## Operation Soteria - meetings

Chair: Euan Wallace

Purpose: To identify next phase developments/enhancements to delivery of Operation Soteria.

Key areas for discussion

- Roles/responsibilities (including staffing and governance arrangements)
- Data and documentation (to support reporting and information flow between groups)
- Care pathways and providers (including escalation and decision-making points)

**Table 1 - Action log**

| Meeting Date | Action | Notes |
|---|---|---|
| 26/06/2020 | Euan reach out to REDACTED re additional resources for hotel quarantine | |
| 26/06/2020 | Euan, Merrin/Pam to contact Katherine Ong regarding IPC protocol and changes required. | |
| 22/6/2020 | Merrin working offline next week (29/6) to lock down Brady operations and contract with Alfred. | Fully operational at Bradys and working on expanded services. |
| 22/6/2020 | REDA to review and identify opportunities and gaps in health care pathways. | In progress |
| 15/6/2020 | Leanne developing a policy for voluntary guests seeking to quarantine with passengers in the hotel. Noting guests will only be permitted in exceptional circumstances | Merrin will follow up progress |
| 10/06/2020 | Murray to remove compliance forms from Annexures so the central document can be shared broadly | Leanne/Murray to have a conversation with EOC re: sharing of document and purpose |
| 28/05/2020 | Euan to follow up options for day 3 and 11 testing data analysis and possible hypotheses to test. | In progress, further data received 22/6 |
| 22/5/2020 | Meena to draft a protocol to manage exemptions and complex mental health situations, in collaboration with mental team. | New executive coming on board and should be able to take forth some of these residual protocols. |
| May 2020 | All other actions complete | |
| Apr 2020 | All actions complete | |

Agenda items for meeting Fri 26/6

- Review/discussion of meeting group purpose and ongoing need

**Meeting date 26/06/2020**

Attendees: Euan Wallace, [redacted], [redacted], [redacted], [redacted]

Meeting did not progress. Further consideration on future of meetings to be considered by Euan and raised at EB

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**Meeting date 26/06/2020**

Attendees: Euan Wallace, [redacted], [redacted], Merrin Bamert, Nicole Brady, Leanne Hughson, Pam Williams, Andrea Spiteri, Belinda Mccullough, [redacted], [redacted], [redacted]

**Actions**

- Euan to reach out to [redacted] re additional resources for hotel quarantine
- Euan, Merrin/Pam to contact Katherine Ong regarding IPC protocol and changes required.

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**Meeting date 22/06/2020**

Attendees: Euan Wallace, [redacted], [redacted], [redacted], Leanne Hughson, Merrin Bamert, Nicole Brady, [redacted], [redacted].

**Actions**

- Merrin/Pam to capture of a list of IPC actions in place for hotel security and what exposure/risk remains
- Merrin working offline next week (29/6) to lock down Brady operations and contract with [redacted].
- [redacted] to review and identify opportunities and gaps in health care pathways.
- Euan to liaise with [redacted] re: possible engagement with Unions regarding the voluntary testing of hotel staff

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**Meeting date 15/06/2020**

Attendees: [redacted], Meena Naidu, [redacted], Anita Morris, Nicole Brady, [redacted], [redacted], Leanne Hughson

**Actions**

- Leanne developing a policy for guests seeking to quarantine with a detainee in the hotel. Noting guests will only be permitted in exceptional circumstances
- Maritime policy (including quarantine requirements for crew) is with DPC for finalisation. Nicole will follow up with Brett to ensure progression

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**Meeting date 10/06/2020**

Attendees: Euan Wallace, REDACTED, Murray Smith, REDACTED REDACTED, REDACTED, Andrea Spiteri, REDACTED, Anita Morris, Merrin Bamert, REDAC, REDACTE, Pam Williams

**Actions**

- Pam to chair a governance group to oversee the incident review recommendations. Meeting group to email Pam any suggestions on who should be on the governance group
- Collection of country of residence to be discussed/progressed offline.
- Murray to remove compliance forms from Annexures so the central document can be shared broadly

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**Meeting date 01/06/2020**

Attendees: Euan Wallace, REDACTED, REDACTED, Pam Williams, Nicole Brady, REDACTED, Helen Mason, REDACTED, REDAC, REDACTE, Jason Helps, Anna Love, Anita Morris, Merrin Bamert, Annaliese Van Diemen

**Actions**

- Pam and Euan to discuss the establishment of a governance group to oversee the implementation of the incident report recommendations

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**Meeting date 28/5/2020**

Attendees: Euan Wallace, REDACTED, REDACTED, REDACTED Claire Harris, Jason Helps, Andrea Spiteri, Pam Williams, REDACTED, REDAC, REDACTE

**Actions**

- Euan to follow up options for day 3 and 11 testing data analysis and possible hypotheses to test.
- Mental Health team to meet with Merrin to discuss proposed improvements to mental health screening and referrals
- Pam to follow up progress of recruitment for clinical lead role

- Pam considering longer term solution for improved infection control within hotels

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**Meeting date 25/5/2020**

Attendees: Andrea Spiteri, Murray Smith, Pam Williams, Nicole Brady, REDAC, REDACTE, REDACTED

**Actions**

- Nicole Brady to liaise with relevant parties regarding any proposed changes and finalising the 'Roles and responsibilities for routine testing on Day 3 and 11' document

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**Meeting date 22/5/2020**

Attendees: Euan Wallace, REDACTED, REDACTED, REDACTED, REDACTED, REDACTED, Nicole Brady, Meena Naidu, Merrin Bamert, Andrea Spiteri

**Actions**

- Meena to draft a protocol to manage exemptions and complex mental health situations, in collaboration with mental team.
- Content owners to update and confirm (point in time finalisation) of annexures by Mon 25/5.

**Meeting date 19/5/2020**

Attendees: Euan Wallace, REDACTED, REDACTED, REDACTED, Meena Naidu, Pam Williams, Anita Morris, REDACTED, Merrin Bamert, REDACTED, Nicole Brady, Anthony Clark, REDA, REDA, REDACTED

**Actions**

- Mental health team to meet with welfare cell, compliance and EOC, to discuss key feedback re: mental health triaging, mental health nurse responsibilities and mental health assessments
- Mental health team to liaise with EOC to organise a visit to airport to experience arrival process
- REDAC to follow up with BTIM on technical issues with the 'app' and report back
- Nicole to liaise with EOC and compliance regarding any proposed changes to the testing notification process prior to implementation (currently being undertaken by Claire Harris)

**Key Decision**

Continue with day 11 testing and review as required

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**Meeting date 14/5/2020**

Attendees: Euan Wallace, REDACTED, REDACTED, REDACTED, Meena Naidu, REDACTED, Nicole Brady, REDACTED, REDACTED, REDACTED, Merrin Bamert

**Actions**

- Nicole to follow up advice on whether testing can be undertaken day 10 instead of day 11
- Mental Health will review central Operation Soteria documents and note track changes/comments.

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**Meeting date 11/5/2020**

Attendees: Euan Wallace, Andrea Spiteri, REDACTED, REDACTED, REDACTED, Meena Naidu, REDACTED, Annaliese Van Diemen, REDACTED, Merrin Bamert, and REDACTED, Nicole Brady, Anna Love, Anita Morris, REDACTED

**Actions**

- Meena to work on a daily reporting template (consolidating compliance and health/welfare reporting information)
- REDAC to provide feedback on implementation of revised testing processes
- SCV to progress Care Opinion brief and procurement
- On (or before) Fri 22/5 review progress of day 3 & 11 testing to support decision on ongoing testing requirements

**Meeting date 7/5/2020**

Attendees: Euan Wallace, REDACTED, REDACTED, REDACTED, Meena Naidu, REDACTED, Annaliese Van Diemen, REDACTE, REDACTED, Merrin Bamert, REDACTED, REDACTED and REDACTED

**Actions**

- Public health (intelligence team, Sheena) to work with EoC and Compliance teams to ensure coordination and alignment of compliance and health/welfare reporting.
- REDACT and REDAC to work offline re: policy and support for interstate passengers who are COVID positive and sill symptomatic on day 14.

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**Meeting date 5/5/2020**

Attendees: Euan Wallace, Andrea Spiteri, REDACTED, REDACTED, REDACTED, REDACTED, Anita Morris, Merrin Bamert, Meena Naidu, Angie Bone Annaliese Van Diemen and REDACTED

**Actions**

- Annaliese to follow up with Matt Williams re: engagement of three experienced clinicians who can work with the operations team to manage clinical governance and operations
- Public health to advise on policy position for 'close contacts' of those that have tested positive at day 11 i.e. are the able to exit/leave the state, are they required to self-isolate etc.

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**Meeting date 4/5/2020**

Attendees: Euan Wallace, Andrea Spiteri, REDACTED, Annaliese Van Diemen, REDACTED, REDACTED, Claire Harris, Angie Bone, Anita Morris, Merrin Bamert and Pam Williams

**Actions**

- Merrin to finalise FAQs for passengers re: testing for day 3 and 11 and will send for feedback
- Annaliese to progress notifications on testing status through NIR to other jurisdictions
- Maintain day 3 and 11 testing until further notice. Merrin/Pam to monitor and provide update.
- Andrea to review annexures and finalise version 2. Any new content to be populated in version 3.

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**Meeting date 30/4/2020**

Attendees: Euan Wallace, Andrea Spiteri, REDACTED, Annaliese Van Diemen, REDACTED, REDACTED, REDACTED, Claire Harris, REDACTED

- No new actions from meeting

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**Meeting date 28/4/2020**

Attendees: Euan Wallace, Andrea Spiteri, REDACTED, Annaliese Van Diemen, REDACTED, REDACTED, REDACTED, Anita Morris, Meena Naidu, Pam Williams, REDACTED, Claire Harris

**Actions**

- Merrin to coordinate a meeting with public health and various team representation to discuss implementation of day 11 COIVD testing for all passengers
- REDACTED to coordinate a meeting with Merrin and Euan to discuss Care Opinion

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**Meeting date 27/4/2020**

Attendees: Euan Wallace, Andrea Spiteri, REDACTED, REDACTED, REDACTED, REDACTED REDACTED, Anita Morris and Meena Naidu

**Actions**

- Meena and Anita to discuss and develop content for exemption FAQs
- Euan to send through consumer contact to help with reviewing exemption FAQs
- REDACTED to send updated feedback on Health and Welfare section to Helen and Claire
- SCV to send through state safe sleeping guidelines to Helen and Claire for inclusion in Health and Welfare section

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**Meeting date 24/4/2020**

Attendees: Euan Wallace, Andrea Spiteri, REDACTED, REDACTED, REDACTED, REDACTED REDACTED, Merrin Bamert, Angie Bone and Annaliese Van Diemen, Anita Morris

**Actions**

- Central plan - Andrea to finalise the central plan and send to the Commissioner today (24/4/2020)
- Central plan - Annexures to completed as soon as possible and confirmation provided to Andrea once complete. Andrea will submit the full plan and annexures to the Secretary and Melissa
- Euan and Annaliese to review and discuss DHHS medical lead paper developed by Anthony
- Database/App - Merrin's team testing nurse access to the database/app over the weekend and will report back Monday
- Database/App - Angie's team testing improved early data entry into the database/app this weekend and will report back Monday

**Meeting date 23/4/2020**

Attendees: Euan Wallace, Andrea Spiteri, REDACTED, Claire Harris, Meena Naidu, REDACTED, REDACTED and REDACTED

**Actions**

- Claire/Annaliese to confirm content with Andrea for section 5 (Health and Welfare) as a priority.
- REDA to liaise with Anita about engaging with nurses at hotel and Alfred re: feedback and improvements to activity and functions. (include follow up on database issues)
- All to review overarching structure for central document and advise Andrea if any issues
- Euan, Annaliese and REDACT to meet and discuss the role of a DHHS medical lead.
- Andrea and team will record content owners/approvers for each section and prepare document for final review

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**Meeting date 22/4/2020**

Attendees: Euan Wallace, Pam Williams, Andrea Spiteri, Annaliese Van Diemen, REDACTED, REDACTED, Claire Harris, Meena Naidu, REDACTED and REDACTED

**Actions**

- EOC (REDAC) reviewing all documents, ensuring they are all captured in the central document and proposing content owners/approvers and review dates for key sections
- REDAC to follow up with Colleen status of database issues

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**Meeting date 21/4/2020**

Attendees: Euan Wallace, Pam Williams, Andrea Spiteri, REDACTED, REDACTED, Claire Harris, Meena Naidu, REDACTED

**Actions**

- Andrea and Pam to discuss and propose key changes to the 'Draft Operation Steria documents 20200420', including content owners and approvers for key sections

**Key Decision**

Agreed that the 'Draft Operation Steria documents 20200420' as saved on the 'PHC Health and Wellbeing-DHHS-GRP' teams site is the central document for review and finalisation. Agreed that EOC would lead the coordination to finalise the document.

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**Meeting date 20/4/2020**

Attendees: Euan Wallace, Pam Williams, Andrea Spiteri, REDACTED, REDACTED, , Claire Harris, Annaliese Van Diemen, Denise Ferrier, Meena Naidu, REDACTED

**Actions**

- Andrea, Meena and Annalise to discuss draft escalation process morning of 21/4
- Claire to send through revised documents that she has been working on. REDAC to distribute to all meeting attendees

**Key Decision**

Documents in their entirety will sit within the EOC, acknowledging that various components/policy areas will have different owners/approvers.

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**Meeting date 17/4/2020**

Attendees: Euan Wallace, Annaliese Van Diemen, Andrea Spiteri, REDAC, REDAC, Helen Mason, REDACTED, REDACTED, Finn Romanes, Claire Harris and REDACTED

**Actions**

- Euan/REDAC to follow up with Ann Maree Keenan re: guidance on moving staff between hospitals and how this can be applied to hospital staff working at hotels
- Euan (SCV), Andrea (EoC) and Annaliese/Finn to meet to discuss alignment and collaboration on incident and escalation reporting.
- REDAC (EOC team) to draft a proposed document architecture plan to ensure all teams are able to collaborate and work on central document/s. Claire to send through to REDAC preliminary work undertaken today. drafted for next week. REDAC and Claire to liaise as Claire already undertaken

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**Meeting date 16/4/2020**

Attendees: Euan Wallace, Annaliese Van Diemen, Andrea Spiteri, REDACTE, REDA, Angie Bone, Helen Mason, REDACTED, REDACTED REDACTED, Finn Romanes, Claire Harris and REDACTED

**Actions**

- Euan to follow up with REDACT to confirm status of staffing for welfare checks
- Andrea to confirm with Melissa Skilbeck re: allocation of data custodian to a rostered role.
- Andrea to allocate a position within the EoC to support database engagement
- Euan, Claire and REDACTED to discuss care pathways development
- REDAC to email Andrea a consolidated list of operational/planning documents distributed this week
- Annaliese/Finn to email Andrea PH operational/planning documents after final review
- Planning coordination officer (EoC) to coordinate single repository of documents

**Key Decisions**

- Re: data collection. DHHS App/Database will be 'single source of truth' with welfare team, AOs and nurses all entering data into this system. Noting that data entry back log, access and training is still in progress. GPs will use Best Practice for clinical notes.
- Distinction of roles noted: The policy and protocols around health and welfare will be the responsibility of Public Health IMT. The implementation of these policies and protocols, including logistics, rostering etc will sit with the EoC (as per email sent by Annaliese (15/4)

**Meeting date 15/4/2020**

Attendees: Euan Wallace, Annaliese Van Diemen, Andrea Spiteri, Pam Williams, REDACTED, Angie Bone, Helen Mason, REDACTED, REDACTED and REDACTED

**Actions**

- Andrea to provide feedback on number of additional nursing staff required for hotels. Feedback required to enable REDAC to liaise with health services to secure additional staff
- Euan to discuss database data custodian role with Melissa Skilbeck. Liaising with Brett and Annaliese as required.
- Euan to seek clarity on short term management of database

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**Meeting date 14/4/2020**

Attendees: Euan Wallace, Annaliese Van Diemen, Andrea Spiteri, Angie Bone, REDACTED and REDACTED

