the close contact definition but for whom actions are being undertaken.

In this setting casual contacts include

- Staff who were not on those shifts or only worked prior to 11 June with a negative test
- If they have worked on later shifts, are not close contacts (not at risk) and returned a negative test

Epidemiological Link: any person who attended the Stamford Plaza (not as a resident detainee) for longer than 30 minutes on or after 1 June OR a contact of a confirmed case that is part of the Stamford Plaza outbreak.

Close contacts

All staff members and contractors who spent 30 minutes or more at the Stamford Plaza Hotel from Monday 8 June to Wednesday 17 June inclusive are considered close contacts and are being advised to quarantine for a period of 14 days. The total number of exposure site contacts at Stamford Plaza is ~440 including:

- RED security guards
- R DJPR staff
- R Swingshift staff
- RE DHHS staff
- RE hotel staff
- RE YNA nurses
- R Dnata staff
- R Medi7 staff

- [redacted] AOs
- [redacted] Alfred Health nurses (NB: Alfred Health managing these staff)

For the Park Royal, there are ~ 77 identified close contacts:

- MSS Security [redacted]
- YNA nurses - [redacted]
- Swingshift nurses - [redacted]
- DHHS AOs- [redacted]
- DHHS TL – [redacted]
- Alfred- no close contacts identified
- Medi 7- no close contacts identified
- DNATA [redacted]
- Park Royal Hotel staff- no close contacts
- DJPR- still awaiting contact list

Environmental investigation

Department outbreak control squad nurses have visited the Stamford Plaza Hotel site to assess the situation on 16 June and 17 June.

Observations include:

- Alcohol based hand rub scattered over floors in hotel, readily available and visible
- Hand-rub signage posted on floors, not laminated
- Separate team access to bathrooms (Nursing, Security Staff)
- Some security staff wearing masks on floors
- Clinical waste bins were not available on every floor
- Some general waste observed outside hotel rooms
- Independent Hairdressing facility located on ground floor of hotel which is accessed by the public. Proprietor reports [redacted] clients use hotel bathroom facilities on level 1
- Appropriate physical distancing of security staff in staff area
- Nursing staff feeling unsupported with several issues (including supply of masks, increased workload due to COVID-19 testing, insufficient phone points for screening calls)
- Security staff reporting some gaps in knowledge for hand hygiene and PPE, and are unsure what to do when staff report symptoms consistent with COVID-19
- Nurses and PCAs are reportedly wearing full PPE whenever they go to a room of a guest in quarantine or isolation.

Assessment indicates that there is a risk of fomite and person-to-person cross contamination.

Education of staff was conducted at the site.

A site visit by the Outbreak Squad occurred for the Park Royal Hotel. Cleaning at this site was completed on 22 June.

Genomic Investigation

Request:

On 22 June, the department requested genomic analysis of isolates from cases associated with this outbreak. At this point there were 12 cases associated with the outbreak. A list of 13 COVID-19 positive cases identified in the hotel was also provided to MDU for comparison, their details are below in the table.

Analysis was requested to identify if isolates from cases epidemiologically linked to the outbreak cluster genomically together; and also if these sequences cluster with any sequences from positive detainees at the hotel or those reporting recent overseas travel. If the latter were true, it would support the hypothesis of transmission occurring within the hotel from returned travellers in isolation to staff.

Additionally, a case was identified that was epidemiologically associated with both the Stamford Plaza Outbreak and the Hallam Family Outbreak. Genomic analysis was requested to identify if this case had genomic links to both outbreaks and if they cluster with sequences from cases reporting recent overseas travel. Analysis could support the theory of the source of infection being the case associated with the Hallam Family Outbreak and not from overseas returnees.

Diagnosis Date	PHESS	Age group	Sex	Country of origin
13/05/2020	320203272619	REDACTED		REDACTED
15/05/2020	320203159072			
27/05/2020	320203488762			
04/06/2020	320203543220			
04/06/2020	320203543316			
11/06/2020	320203597559			
12/06/2020	320203603442			
14/06/2020	320203619528			
15/06/2020	320203624264			
15/06/2020	320203624265			
16/06/2020	320203625844			
16/06/2020	320203626373			
16/06/2020	320203626374			

Table showing details for positive cases identified in overseas returnees at the Stamford Plaza Hotel

Results:

As of 13 July, MDU has provided information on the genomic links to the Stamford Plaza Hotel Outbreak. There are sequences from 44 cases that link to form two distinct but closely related genomic clusters that include sequences from cases associated with the Stamford Plaza Hotel.

The first genomic cluster includes sequences from 18 cases. This includes 11 cases associated with Stamford Plaza, seven from the Hallam Family Outbreak (one case is associated with both Stamford Plaza and Hallam Family 320203619599) and one case that reports recent overseas travel to

REDACTED The case reporting recent travel was in hotel detention as of 11 June at Stamford Plaza after travelling with REDACTE who reports an earlier symptom onset, but we are yet to have sequence data available for her. This cluster is distinct from but closely related to a sequence in a returned traveller from REDACTED who was in hotel isolation commencing 1 June.

The other genomic cluster contains sequences from 26 cases. This includes 16 from cases associated with Stamford Plaza (including the case that had completed their hotel detention and subsequently tested positive and th REDACTED at drove this case home), six associated with the Hugo Boss Outbreak, two associated with the REDACTE (one case is associated with both Hugo Boss and M REDACT ED) and three cases that reported recent overseas travel and were completing their isolation in the hotel. Of the three cases reporting recent travel, two were from REDACTED and one was from REDACT ED The two cases from REDACTED were travelling REDAC and commenced hotel isolation at the Stamford Plaza Hotel on 11 June. The case from REDACT was in hotel isolation commencing 26 June at a different hotel (The Brady Hotel) and reports a symptom onset of 29 June. It is unclear what epidemiological link this case has to the outbreak.

Genomic analysis suggests that cases associated with the Stamford Plaza Outbreak were introduced to the hotel via returned travellers from overseas. There is genomic evidence of transmission within the hotel.

Hypothesis

Control measures

- 16 June: All staff members and contractors who spent 30 minutes or more at the Stamford Plaza Hotel between Monday June 1 (14 days prior to symptom onset in the case) and Wednesday 17 June have been asked to undergo testing for COVID-19 as soon as possible
- 17 June: A deep clean of the Stamford Hotel commenced at 1pm
- 17 June: Staff members and contractors who spent 30 minutes or more at the Stamford Plaza Hotel on Saturday 13 June and/or Sunday 14 June are now considered close contacts and are being advised to quarantine for a period of 14 days. This includes all staff and contractors who worked day, afternoon or night shifts on Saturday 13 June and all staff and contractors who worked day or afternoon shifts on Sunday 14 June. It also includes security staff who worked the night shift on Sunday 14 June.
- 17 June: Staff members and contractors who spent 30 minutes or more at the Stamford Plaza Hotel between Monday June 1 and Wednesday 17 June but did not work on Saturday 13 June OR Sunday 14 June are considered exposure site contacts. These staff may return to work if they can provide evidence of a negative test result on or after 17 June 2020. Staff should be advised to be aware of COVID-19 symptoms. If they develop any symptoms, they should be advised not to attend work and to seek further testing.
- 18 June: All staff members and contractors who spent 30 minutes or more at the Stamford Plaza Hotel from Monday 8 June to Wednesday 17 June inclusive are considered close contacts and are being advised to quarantine for a period of 14 days.
- 22 June: All staff and contractors who spent 30 minutes or more at the Park Royal Hotel between 18:35 on 16 June and 07:00 on 17 June are considered close contacts. Additionally, all staff who attended the level 5 staff room used by security personnel on 17 June are considered close contacts.
- 22 June: A deep clean of the Park Royal Hotel was completed.

Stakeholder mapping

Authorised officers (DHHS):

- Key contact: Steve Ballard - Commander, Enforcement and Compliance; [redacted]
  [redacted]

Security:

- Key contact: [redacted]
  [redacted]
- [redacted]
-

Stamford Plaza Hotel:

- [redacted]

Your Nursing Agency (YNA)

- [redacted]

SwingShift (mental health nurses)

- [redacted]

Alfred Hospital (nursing staff)

- [redacted]

Medi7 GPs:

- [redacted]

DJPR:

- [redacted]

Operation Soteria

- Key contact: Merrin Bamert, Pam Williams

Hairdressing facility:

- Key contact: REDACTED

Child Protection Services (Relevant for Case 1)

- REDACTED

Issues/risks:

Relating to populations and transmission

Relating to control measures and contact tracing

Relating to communication about the outbreak

Concerns have been raised about potential transmission risk to guests who have been staying in hotel quarantine, as 'fresh air breaks' have been allowed with individuals accompanied by security guards:

- Guests who require fresh air breaks are recorded in CWMS database – data can be accessed by REDACTED from COVID-19 Enforcement and Compliance and his team
- There are no records of which security guards accompany the guests on their breaks/walks
- According to hotel guest register data:
    - 61 guests arrived on 21 May and departed on 4 June
    - 46 guests arrived on 22 May and departed on 5 June
    - 55 guests arrived on 23 May and departed on 6 June
    - 88 guests arrived on 25 May and departed on 8 June
    - 40 guests arrived on 31 May and departed on 14 June
    - 60 guests arrived on 7 June and due to depart on 21 June
    - 208 guests arrived on 11 June and due to depart on 25 June
- On 20 June, plan discussed to send SMS 'pushes' out to guests following departure to hotel prompting them to seek testing in the event of symptoms

Risk communication

Key messages – general public

Media lines for release on 19 June:

“Four new cases have been detected in security contractors at the Stamford Plaza Hotel, which hosts returned overseas travellers in quarantine. This takes the number of cases in this outbreak to six.

As a result of the exhaustive and detailed contact tracing efforts of the department, a link has been discovered between the Stamford Plaza cases and a case in what is now known as the Hallam family outbreak. An adult associated with the Hallam outbreak had previously worked as a security contractor at the hotel, which was revealed to the department only yesterday.

The investigation into these cases is ongoing and all public health actions are being taken, including further contact tracing and deep cleaning.

The department has reinforced the need for infection control procedures to be followed at all times to protect contractors, staff and guests at the hotel.

This was done yesterday when the outbreak control team made another site inspection at the hotel.”

Timeline of outbreak

Date	Action
16 June	Case 1 notified to DHHS
16 June	PAG held and OMT stood up • Decision made to ask all staff who spent 30 min or more on site between 1 June and 16 June to seek COVID-19 testing
17 June	OMT meeting #2 • Decision made to quarantine all staff who worked overlapping shifts with the case during RE infectious period (all staff on day and night shift 13 June; all staff on day shift 14 June, security staff on night shift 14 June)
17 June	Deep clean of Stamford Hotel conducted
18 June	OMT meeting #3
20 June	Case 11 and 12 notified to the department, first household contact external to the facility notified.
21 June	OMT meeting #4
21 June	Case 14 notified to the department
22 June	OMT meeting #5
22 June	Deep clean of Park Royal Hotel conducted
24 June	Case 15 and 16 notified to the department
25 June	Case 17 linked to the outbreak (this case was notified on 22 June)
26 June	Case 18 and 19 notified to the department OMT meeting #6
27 June	Cases 20, 21 and 22 notified to department
28 June	Cases 23 and 24 notified to department OMT meeting #7
29 June	Cases, 25, 26, 27, 28 and 29 notified to department
30 June	Cases 30 and 31 notified to department
1 July	Case 32 notified to department. OMT meeting #8
2 July	Case 33, 34 and 35 notified to department
4 July	Additional 7 cases notified
15 July	Case 47 notified
18 July	Case 48 notified