**Actions**

- Euan to identify clinical resource to support models of care reviews
- REDA (and Pam) to share planning and operation documents. Euan and REDAC to collate and provide to everyone
- Clarity on database issues required. Andrea, Annaliese and Angie to attend database meeting at 4:30 (14/4)

| Ref ID | Recommendation | Status | Outstanding Actions | Outcome Measure(s) | WHERE ADDRESSED | Executive Sponsor | Position Responsible | Due |
|---|---|---|---|---|---|---|---|---|
| **HOTEL QUARANTINE - INCIDENT ONE - RECOMMENDATIONS AND ACTION PLAN** | | | | | | | | |
| 1A | Develop and implement a detainee arrival pack that consolidates the current suite of 'onboarding' forms into a single onboarding form (for data entry into the central repository in Recommendation H), alongside printed information for detainees. | Determined as Partly Enacted by DHHS. Further comments added for context. | **In place:**<br>•Titled 'Food safety questionnaire,' these are completed by travellers at airport and now include questions about food allergies, medical or mental health conditions that need support, alcohol/smoking/drug use for example.<br>•New questionnaires to be tested.<br>•Information provided to travellers at the airport includes: information about the health and welfare act; privacy collection notice; questionnaires to be completed by guests in transit to hotel<br>•'Welcome pack' received by guests on arrival at hotels.<br><br>**Actions required:**<br>1.Convert paper questionnaire to digital format and enter into CWMS.<br>2.Change name from 'Food safety questionnaire' to reflect additional scope of questions to 'Traveller Survey'<br>3.Determine if to be completed by travellers only, or also community guests – considering different operational models.<br>4.Review content of hotel information 'welcome pack.' | **Proposed:**<br>1.Documentation audit: % of guests that complete the questionnaire; % of guests with allergy information recorded. | The updated Arrivals OI requires collection of information from residents at the airport or pre arrival on an online return traveller questionairre, which is then provided via CWMS to hotels and other staff (health included) in situ. OI 3.1 (Food) sets out the detailed requirements for information provided to residents on arrival at a airport and confirmed by hotel. Residents are also provided detailed, printed information packs on arrival. | ED Hotel Services | Compliance and oversight via the Performance Framework | 28-Aug-20 |
| 1B | Design the new onboarding form to: including a specific question(s) about past or current self-harm and suicidal ideation; be clear, direct and use plain language; not use relative, subjective words such as 'significant' to delineate what information is important; encourage disclosure beyond binary answers; address mental wellbeing from both medicalised and non-medicalised perspectives; and provide specific examples of common support needs. | Determined as Partly Enacted by DHHS. Further comments added for context. | **In place:**<br>•Day 0 clinical assessment by a nurse on entry into the hotel, completed in CWMS.<br>•Requirement to complete for every guest within first 24 hours<br><br>**Actions required:**<br>1.Questions under review by Welfare team.<br>2.Possible for an automatic 'alert' if not completed in 24 hrs in CWMS? | **Proposed:**<br>1. % day 0 clinical assessment completed with first 24 hours.<br>2. % appropriate referral to CART, mental health team at day 0 clinical assessment. | The HSP contract will require an intiial health screening within 12 hours of arrival to assess mental health risks and made onward referrals (including to the onsite mental health nurse) as required. | ED Hotel Services | Compliance and oversight via the Performance Framework | 28-Aug-20 |
| 1C | Establish a formal process to ensure each (newly consolidated) detainee onboarding form is reviewed by a single staff member within 48 hours, adopting a holistic approach, to identify and act upon any immediate or ongoing support needs or health and welfare risks factors, identify detainees requiring further risk and assign an initial risk level (see Recommendation 1D) | Determined as Partly Enacted by DHHS. Further comments added for context. | **In place:**<br>•Reviewed by nurse as part of clinical assessment in each hotel within first 24 hours of arrival at hotel.<br><br>**Actions required:**<br>1.SOP to support questionnaire review process and timeframes.<br>2.Agree action required to ensure process is completed and when referrals needed. | As per Recommendation 1B | Recommendation voided through the introduction of the health screening within 12 hours of arrival, enabled by forms at the airport that will be provided to the HSP via CWMS and linkages to the Nurses App. | ED Hotel Services | Compliance and oversight via the Performance Framework | 28-Aug-20 |

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| 1D | Establish a formal process for nursing staff (with additional clinical advice if required) to assign and monitor a health and welfare risk level (low, medium or high) for each detainee, based on all information available (e.g. onboarding form, 'initial screening call', staff observations). This level should be dynamic and changeable at any time in the face of new information or circumstances, with a schedule for regular review of each detainee's risk level. | Determined as Partly Enacted by DHHS. Further comments added for context. | **In place:**<br>1.Day 3 long survey and day 9 survey, including welfare questions 'how are you coping at the moment?'<br>2.Risk level now in Nurse App – low, med, high<br>3.Have worked with DHHS Health and Wellbeing to define escalation process for staff completing day 3 & 9 welfare surveys – '000' if imminent risk to health and safety and alert Team Leader in hotel.<br><br>**Actions required:**<br>1.Training to support Nurse App use by nursing and mental health teams.<br>2.Develop process for AH staff to be provided access to NurseApp to avoid delays - underway<br>3.Consider Nurse App updates to improve guest health status visibility – 'alerts,' paediatric specific page etc. | 1. % of guests assigned an appropriate alert level at time of documentation review. | Section 6 of the Health and Wellbeing OI sets out the process for dynamic risk-informed care (low / mod / high). Note that the Day 3 and Day 9 survey will not exist under the new model. | ED Hotel Services | Compliance and oversight via the Performance Framework | 28-Aug-20 |
| 1E | Replace current daily COVID-19 Assessment symptom screening calls with daily 'health and welfare screening calls', delivered by nursing staff for detainees of all risk levels. Include in these calls the COVID-19 Assessment symptoms screening questions, and other basic health and welfare questions to screen for unmet support needs or elevated safety and welfare risks. | Determined as Partly Enacted by DHHS. Further comments added for context. | **In place:**<br>•Work underway to include welfare questions in daily symptom check calls, to be undertaken by nurses.<br>•3 welfare questions have been added to daily screening calls.<br><br>**Actions required:**<br>1.Confirm with DJCS/AH plan for calls to guests in new operating model.<br>2.Implementation plan with AH staff, including education to support understanding of when to escalate to MH nurse. | 1. % guests receive daily screening call & appropriate intervention if appropriate. | Section 7.3 of the Health and Wellbeing OI sets out clear direction for health and mental health care and management. Daily welfare checks of all residents are conducted ny nursing staff , with clear escalation protocols and notifications if a resident does not answer. This process and assessment will also link to referrals to | ED Hotel Services | Compliance and oversight via the Performance Framework | 28-Aug-20 |
| 1F | For detainees classified as medium or high risk only, extend the purpose of the new daily 'health and welfare screening calls' (see Recommendation E) to specifically discuss, monitor and provide support around their specific health and welfare issues. | Determined as Partly Enacted by DHHS. Further comments added for context. | **Actions required:**<br>1.Confirm if to be included in new model of care.<br>2.If Nurses App to be used for this function, additional training for nurses required. | As per Recommendation 1E | Section 7.3 of the Health and Wellbeing OI sets out clear direction for daily welfare checks of all residents, with clear escalation protocols if a resident does not answer. This is closely linked to referrals to required for mental health and welfare services escalation | ED Hotel Services | Compliance and oversight via the Performance Framework | 28-Aug-20 |

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| 1G | For detainees classified as low risk, make the provision of regular 'check-in calls' from the welfare team an optional, opt in addition to receiving the mandatory 'health and welfare screening calls' (to provide social contact and practical needs-check) (see Recommendation E).<br>Implement processes for welfare team members with concerns to escalate these for potential re-classification of a detainee as a higher risk. | Determined as Fully Enacted by DHHS. Additional comments provided for context. | **In place:**<br>•Escalation processes in place for Welfare team<br><br>**Actions required:**<br>1.Determine how guests are stratified according to risk – low, medium & high - using Nurses App?<br>2.Determine escalation process to mental health nurses. | As per Recommendation 1E | Section 7.3 of the Health and Wellbeing OI sets out clear direction for daily welfare checks of all residents, with clear escalation protocols if a resident does not answer. This is closely linked to referrals to required welfare services. Note that it is intended that this activity will be carried out by HSP staff, not Welfare team members under the new model. | ED Hotel Services | Compliance and oversight via the Performance Framework | Closed |
| 1H | Implement a comprehensive central repository for detainees personal information (including health and welfare information) accessible to all staff with a role in providing services, care, support and oversight for detainees. Include functionality to provide an 'alert list' for each shift to identify detainees with a medium or high risk level, and the reasons for those rating. | Determined as Partly Enacted by DHHS. Further comments added for context. | **In place:**<br>•CWMS data segregation between modules means nurses unable to view CART system.<br>•Daily guest priority report – escalate to CART and welfare check team and reviewed by DC – Welfare.<br>•Medical practitioners document in separate database 'Best practice.'<br><br>**Actions required:**<br>1.Determine data segregation is appropriate for needs of clinical teams.<br>2.As a priority, nurses and CART must be able to view relevant entries.<br>3.Review medical entries into CWMS (versus Best Practice software used by Medi7 medical team) to determine information is appropriate and sufficient for continuity of care. | 1.% compliance with daily priority report and appropriate actions. | Applicability of CWMS is for the future state is still being investigated. All current functionality is being leveraged to meet this Recommendation and work continues to meet in full. This will be further enabled by daily operational meetings, which will include HSP staff. | ED Hotel Services | Compliance and oversight via the Performance Framework | 28-Aug-20 |

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| 1I | In the central repository of detainee personal information, design the section for logging health and welfare calls (from the nursing and welfare teams) to include a specific field(s) for users to record the dates and times of both answered and unanswered calls to detainees (with the list of unanswered calls automatically visible to users). | Determined as Partly Enacted by DHHS. Further comments added for context. | **In place:**<br>•Paper based survey converted to 'live'<br>•Dates and times now visible in CWMS when each survey is saved.<br>•If unanswered, documented in notes field, and referred to AO via email, captured on referral spreadsheet.<br><br>**Actions required:**<br>1.Confirm timeframe for phasing out welfare calls at day 3 and 9, to daily call by AH nurses including welfare questions.<br>2.Confirm clear escalation process for guests not answering calls. | 1.No incidents or complaints related to unanswered calls not being follow-up.<br>2.% compliance with welfare calls being made. | The Health and Wellbeing model has been refreshed, with Day 3 & Day 9 welfare checks removed in preference for all health and wellbeing assessments be triaged through the Alfred on site nurse and mental health nurses to . CART will provide welfare support where referred or as required by case complexity. Applicability &utility of CWMS to support case information | ED Hotel Services | Compliance and oversight via the Performance Framework | 05-Sep-20 |
| 1J | Offer detainees the option (at onboarding and throughout their detainment, for example via a text message or email) to nominate a time slot each day in which they prefer to take calls from the welfare and/or nursing staff, and call detainees during the nominated time slot. | Determined as Fully Enacted by DHHS. Additional comments provided for context. | **In place:**<br>•Calls within business hours (09.30 – 15.30hrs)<br>•Nurses are able to accommodate requests once a guest receives a call eg. "I'm having lunch, please call back in an hour" and anecdotal reports suggest nurses know the times guests prefer to receive a call.<br>•Tailored management plans are being developed dependent on guests needs through nursing/CART teams. | | The updated Health and Wellbeing OI (daily calls per Section 7.3) will provide residents with a tiered medical and mental health traige and escalation pathway to address identified health and wellbeing issues. DJCS will not request residents nominate a | ED Hotel Services | Compliance and oversight via the Performance Framework | Closed |
| 1K | Implement a formal policy about when to escalate situation in which detainees are not answering calls from nursing or welfare teams – using a decision-tree approach that accounts for factors such as number and frequency of unanswered calls, detainee's existing health and welfare risk factors, and previous behaviour in answering/not answering calls. | Determined as Fully Enacted by DHHS. Additional comments provided for context. | **In place:**<br>•Escalation process in place for welfare calls.<br>•3 calls; when no answer, escalate to the DJCS site manager.<br><br>**Actions required:**<br>1.Decision tree needed to ensure escalation plan is clear ie. when do you need to physically go up to a room, who needs to go etc. | % compliance with escalation process. | Section 7.3 of the Health and Wellbeing OI requires 3 unanswered calls within a 2 hour window to be escalated for further action. | ED Hotel Services | Compliance and oversight via the Performance Framework | Closed |
| 1L | Increase and/or more strategically roster the number of AOs on duty at one time to ensure adequate baseline capacity, and rapid response surge capacity that AOs can directly and immediately request if they are task-or demand-overloaded. | | **In place:**<br>•For input - compliance team.<br><br>**Actions required:** | | The new organisational structure (and transfer of hotel-based AOs to DJCS) will consider and address this recommendation. | ED Hotel Services | Compliance and oversight via the Performance Framework | 28-Aug-20 |

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| 1M | Establish a formal selection process for taking up new roles that accounts for their skills, preferences and attributes. Require that welfare team members have relevant background or experience (e.g. mental health, counselling, social work, peer support etc). Complement this with targeted initial and ongoing training and supervision (including for remote working staff) for all new and current staff. | Determined as Partly Enacted by DHHS. Further comments added for context. | **In place:**<br>•Welfare surveys will be phased out.<br>•Recruitment of CART staff will address these attributes.<br><br>**Actions required:**<br>1.Confirm date for transition from ending welfare check and new process of combined daily checks including welfare questions by AH nurses.<br>2.Confirm DJCS operating model and recruitment plans.<br>3.Alfred Health mental health model support model has been released – imbed with clinical teams. | | The HSP will be contracted to provide the skills, capabilities and qualifications needed, supported by the CART Intervention team who will provide complementary welfare support via appropriately skilled clinicians. | ED Hotel Services | Compliance and oversight via the Performance Framework | 28-Aug-20 |
| **HOTEL QUARANTINE - INCIDENT TWO - RECOMMENDATIONS AND ACTION PLAN** | | | | | | | | |
| 2A | As a matter of priority, implement measure to ensure an adequate and reliable on-site supply of Personal Protective Equipment (PPE) that is readily accessible to all staff working in the hotel quarantine system. | Determined as Fully Enacted by DHHS. | **In place:**<br>Hotel nominated delegate within hotels order PPE through Alfred health. | | This is now in place, with compliance measured against the IPC Framework. Note there are now proposed DJCS IPC Specialists at each hotel. | ED Hotel Services | Compliance and oversight via the Performance Framework | Closed |
| 2B | Develop and implement robust, fit-for-purpose, readily accessible policies and procedures relating to the appropriate use of PPE for staff working in the hotel quarantine. | Determined as Fully Enacted by DHHS. Additional comments provided for context. | **In place:**<br>•Mapped the communication cascade to the front line staff in order to understand how we communicate PPE guidelines and changes to Hotels.<br>•Developed simulation and drill guides to assist in PPE and infection prevention training of staff before activities such as arrivals and departures.<br>•Training logs for to evidence PPE training for new staff to hotels.<br>•Gap analysis completed for current hotels by DJCS infection control.<br><br>**Action required:**<br>1.Working with Alfred Health (AH) to finalise PPE guidance for all hotel operations scenarios. | 1.Number of simulation drills to test PPE guidance. implementation.<br>2.PPE audit as per Alfred Health schedule. | DJCS has a IPC framework to align PPE Matrix, policies and procedures, training, IPC inspections and audits, clinical and IPC governance and clear escalation pathways for IPC breaches and incidents. This is all documented in IPC OI. | ED Hotel Services | Compliance and oversight via the Performance Framework | Closed |

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| 2C | Develop and implement processes to enable clinical staff working in the hotel quarantine system to conduct visual telehealth (i.e. video calls) consultations for returned travellers who are willing and able to use these methods, particularly those identified as higher risk. This would enhance initial 'contactless' clinical assessments for returned travellers. These processes should be co-designed. The visual telehealth platform should be capable of including external family members, community caregivers in telehealth consultations, at the discretion of the returned traveller, particularly in circumstances requiring a case management approach. The visual telehealth platform should also enable participation of language interpreters, consider the specific needs of returned with visual or hearing impaired and other physical and/or mental disabilities, as needed | Determined as Partly Enacted by DHHS. Further comments added for context. | **In place:**<br>•Telephone call assessments in place, at times using video calls/Facetime as appropriate.<br>•Maternal & Child Health (MCH) telehealth service via Melbourne city council.<br>•Interpreter services accessible via phone.<br>•GP Clinical Lead for quarantine hotels.<br><br>**Actions required:**<br>1.Determine if access to telehealth platform/service required through Alfred Health?<br>2.Determine GP protocols/processes for telehealth assessments. | 1.Telehealth service in place, frequency of use & outcomes. | Section 7.3 of the Health and Wellbeing OI provides for Telehealth and Face to Face consultation as assessed by Alfred's clinical care escalation and referral pathways based on care plan. | ED Hotel Services | Compliance and oversight via the Performance Framework | 28-Aug-20 |
| 2D | As a matter of priority and in consultation with clinical leads, implement measures to ensure an adequate and readily accessible on-site clinical equipment and the resources required to effectively sanitise this equipment. This would ensure timely assessment, monitoring and first line treatment of returned travellers. | Determined as Fully Enacted by DHHS. | **In place:**<br>•Protocol for decontamination of medical equipment after each use.<br>•'Bump in' medical equipment list | | | ED Hotel Services | Compliance and oversight via the Performance Framework | Closed |
| 2E | Develop and implement a policy with clear guidance and specific criteria for when medical staff are required to assess returned travellers via a visual telehealth or face-to-face whilst in mandatory hotel quarantine. | Determined as Partly Enacted by DHHS. Further comments added for context. | **In place:**<br>•Day 0 traveller survey completed by guests on arrival, screened by nurses & used to determine if GP referral required.<br><br>**Actions required:**<br>1.Protocol or decision tree required for when medical review requires face-to-face assessment.<br>2.Confirm documentation process for photos taken of wound or rash for medical review – include in medical record/CWMS? | 1.Complaints or incidents relating to appropriateness of GP assessment. | Section 7.3. of the Health and Wellbeing OI provides for Telehealth as the preference for consult mechanism, with Face to Face consults utilised where clinical necessary (noting this may be required to manage resident expectations). | ED Hotel Services | Compliance and oversight via the Performance Framework | 28-Aug-20 |

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| 2F | Implement an off-the-shelf, fit-for-purpose (or easily customised), single, centralised and real-time information sharing and tracking system containing all individual returned traveller information (including their health and welfare), accessible by all staff with a role in providing services, care, support and oversight for returned travellers. This should include functionality to provide 'alerts' to identify to staff working on each shift, returned travellers with significant health and/or welfare risks requiring monitoring or follow-up | Determined as Partly Enacted by DHHS. Further comments added for context. | **In place:**<br>•Compliance and Welfare Management System (CWMS) developed with 4 modules; compliance form, welfare management system, Nurses Health Record, Complex Assessment & Response Team (CART) system<br>•All clinical staff have access, including medical staff.<br>•Medical staff use 'Best Practice' software, and double-enter into CWMS for allied health line-of-sight of medical assessment and interventions.<br><br>**Actions required:**<br>1.Confirm alert system in place for high-risk conditions.<br>2.Determine appropriate data segregation between Nurses Health Record and CART system.<br>3.Determine appropriate process for medical staff input into CWMS. | 1.Incidents/complaints/near misses relating to communication between clinicians. | Applicability of CWMS is for the future state is still being investigated. All current functionality is being leveraged to meet this Recommendation and work continues to meet in full. | ED Hotel Services | Compliance and oversight via the Performance Framework | 28-Aug-20 |
| 2G | Undertake ongoing needs analyses to strategically match the number and designation of staff rostered on shifts to ensure there are adequate staff available to be able to provide a rapid response surge capacity to meet the dynamic needs of specific cohorts of returned travellers. This should include a mechanism by which if necessary additional resources can be mobilised to respond to evolving situations. | Determined as Fully Enacted by DHHS. | **In place:**<br>•Alfred Health clinical staffing model in place. | | | ED Hotel Services | Compliance and oversight via the Performance Framework | Closed |
| 2H | Expand the daily COVID-19 assessment symptom screening calls to include other basic health and welfare questions to screen for unmet support needs or issues. For return travellers with medium to high risk health conditions, this presents an opportunity to discuss their specific issues.<br>Ensure adequate, dedicated and appropriately qualified staff are available to conduct these calls daily for the duration of returned travellers' period of mandatory quarantine. | Determined as Partly Enacted by DHHS. Further comments added for context. | **In place:**<br>1.Daily symptom screening calls being developed to include welfare questions<br>2.Daily calls to be undertaken by appropriately trained Alfred Health clinical nursing staff.<br><br>**Action required:**<br>1.Confirm questionnaire content and start date for roll out.<br>2.Protocol to support escalation process for daily calls and process for escalation. | 1.% compliance with welfare call escalation process on documentation review. | The new HSP process embeds daily welfare calls for all residents by HSP nursing (Section 7.3 of Health and Wellbeing OI). This is underpinned by clearly defined staff qualification requirements and a clear medical escalation process where risk is identified. | ED Hotel Services | Compliance and oversight via the Performance Framework | 28-Aug-20 |

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| 2I | Implement formal, standardised processes for the recording and tracking of issues raised by returned travellers with hotel quarantine staff (via all means – including screening calls). This should include assignment of these issues for follow up, tracking progress to completion, and alerting relevant staff when issues have not been action and closed. | Determined as Partly Enacted by DHHS. Further comments added for context. | **In place:**<br>•Daily guest welfare situation reports with documented issues – escalate to CART and welfare check team as necessary.<br><br>**Action required:**<br>1.Confirm clinical handover protocol.<br>2.Confirm issues tracking process and documentation with DJCS and clinical team leaders, including who has visibility of issues and actions. | 1.Numbers of incidents, complaints etc<br>2.Action reviews. | OP 2.6 (Complaints Process) will enable this. | ED Hotel Services | Compliance and oversight via the Performance Framework | 28-Aug-20 |
| 2J | Co-design with frontline and implement the use of specific fit-for-purpose materials, methods and systems suitable for recording returned traveller health and welfare information in a consistent, comprehensive and systematic way. This includes record keeping templates and information systems. Ensure the availability of resources so these systems are readily accessible to all relevant staff, and feedback mechanisms ensure continuous evaluation and improvement relating to the suitability of related current policies and processes. | Determined as Partly Enacted by DHHS. Further comments added for context. | In place:<br>•CWMS is the central repository of information<br>•Medical staff double-enter into 'Best Practice' software and provide a summary of this info into the CWMS for nursing team line-of-sight.<br>•Alfred Health handover verbal and written and includes mental health nursing team.<br>•Multidisciplinary team (MDT) meetings 2 – 3 times/day to raise and discuss guest issues and concerns.<br><br>Action required:<br>1.Confirm feedback mechanism for issues that cannot be immediately resolved or require escalation to DJCS/Alfred Health team leaders. | | Applicability of CWMS is for the future state is still being investigated by DJCS, with due consideration to the requireemnts for frontline workers. | ED Hotel Services | Compliance and oversight via the Performance Framework | 28-Aug-20 |
| 2K | Develop and implement formal policies and procedures for recording information provided by external providers and returned travellers in quarantine, and ensure that relevant information be reviewed, actioned as needed and evaluated by an appropriate clinician on-site. | Determined as Partly Enacted by DHHS. Further comments added for context. | **In place:**<br>•CWMS central store of guest information<br><br>**Action required:**<br>1.Confirm processes for recording information from external providers/consultations/ care provided. | | Applicability of CWMS is for the future state is still being investigated. All current functionality is being leveraged to meet this Recommendation and work continues to meet in full. | ED Hotel Services | Compliance and oversight via the Performance Framework | 28-Aug-20 |

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| 2L | Implement formal processes for conducting handover and communication within and between teams working in the hotels in the quarantine system. | Determined as Partly Enacted by DHHS. Further comments added for context. | **In place:**<br>•Handover processes in place.<br><br>**Action required:**<br>1.Confirm clinical handover protocol between AH and DJCS staff.<br>2.Confirm medical team handover with AH and DJCS staff as appropriate. | 1.% compliance with handover audit processes and content. | OP 2.8 (Governance and Communications) provides detail on daily operational briefings and shift handovers that will meet this Recommendation. This includes a daily operational meeting at each hotel and processes for shift handovers. | ED Hotel Services | Compliance and oversight via the Performance Framework | 28-Aug-20 |
| 2M | Co-develop with staff detailed descriptions for all roles in the hotel quarantine system, and a visual and simple written guide to how these roles work together. Provide this to all existing and future staff and include this information in staff orientation and in-service training. | Determined as Partly Enacted by DHHS. Further comments added for context. | **In place:**<br>•Job cards for DJCS and AH clinical staff.<br><br>**Action required:**<br>1.Confirm job cards have been developed for all staff (DJCS and AH), and have been shared with all parties. | 1.Job cards/role descriptions available for all staff working in Operation Soteria | As part of transition, DJCS will manage the development of position descriptions and workflow requirements for all staff. | ED Hotel Services | Compliance and oversight via the Performance Framework | 28-Aug-20 |
| 2N | Based on experience to date and staff input, revise method for determining the staffing level and mix needed around the time of large returned traveller influxes and implement revised model of staffing and rostering based on these. Ensure readily available increased staffing capacity for surges in workload associated with arriving cohorts of returned travellers. | Determined as Fully Enacted by DHHS. | **In place:**<br>•AH staffing model for clinical nursing staff, cleaning, security<br>•Rostering by DJCS operations team.<br><br>**Action required:**<br>1.Operational model to be confirmed. | 1.% incidents or complaints with staffing skill mix or availability a contributing factor. | | ED Hotel Services | Compliance and oversight via the Performance Framework | Closed |
| 2O | Co-develop agreed formal processes with relevant entities (e.g. Australian Border Force, the Department of Foreign Affairs and Trade) to improve the accuracy, detail and optimise timeliness of information received about incoming returned traveller cohorts to facilitate planning and preparedness. | Determined as Fully Enacted by DHHS. Additional comments provided for context. | **In place:**<br>•Information provided by Aust Border Force (ABF) from travellers manifest prior to arrival.<br><br>**Action required:**<br>1.Ongoing review of earlier access to traveller information with ABF to support preparedness, including hotel allocation. | | OP 4.2 (Arrivals Process) provides further detail on the future state of this Recommendation. Consultations have been undertaken with relevant entities (ABF, DFAT) and processes have been aligned. Relevant data is now being collected and shared. | ED Hotel Services | Compliance and oversight via the Performance Framework | Closed |

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| 2P | Co-develop and implement a formal agreement between all relevant parties in the hotel quarantine system and Ambulance Victoria regarding the ambulance service requirements of returned travellers. This agreement must provide specific guidance to support decision-making by frontline staff; reflect the rights and role of consumers (returned travellers or their significant others) in participating in these decisions; and provide clear guidance on ambulance dispatch and cancellation. | Determined as Fully Enacted by DHHS. | **In place:**<br>•AV transfer form for non-urgent transfer in Team Leader pack.<br>•Clear understanding of PPE required by AV staff<br>•Escalation process for clinical concerns in AH clinical staffing model.<br><br>**Action required:**<br>1.Confirm process for emergency services to enter guests rooms (eg. AV, MFB)<br>2.Confirm emergency transfer by AV will be notified through Riskman/DJCS incident form. | 3.% incident or complaints with emergency services access to guests raised as an issue or contributing factor. | | ED Hotel Services | Compliance and oversight via the Performance Framework | Closed |
| 2Q | On arrival, all returned travellers and their external family member should be routinely provided with clear information about how to escalate unaddressed or inadequately addressed concerns. This information should be easily accessible for those from culturally and linguistically diverse backgrounds, the elderly, the visually impaired, and be suitable for varying levels of health literacy. | Determined as Partly Enacted by DHHS. Further comments added for context. | **In place:**<br>•Information provided to guests on arrival, including how to raise a concern or make a complaint.<br><br>**Action required:**<br>1.Confirm escalation of concerns process included in arrival information.<br>2.Confirm if information relating to and for children is required. | 1.Information is provided to guests about how to escalate unaddressed or inadequately addressed concerns. | Addressed by revised guest information packs and OP 2.6 (Complaints). Residents should contact the Hotel in the first instance to register a complaint and take first steps to its resolution. | ED Hotel Services | Compliance and oversight via the Performance Framework | 28-Aug-20 |
| 2R | On arrival, all returned travellers should have suitable access to a functioning mobile telephone for the duration or their mandatory detention, (e.g. telephone handset, charges, Australian SIM cards and access to credit and top-up methods to be able to make calls). | Determined as not to be implemented by DHHS. | **In place:**<br>•Not implemented.<br>•Guests have access to telephones through their rooms, and their own personal devices if applicable.<br><br>**Action required:**<br>1.Consider offer of Australian SIM card to returned travellers. | | DJCS have made SIM cards available on a needs basis to be managed via Site Managers . | ED Hotel Services | Compliance and oversight via the Performance Framework | 28-Aug-20 |
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Safer Care Victoria

**Safer Care Victoria report on clinical incidents occurring in hotel quarantine in Victoria**

At the request of the Secretary of the Department of Health and Human Services, Safer Care Victoria undertook reviews into two serious clinical incidents involving detainees in hotel quarantine in Victoria. The first incident involved the apparent suicide death REDACTED (Hotel Quarantine Incident 1), and the second incident involved the care of [redacted] year old REDACTED who developed COVID-19 symptoms and deteriorated rapidly, requiring intensive care unit admission at the Alfred Hospital (Hotel Quarantine Incident 2).

Two teams of reviewers with relevant incident review and subject matter expertise were convened to undertake the reviews. The purpose of the reviews was to identify contributing factors relevant to the specific incidents, as well as provide insights into issues affecting the operation of hotel quarantine in Victoria, with the view to facilitating timely system improvements. To this end, the final output will be two separate reports, each detailing the contributing factors relevant to the incident, along with a summary of key high-level themes identified in both reviews which are relevant to the overall operation of hotel quarantine. These will be shared with the Secretary as well as the Operation Soteria Working Group, which includes representatives from Public Health, Emergency Operation Centre, Accommodation Commander, Welfare Cell, Office of Chief Psychiatrist and Safer Care Victoria. The Operation Soteria Working Group will be responsible for monitoring the implementation of the recommendations.

Herewith please find a draft report detailing the contributing factors for Hotel Quarantine Incident 1, along with a summary of key themes relevant to the overall operation of hotel quarantine in Victoria that have so far been identified across both reviews (see Appendix 2). The draft report for Hotel Quarantine Incident 2 will follow shortly.

The findings and recommendations provided are based on evidence and information available to the review teams at the time of writing and relate to issues and circumstances at the times and places the incidents took place (i.e. 3 to 13 April 2020). It is also noted that certain information sought by the review teams was not able to be provided or obtained, or was conflicting, and some individuals with potentially relevant information declined to be interviewed. It is further acknowledged that a number of recommendations and key themes may have since been addressed.

Yours sincerely,

REDACTED

REDACTED
Director, Patient Safety and Experience
Safer Care Victoria

Date: 10 June 2020

VICTORIA State Government

# Incident review report: Hotel Quarantine Incident One

## ENDORSEMENT

**Review lead**

**Signature:** REDACTED **Date:** 03/06/2020

**Executive sponsor**

**Signature:**  **Date:** 10/06/2020

## REVIEW TEAM

| | |
|---|---|
| **Executive sponsor** | Director, Centre for Patient Safety and Experience, Safer Care Victoria |
| **Review project manager** | Senior Project Officer, Centre for Patient Safety and Experience, Safer Care Victoria |
| **Review lead** | Academy Member, Safer Care Victoria |
| **Human factors / methodology lead** | Manager, Patient Safety Review, Centre for Patient Safety and Experience, Safer Care Victoria |
| **Review coordinator** | Senior Project Officer, Centre for Patient Safety and Experience, Safer Care Victoria |
| **Team member** | Academy Member, Safer Care Victoria |
| **Team member** | Chair, Mental Health Clinical Network, Safer Care Victoria |
| **Review team support** | Senior Project Officer, Safer Care Victoria |
| **Administrative support** | Project Officer, Centre for Patient Safety and Experience, Safer Care Victoria |

# Contents

Safer Care Victoria

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## ABOUT THE REVIEW

### Background

On 11 April 2020, REDACTED was found deceased in his room at the Pan Pacific Hotel, Docklands, while in mandatory detention as part of the initiative that would later become known as Operation Soteria. As part of the response to REDACT death, the Secretary of the Department of Health and Human Services requested that Safer Care Victoria undertake an independent review into the incident. This report pertains to that review. We acknowledge that REDACT death will be examined by the Coroner, who is the authority on his official cause of death. However, for the purposes of this review, the review team considered his death as though it were a suicide.

Unless otherwise specified or indicated by grammatical tense, the information in this review describes and relates to the period of the incident, being 3 April 2020 to 11 April 2020. The team acknowledges, based on evidence provided during the review, that some systems and processes have changed since that time. This may mean that certain recommendations have since been addressed, or some findings do not reflect the current state. However, the methodology requires that the review address the events and circumstances as they were at the time.

### Method

The ongoing detention of people in hotel quarantine, and need to identify and address any ongoing risks to these individuals in real time, necessitated a rapid review methodology. This methodology has certain limitations regarding data collection and scope. These limitations were weighed against the need for a rapid review process in making final determinations about the methodological approach and scope of the review. The review used a version of the AcciMap method, customised to use the London Protocol – both widely-recognised and validated approaches to rigorous incident review.

The review team acknowledges that REDACT death was unexpected for all involved. We note that in cases of suspected suicide, the purpose of a review is not to determine the 'cause' of the person's death, as this requires speculation about the state-of-mind and complex circumstances of the person who has died. Therefore, the review team cannot determine for certain whether changes to the events and factors surrounding REDACT death would have ultimately contributed to a different outcome. For this reason, the review focuses on addressing whether the management of REDACT quarantine corresponded to an adequate standard of care, based on the information available about him to those involved at the time. Therefore, in producing this report, the team do not purport to make any conclusions about fault or blame, nor whether any changes to the circumstances outlined would have prevented REDACT death.

### Evidence

The team has collected and considered a variety of evidence, including (but not limited to):

- Interviews with staff from the following categories: DHHS/Operation Soteria management, welfare check team members, hotel team leaders, nursing staff, Authorised Officers and REDACT family.
- Templates, forms and questionnaires pertaining to detainee health and wellbeing including the 'Welfare Check – Initial long form survey', 'Confidential Hotel Questionnaire', 'DHHS Hotel Isolation Medical Screening Form' and 'COVID-19 Assessment Form'.
- Copies of the above containing REDACT information. Except for the 'Confidential Hotel Questionnaire', for which only a blank template was provided, despite the completed version being requested.

- Other ad hoc records including an incident report, Victoria Police witness statement, handwritten on-site nurse notes, Post-it notes, Pan Pacific Room Request records (provided for 5-7 April 2020).
- Plans, policies and procedures including 'Operation Soteria – Operations Plan', 'COVID-19 – Interim Healthcare and Welfare Mandatory Quarantine Plan (Draft)', 'Team Leader Pack – Hotels' and 'Referral Pathways for people issued COVID-19 quarantine orders'.
- Information for detainees including 'Mental Health and coronavirus (COVID-19) – Information for those in isolation' and 'Mental Health and Wellbeing'.

We acknowledge the cooperation and openness of the Operation Soteria staff who shared their experiences with us, and their willingness to do so despite the significant emotional impact the event had on some of them. We are especially grateful to REDACTED for providing information about REDAC who he was to those who loved him, his life, and the events surrounding his death, during their time of grief.

The information in this report is based on evidence and information available to the team at the time of review. It is noted that certain information sought by the team was not able to be provided or obtained, and some individuals with potentially relevant information declined to be interviewed. Therefore, the review team acknowledges that there may be unintended gaps or inaccuracies in the report that the team's reasonable efforts to seek required information were unable to rectify. The information presented was accurate - to the best of the team's knowledge – at the time of writing, given the information available to us, and with an eye to the potential limitations identified above.

Safer Care Victoria

## INCIDENT REVIEW

### Description of the Incident

On 03/04/2020 REDACTED was issued a detention notice after arriving from REDACTED where he normally resided. The detention notice required him to remain in hotel quarantine for 14 days.

REDACTED was detained as part of the Victorian government's response to the COVID-19 pandemic (later known as Operation Soteria), in line with a national agreement to require mandatory quarantine of any international arrivals after midnight 28/03/2020. REDACTED was detained alone in REDACTED at the Pan Pacific Hotel in Docklands, Melbourne.