OMT meeting actions list

Line list

Exposure PHESS ID: 320203632182

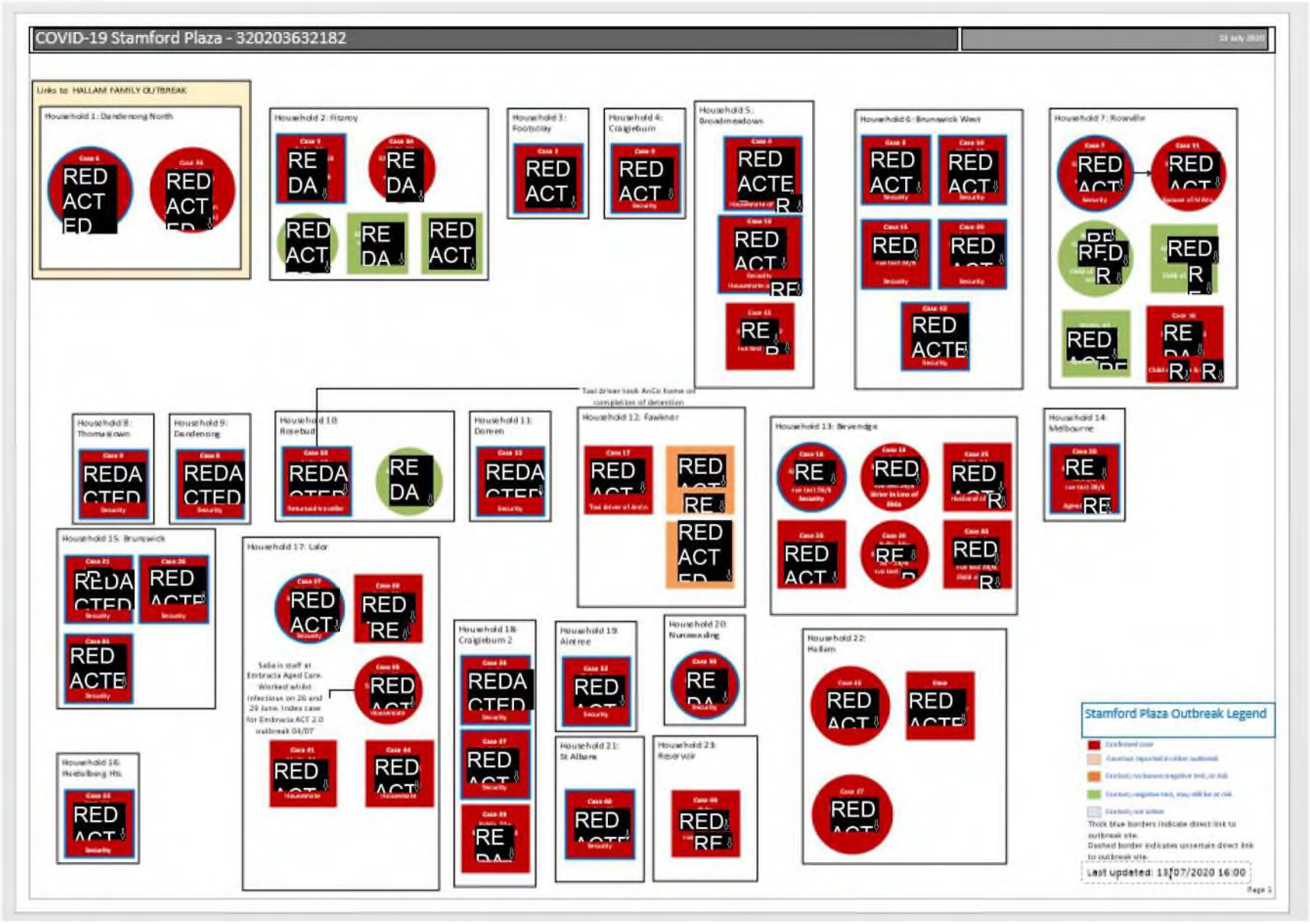
This outbreak is linked to the Halam family though the REDACTED case (320203619599). RE is therefore included in both outbreak s RED contacts are not included here but are in the Hallam Family Outbreak (320203632182). Please check PHESS before entering new IDs as several Hallam Family IDs are marked to note not to link to this Stamford outbreak to avoid double counting.

Case	PHESS ID	Age Group	Sex	Onset Date	Diagnosis Date	Clinical Status	Cluster Link
48	320203821036	REDACTED	REDACTED	NA	2020-07-18	Under investigation	Other
47	320203643137			NA	2020-07-15	Under investigation	Unknown
46	320203847248			NA	2020-07-16	Under investigation	Household
45	320203659232			2020-07-04	2020-07-09	Well, isolation complete	Household
44	320203847222			NA	2020-07-07	Well, isolation complete	Household
43	320203967543			2020-07-04	2020-07-05	Well, isolation complete	Household
42	320203650594			NA	2020-07-04	Well, isolation complete	Staff
41	320203847199			NA	2020-07-04	Well, isolation complete	Household
40	320203650558			NA	2020-07-03	Well, isolation complete	Staff
39	320203847200			2020-06-29	2020-07-03	Well, isolation complete	Household
38	320203544104			2020-06-27	2020-07-02	Under investigation	Household
37	320203556318			2020-06-29	2020-07-02	Well, isolation complete	Household
36	320203676037			NA	2020-07-02	Well, isolation complete	Staff
35	320203847614			2020-06-27	2020-07-02	Well, isolation complete	Household
34	320203847624			2020-06-29	2020-07-02	Well, isolation complete	Household
33	320203872729			2020-06-29	2020-07-02	Home isolation	Household
32	320203650549			NA	2020-07-01	Well, isolation complete	Staff
31	320203659366			NA	2020-06-30	Home isolation	Staff
30	320203797824			NA	2020-06-30	Well, isolation complete	Household
29	320203650560			2020-06-25	2020-06-29	Well, isolation complete	Staff
28	320203650586			NA	2020-06-29	Well, isolation complete	Staff
27	320203650600			2020-06-19	2020-06-29	Well, isolation complete	Staff
26	320203797679			2020-06-26	2020-06-29	Well, isolation complete	Household
25	320203797716			2020-06-26	2020-06-29	Well, isolation complete	Household
24	320203650567			2020-07-02	2020-06-28	Well, isolation complete	Staff
23	320203650569			2020-06-22	2020-06-28	Well, isolation complete	Staff
22	320203659363			NA	2020-06-28	Well, isolation complete	Staff
21	320203650548			2020-06-27	2020-06-27	Well, isolation complete	Staff
20	320203757700			2020-06-25	2020-06-27	Well, isolation complete	Household
19	320203650568			2020-06-19	2020-06-26	Well, isolation complete	Staff

Case	PHESS ID	Age Group	Sex	Onset Date	Diagnosis Date	Clinical Status	Cluster Link
18	320203775646	REDACTED	REDACTED	2020-06-24	2020-06-26	Well, isolation complete	Household
17	320203650539			2020-06-18	2020-06-24	Well, isolation complete	Staff
16	320203687634			2020-06-19	2020-06-23	Well, isolation complete	Household
15	320203695610			2020-06-17	2020-06-22	Well, isolation complete	Other
14	320203659159			2020-06-18	2020-06-20	Well, isolation complete	Staff
13	320203669993			2020-06-16	2020-06-20	Well, isolation complete	Household
12	320203672507			2020-06-19	2020-06-20	Well, isolation complete	Staff
11	320203682536			NA	2020-06-20	Well, isolation complete	Staff
10	320203532956			2020-06-16	2020-06-19	Well, isolation complete	Resident
9	320203661419			2020-06-17	2020-06-19	Well, isolation complete	Staff
8	320203669007			2020-06-15	2020-06-19	Well, isolation complete	Staff
7	320203635486			2020-06-11	2020-06-18	Well, isolation complete	Staff
6	320203655225			2020-06-17	2020-06-18	Well, isolation complete	Staff
5	320203655226			2020-06-15	2020-06-18	Well, isolation complete	Staff
4	320203655227			NA	2020-06-18	Well, isolation complete	Staff
3	320203655972			NA	2020-06-18	Well, isolation complete	Staff
2	320203630268			2020-06-15	2020-06-16	Well, isolation complete	Staff
1	320203619599			2020-06-10	2020-06-14	Well, isolation complete	Staff

Case demographics summary

		N	Perc %
Total		**48**	**100**
Sex	Female	12	25
	Male	36	75
	Unknown	0	0
Age group	0-9	3	6.2
	10-19	2	4.2
	20-29	25	52.1
	30-39	10	20.8
	40-49	2	4.2
	50-59	6	12.5
	60-69	0	0
	70-79	0	0
	80-89	0	0
	90+	0	0
Indigenous status	Indigenous	1	2.1
	Non-Indigenous	46	95.8
	Unknown	1	2.1
Clinical status	Admitted, not known to be in ICU	0	0
	Admitted to ICU	0	0
	Home isolation	2	4.2
	Hospital in the home	0	0
	Deceased	0	0
	Well, isolation complete	42	87.5
	Not recorded	4	8.3


COVID-19 Stamford Plaza - 320203632182
Links to HALLAM FAMILY OUTBREAK
Household 1: Dandenong North
Household 2: Fitzroy
Household 3: Footscray
Household 4: Craigieburn
Household 5: Broadmeadows
Household 6: Brunswick West
Household 7: Rowville
Household 8: Thomastown
Household 9: Dandenong
Household 10: Rosebud
Household 11: Doreen
Household 12: Fawkner
Household 13: Bevendale
Household 14: Melbourne
Household 15: Brunswick
Household 16: Healesville Hts
Household 17: Lalor
Household 18: Craigieburn 2
Household 19: Aintree
Household 20: Nunawading
Household 21: St Albans
Household 22: Hallam
Household 23: Reservoir
Stamford Plaza Outbreak Legend
Last updated: 18/07/2020 16:00

Add additional information below

Shifts worked by staff cases at Stamford Plaza *discrepancies between shifts reported for NaKa between PHESS notes (day shift) and roster (night shift)

Date	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6	Case 7	Case 8	Case 9	Case 12	Case 13
Details	REDACTED										
	320203630268	320203655972	3202036552	320203655226	320203655225	320203635486	320203619599	320203669007	320203661419	320203672507	
	REDACTED										
Role	Security	Security	Security	Security	Security	Security	Security	Security	Security	Security	
Sx onset	15/06/2020	Asymp: test 17/06/2020	Asymp: test 17/06/2020	15/06/2020	17/06/2020	15/06/2020	10/06/2020	17/06/2020	17/06/2020	19/06/2020	
1 June	REDACTED										
2 June											
3 June											
4 June											
5 June											
6 June											
7 June											
8 June											
9 June											

10 June	REDACTED									
11 June										
12 June										
13 June										
14 June										
15 June										
16 June										
17 June										
18 June										

*text in red denotes shifts worked during infectious period (i.e. from 48 hours prior to symptom onset or test date for asymptomatic cases)

Stamford Plaza complex case - OMT

From: "Simon Crouch (DHHS)" REDACTED

To: "Annaliese Van Diemen (DHHS)" REDACTED

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

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

Dear Annaliese

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

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

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

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

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

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

Actions
The OMT agreed to the following immediate actions:

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

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

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

Thanks
Simon

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

RE: Letter for staff - Stamford

From: "Merrin Bamert (DHHS)" <"/o=exchangelabs/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=638a479568194a798229202add0cc910-mbam1802">

To: "DJPR COVID Accom-Lead (DJPR)" <djprcovidaccom-lead@ecodev.vic.gov.au>, "Melody Bush (DHHS)" REDACTED REDACTED REDACTED REDACTED

Cc: "Simon Crouch (DHHS)" REDACTED "Pam Williams (DHHS)" REDACTED , "Michael Mefflin (DHHS)" REDACTED , "Simon Crouch (DHHS)" REDACTED

Date: Wed, 17 Jun 2020 00:35:37 +1000

Thanks REDACTED

Will do

Kind regards

merrin

Merrin Bamert
Commander, Operation Soteria, Covid - 19
Director, Emergency Management, Population Health and Health Protection
South Division
Department of Health and Human Services
Level 5 / 165-169 Thomas Street, Dandenong, 3175
REDACTED

From: DJPR COVID Accom-Lead (DJPR) <DJPRcovidaccom-lead@ecodev.vic.gov.au>
Sent: Wednesday, 17 June 2020 12:34 AM
To: Merrin Bamert (DHHS) REDACTED ; Melody Bush (DHHS) REDACTED REDACTED REDACTED REDACTED REDAC
Cc: DJPR COVID Accom-Lead (DJPR) <DJPRcovidaccom-lead@ecodev.vic.gov.au>; Simon Crouch (DHHS REDACTED Pam Williams (DHHS) REDACTED Michael Mefflin (DHHS) REDACTED
Subject: RE: Letter for staff - Stamford

Hi all,

I confirm that I will send this letter to all relevant DJPR staff.

DHHS will need to send it to hotel, dnata and security staff. Contact details are:

MSS Security
REDACTED

Stamford Hotel
REDACTED

Dnata
REDACTED

Regards
REDACTED
Operations Soteria (COVID-19)
DJPR REDACTED
REDACTED

REDACTED
Department of Jobs, Precincts and Regions
402 Mair Street Ballarat, Victoria Australia 3350
REDACTED

djpr.vic.gov.au

From: Merrin Bamert (DHHS) REDACTED
Sent: Tuesday, 16 June 2020 11:30 PM
To: Melody A Bush (DHHS) REDACTED REDACTED
REDACTED
Cc: DJPR COVID Accom-Lead (DJPR) <DJPRcovidaccom-lead@ecodev.vic.gov.au>; Simon Crouch (DHHS) REDACTED Pam Williams (DHHS) REDACTED
Michael N Mefflin (DHHS) REDACTED
Subject: FW: Letter for staff - Stamford

Hi can we meet first thing tomorrow morning

And organise for this letter to be sent through YNA, SWING, our staff, DNATA, AO's

DJPR will send to security and hotel staff and their own staff.

Kind regards

merrin

Merrin Bamert
Commander, Operation Soteria, Covid - 19
Director, Emergency Management, Population Health and Health Protection
South Division
Department of Health and Human Services
Level 5 / 165-169 Thomas Street, Dandenong, 3175
REDACTED

From: Simon Crouch (DHHS) REDACTED
Sent: Tuesday, 16 June 2020 11:42 PM
To: Merrin Bamert (DHHS) REDACTED
Cc: Annaliese Van Diemen (DHHS) REDACTED ason Helps (DHHS)
REDACTED Braedan Hogan (DHHS) REDACTED
Naveen Tenneti (DHHS) REDACTED Nectaria Tzimourtas (DHHS)
REDACTED Meena Naidu (DHHS REDACTED
Subject: Letter for staff - Stamford

Dear Merrin

Please can you facilitate getting the attached letter to all staff who have worked at the Stamford

Plaza since 1 June. This will include DHHS staff (Operation Soteria and AOs), DJPR staff, hotel staff, medical/nursing staff, security staff and any others I have missed. I believe initial comms at the Rydges did miss some groups.