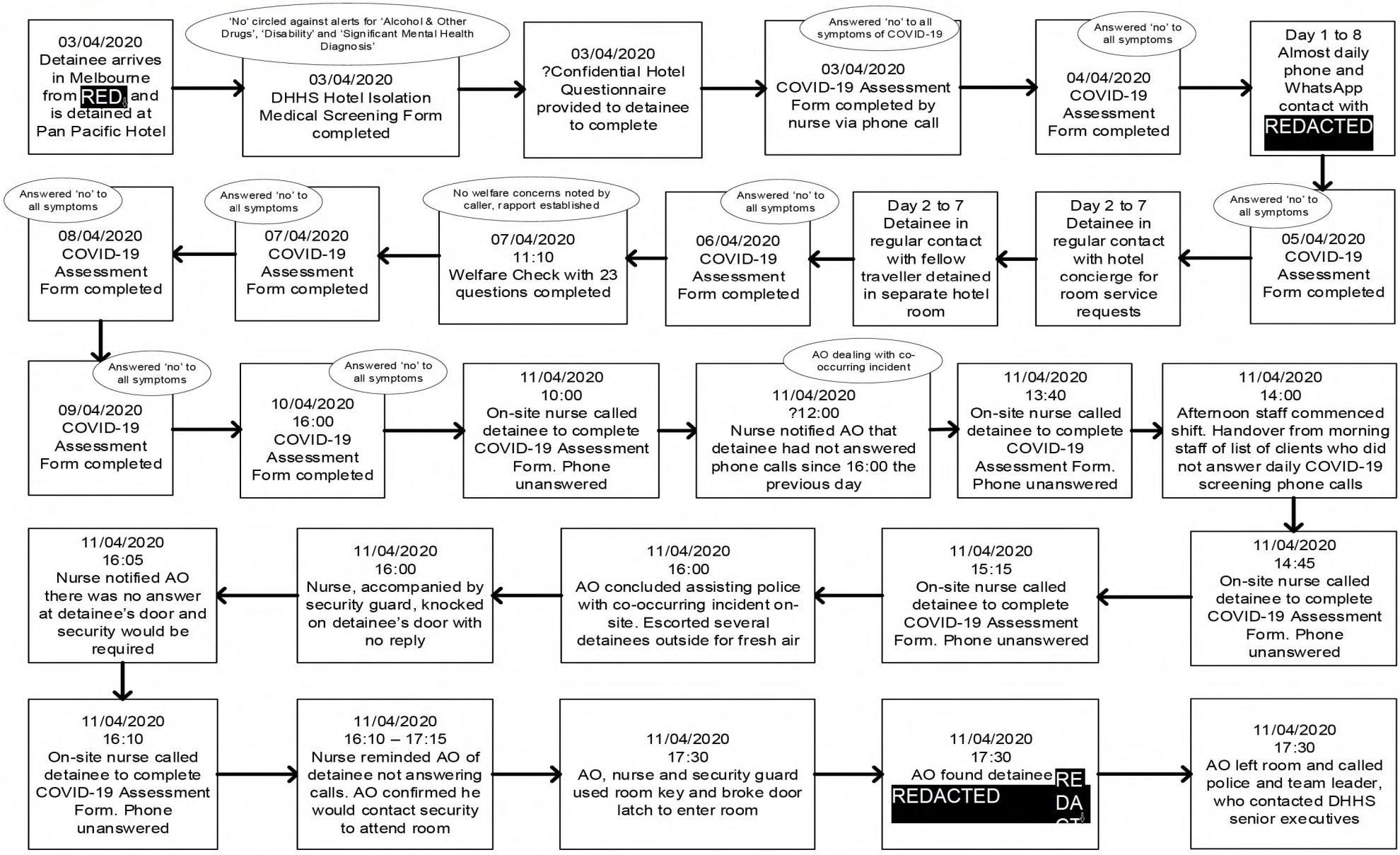
REDACTED

REDACTED on-site nurses phoned him daily to complete the COVID-19 Assessment form (to screen for COVID-19 symptoms). He completed this assessment daily, and did not report COVID-19 symptoms during his detainment. The 'Welfare Check – Initial long form survey' was completed on day five of REDACTED REDACTED No concerns were identified. The welfare check caller spent approximately REDACTED REDACTED

On 10/04/2020, there was a serious incident involving another detainee barricading themselves in their room. The incident resulted in significant police attendance and activity at the hotel. That incident continued into 11/04/2020 – the day REDACTED was found deceased REDACTED

Throughout day nine of his detainment (11/04/20), REDACTED did not answer repeated calls to his room from nursing staff attempting to complete the COVID-19 Assessment form. Nursing staff escalated the issue of R REDACTED unanswered calls to the Authorised Officer. The Authorised Officer attended to some other matters, including the barricading incident and other detainees with identified significant mental health concerns, before turning his attention to the concerns raised REDACTED On the basis of the repeated unanswered calls, at approximately 17:30 on 11/04/2020, the Authorised Officer, a security guard and on-site nurse attended RE REDACTED room, and obtained entry. They found REDACTED deceased. It appeared he had died by suicide, REDACTED REDACTED

## TIMELINE OF EVENTS



## ACTOR MAP

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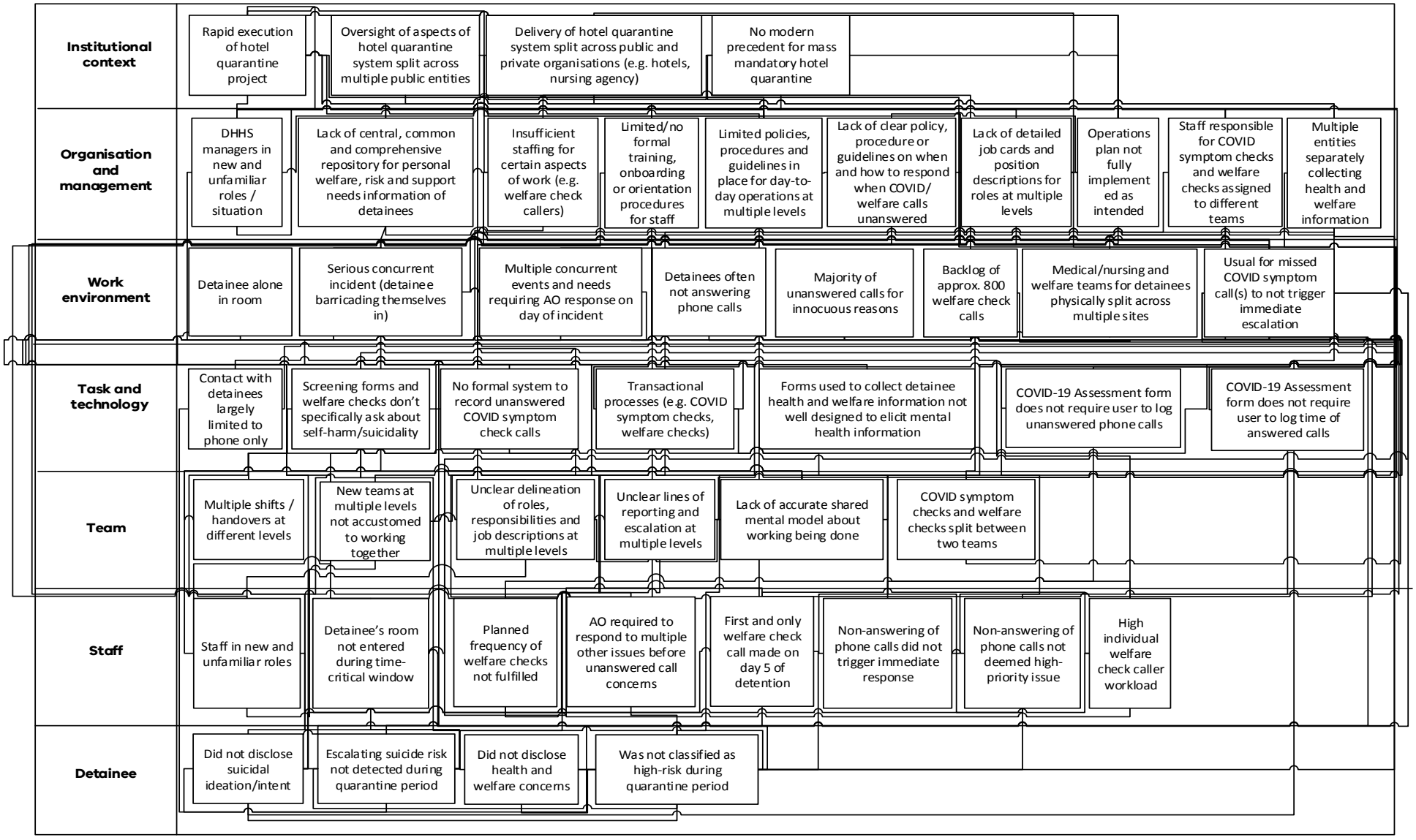
|---|---|---|---|---|---|---|
| **Institutional context** | Victorian Government | Department of Health and Human Services | Department of Jobs, Precincts and Regions | | | |
| **Organisation and management** | DHHS management | | | | | |
| **Work environment** | Hotel public areas | Hotel room | Hotel work areas | DHHS offices | | |
| **Team** | DHHS Authorised Officer Team Leader | | | | | |
| **Task and technology** | DHHS Hotel Isolation Medical Screening Form | Welfare check - initial long form survey | COVID-19 Assessment Form | Confidential Hotel Questionnaire | | |
| **Staff** | Welfare check caller | DHHS Authorised Officer | Nurse 1 | Nurse 2 | Nurse 3 | Team Leader |
| **Detainee** | Detainee | REDACTED | REDACTED | Fellow detainee involved in major incident | | |

## ACCIMAP



Safer Care Victoria

## ANALYSIS OUTCOMES

The review team has identified system and process improvement opportunities. Some are directly related to the event. These are described in 'Findings'. Others were identified in the course of reviewing the event, but the review team did not establish that they played a direct role in the events surrounding REDACTED death. These are described in 'Learnings'.

## FINDINGS

Findings describe contributing factors identified through the review and AcciMap process that directly related to, or arose from, the sequence of events under review.

1. **The welfare check team were unable to undertake welfare check calls to the planned schedule, as they did not have enough staff to match the required workload. As a result, initial welfare checks were often delayed, and subsequent checks were often infrequent.**

### Reasoning

While not completed prior to the incident, the Operation Soteria 'Operations Plan' is indicative of the intentions for running the hotel quarantine system at the time. It notes that DHHS would be responsible for the "provision of regular welfare calls to all quarantined passengers". The meaning of "regular" is not further specified. Interviewees advised the review team that the original intention was that welfare check calls would be made daily. Staff from outside the welfare check team indicated they believed or assumed that welfare check calls were and had always been made daily to all detainees.

Staff reported that at the time of the first and only welfare check call to REDACTED the welfare check team had a backlog of approximately 800 calls to work through. In interview, staff also noted that the script/form provided to welfare check staff for making initial calls to detainees included a paragraph – to be read to the detainee – telling the detainee to expect welfare calls "regularly". This script has been sighted by the review team. They told the review team that staff were instructed not to convey this information, as it was no longer accurate. In interview, staff indicated that due to the backlog, the revised aim was for two welfare calls to be made to detainees throughout their detainment.

Due to the backlog, the first welfare check call (to administer the 'Welfare Check – Initial long form survey') was not made to REDACTED until day five of his detainment. It was the only welfare check call made during the nine days of detainment before his death. Evidence obtained in interview indicated that it was not unusual for detainees who were not already identified as high risk to receive their first welfare check call around detainment day 5-7.

### Detainee safety implications

The delayed and infrequent welfare check calls resulted in missed opportunities to monitor detainee welfare and meet duty-of-care obligations in a timely and consistent manner. It also resulted in missed opportunities for detainees to request support or disclose health and welfare concerns.

2. **Staff were often not able to access all detainee health and welfare information they needed to provide adequate care to detainees, due to a lack of comprehensive, central, accessible repository for such information.**

**Reasoning**

Welfare check team members reported that they had access to minimal information about detainees prior to calling them for the first time (by then, often day 5-7 of the detainee's detention). Information available to staff making these calls was typically only the detainee's name, date of birth, and expected detention period. Therefore, any information already collected about the detainee's health, welfare and support needs through other channels (including information in the 'welfare questionnaire' referenced in the 'Team Leader Pack – Hotels and Confidential Hotel Questionnaire'), was not accessible to welfare check callers.

The review team has sighted a template of the 'Confidential Hotel Questionnaire' provided to detainees. The template advises detainees that "the information [they] provide will be used to help support [them] during [their] quarantine period". However, the information gathered was not systematically shared with key teams responsible for detainee health and welfare, including welfare check callers and medical staff. The review team requested a copy of the completed 'Confidential Hotel Questionnaire' for REDACTED However, it was not provided. Therefore, it is unclear if REDACTED received and/or completed this questionnaire, or what answers and information he provided on it.

Similarly, staff reported generating and having access to health and welfare information about detainees that was not systematically made readily available to other teams and individual staff members. For example, information about detainee responses to daily COVID-19 Assessment Form calls was available to nurses, but not the welfare check team. In addition, some detainee health and welfare information was written on a whiteboard (visible only to some on-site staff), in staff member's personal notebooks (not visible to others), and on 'Post-it' notes.

**Detainee safety implications**

The lack of central, comprehensive and accessible repository for detainee health and welfare information resulted in inadequate communication about detainee health and welfare concerns and needs within and between teams. It also resulted in staff being unable to have holistic and global oversight to adequately identify, assess and manage health and welfare risks for individual detainees.

3. **Detainee health and welfare information was collected in a fragmented manner, involving multiple entities and teams and multiple formats.**

**Reasoning**

The review team has sighted multiple templates/forms/questionnaires/surveys, some of which have been completed about, for or by REDACTED Examples include the 'COVID-19 Assessment Form', 'Hotel Isolation Medical Screening Form', 'Welfare Check – Initial long form survey' and 'Confidential Hotel Questionnaire'. The content of these forms is not complementary – with evidence of both duplication and, in the view of the review team, notable omissions (see Finding 7).

For example, both the 'DHHS Hotel Isolation Medical Screening Form' and 'Welfare Check - Initial long form survey' ask detainees to answer questions about allergies and "immediate" health/medical conditions. And both the 'Welfare Check - Initial long form survey' and the 'Confidential Hotel Questionnaire' ask the detainee how

children/others travelling with them are “coping”. And the ‘COVID-19 Assessment Form’ and ‘Welfare Check - Initial long form survey’ both ask detainees about symptoms of COVID-19. By contrast, none of the forms sighted by the review team directly and clearly ask the detainee if they have mental health concerns aside from those attached to a formal medical diagnosis, if they are a smoker (there is a question about requiring nicotine patches, but the two are not synonymous), or if they would like to speak with someone about any issues of concern regarding their health and welfare.

The review team requested a copy of REDACTED ‘Confidential Hotel Questionnaire’, but this was not provided. It is therefore unclear if REDACTED received and/or completed this questionnaire, or what answers and information he provided on it.

The review team noted that day-to-day operations were marked by a lack of communication and coordination regarding detainee information collected through these fragmented channels. The review team also noted that the content of each form is focused on issues which match the specific functions of each of the entities and teams administering them. In interview, staff indicated that detainee health and welfare information was collected on separate forms because individual entities and teams were separately collecting only information required to fulfil their designated function. For example, the nursing team received the ‘Hotel Isolation Medical Screening Form’, the hotel received the ‘Confidential Hotel Questionnaire’, and the welfare check team conducted their own 23-question survey in the first call (therefore not receiving substantive information about individual detainees beforehand).

The review team’s view is that, most detainees were most likely unaware of the nuances of the complex structure of the hotel quarantine system and its many teams and entities. Therefore, it would have been unclear that information they provided in the varying forms was not shared among all those who had responsibility for their health and welfare. It would also have been unclear which form or team was most appropriate for raising concerns that were not explicitly addressed by the pre-formulated questions.

**Detainee safety implications**

The lack of a coordinated and consistent method for collecting detainee health and welfare information, and collating and sharing it, compromised staff members’ ability to adequately identify and manage health and welfare risks for individual detainees. It also compromised detainee’s ability to direct their health and welfare questions, support needs and concerns to the individuals and teams best suited to address them.

4. **On a typical day, it was common for several detainees to not answer COVID symptom check calls, almost always for innocuous reasons. Therefore, unanswered calls alone did not typically trigger immediate escalation, beyond attempting follow-up calls.**

**Reasoning**

In interview, on-site staff tasked with completing daily COVID-19 Assessment symptom screening calls articulated a shared mental model that unanswered calls to detainees were almost never a cause for health and welfare concerns. They noted that most unanswered calls were the result of detainees being engaged in innocuous activities such as sleeping (they specifically sighted the effects of jet lag), bathing, talking on the phone or online, or using headphones. Staff reported that the daily transactional nature of the COVID-19 Assessment symptom screening calls became predictable to detainees, contributing to some who were asymptomatic not answering the calls, or taking the in-room landline phone off the hook.

The review team heard that on average, by the end of a typical day, between 5-15 detainees had not answered repeated COVID-19 Assessment symptom screening calls, and a nurse was required to knock on their door to elicit a response. Between them, staff reported that in their personal experiences of such follow-up 'door knocks', only one had uncovered a serious reason for the unanswered calls. Nursing staff and AOs reported that as a result, they did not routinely prioritise or escalate unanswered calls (beyond follow-up calls) until the end of the day, or even later.

In REDACTED case, there were at least five unanswered calls throughout 11/04/2020. Due to a lack of formal system for documenting these unanswered calls (see Finding 5), the review team could not be certain if there were more unanswered calls. There was a delay of more than 24 hours from the time REDACTED last answered a COVID-19 Assessment symptom screening call (approximately 16:00 on 10/04/2020 - as per police witness statement) to when the AO, nurse and security guard forced entry to his room at approximately 17:30 on 11/04/2020.

It is the view of the review team that the frequency of unanswered calls, and the pattern of these unanswered calls not indicating serious issues, resulted in less priority being placed on following up unanswered calls compared with other tasks. In REDACTED case, the AO noted the issue of REDACTED unanswered calls was escalated to him, but he was required to deal with multiple competing issues that he deemed to be of higher priority, before attending REDACTED room for follow-up. The other matters deemed to be of higher priority included the concurrent serious barricading incident, and providing assistance to several detainees with anxiety who has previously been identified as high risk.