Thanks
Simon

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

Department of Health and Human Services

50 Lonsdale Street
Melbourne Victoria 3000
GPO Box 4057
Melbourne Victoria 3001
www.dhhs.vic.gov.au
DX 210081

CORONAVIRUS DISEASE (COVID-19) TESTING FOR STAFF AT STAMFORD PLAZA

Dear staff member,

The Department of Health and Human Services (the department) is currently investigating a case of coronavirus disease (COVID-19) in a staff member who has worked at the Stamford Plaza Hotel on Little Collins Street. The staff member did not attend work while unwell and was tested quickly when they became unwell.

The staff member worked two shifts prior to developing symptoms and while they may have been infectious. The department is working to identify close contacts of the case to advise them to quarantine and to monitor for symptoms. The department is thoroughly reviewing all aspects of the infection prevention and control arrangements at the hotel, and an outbreak investigation is current and ongoing.

A thorough clean will take place at the hotel on 17 June. Once complete, any staff who have worked since 1 June 2020 will not be allowed to work at the hotel while the department undertakes its investigation.

As a precaution, and to further investigate the potential sources of this infection, the department will request that all staff who have spent 30 minutes or more at the Stamford Plaza on or after 1 June 2020 to be tested for COVID-19. **Further information about how and where to get tested will be provided to you in a subsequent letter.**

<u>If you have any symptoms associated with COVID-19 please seek testing immediately and isolate at home until you have received your results.</u>

If you have any questions or wish to discuss this information in more detail, please call 1300 651 160.

Yours sincerely

REDACTED

Dr Simon Crouch
Deputy Public Health Commander COVID-19 (Case, Contact and Outbreak Management)
Department of Health and Human Services

16 June 2020

VICTORIA State Government

Stamford Hotel - update on actions re: family, contractors and staff

From: "Sarah McGuinness (DHHS)" REDACTED

To: REDACTED

Cc: REDACTED

Date: Wed, 17 Jun 2020 12:27:25 +1000

Attachments: Stamford Plaza advice on testing letter.pdf (255.6 kB); Copy of Staff Details - SPM.xlsx (14.02 kB); AO Master Roster 12 June to 20 June.xlsx (309.38 kB); Stamford Rosters - June 1 to June 16.xlsx (34.13 kB)

Hi REDACTED

I have sorted through the many emails that Simon REDACTED have forwarded to me and consolidated this information with the information provided by Merrin Bamert (Operation Soteria) and others.

Regarding the contractors & staff groups at the Stamford Hotel:

AOs (DHHS):

- The AO roster from 12-20 June is attached, we will need a roster going back to 1st June to identify people who need to be tested. Some staff (e.g. Team Leader) are included in the attached Stamford Roster - June 1 to June 16
- Steve Ballard (mobile REDACTED, email REDACTED appears to be the key contact (Commander, Enforcement and Compliance), Merrin has been communicating with him.

SECURITY:

- Contact person is REDACTED REDACTED at **MSS security** (REDACTED REDACTED, Merrin has been communicating with RED ACT
- The company subcontract to two other companies called "**The Security Hub (TSH)**" (REDA REDACTED or REDACTED and the "**Ultimate Protection Group (URM)**" (REDACTED
- Merrin Bamert (Op Soteria) has already notified REDACT who has in turn notified the other security companies (who has forwarded the above details)
- The case is employed by TSH and they have been in contact with RED ACT to check on REDA CTED wellbeing.

NURSING:

- The Alfred provide nursing support to the hotels – contact person is REDACTED REDACTE REDACTED I have spoken to REDAC this morning and sent RED the attached letter to distribute to the relevant staff. Still awaiting a staff list.
- YNA provide nursing support – no contact person identified to me yet
- SwingShift provide mental health nursing support – no contact person identified to me yet

MEDICAL:

- Medi7 is the GP group that provides medical support to quarantine hotels – contact person is REDACTED (email: REDACTED). I have spoken to REDA this morning and sent RED the attached letter to distribute to the relevant staff. Still awaiting a staff list.

STAMFORD PLAZA

- Contact person appears to be REDACTED REDACTED, at Stamford Plaza REDACTED REDACTED. There is also a REDACTED, Human Resources Business Partner, at Stamford Plaza (email: REDACTED REDACTED, mobile REDA REDACTE
- We have received the attached spreadsheet (Copy of Staff Details – SPM) with staff

members roles and contact phone numbers, but this does not have information on shifts worked.

HAIRDRESSING FACILITY
- Located on ground floor of hotel and accessed by public
- IPC nurse report advises that the clients use hotel bathroom facilities on L1 (crossover with staff?)
- Need to clarify movement of clients (e.g. entrance & overlap with hotel staff / facilities)

Regarding the family, I have looked through the PHESS notes and emails and identified the following sites of potential interest:

GP CLINIC
- REDA has contact the GP practice this morning and spoken to the practice manager REDACTE. The practice has a deep clean every 2 days. The GP states RE work PPE and the case was in the consultation room for <15 minutes (approx. 5-6 mins); no close contacts identified (case appropriately socially distanced in waiting room)

ST VINCENT'S HOSPITAL:
- Swabbed on 15 June, presumably at COVID-19 testing clinic
- Admitted to St Vincent's on 16 June (driven by REDA CTED
- REDA has spoken to Richmond from Infection Control team @ St Vincent's who confirms that case was isolated on admission and no public health actions have therefore been identified at St Vincents

EARLY FOUNDATIONS CHILDCARE CLIFTON HILL:
- Childcare drop-off only (2-3 min), unsure which days.

HOUSING ESTATE:
- Family lives in [redacted] ACTED Fitzroy REDACTED
- Listed occupants of apt RED are the REDACTED
- [redacted]
- No public health actions for now, unless case provides info re: contact with other residents
- The contact in the housing area of DHHS (North East Melbourne) is REDA CTED - REDACTED

SUPERMARKETS:
- Attended Coles & Woolworths Collingwood (?during infectious period) – both supermarkets have been contacted

In terms of testing, the attached letter has been approved by REDA and will be distributed to the appropriate contractors today. I've already sent it to the Alfred and Medi7 and will link in with Merrin to see who she has distributed it to REDACTED (Health & Wellbeing) has sent the letter and some information to COVID-19 testing sites (health services, community health, GP clinics and retail sites).

TRIM Folder = IIEF/20/2003
Index case = 320203630268

I'm still awaiting a call-back from Merrin Bamert to find out which of the above agencies she has contacted and provided the new letter to today.

I'm in the process of booking an OMT meeting for 2pm.

Kind regards,

Sarah

Dr Sarah McGuinness
Infectious Diseases Physician
Case, Contact and Outbreak Management | COVID-19 Surge Workforce
Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
REDACTED

Department of Health and Human Services

50 Lonsdale Street
Melbourne Victoria 3000
GPO Box 4057
Melbourne Victoria 3001
www.dhhs.vic.gov.au
DX 210081

17 June 2020

CORONAVIRUS DISEASE (COVID-19) TESTING FOR STAFF AT STAMFORD PLAZA

Dear staff member,

The Department of Health and Human Services (the department) is currently investigating a case of coronavirus disease (COVID-19) in a contracted staff member who has worked at the Stamford Plaza Hotel on Little Collins Street. The staff member did not attend work while unwell and was tested quickly when they became unwell.

The staff member did work two shifts prior to developing symptoms and while they may have been infectious. The department is working to identify close contacts of the case to advise them to quarantine and to monitor for symptoms. A thorough clean will take place at the hotel on 17 June. Once complete, any staff who have worked since 1 June 2020 will not be allowed to work at the hotel or at any other location while the department undertakes its investigation.

As a precaution, and to further investigate the potential sources of this infection, the department is requesting all staff who have spent 30 minutes or more at the Stamford Plaza on or after 1 June 2020 to undergo testing for COVID-19, preferably on **Wednesday 17 June** or as soon as possible thereafter**.** For information on testing centre locations and opening hours, call the 24-hour coronavirus hotline 1800 675 398 or see our website: https://www.dhhs.vic.gov.au/getting-tested-coronavirus-covid-19

Please present this letter when you attend for testing and ensure that the testing provider reads the information on page 2. You will need to provide your name, date of birth and a contact mobile phone number in order to get your results. Your result will be provided to you by the testing provider.

If you have any symptoms associated with COVID-19 please seek testing immediately and isolate at home until you have received your results. If you are do not have any symptoms there is no need for you to isolate while you await your results, but you should not work until you receive further instructions from the department.

If you have any questions or wish to discuss this information in more detail, please call 1300 651 160.

Yours sincerely

REDACTED

Dr Simon Crouch
Deputy Public Health Commander COVID-19 (Case, Contact and Outbreak Management)
Department of Health and Human Services

VICTORIA State Government

17 June 2020

Dear testing provider,

Thank you for providing COVID-19 testing relating to a case of COVID-19 in a staff member who has worked at the Stamford Plaza Hotel that is currently being investigated by the Department of Health and Human Services (the department).

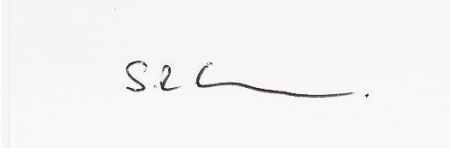
We are asking all staff who have spent 30 minutes or more at the Stamford Plaza on or after 1 June 2020 to undergo testing for COVID-19, preferably on Wednesday 17 June.

Please note the following:

- A single oropharyngeal and deep nasal swab for COVID-19 PCR should be taken; the same swab that has been used to sample the oropharynx should be utilised for deep nose sampling (i.e. one swab per patient only).
- As the testing provider, your organisation is responsible for advising individuals of their test results
- To ensure outbreak samples are prioritised for testing in laboratories please follow these instructions:
    - The outside of the sample bag/s must be clearly labelled with a red sticker and marked for URGENT PRIORITY sample
    - The pathology slip must be clearly labelled with a red sticker and marked as URGENT PRIORITY; Priority 1 – OUTBREAK (Quarantine Hotel Staff Member)
    - The sample should be clearly labelled with:
        - the patient's name
        - patient's date of birth
        - marked as P1 (to indicate the priority group)
    - Samples should be sent to VIDRL, 792 Elizabeth Street, Melbourne, 3000

If you have any questions or wish to discuss this information in more detail, please call 1300 651 160.

Yours sincerely



Dr Simon Crouch
Deputy Public Health Commander COVID-19 (Case, Contact and Outbreak Management)
Department of Health and Human Services

PHESSv3 - Public Health Event Surveillance System - Production

Enter Case ID or Search Term... Search Nico Keogl

Event Summary

Basic Information	
PHESS ID:	REDACTED
Condition:	Exposure Site
Exposure Site:	COVID-19 202006 Stamford Plaza Outbreak
Status:	Open (Change to Closed)
Linked Events/Contacts:	440 linked event(s)/contact(s) (View)
Attachments:	0 attachment(s) (Add)
Notices:	**LabelPrinter Notifier (1)** Print label for: ▼ **Geocoder Notifier (1)** Geocoding pending [Geocode Now] **General Notifications (1)** [ ][ ][ ]

Notes (Add/Edit | Show My Notes)

REDACTED

contacted

Edit Event Properties | Copy Event

Event Data | Lab Results | Concerns | Exposure Site | Tasks | Calendar | Event Properties | Event History

Exposure Site

Name	Address	Status
COVID-19 202006 Stamford Plaza Outbreak	VIC	Active

Edit Exposure Site

Basic Information | Address Information | Demographic History | Notes

Basic Information	
Exposure Site Name:	COVID-19 202006 Stamford Plaza Outbreak
Reference Number:	
Government/Private:	
Category:	Other
Contact person:	
Location within site:	
Deduplication Status:	Done
Additional detail:	
Status:	Active
Contact Information	
Street 1:	
Street 2:	
Suburb/town:	
State:	VIC
Postcode:	
Country:	Australia
Home Phone:	
Mobile Phone:	
Work Phone:	
Email:	
Fax:	
Pager:	
Contact Method:	
Type:	Home
Geocode Status:	Pending
Latitude:	-999.0
Longitude:	-999.0
GIS Process Status:	Error
Locator Status:	
Match Type:	
Geocode Quality:	-1
LGA:	
Region group:	
Region:	
DHHS Division:	
Service area:	
Melway:	
PHN:	
Remoteness:	
Meshblock:	

FW: Interim report on Stamford from outbreak squad nurses

From: REDACTED REDACTED

To: "Merrin Bamert (DHHS)" REDACTED 'Pam Williams (DHHS)" REDACTED "Sarah McGuinness (DHHS)" REDACTED

Cc: REDACTED REDACTED

Date: Wed, 17 Jun 2020 13:59:27 +1000

Hi all REDACTED is our Outbreak Squad Lead for Stamford.
Nicky

From: REDACTED REDACTED
Sent: Wednesday, 17 June 2020 1:52 PM
To: REDACTED REDACTED
Cc: REDACTED @d
Subject: Interim report on Stamford

Stamford Hotel on Little Collins St_ Key concerns from IPC visit 17/06/20_ REDACTED RN

1. The staff of this hotel and MSS security staff are not adequately educated in hand hygiene and PPE.
2. Their work is not visibly readily zoned for safe containment of COVID19 cases, suspected cases and quarantined close contacts.

Problem: Complex case/Outbreak
An MSS security guard who last worked on Sunday 14/6/20 tested positive (result 16/6/20)

Security Guards who all attended a gathering on 70 people including now confirmed cases need to be assessed for possible exposure and quarantined and all be instructed in PPE and hand hygiene

Apart from 3 MSS security guards sent home 15/5/20; at time of visit nobody knew their exposure status because letter for staff from DHHS had not been distributed.

Recommendation: Contain case(s) by containing security staff

Individuals
- Case & Contact will find close contacts asap.Advise case and contact to look broadly within hotel staff
- Educate new staff in hand hygiene and PPE and recognition clean and dirty zones.

Contain security guard room
- IPCON IPC advised General Manager to distribute the letter asap.
- Teach security appropriate handwashing and PPE use
- Coffee machine should be removed from Security Guard room until further notice
- Food service to security guard room needs to be all disposable nothing should go back to the kitchen

Problem: Risk of fomite and person to person cross contamination: Security Guard room to room housing Nursing PCA & DHHS staff.

Today I saw REDACTED -DHHS officer- inside security guard room handling paperwork with head of security before returning to room with Nursing PCA and DHHS staff.

Recommendation: Keep DHHS PCA Nurses area clean

- If the Green room with Nursing PCA and DHHS staff is to stay clean no security guards including head of security should enter it

- Elevators need to be divided into clean a dirty or chlorine wiped after every use
- Nothing should go from any room back to the kitchen

Nurses and PCAs
Reportedly are wearing full PPE whenever they go to a room of a guest in quarantine or isolation but that needs to be checked.

Recommendation: Keep Stanford contained
- Do not send staff from one hotel to another.
- For example AO from DHHS was AO at Novotell yesterday.

Kind regards,

REDACTED
Infection Prevention & Control Outreach Team Nurse, COVID-19

IPC Outbreak Management I Legal and Executive Services Division

Department of Health and Human Services | 50 Lonsdale Street, Melbourne, Victoria, 3000
M. REDACTED
E. REDACTED

Outbreak Management team meeting

Date & Time: 2:00pm Wednesday 17 June 2020

Outbreak Name / Setting: Stamford Plaza

Purpose of Meeting: Daily update

Attendees: Braedan Hogan, REDACTED Merrin Bamert, REDACTED Sarah McGuinness, Simon Crouch, REDACTED Jason Helps, REDACTED REDACTED

Action list

Date allocated	Action	Responsible person	Due date	Date Completed
17/06/2020	Contact head of microbiology at the testing lab – find out specifics of the test result for the case	REDAC Sarah / REDACTED	17/06/2020	
17/06/2020	Conduct an offline discussion to confirm arrangements for the case's [redacted] children	Braedon / REDACTED	17/06/2020	
17/06/2020	Support communication with the family regarding accommodation based on outcome of above discussion	REDACTED	17/06/2020	
17/06/2020	Follow up DET for translated hygiene training / communications which can be shared with security staff and affected families	REDACTED	17/06/2020	
17/06/2020	Prepare comms for DHHS staff who attended Stamford Plaza and send to Merrin	Sarah / Simon	17/06/2020	
17/06/2020	Review Rydges comms for guests, modify as required, and start distribution / translation	REDACTED Sarah	17/06/2020	
17/06/2020	Schedule next OMT meeting for 18/06/2020	Sarah	17/06/2020	
17/06/2020	Schedule outbreak squad visit to Stamford	REDACTED	17/06/2020	
17/06/2020	E-mail Simon and Sarah with proposal for Stamford staff attendance this afternoon	Merrin	17/06/2020	

Notes

Situation:

- Single case – security guard working at the Stamford Plaza
  - 15/06/2020 symptom onset
  - Worked 13/06/2020 and 14/06/2020 REDACTED at Stamford Plaza
    - Floor by floor movements are not known by the employer – the hotel may have this information
  - CCOM have not been able to contact the case today
  - Case's RE has not been answering the phone
  - The case is still at St Vincent's, as are immediate family members (REDACTED all of whom are household contacts)
  - Family members have been swabbed today at St Vincent's
    - All [redacted] returned negative results
    - REDACTE have runny noses
  - R other close contact has been identifies so far through work: contacted and quarantining
- The security roster has not been received yet – this will determine many of the other contacts
  - First names only have been given for potential contacts at this point in time – the CCOM team are unable to start to contact these persons with this information only

Risks:

- Early morning security team meetings take place daily with overlapping shifts (day and night) in a 6x6m room
- Case definition: the following definitions are in place until further investigation of contacts has been completed
  - Anyone who worked an overlapping shift will need to be considered as a close contact in the short term; this includes:
    - All staff on day shift 13/06/2020
    - All staff on night shift 13/06/2020
    - All staff on day shift 14/06/2020
    - Security staff on night shift 14/06/2020
    - Night shift on 12/06/2020 is NOT included as this was prior to the infectious period for the case, which was conservatively designated as 13/06/2020
- Areas of concern at Stamford:
  - Guards have a room that they sit in which was allegedly not used by DHHS staff, however DHHS staff have been observed in hat room to process paperwork
  - Elevators are shared
  - Some bathrooms are shared
  - Security members also go into DHHS room
- If we can confirm that security aren't going into shared service areas (i.e. the kitchen) then we can exclude people working in those areas from close contacts
  - Breakfast services are delivered to the rooms; it is unclear if trays and their contents are then returned directly to the kitchen
  - Staff delivering meals will be designated close contacts until proven otherwise
- Staff who attended work outside of infectious period and return negative test results can return to work
  - This includes staff who worked prior to 13/06/202, and people who worked on 15, 16, or 17/06/2020
  - Testing for these people is for acquisition for the case, rather than transmission from the case
- Getting the case's REDACTED to understand needs of quarantine will be challenge (low medical literacy)

Control Measures:

- Commercial cleaning started 1pm today; this will take a long time to complete
- Testing for staff: all who worked since 1/06/2020 are recommended for testing
    - This can be done at any COVID testing centre
    - Letters have been sent out to all contractors (security, YNA Wingsihft, Alfred, DJPR, DHHS, hotel)
- Outbreak squad feedback:
    - Understanding of clean/dirty areas and hygiene practices are low among security staff
    - "Creative" use of masks has been noted; glove use is OK
    - Alcohol based hand sanitiser has been made available but is not seen to be used often
    - Further PPE and hygiene education needs to be provided for security staff, but also hotel staff
        - Outbreak squads have developed training packages
        - DET have developed messages in many languages which can be shared
        - REDA language is spoken by the family – resources have previously been developed and translated by DPC – these should be used

Comms:

- The hotel was named earlier today
- Comms for commission housing have been contacted to spread hygiene messaging
- Strong community groups exist in the REDACTED
- No comms have gone out to guests at the Stamford Plaza yet
    - There are about 240 guests
    - Language requirements are not yet clear
    - Fact sheets should be prepared as a priority and slid under all doors – in English first, then translated as appropriate
- Comms need to go out to DHHS staff who have been on site

Other Issues:

- This afternoon and this evening's shifts are severely impacted as testing is still progressing
    - A duty manager is required; one duty manager has not worked since Thursday 11/06/2020
        - Provided that this person is asymptomatic, we can permit that individual to return to work this afternoon
    - An REDAC has been living in hotel in a room as RE is concerned about spreading the virus to RE family; this REDACT can provide support this afternoon / this evening if required
    - Stamford's GM is negotiating with the CEO in Sydney to potentially fly down staff to keep hotel working (with DHHS support)
- REDACTED


REDACTED

Outbreak Management team meeting

Date & Time: 2:00pm Thursday 18 June 2020

Outbreak Name / Setting: Stamford Plaza Outbreak

Purpose of Meeting: Daily update

Attendees: REDACTED, Breadan Hogan, Sarah McGuinness, REDACTED REDACTED Naomi Bromley, REDACTED Merrin Bamert, REDACTED REDACTED

Action list

Date allocated	Action	Responsible person	Due date	Date Completed
17/06/2020	Contact head of microbiology at the testing lab – find out specifics of the test result for the case	REDAC Sarah / REDA	17/06/2020	
~~**17/06/2020**~~	~~Conduct an offline discussion to confirm arrangements for the case's~~REDACTED	~~Braedon /~~ REDACTED	~~17/06/2020~~	17/06/2020
~~**17/06/2020**~~	~~Support communication with the family regarding accommodation based on outcome of above discussion~~	REDA CTED	~~17/06/2020~~	17/06/2020
17/06/2020	Follow up DET for translated hygiene training / communications which can be shared with security staff and affected families	REDA CTED	17/06/2020	
17/06/2020	Prepare comms for DHHS staff who attended Stamford Plaza and send to Merrin	Sarah / Simon	17/06/2020	
~~**17/06/2020**~~	~~Review Rydges comms for guests, modify as required, and start distribution / translation~~	REDACTE D ~~Sarah~~	~~17/06/2020~~	17/06/2020
~~**17/06/2020**~~	~~Schedule next OMT meeting for 18/06/2020~~	~~Sarah~~	~~17/06/2020~~	17/06/2020
~~**17/06/2020**~~	~~Schedule outbreak squad visit to Stamford~~	REDACT	~~17/06/2020~~	17/06/2020
~~**17/06/2020**~~	~~E-mail Simon and Sarah with proposal for Stamford staff attendance this afternoon~~	~~Merrin~~	~~17/06/2020~~	17/06/2020
18/06/2020	Schedule next OMT for tomorrow	Sarah	18/06/2020	
18/06/2020	Investigate REDACTED – is this person linked to another outbreak setting?	Sarah	18/06/2020	
18/06/2020	Follow up the existing case for details of movements in/around his home building	CCOM	18/06/2020	
18/06/2020	Organise SCC relief cell / City of Melbourne to provide toys / etc for the case's family (there is nothing in the REDA townhouse and this will make	REDACT ED	18/06/2020	

	REDACTED			

Notes

Situation:

- Info received from VDRL 7 mins ago: there are 3 positives from this morning's run
  - All are security guard contractors
  - More info to come – formal notification to the department has not been received yet
- There are 242 names on the security contractor's list but not clear who worked what dates
- RE guards carpool – one of these persons is a positive case REDACTED (positive). Others are REDACTED (awaiting result) and REDACTED (awaiting result) – all live in REDACTED is not on the list from VDRL.
- Existing case:
  - Family have been relocated to a REDACTED
  - The case is still symptomatic
  - The family are still asymptomatic
  - All are doing OK
  - Case's visit to the childcare centre: dropped kids off, on site 1-2mins only, no contact with staff members
  - The existing case worked on every floor during shifts when he was infectious
  - The existing case also attended 2 meetings – 12/06/2020 evening (approx. 20mins), and 13/06/2020 morning (approx. 20mins) – there awere reported to be up to 130 people attended
- Close contacts identified so far:
  - Approximately 40 nursing staff
  - Approximately 8 AOs
  - Hotel staff still being confirmed
- Going forward it will be best for the contact team to deal directly with contractor groups
  - A template or guidance about exactly what they need is usually provided but was not given to Merrin
- Samples have been requested to be couriered to VDRL
  - Some people got tested before getting letters and therefore are going to take a while to find in the system
- Each of the contractors will need to keep track of their own staff; text message can be used to show that they're clear to return to work. We won't contact individuals who are not close contacts with results but we can share with contractors.

Risks:

- No action is required at the childcare centre where the existing case dropped off RE DA children duye to only being on site for 1-2 minutes and having no interactions with staff
- CCOM need to follow up the case for details of his movements around his home building
-

Control Measures:

- Outbreak squad visit: arrived 4:30 yesterday
  - Cleaning not done as expected – poor PPE practices – rectified by outbreak nurses
  - New cleaners organised today
  - Originally directed only to complete high touch services
  - Cleaning was grossly insufficient
  - Bathrooms were not done
  - Elevators were not done
  - IPC nurses had to complete cleaning for elevators and bathrooms

    - The company has been decontracted
- Testing is planned to take place at the case's public housing residence:
    - Directive from [redacted]: organise onsite testing at [redacted] public housing (symptomatic testing only)
    - The team are currently on site and will stay for a few days
    - Posters etc being put in place to reinforce key messaging

Comms:

- Comms did not go to Stamford guests yesterday due to the requirement for the DPC bunker to review comms
    - EM comms approved the document this morning; it has been sent to the hotel, they should have placed copies under everyone's doors
    - Only the English version has been passed on so far - translation is taking place and is hoped to be completed tomorrow
- There is no need to communicate to tenants of the case's building that a case has been found in in a resident

Other Issues:

- Operations of hotel are compromised by staffing issues – close contacts being contacted to ensure that people can return asap
    - If people did not work on 13-14/06/2020 and a negative result is available, they can return to work. This includes persons who worked on or after 15/06/2020 but this may change based on further test results.
- Request made for other services to help the family (toys, colouring books for kids etc); SCC relief cell / City of Melb council can provide this

Add/Edit Notes

Add Note

Text:

2500 characters left

Category: Generic

Type: Public

Save Close

Previous Notes

REDACTED 08/07/2020 10:40 **Category:** Generic **Type:** Public	Spoke to REDACTED identified possible close contacts.Close contacts identified and same sent to intel. Need initial contact. Housekeeping Staff and maintenance identified.
REDACTED 07/07/2020 12:35 **Category:** Generic **Type:** Public	REDACTED - clarify if there needs to be any close contacts identified.
REDACTED 25/06/2020 15:41 **Category:** Generic **Type:** Public	Update on close contacts for the Stamford plaza as below; Security - 229 close contacts identified, 6 outstanding to be contacted YNA- 70, all contacted Swingshift - 5 all contacted AO - 22 all contacted DNATA- 13, all contacted Hotel staff- 56- 4 outstanding to be contacted Alfred - 10 close contacts DJPR- 2 , all contacted Medi 7- 6 all contacted DHHS staff - 8 all contacted Royal park close contacts; Security 56 - 14 outstanding to be contacted YNA- 14, 2 outstanding to be contacted Swingshifft- 3, all contacted AO- 3 all contacted DHHS TL - 1, all contacted Alfred- no close contacts identified Medi 7- no close contacts identified DJPR- await contact list (if any) Hotel staff- no close contacts DNATA- 3, all contacted
REDACTED 24/06/2020 13:30 **Category:** Generic **Type:** Public	Email to DJPR requesting staff details for Park Royal. Contact number given to call back.
REDACTED 24/06/2020 10:40 **Category:** Generic **Type:** Public	REDACTED at Alfred Health Infection Control - check whether any nursing staff working at Park Royal Airport qualify as close contacts for 16th PM and 17th Am June. RE advised 3 nurses worked at Park Royal during that time that had no clinical contact so do not qualify as close contacts and don't need to be called.
REDACTED 23/06/2020 22:32 **Category:** Generic **Type:** Public	Contact for Park Royal REDACTED
REDACTED 21/06/2020 22:33 **Category:** Generic **Type:** Public	Spoke to REDACTE DHHS, Informed RE of actions to date in regards to Park Royal Melbourne and RED s happy with same. Asked that RE escalate and reinforce that security guards should only work in one hotel and not switch between 2 if at all possible.
REDACTED 21/06/2020 22:16 **Category:** Generic **Type:** Public	Case REDACTED Case linked to SP. Worked in Royal Park Melbourne whilst infectious on a r REDACTED REDACTED has been informed template text message has been sent to RE to send to employees who worked day shifts 16/06 & 17/06 and night shift 16/06. Anyone who was currently working was sent home immediately. RPM Ao REDACT was informed and i asked to escalate same and identify and close contacts. Simone Crouch contacted DHHS,. ** Contact person from RPM for next 48hrs is REDA REDACTED
Sarah McGuiness [vicn9xk] 20/06/2020 21:37	Brief summary of outbreak thus far: - The Stamford Plaza is currently closed to the public and is operating as a mandatory quarantine hotel. - Twelve cases have now been notified to the department linked to this outbreak. Ten are contracted staff

Category: Generic **Type:** Public	members (security guards) who work at the Stamford Plaza hotel on Little Collins Street. One case is a household contact of a contractor. The remaining case is an individual who completed a 14 day mandatory quarantine at the Stamford Plaza hotel on 14 June and has subsequently developed symptoms. This case tested negative on 11 June and positive on 17 June. - One of the above cases, notified to the department on 14 June, initially stated that they were not engaged in paid employment but have subsequently been revealed to work as a contractor at the as a Stamford Plaza; this case is linked to the Hallam family outbreak and is currently hospitalised in a High Dependency Unit (HDU). - All staff who worked 30min or more at the hotel in ther period 8 - 17 June inclusive are considered exposure site close contacts. Over 400 exposure site close contacts have been identified (~240 are security staff)
REDACTED **Category:** Generic **Type:** Public	I have requested the list of those who worked night shift on the 17/6/20 as security with MSS security from REDACTED Awaiting same.
REDACTED 19/06/2020 15:47 **Category:** Generic **Type:** Public	DJPR: attempted to call REDACTED, no answer. Email sent to clarify if they had staff on ground between 1/6/20 and 17/6/20. Await reply. REDACTED
REDACTED 18/06/2020 22:43 **Category:** Generic **Type:** Public	-All stakeholders contacted in relation to the new infectious period. YNA Swingshift Security and Hotel staff. Dnata not answering but email has been sent. -4 new positive security guards all interviewed. -Emailed RED from hotel management for a more detailed spreadsheet R will send on in the morning.
REDACTED 18/06/2020 16:56 **Category:** Generic **Type:** Public	Stakeholder update: MSS security REDACTED
REDACTED 17/06/2020 16:02 **Category:** Generic **Type:** Public	Main stakeholders identified for Stamford Plaza: REDACTED REDACTED REDACTED -Dhhs Merrin Bamert REDACTED
REDACTED 16/06/2020 22:18 **Category:** Generic **Type:** Public	Complex case notified late on 16 June. Security Guard at Stamford Plaza Hotel (a quarantine hotel). OMT held 22:30 16 June for immediate public health actions

Stamford Hotel outbreak update

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

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

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

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

Good evening all,

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

Initial status today:

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

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

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

Actions this evening:

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

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

Please let me know if there are further questions.

Kind Regards

Annaliese

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

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

The Department of Health and Human Services respectfully acknowledges the Traditional Owners of Country throughout Victoria and pays its respect to the ongoing living cultures of Aboriginal peoples.

Rydges on Swanston Handover

From: "Sarah McGuinness (DHHS)"REDACTED

To: "Finn Romanes (DHHS)"REDACTED, "Annaliese Van Diemen (DHHS)" REDACTED, REDACTED

Cc: "Simon Crouch (DHHS)" REDACTED EDACTED REDACTED

Date: Sat, 30 May 2020 22:48:39 +1000

Attachments: PUBLIC HEALTH - HEALTH PROTECTION - COVID-19 - Rydges on Swanston - 320203484772.tr5 (304 bytes); COVID-19 Outbreak Management Report Rydges on Swanston 30 May 2020.tr5 (292 bytes)

Hi All,

Here is a quick handover re: the Rydges Hotel outbreak. TRIM links for outbreak folder and latest version of the Outbreak Management Report attached.

REDACTED – I assume that you will be taking over as OMT Lead from tomorrow.

Brief summary (further information in table below):

- 7 cases have now been notified – 1 hotel staff, 5 security staff and 1 mental health nurse (note: attack rate amongst security guards = 5/42; 12%)
- Cases 1-6 have all worked night shifts at Rydges on Swanston on or before 21st May; work schedule not yet clear for case 7 (discrepancies between what the case is reporting and what the manager has advised)
- One is asymptomatic, the other 6 have symptom onset dates ranging from 24/05/2020 – 29/05/2020 (3 have same symptom onset date = 25/05/2020)
- Current hypothesis is that the hotel is the source of infection, either from environmental contamination in the week prior to 25th May, or possibly from an unrecognised case(s) or known hotel case; at this stage it is not possible to definitively determine. Support for this hypothesis includes preliminary genomic results, which show that the **isolate for Case 1**REDACTED **clusters with a family of four COVID-19 cases who are returned travellers from** REDACTED **and are currently in hotel quarantine at Rydges hotel**. The REDACTED role includes cleaning duties, including of the lift used to transport cases.
- It is likely that environmental risk has been attenuated following a deep clean of the premises on 28th May.
- There is a gradient of risk for staff. Staff who spent more time on site are likely to be at higher risk of exposure. The highest risk period for exposure most likely extends from 7 days prior to symptom onset in cases, until the date that a deep environmental clean & disinfection was performed (date range: 18th – 28th May). There is a lower risk for exposure in the period from 11th-17th May (8-14 days before symptom onset in cases) and in the period from 28th May – today (when a second environmental clean is planned).

Key public health actions to date:

- Full environmental clean & disinfection (28 May) & instigation of regular daily cleaning & disinfection of common areas & frequently touched surfaces (previously only household products used in these areas)
- All staff who attended the site between 11 and 28 May asked to seek testing for COVID-19. Majority of staff tested on site with samples couriered to VIDRL (results received from VIDRL include 127 negative and 2 positive results); some staff have been tested elsewhere – this includes 19 x Alfred Health nurses (all negative).
- As of today (30 May), any staff member who attended the Rydges on Swanston Hotel for 30 minutes or more during the period 18 May to midday on 28 May inclusive is now being asked to **self-quarantine for 14 days** since their last visit to the hotel. Staff should monitor themselves for symptoms of COVID-19 and seek testing if symptoms develop. The department's Case and Contact team will make contact with each of these staff members directly to provide further advice and support.
    - Staff who attended the site between 11 and 17 May only and who have tested negative for COVID-19 can continue with their daily activities (including work).
    - Staff who have only attended the site from midday on 28 May should not work elsewhere for now while the investigation is underway.
- Education and training on appropriate PPE by outbreak squad nurses (particular focus on security staff who have been wearing non-approved porous gloves)

Outstanding tasks & ongoing risks:

- Process of contacting all close contacts **incomplete** – has started today, but will be ongoing tomorrow
    - Letter for close contacts has been approved by Clare for distribution (HHSD/20/245957)
    - Close contacts include 22 household contacts (between the 7 cases), 9 Alfred staff, 2 Medi7GPs, 36 Unified Security staff, 32 YNA nurses, 3 outbreak squad nurses, 1 DJPR staff member, as well as staff from DHHS, SwingShift and the hotel (I don't have the exact numbers for these cohorts currently)
- **Symptomatic close contacts** – of the 22 household contacts, **5 are symptomatic** (risk for more cases) – three of the cases (who live in crowded households) are in emergency accommodation at Rydges, and arrangements are being made for 2 symptomatic contacts of a case to get emergency accommodation
- Ongoing staffing has been highlighted as an acute issue following today's decision to quarantine a large cohort of staff
- **Testing arrangements** for day 11 testing of Close Contacts will need to be made – I would suggest engaging with REDACTED to utilise hospital testing centres, as there were significant issues with using the nurses at the hotels due to very poor documentation and information sharing, which has made it challenging to send negative results out to staff via SMS as per our arrangement with the hotel (the Medi7 GPs only follow up positive results, and the usual process for relaying negative results to people in mandatory quarantine is for VIDRL to fax results to the hotel and staff to slide them under the doors – we felt this wasn't an appropriate process in

this instance).
- Further liaison with WorkSafe from Monday (they have definitely been informed of the first two cases, but may not know the full extent of the outbreak)
- Chasing further Genomics – REDACTED has sent the relevant PHESS IDs to REDACTE who will ask MDU to expedite sequencing

Good luck over the next few days!

Kind regards,
Sarah

Date	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6	Case 7
Details	REDACTED						
	REDACTED						
	REDACTED						
Role							
Sx onset	25/05/2020	25/05/2020	Asymptomatic	27/05/2020	25/05/2020	29/05/2020	24/05/2020
11 May	REDACTED						
12 May							
13 May							
14 May							
15 May							
16 May							
17 May							
19 May							
20 May							
21 May							
22 May							
23 May							
24 May							
25 May							
26 May							

From: Finn Romanes (DHHS) REDACTED
Sent: Saturday, 30 May 2020 4:39 PM
To: Annaliese Van Diemen (DHHS) REDACTED
Cc: Simon Crouch (DHHS) REDACTED REDACTED; Sarah McGuinness (DHHS) REDACTED
Subject: FW: Rydges on Swanston - meeting summary, actions and communication

The is one of the main outbreaks happening at the moment.

I'm sure more will develop on this, but this snapshot is a very good point in time for our handover later tonight.

Finn

Dr Finn Romanes
Public Health Commander
Novel Coronavirus Public Health Emergency

REDACTED
Department of Health and Human Services
State Government of Victoria

From: Sarah McGuinness (DHHS) REDACTED
Sent: Saturday, 30 May 2020 1:10 PM
To: Merrin Bamert (DHHS) REDACTED Clare Looker (DHHS) REDACTED ; Finn Romanes (DHHS) REDACTED REDACTED Anthony J Kolmus (DHHS) REDACTED DHHS EmergencyCommunications (DHHS) <em.comms@dhhs.vic.gov.au>; Euan Wallace (DHHS) REDACTED Public Health Intelligence <publichealth.intelligence@dhhs.vic.gov.au>; Jason Helps (DHHS) REDACTED Meena Naidu (DHHS) REDACTED ; sccvic.stateintelmgr@scc.vic.gov.au; REDACTED ; press (DHHS) <press@dhhs.vic.gov.au>
Subject: RE: Rydges on Swanston - meeting summary, actions and communication

Hi All,

I've just made one minor edit to the following dot point (red text)

- As of today (30 May), any staff member who attended the Rydges on Swanston Hotel for 30 minutes or more during the period 18 May to midday on 28 May inclusive is now being asked to **self-quarantine for 14 days** since their last visit to the hotel. Staff should monitor themselves for symptoms of COVID-19 and seek testing if symptoms develop. The department's Case and Contact team will make contact with each of these staff members directly to provide further advice and support.

Kind regards,
Sarah

From: Sarah McGuinness (DHHS)
Sent: Saturday, 30 May 2020 12:58 PM
To: Merrin Bamert (DHHS) REDACTED Finn Romanes (DHHS) REDACTED Anthony J Kolmus (DHHS) REDACTED (DHHS) REDACTED DHHS EmergencyCommunications (DHHS) <em.comms@dhhs.vic.gov.au>; Euan Wallace (DHHS) REDACTED Public Health Intelligence <publichealth.intelligence@dhhs.vic.gov.au>; Jason Helps (DHHS) REDACTED Meena Naidu (DHHS) REDACTED sccvic.stateintelmgr@scc.vic.gov.au; REDACTED press (DHHS) <press@dhhs.vic.gov.au>
Subject: Rydges on Swanston - meeting summary, actions and communication

Dear All,

Thank you for attending the OMT meeting for Rydges on Swanston this morning.