**Detainee safety implications**

The shared mental model that unanswered COVID-19 Assessment symptom screening calls mostly did not indicate significant concerns increased the risk that a definitive response may be delayed. This posed a risk to safety in instances where the main indicator of a detainee's need for urgent assistance was unanswered calls.

5. **There was a lack of specific formal policy about the threshold for escalating concerns about repeated unanswered COVID-19 Assessment calls, and a lack of formal procedure for tracking these.**

**Reasoning**

In interview, staff stated there was no formal policy about when to escalate instances of repeated unanswered COVID-19 Assessment symptom screening calls for more definitive action (e.g. knocking on or opening the detainee's door), and no formal procedure for tracking unanswered calls. This lack of formal policy was corroborated by an email (sighted by the review team) from then Director, Emergency Management and Health Protection, South Division, to DHHS senior executive on 12/04/2020 (the day after REDACTED was found deceased). In that email, the Director cited the lack of such a policy, and the need for one to be developed.

The lack of clarity about the threshold for escalating unanswered calls was evident when the review team asked staff to describe the escalation process for unanswered calls. They gave variable answers as to when escalation should occur (e.g. after two calls, after four hours), but were clear that the AO was the appropriate line of escalation. They noted that when to act was a matter of judgement (in the absence of a formal policy), and their decisions took into account perceptions that AOs sometimes had high workloads and competing priorities.

In the absence of a formal policy or procedure, nursing staff described having developed a work-around to track and follow-up unanswered calls. If a call was not answered the first time, nursing staff would place the detainee's COVID-19 Assessment Form in a designated box. Nurses would later revisit that box "if [they] had time" and make the follow-up calls. The forms of detainees who answered follow-up calls were removed from the box. The forms of those who did not answer were returned to the box, and were revisited again when a nurse had time available. Post-it notes/whiteboard notes were also used to record the names of detainees with repeated unanswered calls. This cycle continued until the end of the day, when staff would attend the rooms of any detainees whose forms remained in the box, to knock on their doors.

The lack of policy and process for tracking unanswered calls was also evident in the COVID-19 Assessment Form, which does not require (or provide specific space for) the caller to log unanswered calls. It also does not provide space for callers to log the times of answered calls (only the dates). This issue was evident in RE REDA case, where the date of his last answered COVID-19 Assessment was recorded on his form, but not the time. Therefore, the extended time since his last answered call was not readily evident to all relevant staff.

**Detainee safety implications**

A lack of formal policies and processes around tracking and responding to unanswered COVID-19 Assessment calls increased the risk that a definitive response may be delayed. This posed a risk to safety in instances where the main indicator of a detainee's need for urgent assistance was unanswered calls.

6. **Due to workload and delegation challenges, Authorised Officers (AOs) were sometimes required to prioritise multiple competing demands, resulting in delays in attending to potential detainee health and welfare concerns.**

**Reasoning**

Due to the strict legal requirements around detention procedures, and the AOs specific legal role, they had limited ability to delegate tasks required of them under the Health and Wellbeing Act 2008. In addition, the ability to accurately predict any AO's workload from day-to-day was limited. This was due to multiple factors including a reported lack of prior information about the needs of the detainee cohort (and individual detainees) before arrival, and uncertainty about how these needs may arise and change over time. In interview, on-site staff reported that AOs were frequently very busy, juggling multiple competing demands for their time and attention.

This was seen in REDACTED as evident in interviews, as well as the AO's statement to police. On the day nurses escalated their concerns about REDACT unanswered calls to the AO, he was required to deal with a serious concurrent multi-day incident involving a detainee who had barricaded himself in his room, requiring significant police presence. Concurrently, the AO was required to attend at the rooms of multiple people identified as high risk due to anxiety-related issues. He attended to these issues before attending REDACTE room to follow-up the unanswered calls.

**Detainee safety implications**

Because AOs sometimes face complex competing demands and priorities with limited opportunities to delegate to non-AO staff, this may limit their ability to respond to detainee health and welfare needs or incidents in a timely manner.

7. **The forms for collecting detainee information were not well designed to readily elicit specific and detailed information regarding past or current mental health concerns, self-harm or suicidal ideation.**

**Reasoning**

The review team has sighted multiple templates, forms and questionnaires used to gather information from and about individual detainees. None of those sighted by the review team directly and specifically asked about past or current self-harm or suicidal ideation. Welfare check staff also reported they did not routinely ask such questions of detainees.

Overall, the forms sighted contained limited questions that addressed mental health. In the view of the review team, questions that did allude to mental health generally were not direct, in plain language, or written in a manner that was relatable and understandable to the general public. Where mental health was mentioned, this was typically done using a 'medical model' approach, focused on identifying diagnoses, but not more general issues about mental distress, risk factors or concerns that may not specifically correlate to a 'diagnosis'. For example, the questions may not have captured the concerns and risks associated with people worried about managing grief in quarantine. For example, the one direct mental health question in the 'DHHS Hotel Isolation Medical Screening Form' read "Significant mental health diagnosis Y/N". This question only clearly applied to those with a formal diagnosis, used the subjective word 'significant', and only provided for a binary yes/no answer (without encouraging further elaboration or disclosure). In another example, the 'Confidential Hotel Questionnaire's' possible allusions to mental health are vague and indirect (e.g. "are you feeling well at the moment?" and "do you or anyone in your group have any immediate health or safety concerns?"). It also contained questions about how children/people accompanying the detainee were "coping", but did not ask the same about the detainee themselves.

In the forms sighted, questions about their support needs place a significant onus on detainees to anticipate their psychological response to, and needs in an unfamiliar, uncertain and potentially stressful situation. And did so prior to detainees having spent any significant time in that situation. Of note is that the forms do not include a list of common support needs to select from (alongside free text space for other needs), which may otherwise assist detainees in identifying their likely support needs.

**Detainee safety implications**

Not routinely asking a specific question(s) about past or current mental health concerns, self-harm or suicidal ideation represented a missed opportunity for detainees to disclose this information, and thus the opportunity for their welfare and safety to be adequately supported. Forms designed in a way that did not readily elicit information about mental health information and associated risk factors compromised staff members' ability to adequately identify and manage health and welfare risks for individual detainees. It also resulted in missed opportunities for detainees to request support or disclose health and welfare concerns.

Safer Care Victoria

## LEARNINGS

Learnings describe system issues for which there was insufficient evidence to demonstrate that they contributed substantially and specifically to the incident under review, but nonetheless provide important improvement opportunities.

| | Learnings |
|---|---|
| 1 | Separate welfare check calls and COVID-19 Assessment symptom screening calls were made to the same detainees by separate teams located at different sites (welfare check team and nursing team respectively). These teams had ostensibly different remits (general welfare checks vs COVID symptom screening), although the distinction was blurred in practice. This duplication of effort decreased the opportunity for holistic oversight of detainee health and wellbeing. It may also have increased the probability a detainee would mention concerns or issues during a call from one team, where those issues were within the remit of the other team, and the information would not be definitively acted upon. |
| 2 | Staff sometimes had to use (or felt they had to use) indirect means to request escalation and assistance regarding issues and concerns (such as use of general email addresses or helpline-like phone numbers). This lead to a delayed response or definitive action, or none at all. This was exacerbated by escalated issues being 'lost' in generic email inboxes which received copious numbers of emails, or because staff answering calls to generic helpline numbers were unable to provide definitive answers or actions. |
| 3 | Welfare check callers had been working remotely (the team understands this began after the incident), reducing the ability for their work interacting with detainees to be supervised and monitored for quality control and training purposes. |
| 4 | Staff putting themselves forward to take up temporary new roles in the hotel quarantine system did not have an adequate opportunity to nominate at the outset the types of roles for which they would or would not be suitable. In selecting and assigning the above staff to new roles, there were limited checks regarding their relevant skills, experience, education or professional background to assess their suitability. Therefore, some staff were placed in roles for which they were not suitably knowledgeable, skilled or experienced, or for which they were otherwise ill-suited. |
| 5 | For many new roles created for the hotel quarantine system, there was a lack of clear and detailed job descriptions and/or job cards at the outset, resulting in a lack of clarity about roles and responsibilities. |
| 6 | There was limited to no standardised formal training, orientation or shadowing for staff starting new roles in the hotel quarantine system. |

Safer Care Victoria

## RECOMMENDATIONS

Recommendations describe actions that could be taken to address the findings and/or learnings identified in the review, and achieve system improvement.

The strength of recommendations (weak, moderate or strong) describes the overall likelihood that their implementation is likely to succeed in establishing sustained changes in risk and/or behaviour, and achieve the desired outcomes. This likelihood is determined based on general evidence about human factors, systems improvement and change management.

| | Recommendation | Associated findings / learnings | Strength |
|---|---|---|---|
| A | Develop and implement a detainee arrival pack that consolidates the current suite of 'onboarding' forms into a single onboarding form (for data entry into the central repository in Recommendation H), alongside printed information for detainees. | Findings 2, 3 and 7 | Moderate |
| B | Design the new onboarding form to: include a specific question(s) about past or current self-harm and suicidal ideation; be clear, direct and use plain language; not use relative, subjective words such as 'significant' to delineate what information is important; encourage disclosure beyond binary answers; address mental wellbeing from both medicalised and non-medicalised perspectives; and provide specific examples of common support needs. | Findings 3 and 7 | Moderate |
| C | Establish a formal process to ensure each (newly consolidated) detainee onboarding form is reviewed by a single staff member within 48 hours, adopting a holistic approach, to identify and act upon any immediate or ongoing support needs or health and welfare risks factors, identify detainees requiring further risk and assign an initial risk level (see Recommendation D). | Findings 2, 3 and 7<br>Learnings 1 and 5 | Weak |
| D | Establish a formal process for nursing staff (with additional clinical advice if required) to assign and monitor a health and welfare risk level (low, medium or high) for each detainee, based on all information available (e.g. onboarding form, 'initial screening call', staff observations).This level should be dynamic and changeable at any time in the face of new information or circumstances, with a schedule for regular review of each detainee's risk level. | Findings 3 and 7<br>Learning 1 | Weak |
| E | Replace current daily COVID-19 Assessment symptom screening calls with daily 'health and welfare screening calls', delivered by nursing staff for detainees of **all risk levels**. Include in these calls the COVID-19 Assessment symptoms screening questions, and other basic health and welfare questions to screen for unmet support needs or elevated safety and welfare risks. | Findings 1, 3, 4 and 7<br>Learnings 1, 2 and 5 | Moderate |
| F | For detainees classified as **medium or high risk** only, extend the purpose of the new daily 'health and welfare screening calls' (see Recommendation E) to specifically discuss, monitor and provide support around their specific health and welfare issues. | Findings 1, 3, 4 and 7<br>Learnings 1, 2 and 5 | Moderate |
| G | For detainees classified as **low risk**, make the provision of regular 'check-in calls' from the welfare team an optional, opt in addition to receiving the mandatory 'health and welfare screenings calls' (to provide social contact and practical needs-check) (see Recommendation E). Implement processes for welfare team members with concerns to escalate these for potential re-classification of a detainee as higher risk. | Findings 1 and 4<br>Learning 1 | Weak |
| H | Implement a comprehensive central repository for detainee's personal information (including health and welfare information) accessible to all staff with a role in providing services, care, support and oversight for detainees. Include functionality to provide an 'alerts list' for each shift to identify detainees with a medium or high risk level, and the reasons for those ratings. | Findings 2 and 3<br>Learning 1 | Strong |
| I | In the central repository of detainee personal information, design the section for logging health and welfare calls (from the nursing and welfare teams) to include a specific field(s) for users to record the dates *and times* of both answered and | Findings 2, 3 4 and 5 | Moderate |

| | | | |
|---|---|---|---|
| | unanswered calls to detainees (with the list of unanswered calls automatically visible to users). | | |
| **J** | Offer detainees the option (at onboarding and throughout their detainment, for example via text message or email) to nominate a time slot each day in which they prefer to take calls from welfare and/or nursing staff, and call detainees during the nominated time slot. | Findings 1 and 4<br>Learning 1 | Weak |
| **K** | Implement a formal policy about when to escalate situations in which detainees are not answering calls from nursing or welfare teams – using a decision-tree approach that accounts for factors such as number and frequency of unanswered calls, detainee's existing health and welfare risk factors, and previous behaviour in answering/not answering calls. | Findings 4 and 5<br>Learning 5 | Weak |
| **L** | Increase and/or more strategically roster the number of AOs on duty at one time to ensure adequate baseline capacity, and rapid response surge capacity that AOs can directly and immediately request if they are task- or demand-overloaded. | Finding 6<br>Learning 2 | Moderate |
| **M** | Establish a formal selection process for staff taking up new roles that accounts for their skills, preferences and attributes. Require that welfare team members have relevant background or experience (e.g. mental health, counselling, social work, peer support etc). Complement this with targeted initial and ongoing training and supervision (including for remote working staff) for all new and current staff. | Learnings 3, 4, 5 and 6 | Moderate |

## APPENDIX 1: RECOMMENDATION ACTION PLAN TEMPLATE

Please outline the plan for how recommendations will be enacted.

If a recommendation has been wholly enacted when the report is received, indicate 'wholly' in column two of Table 1. Write N/A in subsequent columns of Table 1. Then complete Table 2 for that recommendation.

If a recommendation has been partly enacted when the report is received, indicate 'partly' in column two of Table 1. Complete the remaining columns in Table 1 for aspects of the recommendation that have not yet been enacted. Then provide details in Table 2 for aspects of the recommendation that have been enacted.

If no part of a recommendation has yet been enacted when the report is received, indicate 'no' in column two of Table 1. Complete the remaining columns in Table 1. Do not use Table 2 for that recommendation.

### Table 1.

| Recommendation | Already enacted (Write: 'wholly', 'partly' or 'no') | Actions still required to enact recommendation | Outcome measure(s) | Executive position sponsor | Position responsible/ accountable | Due date for completion |
|---|---|---|---|---|---|---|
| A | | | | | | |
| B | | | | | | |
| C | | | | | | |
| D | | | | | | |
| E | | | | | | |
| F | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| G | | | | | | |
| H | | | | | | |
| I | | | | | | |
| J | | | | | | |
| K | | | | | | |
| L | | | | | | |
| M | | | | | | |

## RECOMMENDATIONS ALREADY IMPLEMENTED

If any recommendations have been wholly or partly implemented when the report is received, use Table 2 to provide details of what has been done, how implementation has been monitored (e.g. monitoring on-the-ground uptake and impacts – intended and unintended), and outcomes (using appropriate outcome measures).

**Table 2.**

| Recommendation | Actions already completed | Monitoring undertaken | Outcomes |
|---|---|---|---|
| | | | |
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| | | | |

## APPENDIX 2: KEY THEMES FROM HOTEL QUARANTINE INCIDENTS 1 AND 2

### Operation Soteria Hotel Quarantine – Common themes arising from two incident reviews as of 15 May 2020.

Below is a summary of key quality and safety issues, and associated contributing factors, identified by Safer Care Victoria during their review of two incidents involving returned travellers in hotel quarantine in Victoria.

Based on evidence and information available to Safer Care Victoria at the time of writing, these issues were evident at the time of the two incidents REDACTED. It is noted that certain information sought by the team was unable to be provided or obtained during the data collection period. In addition, some individuals invited for interview in relation to these incidents declined to be interviewed during the data collection period.