The following information is a summary of discussion points and actions from the meeting and is not for further distribution:

Key discussion points:

- All cases have worked night shifts at Rydges on Swanston on or before 21st May; three have same symptom onset date (25/05/2020), two are asymptomatic, and one is yet to be interviewed
- Cases include hotel staff REDACTED security staff (x4) and mental health nurse (x1)
- Current hypothesis is that the hotel is the source of infection, either from environmental contamination in the week prior to 25th May, or possibly from an unrecognised case(s) or known hotel case; at this stage it is not possible to definitively determine. Support for this hypothesis includes preliminary genomic results, which show that the isolate for Case 1 REDACTED clusters with a family of four COVID-19 cases who are returned travellers from REDACTED and are currently in hotel quarantine at Rydges hotel. The REDACTED role includes cleaning duties, including of the lift used to transport cases.
- It is likely that environmental risk has been attenuated following a deep clean of the premises on 28th May.
- There is a gradient of risk for staff. Staff who spent more time on site are likely to be at higher risk of exposure. The highest risk period for exposure most likely extends from 7 days prior to symptom onset in cases, until the date that a deep environmental clean & disinfection was performed (date range: 18th – 28th May). There is a lower risk for exposure in the period from 11th-17th May (8-14 days before symptom onset in cases) and in the period from 28th May – today (when a second environmental clean is planned).

Summary of actions (and people responsible)

- Assessment
  - Complete interview of Case 6 and assess potential close contacts at Marriott hotel **[CCOM]**
  - Chase genomics over the coming week – **[Intell]**
- Management
  - Cleaning – deep environmental cleaning on an at least daily basis (preferably twice daily for frequently touched surfaces) **[Operation Soteria / DJPR]**

    - PPE training and discussion with security company management **[Outbreak Squad, CCOM]**
    - Embed IPC lead from a health service **[Merrin Bamert]**
    - Limit movement of guests today only, until full environmental clean **[CCOM]**
    - Maintain block on new admissions of well people until full clean today **[Operation Soteria]**
    - Quarantine staff who attended for 30 min or more between 18 May and midday on 28 May inclusive for 14 days from last exposure **[CCOM]**
        - Will involve a letter for quarantined persons
- Consequences
    - Emergency accommodation arrangements for cases – case 5 **[DHHS Commander]**
- Communication
    - Liaise with WorkSafe **[CCOM]**
    - Communicate with hotel guests **[CCOM / Operation Soteria]**
    - Communicate to various work groups/agencies:
        - Operation Soteria **[Merrin Bamert]**
        - AOs REDACT
        - YNA, Swingshift, Alfred, Unified Security **[CCOM, CC Merrin Bamert]**

The following is information that can be communicated with staff and agencies:

- Four new cases of COVID-19 have been detected in staff who worked at Rydges on Swanston, Melbourne, bringing the total for this outbreak to six.
- The new cases were identified as part of testing initiated after the first case was identified among staff working at hotel.
- The source of acquisition for new cases remains under investigation and all potential sources of transmission will be explored
- Thorough cleaning of relevant parts of the hotel has been undertaken, alongside contact tracing, isolation and quarantine of close contacts. A full investigation is underway to review all possible causes of transmission within the hotel, including looking into links between affected staff.
- Infection control experts from the DHHS outbreak squad are attending the hotel to review all infection prevention and control procedures.
- All staff who attended the site in the period from 11 to 28 May should seek testing for COVID-19 if they have not already done so.
- As of today (30 May), any staff member who attended the Rydges on Swanston Hotel for 30 minutes or more during the period 18 to 28 May inclusive is now being asked to **self-quarantine for 14 days** since their last visit to the hotel. Staff should monitor themselves for symptoms of COVID-19 and seek testing if symptoms develop. The department's Case and Contact team will make contact with each of these staff members directly to provide further advice and support.
- Staff who attended the site between 11 and 17 May only and who have tested negative for COVID-19 can continue with their daily activities (including work).
- Staff who have only attended the site from midday on 28 May should not work elsewhere for now while the investigation is underway.

Kind regards,
Sarah

Dr Sarah McGuinness
Infectious Diseases Physician
Case, Contact and Outbreak Management | COVID-19 Surge Workforce
Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
REDACTED

Outbreak Management team meeting

Date & Time: 2:00pm Friday 19 June 2020

Outbreak Name / Setting: Stamford Plaza Outbreak

TRIM reference: IIEF/20/2003

Purpose of Meeting: Daily update

Attendees: REDACTED Merrin Bamert, REDACTED Pam Williams, REDACTED Sarah McGuinness, REDACTED

Action list

Date allocated	Action	Responsible person	Due date	Date Completed
17/06/2020	Contact head of microbiology at the testing lab – find out specifics of the test result for the case	REDACTED Sarah / REDACTED	17/06/2020	
17/06/2020	Follow up DET for translated hygiene training / communications which can be shared with security staff and affected families	REDACTED	17/06/2020	
17/06/2020	Prepare comms for DHHS staff who attended Stamford Plaza and send to Merrin	Sarah / Simon	17/06/2020	
~~**18/06/2020**~~	~~Schedule next OMT for tomorrow~~	~~Sarah~~	~~18/06/2020~~	17/06/2020
~~**18/06/2020**~~	~~Investigate REDACTED – is this person linked to another outbreak setting?~~	~~Sarah~~	~~18/06/2020~~	17/06/2020
18/06/2020	Follow up the existing case for details of movements in/around his home building	CCOM	20/06/2020	
~~**18/06/2020**~~	~~Organise SCC relief cell / City of Melbourne to provide toys / etc for the case's family (there is nothing in the Quest townhouse and this will make caring for the children difficult for the case)~~	REDACTED	~~18/06/2020~~	17/06/2020
19/06/2020	Provide an update on alternative accommodation arrangements for close contacts and cases	REDACTED	19/06/2020	
19/06/2020	Provide an update on cleaning		19/06/2020	
19/06/2020	Contact Child Protection to determine a contingency plan for children of RED		19/06/2020	
19/06/2020	Schedule next OMT for the same time 20/06/2020	Sarah	19/06/2020	

Notes

Situation:

- 2 additional cases
  - Both are [redacted]
  - Both carpool with the [redacted] known [redacted] cases
  - Interviews are still going – no further info at present
  - 1 had symptom onset 17/06/2020
  - The other was en route to hospital
- Alternative accommodation arrangements are in train for many of the new cases and close contacts
- In total there are 7 cases associated with the [redacted] family and 8 associated with the Stamford Plaza outbreak – both figures include the security guard linked to both settings (see "Risks" section)
  - At this stage they need to be treated as separate outbreaks due to great distance between them and single link
  - Discussion will take place later on regarding merging of outbreaks if the link between settings will be confirmed

Risks:

- The link between the security guard case and the [redacted] outbreak setting has been confirmed – [redacted] (contacted through the other outbreak setting) confirmed that [redacted] works as a [redacted] and has worked at Stamford Plaza, but didn't give full details
  - At the initial interviews with this family through the other outbreak setting, everybody said that nobody in the family was employed
  - This [redacted] had symptom onset on 10/06/2020, worked 2 days prior to onset, and worked 4 days with symptoms
  - The period of risk at the hotel is now to be considered as 8/06/2020 to 17/06/2020; this has been communicated to Operation Soteria and all relevant contractors

Hypothesis:

- The [redacted] linked with another outbreak setting (with symptom onset [redacted]/06/2020, which was earliest of all cases in this outbreak setting) may have acquired COVID from the hotel setting
- The virus may have been brought into the family setting by this case and infected family members including the [redacted]
  - Last contact with the [redacted] was 8/06/2020
  - Genomics are to be used to support this hypothesis by comparing virus in the security guard against the virus from cases in guests within the Stamford Hotel

Control Measures:

- Significant issues relating to cleaning
  - Deep clean still not done
  - Proper disinfectants have not been used
  - The outbreak squad are now are talking to the team leader
  - The understanding of clean vs dirty is very very poor
  - Fresh air breaks were taking place for guests – these have been put on hold again
  - The team of cleaners onsite are the same ones that have been there the whole time
  - Spotless are cleaning the positive hotel – we can ask them to clean Stamford Plaza as well
  - There is a general lack of understanding of the process and the products that are suitable for completion of a deep clean. [redacted] team are working to rectify this. The endorsed cleaning guide has been sent back out to [redacted] for implementation.

Comms:

- Media lines that went out today made the link between the Hallam outbreak and this outbreak
- Annaliese Van Diemen will speak directly to Monash CEO and IPC lead to convey this information, and that a link will be made in media today

Other Issues:

- REDA complex family situation (REDACTED with supervision requirements)
  - Symptoms have progressed and will likely need hospitalisation
  - St Vincent's Hospital in the Home visited to review RE DA condition
  - It has been determined that RE DA needs hospitalisation
  - Child Protection need to be contacted to determine a contingency plan for the children
- New staff have been located to run the hotel
  - The only person suitable as a trainer is someone identified as close contact
    - This person is asymptomatic and has had a negative test
    - Arrangements have been made for training to take place with physical distancing, PPE, and IPC support
    - DJPR have supported this proposal
- Media are parked up outside the hotel; unfortunately we can't tell them to move as it's public space but this impacts the fresh air policy and breaches privacy if guests are let out

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Other Hotel Issues

- There has been a new case identified linked to Rydges
  - This is a close contact of the REDACTED RED ACTE who recently went to QLD (who was a close contact of a case)
  - This person is now in quarantine
- Next meeting this time tomorrow

Outbreak Management team meeting

Date & Time: 2:30pm Monday 22 June 2020

Outbreak Name / Setting: Stamford Plaza Outbreak

TRIM reference: IIEF/20/2003

Purpose of Meeting: Daily update

Attendees: REDACTED Merrin Bamert, REDACTED REDACTED Braedan Hogan, REDACTED Pam Williams, REDACTED

Action list

Date allocated	Action	Responsible person	Due date	Date Completed
17/06/2020	Contact head of microbiology at the testing lab – find out specifics of the test result for the case	REDACTED Sarah REDA	17/06/2020	
17/06/2020	Follow up DET for translated hygiene training / communications which can be shared with security staff and affected families	DHHS Comms	17/06/2020	
~~**17/06/2020**~~	~~Prepare comms for DHHS staff who attended Stamford Plaza and send to Merrin~~	~~Sarah / Simon~~	~~17/06/2020~~	22/06/2020
18/06/2020	Follow up the existing case for details of movements in/around his home building	CCOM	20/06/2020	
19/06/2020	Provide an update on alternative accommodation arrangements for close contacts and cases	REDACTED	19/06/2020	
19/06/2020	Provide an update on cleaning		19/06/2020	
~~**19/06/2020**~~	~~Contact Child Protection to determine a contingency plan for children of~~ REDACTED		~~19/06/2020~~	22/06/2020
~~**19/06/2020**~~	~~Schedule next OMT for the same time 20/06/2020~~	~~Sarah~~	~~19/06/2020~~	20/06/2020
22/06/2020	Contact Park Royal for details of the common areas that security staff use	REDACTED	22/06/2020	
22/06/2020	draft e-mail to DJPR accommodation lead requesting CCTV footage (including what is required and in what spaces)		22/06/2020	
22/06/2020	Investigate potential crossover of security staff and other staff, and current cleaning practices		22/06/2020	

Notes

Situation:

- There are now 14 confirmed cases linked to this setting

    - The most recent case was notified last night: a security guard who worked during their acquisition (but not infectious) period
    - This case is a housemate of another Stamford security guard who is a case
    - The case also worked 1 night during their infectious period at the Park Royal Hotel
- Park Royal Hotel:
    - About 15 people identified as close contacts – mainly security staff
        - Still waiting for some contacts' info to come through from the hotel
    - A letter should have gone out to all staff at the Park Royal last night
    - Affected security staff asked to self isolate
    - The case allegedly had no interactions with staff from other areas of the hotel
    - A brief handover conversation takes place with 6-8 other security employees
    - The outbreak squad observed security at Park Royal as being well separated from other staff (especially on night shift)
    - Consensus: close contacts are all security staff who worked on 16 and 17/06/2020
    - We can broaden the definition of close contacts to include anyone who worked the same shift or was part of a handover on the preceding / following shifts
- A large number of staff members have not received test results from 17/06/2020
    - It is unclear whether YNA or other nurses completed testing
    - DHHS are working with VDRL to get results
    - Some people went to their own providers; the letter for contacts that would have enabled expedited testing went out too late and were not available at the time many went to respiratory clinics
- REDACTED
    - RED REDACTED
        - Friday – just RED due to deterioration in presentation
        - Saturday – deterioration in RED and RE spouse – both hospitalised
    - All were transported to Northern on Saturday for overnight admission
    - RED was tested again and returned another negative result, and was discharged back to Quest
    - The family are in better health today and are back at REDA CTED

Control Measures:

- An additional clean will take place at Park Royal at 1pm today

Other Issues:

- YNA staff have been available 24/7 (until Sunday) to support REDACTED
    - This included coordinating with ambulances for the Saturday hospitalisation
    - There were significant delays and stress throughout the process for the family and the YNA staff
- REDACTED

Outbreak summaries - 24 June

From: Clare Looker (DHHS) REDACTED

To: Simon Crouch (DHHS) REDACTED, Annaliese Van Diemen (DHHS) REDACTED Brett Sutton (DHHS) REDACTED

Cc: Jacinda de Witts (DHHS) REDACTED, Kym Peake (DHHS) REDACTED REDACTED REDACTED @minstaff.vic.gov.au>, REDACTED REDACTED @minstaff.vic.gov.au>, Melissa Skilbeck (DHHS) REDACTED REDACTED Jackie Kearney (DHHS) REDACTED Terry Symonds (DHHS) REDACTED sccvic.stateintelmgr@scc.vic.gov.au, Jason Helps (DHHS) REDACTED Andrea Spiteri (DHHS) REDACTED Katherine Ong (DHHS) REDACTED REDACTED Sarah McGuinness (DHHS) REDACTED u>, Helen Mason (DHHS) covid-19projectmanagementoffice (DHHS) <covid-19projectmanagementoffice@dhhs.vic.gov.au>, Finn Romanes (DHHS) REDACTED, Public Health Intelligence <publichealth.intelligence@dhhs.vic.gov.au>, press (DHHS) <press@dhhs.vic.gov.au>, Annaliese Van Diemen (DHHS REDACTED, Annalise Bamford (DHHS) REDACTED

Date: Wed, 24 Jun 2020 23:37:31 +1000

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

Dear Annaliese and Brett,

Please see today's outbreak summaries below.