Due to the ongoing detention of returned travellers in hotel quarantine as a result of the COVID-19 pandemic, a rapid review methodology was employed. This methodology has some limitations regarding data collection and scope. These limitations were considered against the need for a rapid review process to inform system improvement in real time. With that approach and goal in mind, the review teams share a summary of issues identified below.

| Issue | Comments |
|---|---|
| Selection of staff | Victorian public sector staff putting themselves forward to take up temporary new roles in the hotel quarantine system did not have an adequate opportunity to pre-emptively nominate the types of roles for which they would or would not be suitable.<br><br>In selecting and assigning staff to new roles, there were limited checks regarding their relevant skills, experience, education or professional background, in order to assess their suitability for particular roles.<br><br>As a result of the above (and possibly other factors) some staff were assigned to roles for which they did not have the appropriate knowledge base, skill set or relevant experience. |
| Onboarding and training of staff | For many of the new roles created for the hotel quarantine system, there was a lack of clear and detailed job descriptions and/or job cards available to staff when they commenced in their roles. This resulted in a lack of clarity about individual roles and responsibilities.<br><br>There was limited to no formal and standardised training, orientation or opportunities for mentoring available to staff commencing new roles within the hotel quarantine system. Some individuals reported taking the initiative to develop and provide training for their teams. However, these efforts were individually driven by frontline staff and were therefore not consistently adopted across the system.<br><br>On the day of their first shift in their new role, some staff did not experience adequate handover from their counterpart who had worked the previous shift. |
| Continuity of staffing | Continuity of staff rostered at hotel locations was limited. This resulted in staff reporting challenges relating to their roles. These included issues relating to hotel familiarity, teamwork, clarity regarding roles and responsibilities, and continuity of support provided to returned travellers.<br><br>Some staff reported requesting to be rostered at the same location and/or team. However these efforts were individually-driven by frontline staff, and therefore were not consistently adopted across the system. |
| Collection, storage and access to personal information about returned travellers | There were reports of inadequate and inconsistent systems and resources (paper or electronic) available for the recording information about returned travellers. As a result, such information (e.g. health and welfare notes, returned traveller requests and concerns) was commonly recorded in ad hoc ways (e.g. staff member's personal note books, post-it notes, whiteboards etc).<br><br>During a returned traveller's period of detention, they were required to complete (either on paper or via phone) a variety of forms, questionnaires and assessments. These were administered by multiple entities and teams (i.e. nursing staff, welfare check team, hotel staff and the Department of Jobs, Precincts and Regions). The information gathered through the multitude of channels was not centrally coordinated and stored, and thus was not available to all staff who required it. As a result, staff often did not have the information needed to perform their roles optimally and provide adequate support and care to returned travellers. For example, welfare check callers did not have access to nursing notes or the hotel questionnaire when making calls to returned travellers. |
| Policies and procedures | A number of policies and procedures considered necessary to ensure safe operation of the hotel quarantine system were reported to be either under development or not readily accessible by frontline staff at the time these incidents occurred. For example, policies regarding appropriate use of personal protective equipment, |

| | |
|---|---|
| | escalation of concerns about returned travellers not answering calls, how to conduct handovers, record-keeping and issues tracking, or managing ambulance attendance.<br><br>Some policies or procedures reflected plans and intentions that were not operationalised or achieved in practice (e.g. differences between planned frequency of welfare checks and actual frequency of these). |
| **Escalation and leadership responsibilities** | There was a reported lack of clarity among frontline staff about escalation processes and pathways, and the circumstances under which they should be utilised. Where formal policies or processes had been formulated, frontline staff reported being either unaware of these, or these were not operationalised fully.<br><br>There was a reported lack of understanding amongst frontline staff in relation to decision-making hierachies in complex and unprecedented situations. For example, deciding on the appropriate level of clinical care, or when to escalate concerns about a returned traveller not responding to phone calls and door knocks.<br><br>There was no dedicated role on-site with specific responsibility for decision-making regarding returned traveller health and wellbeing. This role was often either shared between nurses, or an informal 'lead' nurse was appointed for the shift by the nursing team, with access to consultation with a doctor (most often off-site) if required.<br><br>Some team leaders, authorised officers and nurses reported not receiving adequate information about to whom they should escalate concerns (e.g. specific names, roles and direct phone numbers). Staff sometimes had to use indirect means to request escalation and assistance about issues and concerns (such as use of general email or 'helpline' phone numbers), leading to reported delayed or no response or definitive action. |

## APPENDIX 3: REPORT VERSION TRACKING

| Date | Action |
|---|---|
| 21/05/2020 | Draft report shared with Merrin Bamert, Director, Emergency Management and Health Protection, South Division requesting fact check. Response received 22/5/20. |
| 25/05/2020 | Final report shared with Merrin Bamert, Director, Emergency Management and Health Protection, South Division and Operation Soteria Working Group. |
| 03/06/2020 | Role description under finding five updated in response to feedback from Andrea Spiteri, Director Emergency Management, Emergency Management Branch |

EMV
EMERGENCY
MANAGEMENT
VICTORIA

# State Health Emergency Response Plan

Edition 4

This plan has been endorsed by the State Crisis and Resilience Council (SCRC) as a subplan to the State Emergency Response Plan.

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**Acknowledgment of Country**

Emergency Management Victoria (EMV) acknowledges Aboriginal and Torres Strait Islander people as the Traditional Custodians of the land. EMV also acknowledges and pays respect to the Elders, past and present and is committed to working with Aboriginal and Torres Strait Islander communities to achieve a shared vision of safer and more resilient communities.

Photographs courtesy of:
- Monash Clinical School (cover – middle photo)
- John Gollings (page 12)

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# Figures



# Tables

# Acronyms

Acronyms used in this plan.

| ACRONYM | DESCRIPTION |
|---|---|
| AV | Ambulance Victoria |
| CAD | computer aided dispatch |
| CFA | Country Fire Authority |
| CHO | Chief Health Officer |
| DEDJTR | Department of Economic Development, Jobs, Transport and Resources |
| DELWP | Department of Environment, Land, Water and Planning |
| DET | Department of Education and Training |
| DHHS | Department of Health and Human Services |
| DTF | Department of Treasury and Finance |
| ED | emergency department |
| EMC | Emergency Management Commissioner |
| EM-COP | Emergency Management Common Operating Picture |
| EMJPIC | Emergency Management Joint Public Information Committee |
| EMMV | Emergency Management Manual Victoria |
| EMT | Emergency Management Team |
| EMV | Emergency Management Victoria |
| EPA | Environment Protection Authority Victoria |
| ESTA | Emergency Services Telecommunications Authority |
| FEMO | Field Emergency Medical Officers |
| GP | general practitioner |
| I-HIMT | Incident tier Health Incident Management Team |
| IMT | Incident Management Team |
| MOUs | memoranda of understanding |
| PHCP | Public Health Control Plan |
| R-HIMT | Regional tier Health Incident Management Team |
| SAC | State Agency Commander |
| SCC | State Control Centre |
| SCM | State Consequence Manager |
| SCOT | State Coordination Team |
| SCRC | State Crisis and Resilience Council |
| SCT | State Control Team |
| SEMC | Security and Emergency Management Committee of Cabinet |
| SEMT | State Emergency Management Team |
| SERP | State Emergency Response Plan |
| SHEMC | State Health Emergency Management Coordinator |
| SHERP | State Health Emergency Response Plan |
| S-HIMT | State tier Health Incident Management Team |
| SPLO | Senior Police Liaison Officer |

# 1 Introduction

The State Health Emergency Response Plan (SHERP) provides an overview of the arrangements for the management of health emergencies in Victoria. This plan describes the integrated approach and shared responsibility for health emergency management between the Department of Health and Human Services (DHHS), the emergency management sector, the health system and the community.

Every day, the health system manages a large volume and variety of incidents. These incidents do not typically stretch the system's ability to effectively respond.

Health emergency, in the context of this plan, includes an incident or emerging risk to the health of community members, from whatever cause, that requires a **significant and coordinated effort** to ensure the health system can effectively respond and mitigate the adverse health consequences for communities.

Within the *Emergency Management Act 2013,* health emergencies can be classified as Class 2 emergencies. The Emergency Management Manual Victoria (EMMV) Part 7 – Emergency Management Agency Roles designates DHHS as the control agency for the following types of health emergencies:

- biological materials, including leaks and spills
- radioactive materials, including leaks and spills
- retail food contamination
- food / drinking water contamination
- human disease (including mass, rapid onset human disease from any cause).

This plan has been developed by DHHS in conjunction with the Victorian emergency management sector. It is a sub-plan of the State Emergency Response Plan (SERP), published as Part 3 of the EMMV, the principal document guiding the State's emergency management arrangements.

This plan replaces the third edition of the SHERP and the Public Health Control Plan (PHCP) to establish a common operating structure for DHHS, Ambulance Victoria and the broader health system when responding to health emergencies.

## 1.1 Purpose

The purpose of this plan is to describe the integrated approach and shared responsibility for health emergency management between DHHS, Ambulance Victoria, the emergency management sector, the health system and the community and how these differ to, or elaborate upon, the arrangements in the SERP.

## 1.2 Objective

The objectives of this plan are to:

- reduce preventable death, illness and disability in all health emergencies and other emergencies with health impacts
- maximise health outcomes by providing treatment in a safe, timely and coordinated manner
- provide timely, tailored and relevant information and warnings to the community
- provide clarity on roles, responsibilities, escalation and communication channels to enable an effective and efficient health emergency response.

## 1.3 Scope

The scope of this plan includes:

- planning and preparedness for the health response in emergencies, including consequence planning, community preparedness, and capability planning for the health system
- public information and warnings processes, roles and responsibilities
- command, coordination and control arrangements at the state, regional and incident tiers for the health response in emergencies
- control arrangements where DHHS is the control agency, as well as where DHHS is a support agency
- roles and responsibilities across the health system for a health emergency response
- escalation and notification processes for health emergency response.

This plan provides strategic information about the Victorian arrangements for managing health emergencies. Details about the response activities of individual agencies are covered in agency operational response plans.

Relief and recovery activities are outlined in EMMV Part 4 – State Emergency Relief and Recovery Plan.

This plan does not cover activities that DHHS delivers as part of its broader portfolio responsibilities, such as housing and disability service activities.

The State Emergency Management Priorities, available at **www.emv.vic.gov.au**, apply to health emergency responses.

## 1.4 Authorising environment

The *Emergency Management Act 1986* and the *Emergency Management Act 2013* form the empowering legislation for the management of emergencies in Victoria.

The EMMV contains policy and planning documents for emergency management in Victoria, and provides details about the roles different organisations play in the emergency management arrangements.

The SERP identifies Victoria's organisational arrangements for managing response to emergencies. This plan is a subordinate plan to the SERP and was endorsed by the State Crisis and Resilience Council (SCRC) in July 2017.

In addition to the *Emergency Management Act 2013,* the *Public Health and Wellbeing Act 2008* and related public health legislation and regulations also provide authority for control functions related to the management of public health incidents and emergencies (refer to Appendix B: Victorian public health legislation relating to SHERP).

## 1.5 Activation of the plan

The arrangements in this plan apply on a continuing basis and do not require activation. Escalation of the arrangements in this plan is outlined in Section 6.3.

## 1.6 Audience

The audience for this plan comprises all relevant health service providers and agencies, including the Victorian government and agencies within the emergency management sector. This also includes business and community groups with a significant role in the management of emergencies, and other organisations that provide additional capacity during a health emergency response.

Although the wider community is not a primary audience, community members may find the contents of this plan informative.

## 1.7 Linkages

This plan reflects Victorian legislation, the arrangements in SERP, the strategic direction for emergency management in Victoria and the accepted state practice for managing emergencies. Arrangements in the SERP have not been repeated unless necessary to ensure context and readability.

There are also a number of Commonwealth Government and national plans relevant to health emergency response, such as the Australian Health Management Plan for Pandemic Influenza (refer to Appendix C: National plans relating to SHERP).

Coordination of inter-jurisdictional support, collaboration and Commonwealth resources when the state government requests assistance is governed by the Australian Emergency Management Arrangements (managed by Emergency Management Australia) and the National Health Emergency Response Arrangements (managed by the Commonwealth Department of Health).

This plan may be used as a framework to support national arrangements within Victoria. The Emergency Management Commissioner is responsible for liaising with Emergency Management Australia during an emergency.

## 1.8 Exercising and evaluation

This plan will be exercised within one year from the date of approval. The exercise will be evaluated and, where improvements to the emergency management arrangements in this plan are required, the plan will be amended and a revised version issued. Exercises will be conducted in accordance with the State Exercising Framework.

In the event of an emergency response utilising arrangements under this plan, the control agency will organise an operational debrief with participating agencies as soon as practicable after cessation of any response activities under this plan. All agencies, including recovery agencies, shall be represented with a view to evaluating the adequacy of the response and to recommend any changes to agency plans and future operational response activities.

## 1.9 Review

This plan was current at the time of publication and remains in effect until modified, superseded or withdrawn.

DHHS will review and update this plan every three years. More frequent reviews may be undertaken if required, for example following experience utilising or exercising this plan, or following substantial change to relevant legislation or machinery of government arrangements.

# 2 The health emergency context

## 2.1 The Victorian health system

The Victorian health system, in the context of this plan, describes the people, agencies and facilities that work together to provide health services to Victorian communities to ensure they are healthy and safe, and that people are able to lead a life they value.

On a daily basis community members interact with the Victorian health system, a dynamic and interdependent network of health services that provides health advice, diagnostic services, clinical and pharmaceutical treatment to maximise health outcomes.

The Victorian health system also includes public health functions and powers available to the Chief Health Officer (CHO) under the *Public Health and Wellbeing Act 2008*. Public health involves preventing the occurrence and spread of disease and illness, and reducing the risk posed by potentially dangerous substances to ensure safe environments across Victoria.

Under this plan, DHHS and Ambulance Victoria work together as the key government agencies that lead a health emergency response. Hospitals, both public and private, also play a critical role in response to health emergencies. Depending on the nature of an emergency, a broader range of health service providers and experts may also be involved to achieve the best possible health outcomes for affected community members. For example, emergencies of longer duration or widely dispersed in nature, may require additional response capacity and capability and this may involve first aid agencies, general practitioners (GPs), community pharmacists, and field emergency medical officers or coordinators.

This plan and relevant operational response plans facilitate a collaborative approach to emergency response that can scale up and down to best meet health needs (refer to Appendix D for a list of relevant operational response plans).

Continuity of health care service provision, particularly to vulnerable community members, during and following an emergency is also a priority for the health system and complements the arrangements in this plan.

This plan further acknowledges that health system support may continue into the relief and initial recovery activities. Refer to the EMMV Part 4 – State Emergency Relief and Recovery Plan for more information.

## 2.2 Types of health emergencies

This plan applies to all types of health emergency which, due to the scale or extent of health consequences, require a significant and coordinated effort to ensure the health system can effectively respond and mitigate the adverse health consequences for communities.

This includes:

- Public health emergencies (for which DHHS is the control agency), such as:
  - biological and radioactive incidents, such as transport accidents involving biological releases or radioactive substances, loss of control of biological releases or radioactive substances associated with an authorised practice (for example: spillage or unintended dispersion), and dispersion of a biological release or radioactive substance
  - retail food contamination, such as contamination of food during manufacturing, storage or transport
  - water contamination, such as loss of disinfection of a drinking water supply, contamination of a drinking water supply, contamination of food following natural disasters (due to food spoilage), and infectious disease outbreaks arising from food preparation and consumption
  - human disease, such as communicable diseases, gastro and respiratory outbreaks, thunderstorm asthma, and clusters of non-communicable disease.
- Other health emergencies (for which DHHS is a support agency), such as:
  - natural disasters with health impacts, such as bushfires, floods, storms or extreme heat
  - deliberate acts resulting in casualties, such as warlike acts, acts of terrorism, hi-jacks, sieges or riots
  - other mass or complex casualty situations, such as structure fires, drug overdoses or stampedes at mass gatherings or public events, and transport incidents.

## 2.3 An integrated response to health emergencies

This plan outlines Victoria's integrated health emergency response arrangements. The arrangements in this plan are specific to the State's health system.

The arrangements integrate the three key lines of health system communication with the necessary line of control for effective emergency management. The three key lines of health system communication are:

- health command (predominantly pre-hospital)
- health coordination (hospital and health services)
- public health command.

This ensures that the roles and responsibilities for decision-making and response coordination are clear and well understood by all stakeholders in the event of a health emergency.

This plan also embeds an 'all communities, all emergencies' approach, focusing on:

- clarifying roles and responsibilities for a coordinated and integrated health emergency response, including decision-making, notification and warning, across health and the emergency management sector and service providers
- identifying how health system agencies and providers can work collaboratively to build sector capacity and achieve the best possible outcomes for community members affected by an emergency, while still meeting the needs of other individuals requiring health services
- outlining actions individuals, health sector agencies and service providers, and governments can undertake to strengthen their resilience to health emergencies, in line with the principle of shared responsibility described within the National Strategy for Disaster Resilience, available at **www.ag.gov.au**, as well as the Victorian Community Resilience Framework for Emergency Management, available at **www.emv.vic.gov.au**.

Given the dynamic and interdependent nature of the Victorian health system, it is vital that all relevant health service providers and agencies follow this plan to ensure a coordinated and effective health response to emergencies.

# 3 Consequences

The direct consequences of health emergencies are human disease, harm and mortality. Health emergencies may also have broader consequences for our social, economic, and natural environments. Beyond health and wellbeing, appropriate consideration of health emergency consequences can minimise broader, ongoing impacts for communities, including social and economic impacts.

Planning for the effective management of consequences of a health emergency should account for the changing profile and expectations of Victorian communities. This includes considering future implications for the health of the population, for example, rising chronic disease and increasing antibiotic resistance.

The consequences of a health emergency vary greatly, depending on the:

- nature of the particular illness or injury
- scale of people affected, or potentially affected
- extent to which the illness or disease can be contained or controlled
- likelihood and extent of disruption to the delivery of government services (such as health services and schools)
- extent to which health consequences are likely to be worsened by disruption to essential services (such as electricity or telecommunications due to extreme heat).

The nature and extent of consequences will inform response, relief and recovery arrangements for a health emergency. Planning for these consequences will ensure that the community receives timely, tailored and relevant information and services before, during and after a health emergency.

DHHS will work with the Emergency Management Commissioner (EMC), Emergency Management Victoria (EMV) and other government agencies, the health system, industry, business and the community to identify and mitigate potential consequences of the emergency.

## 3.1 Wellbeing

Health emergencies have direct consequences on individuals affected. This may include physical injuries, illness, permanent disability and mortality. However the consequences of a health emergency extend far beyond these initial physical impacts.

Individuals impacted by a health emergency may experience mental health challenges associated with prolonged illness, ongoing or terminal disease, or the trauma of a mass casualty situation. The mental health consequences of an emergency may also extend to the friends, families or carers of impacted individuals, or to bystanders who may have witnessed multiple injuries or fatalities.

## 3.2 Community connection

Health emergencies have the potential to impact social connections, due to some methods for controlling the spread of disease such as restrictions on movements or public gatherings. Depending on the scale of the incident, individuals, communities or entire regions across the state may experience mental health (and other) challenges associated with a loss of community connectedness or independence. There may also be community concern and associated mental health challenges in circumstances where the nature and extent of illness from exposure to a biological release or radioactive substance is unknown.

Physical and psychosocial impacts of an emergency can also exacerbate social problems in communities, such as drug and alcohol abuse or family violence.

## 3.3 Liveability

Health emergencies may disrupt accessibility of critical health infrastructure and services. For example, epidemic thunderstorm asthma has the potential to overwhelm the health system and disrupt services to other patients requiring care. The uncontrolled spread of antibiotic-resistant bacteria and pandemics are examples of health emergencies that can significantly disrupt critical health infrastructure and health services. The longer the emergency, the greater the pressure on the health system to respond to and treat both individuals impacted by the emergency, as well as others who also need to access acute, ambulance, primary and other healthcare services.

Health emergencies may have further consequences for the provision of critical health care services as a result of health care workers being unable to attend work due to illness or the risk of infection.

This risk extends to the delivery of other services. Disruptions to critical infrastructure such as public transport services, essential services (such as water, electricity and fuel) transport of food and goods, education and government services are further potential consequences of health emergencies due to individuals being unable to attend work.

Additional consequences of a health emergency for health services may relate to disruption to relevant vaccinations, pharmaceuticals or medical supplies due to unprecedented demand.

## 3.4 Sustainability and viability

Health emergencies may have economic consequences at the local, regional or state level. A communicable disease outbreak contained to a community or region for example, may disrupt a local vibrant economy due to employers and/or employees being unable to attend work, or community members being unable to leave their homes and purchase local goods and services as they normally would.

A larger scale health emergency, such as a dangerous highly infectious disease like Ebola, may result in further consequences for the Victorian economy. Depending on the timing of the outbreak, for example, it may have a significant impact on major sporting, music or cultural events due to large number of people being unable to attend due to illness or the risk of infection. Events may be cancelled.

Tourism may also be significantly impacted. Individuals may choose not to visit Victoria due to a perceived risk of infection or, in the case of a health emergency resulting from a mass casualty situation, due to a perceived risk of another event being likely.

A major health emergency may also have significant economic consequences for the state associated with disruption to business and services.

Costs associated with the treatment of illness or injury (including any preventative measures which may be taken) may also be significant, depending on the nature and scale of health consequences.


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# 4 Community resilience

'Safer and more resilient communities' is the shared vision of Victoria's emergency management sector and underpins the arrangements in this plan. The Community Resilience Framework for Emergency Management also provides the foundation upon which the emergency management sector's strategies, programs and actions can be planned, integrated and implemented in order to build safer and more resilient communities. Building resilient communities is a shared responsibility. In the health emergency context, building resilient communities requires communities, governments, and the health system to work in an integrated way that puts people at the centre of decision making.

## 4.1 Shared responsibility for action

The National Strategy for Disaster Resilience, developed by the Council of Australian Governments, provides high-level guidance on disaster management.

The strategy recognises that application of a resilience-based approach is not solely the domain of emergency management agencies; rather it is a shared responsibility between individuals, communities, business and governments. Examples within the health emergency context include:

- individuals taking responsibility for their own health and health of those in their care
- local government and communities conducting first aid training and emergency preparedness programs
- the health system, to which the community may turn for support or advice, preparing for increased or diverse service demand during health events and emergencies
- business and industry, including critical infrastructure providers, engaging in business continuity planning that links with community and emergency management arrangements to ensure they are able to provide services during or soon after an emergency.

- government agencies through:
  - creating partnerships with health service providers to build capability and capacity
  - undertaking monitoring and surveillance of infectious diseases and other notifiable conditions
  - providing timely, tailored and relevant information to the community to allow people to make informed decisions about their health and safety
  - providing education including recommended actions to prepare for or mitigate health impacts of emergencies
  - supporting individuals and communities to prepare for, respond to and recover from health emergencies.

### 4.1.1 Individual preparedness

Individual community members can prepare for a health emergency by undertaking some or all of the following actions:

- follow any public health directions when ill or there is an increase in illness in the community, such as social distancing and avoiding mass gatherings, immunisation, hand hygiene, cough etiquette
- put together an emergency kit (which includes a first aid kit)
- ensure medication supplies for all family members are kept up to date
- register themselves and their family for a My Health Record (visit: **myhealthrecord.gov.au**)
- learn first aid
- join a volunteer first aid organisation.

### 4.1.2 Planning for vulnerable people in emergencies

Planning for emergencies should consider the needs of vulnerable people to improve the safety and resilience of vulnerable people and their ability to respond safely to emergencies. Vulnerable people, for the purposes of this plan, refers to those who, due to physical or cognitive impairment, are unable to understand emergency warnings and directions, or are unable to respond in an emergency situation. Vulnerable persons who cannot identify personal or community support networks to help them in an emergency may be included on the Vulnerable Persons Register (search for the Vulnerable people in emergencies policy: **www.dhhs.vic.gov.au**).

## 4.2 Public information and warnings

Access to timely, tailored and relevant information about an emergency assists a community to make informed decisions and to act purposefully. Communities, individuals and households need to take responsibility for their own safety and act on information, advice and other messages provided before, during and after health emergencies.

Consistent with the State Emergency Management Priorities, public information and warnings issued under this plan will be:

- relevant, timely, clear, targeted, credible and consistent
- responsive and empathetic
- accurate and informed by evidence
- tailored to the impacted community
- provided through a range of communication channels
- aligned with the Victorian Warning Protocol available at **www.emv.vic.gov.au/responsibilities/victorias-warning-system/victorian-warning-protocol**.

Communication may include channels such as CHO Alerts, warnings published through Victorian Warnings System, media conferences, information uploaded to the Better Health Channel, radio, social media, and community information hotlines.

### 4.2.1 Management of public information and warnings

Collaboration, coordination and early notifications between agencies are necessary to ensure communities receive consistent and complementary messaging before, during and after a health emergency.

DHHS, in collaboration with Ambulance Victoria, is responsible for issuing warnings and providing public information during a health emergency. DHHS as the control agency will authorise all public information and warning messages prior to their release to the community, where practicable.

The CHO will approve all public health messaging, CHO alerts and CHO advisories, in line with the *Public Health and Wellbeing Act 2008,* as required.

Ambulance Victoria may disseminate public information and warnings, in collaboration with DHHS, for the purpose of enabling the community to make informed decisions. For example, where there are significant delays for ambulances, that people should make their own way to hospital. The purpose of providing this information is to increase community awareness regarding current demand for ambulance services.

To facilitate the rapid communication of information and warnings, the State Controller may delegate authority to a Deputy Controller or a public information officer to authorise the release of information and warnings to the community.

All warnings issued should adhere to the Victorian Warning Protocol. The warning protocol can be found at: **www.emv.vic.gov.au**.

The DHHS Public Information and Warning Business Rules and Decision-making Guide outlines the roles and responsibilities for issuing public information and warnings for health emergencies. The DHHS public information officer, the State Control Centre warnings officer or the State Warnings and Advice Duty Officer will issue warnings on behalf of DHHS. Public information and warnings will be available on the VicEmergency website and app. Supporting information may be published on the Better Health Channel or the Department of Health website.

Under the SERP, where the timeframe is short and an extreme and imminent threat to life exists, any response agency personnel (such as Victoria Police or Ambulance Victoria) can issue warnings to people likely to be affected, providing they notify the relevant Controller as soon as possible following issue of the warning.

### 4.2.2 Emergency Management Joint Public Information Committee

The Emergency Management Joint Public Information Committee (EMJPIC) provides strategic guidance for state-level messages across all state government departments and agencies. EMJPIC is responsible for ensuring public information across all state government departments and agencies is consistent, and distributed in a timely and accurate manner to inform and advise community members during a major emergency, as well as ensuring media needs are met.

The State Controller (or delegate) will engage the support of the EMJPIC to ensure that state-level messages from all agencies with a role or responsibility in managing the impact and consequences of health emergencies are prioritised and included in key messages to the public. This may also include the integration of messaging across all emergencies, such as fires and storms. EMMV Part 8 – Appendices and Glossary provides further information on the role of EMJPIC.

# 5 Capability and capacity

The *Victorian Preparedness Framework 2017* and supporting documents set the foundation for how Victoria prepares for, responds to and recovers from emergency incidents. The framework identifies 21 core capabilities, each considering the crucial elements of people, resources, governance, systems and processes which are needed to manage events, reduce impacts, protect our community and increase resilience.

While many of the 21 core capabilities are required to effectively manage before, during or after a health emergency, there are three capabilities particularly relevant to this plan:

- health emergency response
- health protection
- planning.

The first two capabilities are especially important in the context of the State Emergency Risk Assessment, which identifies pandemic influenza, bushfires and floods as Victoria's highest priority emergency threats. Each of these threats will involve a significant and coordinated health response. Other core capabilities relevant to health emergency response capability will be outlined in the relevant agency operational response plans.

Planning is critical to the effective delivery of this plan. A collaborative approach to understanding, testing and building capability across the entire health system is fundamental to our ability to effectively respond to health emergencies.

## 5.1 Health emergency response capability

Health emergency response capability within the context of this plan is the collective ability of people, resources, governance arrangements, systems and processes to limit the adverse health consequences of emergencies on individuals and communities. It is based on the collective capability of all involved in undertaking health emergency response activities, including community members, government, agencies and health service providers.

The Victorian Preparedness Framework 2017 describes health emergency response capability as involving "the planning, provisioning, response and coordination of pre-hospital and health emergency care, including triage, treatment and distribution of patients, in a timely and structured manner, using all available resources to maximise positive health outcomes".

All health service providers with a role or responsibility under this plan are required to maintain their capability to fulfil health emergency response activities.

Agencies should also undertake training to maintain capability and capacity to respond under this plan, in addition to maintaining their relevant clinical or other professional skills, competencies and authorities. Arrangements for obtaining additional capabilities and capacity during a health emergency response are outlined in agency operational response plans.

## 5.2 Health protection capability

The Victorian Preparedness Framework 2017 describes health protection capability as the ability to "promote and protect the public health of Victorians by monitoring notifiable diseases and responding to any disease outbreaks in order to control and minimise the risk of infection. This includes regulating the safety of food, drinking water and human environmental health hazards such as radiation, legionella and pesticides. This includes informing the community and health providers about public health risks and promoting behaviours and strategies to mitigate and avoid risk. It also includes the development of national policies, standards and strategies to promote improvements in public health generally and support the health system to respond to national public health risks".

Critical tasks to support health protection capability development include development and delivery of programs to detect and identify risks, undertaking and delivering specialist clinical epidemiological analysis and investigation, and communicating health risks through public health promotion and prevention campaigns. Refer to Section 4.2 Public Information and Warnings for more information.

Support arrangements, including arrangements for sourcing additional state, national and international resources to respond to emergencies if required, are outlined in the SERP and the National Health Emergency Response Arrangements.

## 5.3 Health sector emergency planning and preparedness

The Victorian Preparedness Framework 2017 describes planning capability as the ability to "conduct a systematic process engaging the whole community as appropriate in the development of executable strategic, operational or tactical level approaches to meet defined objectives."

All organisations with roles or responsibilities under this plan must ensure they are adequately and appropriately prepared to respond to health emergencies and emergencies with health impacts. This includes assuring that they have effective plans, processes and systems in place to fulfil their roles and responsibilities under this plan. In addition, all organisations with emergency response plans that interface with this plan need to be familiar with these arrangements.

### 5.3.1 Health service planning

Health service providers use a nationally recognised set of codes (guided by the Australian Standard (AS) 4083-2010 Planning for emergencies – Health care facilities) to plan for response to and recovery from internal and external emergencies (refer to Appendix G: Summary of relevant emergency codes in hospitals and health care facilities). This includes plans for external emergencies, such as mass casualty incidents (Code Brown), infrastructure and other internal emergencies, such as power failure (Code Yellow) and evacuations (Code Orange).

Health service planning needs to include occupational health and safety planning to ensure that, as far as possible, the physical and psychological wellbeing of staff is protected when they are involved in a health emergency response.

Effective health emergency preparedness and response requires consistent, effective and practised integration of health services providers with other members of the emergency management community, as well as across the health system. Coordinated arrangements for an anticipated or actual emergency enable the provision of seamless and integrated services for communities.

It is important that health services providers develop and exercise their plans as part of normal business operations to minimise service interruption and health consequences for communities in the event of an emergency.

Health service providers should ensure that their plans integrate with this plan to facilitate an effective response where escalation of a health emergency response is required.

Code Brown is a nationally recognised code used by health services to plan, prepare, respond and recover from an external emergency. A guidance note for Code Brown planning for health service providers is available at: **www.health.vic.gov.au**.

# 6 Collaboration

Victorian Government agencies have roles and responsibilities under this plan to work together to ensure the health system can effectively respond to an anticipated or actual health incident and mitigate the adverse health consequences for communities by:

- managing the safe, effective and coordinated health response to Class 2 health emergencies, and
- coordinating the effective health response to other emergencies with health consequences that require a significant and coordinated effort, beyond normal health system operations, for effective response.

## 6.1 Emergency Management Commissioner role and responsibilities

Under the *Emergency Management Act 2013,* the Emergency Management Commissioner (EMC) has legislated management responsibilities across major emergencies. These include response coordination, ensuring the establishment of effective control arrangements, consequence management and recovery coordination.

## 6.2 Agency roles and responsibilities for Class 2 health emergencies

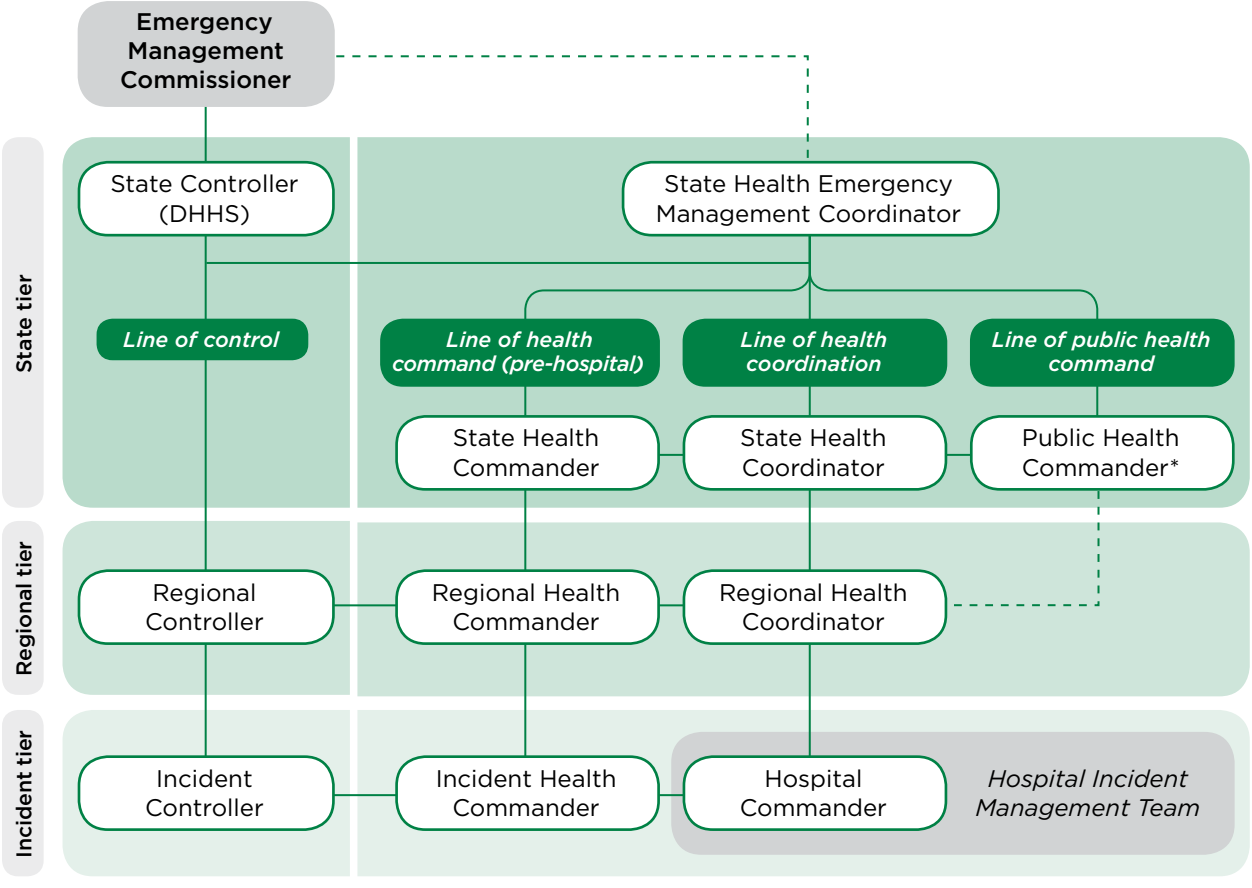
Under the EMMV Part 7 – Emergency Management Agency Roles, DHHS is the nominated control agency for specified health emergencies in Victoria (refer to Section 1).

DHHS is responsible for identifying unfolding or potential health emergencies, and escalating health emergency response arrangements outlined in this plan to ensure the health system can effectively respond and mitigate the adverse consequences for communities (refer to Section 6.3.3).

DHHS may activate the State Emergency Management Centre (located at DHHS) when considered necessary for the effective management of an emergency. To ensure an effective response to adverse health consequences for communities DHHS may also, in consultation with the EMC, request activation of the State Control Centre (SCC) to provide support to the State Controller. The SCC provides a range of services to assist with the coordination and control of emergencies and has well-established protocols for working across all government agencies and for providing information and warnings to the community.

The reporting relationship for Class 2 health emergency response is illustrated at Figure 1.

**Figure 1: Reporting relationship for Class 2 health emergencies**




* Public Health Commander appointed State Controller for identifiable public health emergencies.

Table 1 outlines the authority and role for key decision-making functions (functional leads) in a health emergency.