Brimbank Cluster

- * Five cases across two households in Airport West and Keilor East
- * First case notified on 16 June and is REDACTED manager. Two work close contacts identified from infectious period (no patients). Details confirmed with workplace.
- * First case attended family gathering and children's birthday party while infectious (asymptomatic at the time).
- * Two household contacts of first case now positive (no school attendance while infectious).
- * Third and fourth case identified in related household on 24 June 2020. Numerous social close contacts from two family gatherings/children's birthday party.

REDACTED

- * Three staff members have tested positive at a dental clinic REDACTED
- * Two staff members had symptom onset on 16 June. The third had symptom onset on 19 June. Potential acquisition within the clinic from a staff member or patient is being examined

- * All staff members of the clinic have been classified as close contacts and are being asked to seek immediate testing. They will also be required to have day 11, end of quarantine testing
- * The department has requested patient lists since 2 June to explore any potential exposures from patients
- * Contact tracing for close contacts from outside of the clinic is under way
- * The clinic has been closed and has undertaken a clean
- * An outbreak squad visit is planned for 25 June.

Albanvale Primary School

- * Two staff members and a household contact of one of the staff members have tested positive.
- * The first identified case was REDACTED A and was notified on 19 June with a symptom onset date on 17 June.
- * The second case was notified on 21 June and is a REDACTED The symptom onset date for case two is 15 June.
- * The third case was notified on 21 June and is a household contact of the first case. Symptom onset date for this case is 18 June.
- * Both DET and the school are aware of the cases. A list of close contacts of REDACTE REDACTE has been provided by the school principal. Close contacts are currently being contacted by the department and asked to isolate.
- * **Students in both teachers' classes are household** contacts of known cases linked to the Keilor Downs outbreak. Both children are reportedly asymptomatic currently. Immediate testing for these 2 students has been declined by their parent. They have previously expressed being agreeable to testing at the day 11 mark, however are now refusing this also. This family is of a REDAC background and support from within the REDACT community has been organised.
- * Five siblings from this household attend the school, and there is a cousin of the family who is also a pupil at the school.
- * The school has been closed since 20 June and will remain closed until testing of all staff and students has been completed. Given testing capacity this week the school will need to remain closed throughout the week. Testing for students via Sunshine Hospital and staff via Deer Park has been organised, and a letter from DHHS is being distributed by the School.
- * A site visit by the outbreak squad was completed on 20 June and no major concerns were identified.
- * Cleaning was conducted on 21 June.
- * The third case worked while potentially infectious at an Interpack worksite in Deer Park. This worksite and Worksafe have been notified. The workplace closed for a clean and close contacts were identified by the workplace. The worksite plans to reopen on 23 June.

North Melbourne Family (previously H&M Northland)

- * A total of 10 cases have been linked to H&M Northland. The majority of these have been appearing in one extended family and the outbreak has been renamed to reflect this.
- * The first case worked two shifts at H&M Northland during his infectious period (while asymptomatic). The store was closed and cleaned following identification of the first case.
- * A small group of co-workers were identified as close contacts and isolated immediately.
- * A second case was identified on 19 June among these close contacts. The second case has not worked while infectious.
- * The third case was notified on 21 June. They did not work at H&M while infectious but did work in their acquisition period. They also attended the Black Lives Matter Rally during their acquisition period. The fourth and fifth cases are siblings of case 3. Contact tracing for these cases is underway. Case 5 has been symptomatic from 8 June and is potentially the index case.
- * The store was closed for two days following the initial case and reopened on 20 June
- * Given the risk of asymptomatic transmission, all remaining staff on the June roster will undergo asymptomatic testing starting on 22 and 23 June. Test results will be required prior to staff returning to work.
- * A department outbreak squad attended the store on 22 June to advise on infection control measures
- * A number of additional cases have arisen over 22-24 June within the extended family of the index case. The family is mostly from REDAC The mother of the index case has attended family

gatherings on 13 and 17 June.

- * The extended family is being contacted, tested and isolated. Many are symptomatic and case numbers are predicted to rise.
- * One presumed positive case attended Craigieburn Superclinic while symptomatic on 22 June. They attended for ~20 minutes with no close contacts identified. Deep clean conducted on 24 June.
- * One presumed positive works as dental hygienist at[redacted]. They developed symptoms on 22 June. The case attended Craigieburn for online training 22 June with three other nurses. No close contacts identified. Deep clean of site conducted. Practice has elected to test and furlough all staff that have attended training site until test results return.

Stamford Plaza outbreak

- * The Stamford Plaza is currently closed to the public and is operating as a mandatory quarantine hotel.
- * Sixteen cases have now been notified to the department linked to this outbreak. Twelve are contracted staff members (security guards) who work at the Stamford Plaza hotel on Little Collins Street. One case is a household contact of a contractor. The remaining case is an individual who completed a 14 day mandatory quarantine at the Stamford Plaza hotel on 14 June and has subsequently developed symptoms. This case tested negative on 11 June and positive on 17 June.
- * One of the above cases, notified to the department on 14 June, initially stated that they were not engaged in paid employment but have subsequently been revealed to work as a contractor at the Stamford Plaza; this case **is linked to the** [redacted] **family outbreak** and is currently hospitalised in intensive care.
- * Four of the cases frequently car-pool together
- * Six cases worked at least one shift during their infectious period, with shift dates ranging from 8 June to 17 June.
- * Several of the cases live in settings where they cannot isolate effectively. Six cases and 11 close contacts related to the outbreak are isolation in hotel accommodation.
- * The most recent case linked to the outbreak has also worked one night shift at the Park Royal Hotel (over 16-17 June) in their infectious period (prior to being identified as a contact and prior to showing any symptoms). All close contacts at the Park Royal are being identified and quarantined.
- * Approximately 150 close contacts have been identified from the exposure at Park Royal Hotel, however this number may be refined following further assessments, including from CCTV footage review.
- * A clean has taken place on Monday 22 June.
- * Planned transit bookings of guests resumed at the Park Royal on 24 June.
- * All staff members and contractors who spent 30 minutes or more at the Stamford Plaza Hotel from Monday 8 June to Wednesday 17 June inclusive are considered **close contacts** and are being advised to **quarantine** for a period of 14 days. More than 400 workplace close contacts from this site have been identified.
- * All staff members and contractors who spent 30 minutes or more at the Stamford Plaza Hotel between Monday June 1 (14 days prior to symptom onset in the case) and Wednesday 17 June were asked to undergo testing for COVID-19 on 17 June.
- * Staff members and contractors who worked at the Stamford Hotel prior to 8 June only AND who have shown evidence of a negative test result to their employer may return to work, but this recommendation is subject to change as the investigation progresses.
- * Department outbreak control squad nurses have visited the site to assess the situation and to provide education.
- * The fifteenth case was notified on 24 June. This case worked as a security guard at Stamford Plaza during the risk period and had previously been identified as a close contact.
- * The sixteenth case is a 4 year old who was identified as household contact of 2 previous cases. This child has not attended the child care during their infectious period. No close contacts or exposure sites outside of the household have been identified for this case.

Keilor Downs 2.0

- * Nineteen cases are currently associated with this outbreak, across eight households
- * Seven of the cases are teenagers who belong to a common social group; the remaining three cases are parents of the teenagers
- * There are a large number of social exposures through social activities, sport and

workplace which are being investigated.

- * One of the cases has 12 household close contacts; six children in the household attend Albanvale Primary School, one attends Keilor Downs Secondary College and one attends St Albans High School.
- * Two staff members and a household contact at Albanvale Primary School are now counted as part of a separate outbreak at that site (see separate text). The Albanvale Primary School Outbreak is suspected to be linked to the Keilor Downs outbreak.
- *** Three further cases were notified on 22 June and are all household members of a previously identified case that is part of this outbreak.**
- *** One of the cases notified on 22 June is a Grade REDACTE at Keilor View Primary School and attended the school for 3 days while infectious.**
- *** The Keilor View Primary School was closed from 23 June. An outbreak squad site visit was performed on 23 June and cleaning of the school also commenced on this date.**
- *** The second case notified on 22 June is a worker at a fresh and chilled produce distribution centre for the Coles Group. This case attended this site for 3 days while infectious.**
- *** Management at Coles were informed of the exposure on 22 June. A facility wide clean is to be undertaken overnight on 22-23 June and the centre will resume services thereafter. Five staff members have been identified as close contacts and are to be quarantined. A site visit was conducted by the Outbreak Squad on 23 June.**
- *** The third case identified on 22 June has not worked or attended any healthcare or sensitive sites during their infectious period.**
- *** Two of the cases are high school students at Keilor Downs College and attended school while infectious.**
- *** The first student case at Keilor Downs Secondary College is in REDACT and attended school while infectious on 12 and 15 June.**
- *** The second student case at Keilor Downs Secondary College was notified to the department on 23 June. This case is also a student i REDACT and has had significant exposure to the first case at this school in both education and social settings. This second student case attended school while infectious on 18 and 19 June.**
- *** Keilor Downs College has been closed until the end of term for whole of school testing and contract tracing, and 156 close contacts have been identified among staff and students at the school.**
- *** Department outbreak control squad nurses visited Keilor Downs Secondary College on 22 June.**
- *** School-wide testing for all staff and students is to commence from 24 June. A dedicated testing site at the Melbourne Showgrounds has been stood up for this purpose and will provide testing exclusively for the school community this week. An alternate testing site at Sunshine Hospital Respiratory Infection Clinic has also been provided.**
- *** The fifteenth case notified is a household contact of a previously identified case in the outbreak. This case worked overnight as a security guard at a serviced apartment complex and was potentially infectious while working at this site for up to 7 hours on 18 June.**
- *** The sixteenth case was notified on 23 June. This case is a household contact of a previously notified case.**
- *** Cases 17 was notified and interviewed on 24 June and is a worker at the Coles distribution centre in Laverton. This case is the second employee identified as a case at this workplace. Case 17 worked at this site for 2 days while infectious as well as for several days during their acquisition period.**
- *** Further contact with Coles management was made on 24 June. All employees at the site who worked on the same shifts as the 2 identified cases are being quarantined. Contact tracing is ongoing with this group. Widespread testing of employees at the site is planned.**
- *** Case 18 and 19 are household contacts of case 17. Case 19 is a REDACTED who is student in REDACT at Epping View Primary School, however, has not attended the school while infectious. The Department of Education are aware of case 19.**

St Monica's College, Epping

- *** There are now 5 cases linked to this outbreak.**
- *** The first case notified on 20 June is a REDACTED at the school and worked for 2 days while infectious and for 7 days during their acquisition period.**
- *** Sixty two students and 9 staff were identified as close contacts in relation to the first case. This group were also included in the 'upstream' contacts during this case's**

acquisition period.

- * A site visit to St Monica's College by the Outbreak Squad was conducted on 22 June.
- * Two further cases were notified to the department on 23 June. These were both close contacts through social settings of the first notified case. One of these cases (case 2) has an onset that precedes that of the first notified case and may be the true index case of this outbreak. Both case 2 and 3 have no association with the school
- * Case 3 and 4 were notified on 24 June. Case 3 is a social contact of cases 1 and 2.
- * Case 4 is a co-worker of case 1, also employed at St Monica's College and had been previously identified as a close contact. Two staff and no students so far have been identified as close contacts from the school, however, further contact tracing is underway.
- * Further investigation of common exposures and close contacts for all three cases is underway and an OMT will be convened tomorrow.
- * The acquisition source for the entire outbreak is under investigation. Given this, testing of 'upstream' contacts during the acquisition period will be performed at the school as well as for household and social contacts. Testing for the school will be facilitated by Northern Health starting from 24 June for the students.
- * Cleaning at the school commenced on 22 June.
- * The school will remain closed this week.

Lifeview Willow Wood RACF

- * A single case in a resident of this facility was notified to the department on 19 June. Symptom onset was on 17 June. The case is currently isolating at the facility and has had two subsequent negative test results
- * The facility houses 115 residents across a single level; there are 98 staff. The facility is separated into a number of 'neighbourhoods'. Residents and staff have been cohorted within their neighbourhood.
- * The facility is currently in lockdown with all residents isolating in their rooms. All close contacts have been identified
- * A department outbreak squad visit occurred on 20 June. A Commonwealth first responder also visited the site on 20 June
- * On-site testing of all residents and staff commenced on 20 June. Negative test results have been received for all 115 residents – a resident who was away from the facility tested negative at another house on 22 June.
- * Negative test results have also been received for 105 staff members – this included some surge staff
- * 3 symptomatic residents tested negative and have recovered. Two further residents from a different 'neighbourhood' to the index case who developed symptoms tested negative on 22 and 24 June.
- * End of quarantine (Day 11) testing is due 28 June.
- * The department is working the facility to tailor communications for patients and their families and provide updates on the situation

Royal Freemasons Springtime RACF

- * A single case in a resident of this facility was notified to the department on 19 June. Positive test date was 16 June (thought to be asymptomatic), however subsequent clarification revealed symptom onset was on 14 June. The case was initially isolating at the facility in a shared room REDACTED but has now been transferred to Sunshine Hospital on 20 June.
- * The facility houses 48 residents, 44 of whom occupy shared rooms.
- * The facility is currently in lockdown with all residents isolating in their rooms (some of which are shared)
- * A department outbreak squad visit occurred on 20 June.
- * A Commonwealth first responder also visited the site on 20 June
- * On-site testing of all residents and staff was undertaken on 20 June. Preliminary results from the testing provider are available. Of the staff tested, 53 of 53 have returned negative results. Of the residents, all 48 (including the index case) were tested and all have returned negative results.
- * The facility provided an updated list of staff close contacts late Tuesday 23 June, taking into consideration a revised infectious period onset date. These additional close contacts are currently being contacted.
- * Given the high number of shared rooms and wandering patients at the facility, an additional round of testing for all staff and residents was conducted on day 5 post last

infectious exposure. This was conducted on site on Wednesday 24 June.

Rosstown Carnegie RACF

- * A single resident of this facility has tested positive. Symptom onset was on 14 June. The case is currently isolating at the facility. There are no other symptomatic staff or residents.
- * The facility is a low level nursing home with 38 residents split across two levels.
- * The facility is currently in lockdown with all residents isolating in their rooms.
- * A Commonwealth first responder and department outbreak control squad visited the facility on 17 June
- * The index case has been re-swabbed on 16 June and returned a negative result.
- * All staff and residents who have been at the facility since 31 May are undergoing an initial round of testing. Testing commenced on 17 June through Melbourne Pathology. All 38 residents tested negative. 65 staff tested negative
- * All 38 residents are isolating as close contacts. 2 staff are isolating as close contacts. Repeat testing for this group is planned for 27 July

Hallam family outbreak (formerly Monash Health)

- * This outbreak was renamed from Monash Health ICU to Hallam Family outbreak on 15 June to ensure appropriate media reflection of the nature of the outbreak
- * There are eight cases linked to this outbreak. On June 18, it was revealed to the department that a case linked to this outbreak works as a security contractor at the Stamford Plaza hotel and worked at the hotel during their infectious period.
- * A single case in a REDACTED child was notified to the department late on 13 June – symptom onset 11 June. The child has a complex medical history and has had significant healthcare contact. This case has deteriorated significantly and has been transferred to the Royal Children's Hospital ICU (critical but stable condition, remains intubated).
- * A second case in a healthcare worker was notified on 14 June. This HCW is a hospital-in-the-home nurse who visited the first case
    - * Contact tracing at MMC conducted by Monash Infection Prevention and Control. 44 healthcare workers identified as contacts. Of these, 22 isolated as close contacts. These cases are being reviewed by the department. A further 20 HITH patients and family members were identified as close contacts
    - * Further contact tracing of contacts outside of the hospital is being undertaken
    - * Five other HITH nurses visited the case. They have been contacted by both Monash and the department. All have been furloughed from Monash. Three have been identified as close contacts by the department and quarantined. All are asymptomatic and have tested negative on preliminary testing.
    - * Five additional family cases have been notified:
        - * This includes three household contacts REDACTED All currently asymptomatic.
        - * Two other family members who had visited the household have also been identified REDACTED . Both are symptomatic. The REDACTED is currently admitted to the high dependency unit at Dandenong Hospital.
        - * All five are isolated
        - REDACT worked REDACTED at MYER Knox Shopping Centre between June 4-14. Myer have been contacted and advised on cleaning. No in-store contacts have been identified. WorkSafe have been notified.
        - * The most recent case has been identified from a recently notified case as a social contact of REDACTE after further investigation.
        - * The source of acquisition for these cases is most likely to come from Stamford Plaza rather than Monash Health – the outbreak has been renamed; people who have had contact with cases during their acquisition period have been asked to seek testing.

REDACTED Family Practice

- * Six confirmed cases have been linked to this outbreak. One case is currently an inpatient in hospital; this case deteriorated on 19 June and is currently in ICU on CPAP.
- * The initial index case has an unknown acquisition source and was notified to the department late on 10 June 2020.
- * Four cases are all people identified as close contacts of the initial index case
- * The department was notified that one of these cases, a man in his 80s with

significant comorbidities, passed away on 23 June

- * One case of this initial cluster is a healthcare worker (GP) – the direction of transmission is under investigation.
- * The GP worked at Lilydale Medical Clinic on June 4 and 11, at [redacted] Family Practice 2, 4 and 9 June and Cedars Medical Clinic on June 2, 5, 6 and 9 while asymptomatic or possibly minimally symptomatic. The GP went into isolation immediately upon being informed they were a close contact of a confirmed case by the department on June 11. The GP sought testing for COVID-19 while asymptomatic and was notified to the department as a confirmed case late on June 12.
- * All three GP practices have been notified and deep cleans have been conducted (on 13 June). Cedars Medical Clinic has no immediate plans to reopen as most of the staff are quarantined.
- * All three GP practices provided an initial list of potential close contacts (Lilydale – 8; Croydon – 9; Cedar – 10) – all have been contacted. Further information on the expanded number of contact dates has been received from the practices tracing is being undertaken
- * An early case from the Coburg family outbreak consulted the GP case in this outbreak on June 2 during her acquisition period – although this is 9 days before this asymptomatic GP tested positive, he may have been minimally symptomatic during this time. Investigation into this link is ongoing.
- * The fifth case saw the GP at the [redacted] Family Practice on 2 June and had a symptom onset of 12 June. He was notified to the department in the evening of 17 June.
- * There are ongoing investigations based on the possibility that the GP was infectious on 2 June. Contact tracing is being conducted for people within the 14 day exposure period. Contacts with past or current symptoms are being asked to seek testing
- * Genomics has shown that this outbreak is connected to the Coburg Family and Rydges outbreaks.
- * Case 4 attended Vision Eye Institute on 10 June for two hours while infectious. The clinic was closed, staff sent home, and two close contacts identified. The clinic was cleaned and will have now reopened.
- * This outbreak is active and under investigation. There is no projected closure date.

Coburg Family Cluster

- * Fourteen confirmed cases have been linked to this outbreak. Thirteen cases are related but live in four different households. The other case is a healthcare worker who reviewed one of the cases during their infectious period and was a known close contact.
- * The index case is unknown and continues to be investigated.
- * Two cases (children) attend [redacted] Primary School, and one of these children attended school on 2 days while potentially infectious.
    - * The school closed prior to Monday and underwent cleaning. IPC nurses visited and close contacts were identified and contacted by DHHS to isolate.
    - * The case that attended school has the earliest symptom onset identified in this outbreak, and acquisition testing of students at school prior to 3 June has been requested.
    - * The school reopened on Friday the 19 June
    - * Day 11 testing for close contacts of the case has been completed. Acquisition testing has been completed. These results are being followed up.
    - * The father of 2 students at this school is a positive case (tested positive on 17 June). This link has been investigated by the department and no further action is needed.
    - * Two cases attend [redacted] Primary School – one while infectious on June 9 and 10
        - * The school closed prior to Monday and underwent cleaning. IPC nurses visited and close contacts were identified and are being contacted by DHHS to isolate.

- * The school reopened on Friday 19 June.
- * 51 students who are close contacts had Day 11 testing on Sunday 21 June – this occurred via Monash Health. These results are being followed up.
- * A further case in a parent who has children that attend REDACTED Primary School has been notified to the department and is currently under investigation – this parent is a HCW. The case had one positive and one negative test (both performed on Monday 15 June). The case's partner and 2 children all tested negative on 16 June.
- * A childcare centre co-located with REDACTED Primary School elected to close (decision by council) for a clean, and will remain closed while the primary school is closed. There has been no cases associated with the childcare centre and DHHS has not identified any risk to the staff or children at the centre. This centre will open tomorrow in line with the school. A parent of two children who attend this school has tested positive. Their household close contacts are now in quarantine and contact tracing is ongoing.
- * One case attends Homegarth Kindergarten, but did not attend while infectious. It appears that one or two allied health professionals associated with the kindergarten visited the home of the confirmed case on 10 June (during their infectious period) – the department is actively following up to find out more and advise this allied health staff to isolate as needed. The centre reopened on 18 June.
- * One case underwent day surgery at the RCH while potentially infectious. IPC at the RCH were contacted and close contacts identified. All have undergone day 11 testing with negative tests.
- * One case (and their asymptomatic partner) attended the RWH while potentially infectious. IPC were contacted at the RWH. On 17 June, 3 close contacts and 1 casual contact were identified. All close contacts have been contacted and informed to quarantine.

Complex cases to note:

Villa Bambini, Essendon

- * A single case in a child who attends Villa Bambini (childcare) in Essendon has been notified
- * The child attended childcare while infectious
- * The facility has been closed and has been asked to undertake a clean
- * Contact tracing is still under way. Close contacts will be asked to quarantine for 14 days and seek testing prior to the end of quarantine

Brunswick East Primary School

- * A single case in a child who attends Brunswick East Primary School has been notified
- * The child attended school while infectious for 2 days
- * The school has been closed and asked to undertake a clean
- * The department outbreak control squad has visited the school and assessed adequacy of the clean and infection prevention and control measures
- * Close contacts identified include 44 students and 3 staff. Day 11 testing is planned for 28 June.
- * The department is working closely with DET and the school

Maidstone family

- * Six cases have been notified in a family from Maidstone
- * All six live within the same household which means that this is

not classified as an outbreak (which requires transmission outside of a household setting)

- * Two positive cases have transferred to hotel accommodation to support appropriate isolation from the family
- * Two household members have recently returned from international travel and exited hotel detention in early June
- * Contact tracing is still under way, however no sensitive settings have been identified at this time

St Mary's Primary School, Hampton

- * A single case in a student at this primary school
- * The case developed symptoms on 16 June and attended school during their infectious period
- * School and non-school contact tracing is under way. Thus far, 2 staff members and 22 students have been identified as close contacts
- * Household and other family members were asked to seek testing and have all returned negative results. School close contacts will be tested on day 11 for end of quarantine testing as per usual processes.
- * The department outbreak control squad visited the facility on 21 June.
- * The school is closed and plans to reopen on 25 June

AFL Player

- * A single case identified in a professional AFL player on 20 June
- * Confirmatory testing at VIDRL of the initial two tests have returned positive results.
- * The case's acquisition is being investigated. They returned from international travel and completed mandatory detention on 6 June but have multiple negative test results since this time
- * The case trained while infectious. The department is working closely with the football club to identify close contacts. One close contact has been identified from the club
- * There are a small number of household and social contacts.
- * Regular testing of the staff and player cohort means that broader acquisition testing will not be required. Test results for the club from 22 June were all negative.

Springside Primary School

- * A single case in [redacted] Primary School, Caroline Springs who lives with elderly parent
- * The case developed symptoms on 17 June and worked three days while infectious (15-17 June). They have been in isolation since 18 June
- * Close contacts identified include 10 staff, 19 students and 1 household contact.
- * Teacher has been provided with emergency accommodation
- * All close contacts have been asked to get tested as soon as possible and then at day 11 prior to end of quarantine. This testing has started at Sunshine Hospital and the department is following up the results.
- * The School reopened on the 24th of June despite there being some concern raised about the appropriateness of the clean that was undertaken. This concern related to:
- * The use of a "fogging" methodology of applying a disinfectant
- * The remains of a residue on surfaces at the school
- * The concern regarding this clean was raised back through DET and the VSBA who manage the cleaning contractors. A

meeting facilitated by DET included DHHS IPC and cleaners on the 24 June. It was felt there was no ongoing coronavirus risk resulting to the school from the cleaning processes that required further action, though the DET were following up with the school about further cleaning.

Camberwell Grammar School

- * A single case in a Year 7 student
- * The case developed symptoms on 16 June and attended school for three days while infectious (15-17 June)
- * Parents are both REDACTED both tested negative. Sibling attends Auburn South Primary School and has tested negative.
- * Close contacts identified include 12 staff and 102 students.
- * All close contacts will be asked to get tested as soon as possible and then at day 11. This testing has started at Box Hill Hospital and the department is following up the results.
- * The school was cleaned on 21 June and advised that it could re-open on 22 June

The Learning Sanctuary Pakenham childcare centre

- * Single case in a REDACTED was notified on 17 June. Case worked for one day during their infectious period and a number of days during their acquisition period.
- * Staff member was symptomatic when tested and her REDACTED child also had symptoms but tested negative
- * Four household contacts REDACTED Older children attend Pakenham Consolidated School (not Pakenham Springs). Older family members were tested 18 June; results are pending. Have requested that the REDACTE child be tested again due to similar timing of symptoms with mother's symptoms and the child attends same day care.
- * 6 social close contacts identified
- * Childcare centre contacted, has provided contact details for children and staff. Total children ~125: infectious period close contacts 17 children and 3 staff members identified
- * Centre closed from 18 June for deep clean. Outbreak squad visited 19 June and conducted full risk assessment.
- * Acquisition testing is being undertaken. Test results received so far are all negative.
- * Unclear acquisition. No direct epidemiological link established to Pakenham Springs students, however centre reports that many children have older siblings who attend the school.
- * Childcare intends to re-open on 29 June

Kind regards

Clare

Dr Clare Looker
Deputy Public Health Commander COVID-19 (Case, Contact and Outbreak Management)
Senior Medical Advisor
Health Protection Branch | Regulation, Health Protection and Emergency Management Division
Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
REDACTED