**Table 1: Key functions in a health emergency (DHHS as both control and support agency)**

| | AUTHORITY AND ROLE | |
|---|---|---|
| **FUNCTION** | **DHHS AS CONTROL AGENCY** | **DHHS AS SUPPORT AGENCY (DIFFERENCES BY EXCEPTION)** |
| Emergency Management Commissioner | The Emergency Management Commissioner is accountable for ensuring the response to emergencies in Victoria is systematic and coordinated.<br>This includes ensuring that control arrangements are in place during a Class 2 emergency, responsibility for consequence management for a major emergency, and management of the State Control Centre on behalf of (and in collaboration with) agencies that may use it for emergencies. | |
| State Controller (DHHS as control) / State Health Incident Management Team Lead (DHHS as support) | As agency lead, the Secretary to DHHS appoints the State Controller (by instrument of appointment) to enable appropriate focus on managing health consequences according to the nature of the emergency:<br>• the Public Health Commander will be appointed State Controller for identified public health emergencies (most likely to occur in circumstances where a public health emergency is anticipated)<br>• all other emergencies, including in the event of a rapid onset health emergency where the causation is unclear, the State Health Coordinator will be appointed as State Controller.<br>The State Controller is responsible for the following initial decisions and actions, in consultation with the appropriate internal and external stakeholders:<br>• verify the relevant response assessment (refer to Section 6.3.3)<br>• determine the strategic objectives for response<br>• determine the incident management model or activate pre-agreed plans for the initial response<br>• establish incident management team(s) (as applicable)<br>• ensure timely and appropriate public information and warnings are provided to the community<br>• notify the EMC, support agencies and relevant health system service providers.<br>The State Controller may appoint a Deputy Controller.<br>The State Controller should delegate their function on the State Health Incident Management Team (that is, Public Health Commander or State Health Coordinator) to a deputy or equivalent. | Where DHHS is the support agency, it is not responsible for the control function.<br>Under these arrangements, the lead of the State Health Incident Management Team where DHHS is a support agency is:<br>• the State Health Coordinator, where coordination of emergency response activities across the health system is required (including hospitals, primary health and other acute services);<br>• the Public Health Commander where the control agency requires public health expertise. |

| | AUTHORITY AND ROLE | |
|---|---|---|
| **FUNCTION** | **DHHS AS CONTROL AGENCY** | **DHHS AS SUPPORT AGENCY (DIFFERENCES BY EXCEPTION)** |
| State Health Emergency Management Coordinator (SHEMC) | The SHEMC is an executive-level public administration function performed by DHHS and appointed by the Secretary of the department.<br>The SHEMC is responsible for ensuring that appropriate appointments are made to state tier functions (the State Health Commander, State Health Coordinator and the Public Health Commander), as well as providing executive administrative support to ensure these functions operate effectively.<br>While an instrument of appointment will determine whether the Public Health Commander or State Health Coordinator performs the function of State Controller, the SHEMC may advise the Secretary to DHHS who should fulfil the function of State Controller (with advice from the State Health Incident Management Team) according to the nature of the emergency and response, and consistent with the instrument of appointment. | |
| Public Health Commander (Public Health Command functional lead) | The Public Health Commander function is performed by the Chief Health Officer (or delegate).<br>The Public Health Commander reports to the State Controller and is responsible for commanding the public health functions of a health emergency response (including investigating, eliminating or reducing a serious risk to public health).<br>Performing the function of Public Health Commander does not alter in any way the management, control and emergency powers of the Chief Health Officer under the *Public Health and Wellbeing Act 2008*.<br>In performing this function, the Public Health Commander will liaise directly with the State Health Commander and State Health Coordinator.<br>For emergencies where the Public Health Commander is not appointed the State Controller, the Chief Health Officer's authority under the *Public Health and Wellbeing Act 2008* remains unaffected, and their decisions on matters of public health should not be overridden by a State Controller. | The Public Health Commander function will be the State tier Health Incident Management Team Lead where the control agency requires public health expertise. |

| | AUTHORITY AND ROLE | |
|---|---|---|
| **FUNCTION** | **DHHS AS CONTROL AGENCY** | **DHHS AS SUPPORT AGENCY (DIFFERENCES BY EXCEPTION)** |
| State Health Coordinator (Health Coordination functional lead) | The State Health Coordinator function is performed by a senior DHHS officer appointed by the SHEMC.<br>The State Health Coordinator reports to the State Controller and is responsible for coordinating DHHS' emergency response activities across the health system (including hospitals, primary health and other acute services) at the state tier.<br>In performing this function, the State Health Coordinator liaises directly with the State Health Commander and Public Health Commander. | The State Health Coordinator function will be the State tier Health Incident Management Team Lead for all events where the Public Health Commander is not the Lead. |
| State Health Commander (Health Command functional lead) | The State Health Commander function is performed by the appointed Ambulance Victoria Emergency Management Director (unless otherwise appointed by the SHEMC).<br>The State Health Commander reports to the State Controller and is responsible for commanding the pre-hospital and field response to an emergency (including ambulance services, first responder assistance, and spontaneous volunteers) at the state tier.<br>In performing this function, the State Health Commander will liaise directly with the State Health Coordinator and Public Health Commander. | |

The State tier Health Incident Management Team is responsible for managing the whole of health response to an emergency.

### Key support agencies

In addition to DHHS' nominated role as control agency for response to Class 2 health emergencies in Victoria, the department is also responsible for delivering human services and business continuity services during the emergency.

DHHS has further responsibility for leading the coordination of emergency relief and recovery activities at the regional tier. This includes coordination of relief and recovery planning, the provision of personal support (including psychological first aid) at incident sites and across the community, and the provision of interim accommodation following emergencies with major housing impacts.

EMMV Part 7 – Emergency Management Agency Roles lists the key support agencies for Class 2 health emergencies and their responsibilities (refer to Table 2).

Many of these agencies coordinate their response activities across a range of other agencies within their functional sector. The State Controller leads the coordination of these functional sectors through the State Emergency Management Team (SEMT) (refer to Table 4: Functions and membership of key state response teams).

Table 2 identifies the key supporting functions these agencies provide during Class 2 health emergencies. All of these agencies should have internal plans for managing their responsibilities.

This table is not exhaustive and should be read in conjunction with the relevant legislation and the EMMV, noting any government or non-government agency may be requested to assist in a health emergency response (or relief or recovery) if it has the skills, expertise or resources to contribute to the management of the emergency (EMMV Part 7 – Emergency Management Agency Roles).

**Table 2: Functions of key support agencies for Class 2 health emergencies**

| AGENCY | RESPONSIBILITY FOR RESPONSE |
|---|---|
| Ambulance Victoria | • deploy Health Commanders to relevant tiers to direct the operational health response<br>• respond to requests for pre-hospital emergency care, triage patients, determine treatment priority and provide pre-hospital clinical care<br>• transport and distribute patients to appropriate medical care<br>• provide health support to patients undergoing decontamination<br>• manage additional medical and nursing capacity, such as FEMO and VMAT teams, where required<br>• notify receiving hospitals of patients<br>• support evacuations of vulnerable people<br>• liaise with control agencies to ensure the safety of responders, health care workers, and the public for identified and emergent risks from an incident. This includes activation of personal support arrangements.<br>• liaise with Public Health Commander and Health Coordinator. |
| DET | • provide emergency notifications and reporting services between schools and emergency services<br>• provide advice and list of suggested resources to non-government schools. |
| DELWP | • support emergency response for drinking water supply and contamination. |
| DEDJTR | • Agriculture Victoria provides notifications and coordination with DHHS, regarding agricultural incidents and risks with possible health impacts, for example, food-borne illness outbreaks in primary production systems and zoonotic diseases, including anthrax and vector-borne disease. |
| EMV | • manage the operation and administration of the State Control Centre<br>• in collaboration with the whole-of-government, lead the coordination of public information and warnings for major emergencies<br>• lead the coordination of consequence management for major emergencies<br>• coordinates relief and recovery activities at the state level. |
| ESTA | • answer and process Triple Zero (000) emergency calls from the community and dispatch emergency resources<br>• provide early warnings to EMV and agencies of significant incidents, detected through triple zero information channels<br>• maintain support and management of multi-agency operational communication systems. |
| EPA | • assess the environmental impact of the emergency<br>• advise the emergency services on the properties and environmental impacts of hazardous materials<br>• provide Air Monitoring capability in emergencies to support analyses of community health impacts in accordance with air monitoring protocols<br>• provide environmental public health surveillance, risk assessment and initial response in accordance with environmental public health protocols and MOUs between EPA and DHHS<br>• ensure that appropriate transport and disposal methods are adopted for wastes generated from response activities. |
| Local Government | • coordinate municipal resources needed by the community and response agencies<br>• facilitate the delivery of warnings to the community and the provision of information to the public and media<br>• support investigations and control of illness outbreaks and other public health incidents. |

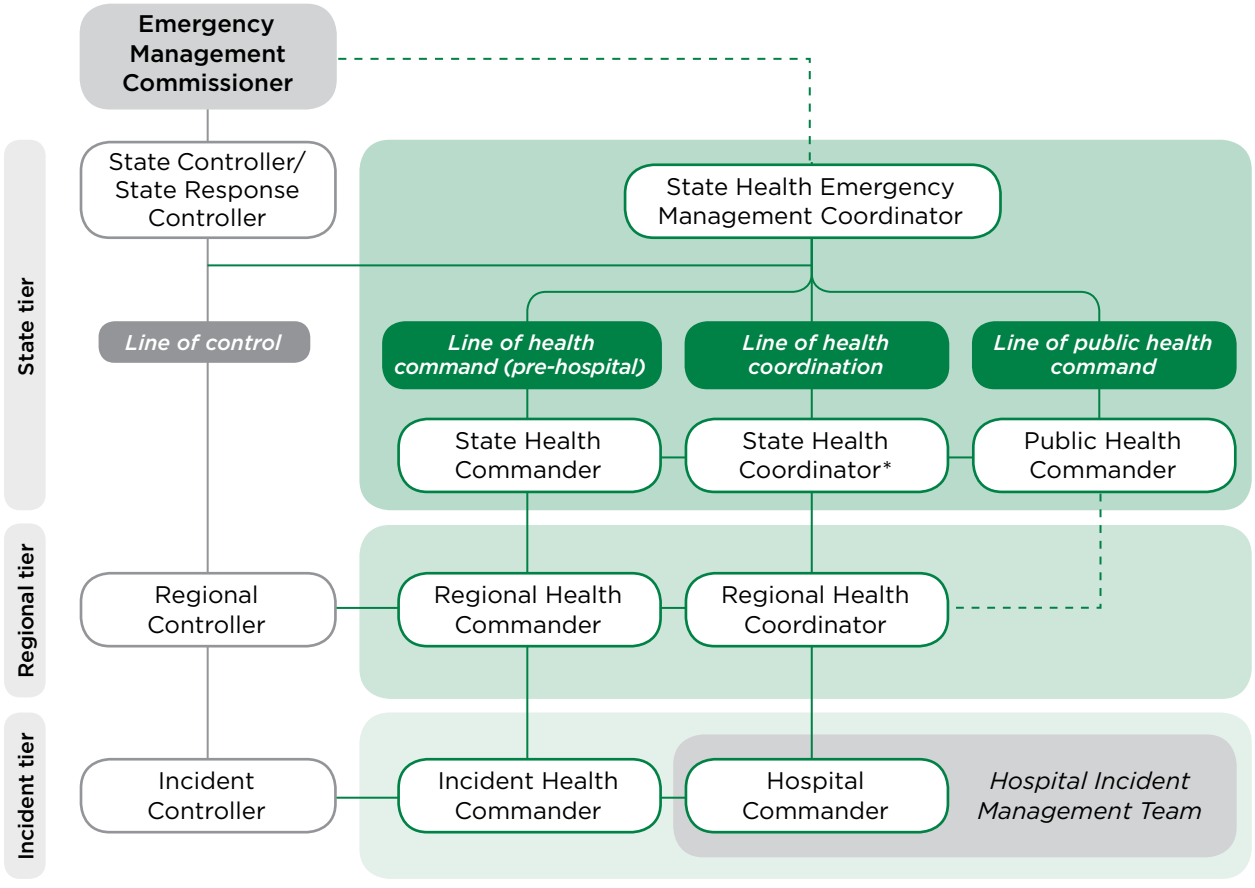
### 6.2.1 Agency roles and responsibilities for health emergency response (where DHHS is operating as a support agency)

Where monitoring and notifications suggest the health system is, or is likely to, experience an impact over day-to-day operations (e.g. refer to Section 6.3.3: Escalation process), the arrangements outlined in this plan will be escalated as required to ensure the system can effectively respond to and mitigate the adverse health consequences for communities. This includes emergencies other than a Class 2 health emergency.

Where another control agency (such as Victoria Police or a fire service agency) is activated for a major emergency that requires a health response, that control agency directs the emergency response, as depicted at Figure 2.

The Chief Health Officer's authority under the *Public Health and Wellbeing Act 2008* to make decisions on matters of public health and to exercise management, control and emergency powers applies in all health emergency response situations and should be made in consultation with the State Controller.

**Figure 2: Reporting relationship for health emergency response (where DHHS is operating as a support agency)**




* State Health Coordinator to lead the State Health Incident Management Team for rapid-onset emergency.

## 6.3 Escalation and notification

The majority of health emergencies are managed by the health system either as business as usual, or using an incident management system as part of normal operations (refer to Section 6.4: Incident management arrangements).

Arrangements will be escalated under this plan when information is received to suggest that an incident is impacting, or likely to impact, the health system's ability to effectively respond to an incident and mitigate the adverse health consequences for communities.

Arrangements may be escalated in anticipation of, or in response to notifications or observations.

### 6.3.1 Notifications to DHHS

DHHS relies on notifications to inform its situational awareness of the whole of the health system. This is fundamental to determining when arrangements under this plan should be escalated to ensure the health system can effectively respond to an incident and mitigate the adverse consequences for communities.

There are four types of notifications:

- notification of a public health incident, for example notification of a communicable disease outbreak
- notification from Ambulance Victoria of a significant increase or change in the volume and nature of Triple Zero (000) calls or requests to attend
- notification of increased demand on health system, for example Code Brown or Code Yellow activations, information on emergency department presentations provided to DHHS through its real-time monitoring system or information on change in nature or volume of GP presentations
- notification of other situations, for example notification from a Control Agency of a terrorist event with mass casualties.

Notifications are required to include information, to the extent known, on the location, type of incident, hazards, number of cases or patients and the required emergency and/or health services.

This whole-of-system view is an important function for DHHS as part of its system management role in the health system.

Advice, warnings and planning arrangements related to potential threats to public health (such as a new strain of pandemic flu identified overseas) or upcoming events with potential significant health impacts (such as extreme weather days or major public events) are also an important source of information, and needs to be considered in a collaborative manner and

issued in a coordinated manner. This information enables early assessment to determine the appropriate initiation of readiness activities in anticipation of a major emergency or incident with significant health consequences for communities (refer to Section 6.3.3: Escalation process).

## 6.3.2 Notifications by DHHS to the health system

Appropriate and timely two-way communications between DHHS, hospitals, primary health care providers and the broader health system is integral to an effective health emergency response.

### DHHS notifications

Health system practitioners, agencies and hospitals rely on notifications from DHHS to provide situational awareness of the health system. This is fundamental to support planning for mobilisation of resources and the creation of short term capacity (for example, through activating Code Brown) to accommodate additional health system demand and mitigate the adverse health consequences for communities. Health system practitioners, agencies and hospitals should also maintain their own situational awareness and mobile resources as necessary in the absence of notifications from DHHS.

The relevant Commander or Coordinator (or delegate) will issue a 'first wave' alert for any incident that may present a substantial risk to the health and wellbeing of Victorian communities. The alert provides a state-wide communication to the Victorian public and private health sector, including:

- all public health services
- all private hospitals
- other health sector stakeholders, as appropriate, to support the response.

### Actions for the health system

All practitioners, agencies and hospitals operating within these arrangements are required to have:

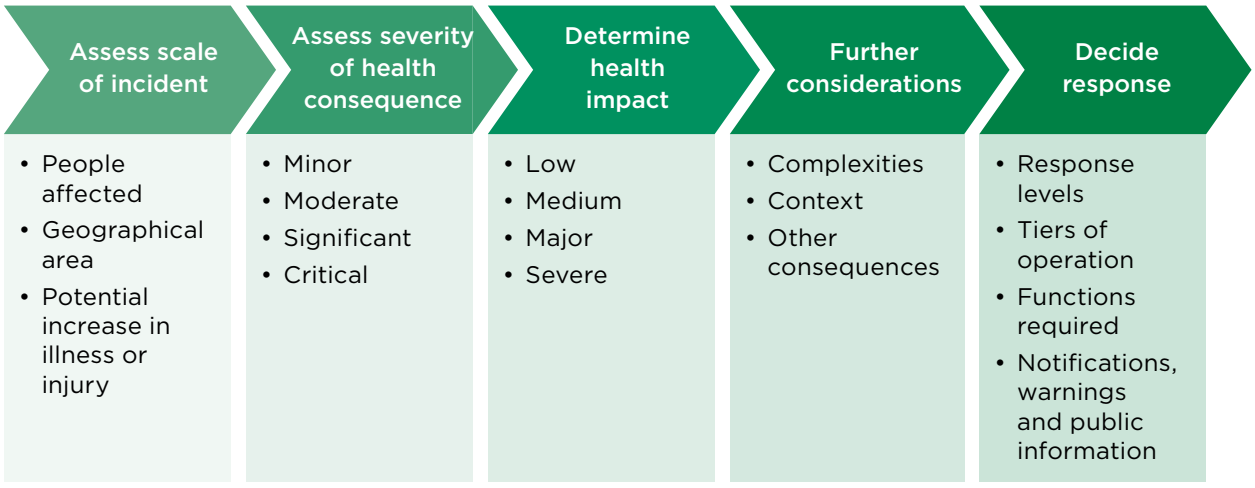
- a single point of contact that is monitored at all times for receiving DHHS notifications
- a plan to escalate their response if and as required.

All health system services that receive a first wave alert need to consider what, if any, impact the incident will have on their operations and respond as required.

### 6.3.3 Escalation process

Health emergency response is escalated when an incident is assessed as impacting, or likely to impact, the health system's ability to effectively respond to an incident and mitigate the adverse health consequences for communities (refer to Figure 3).

**Figure 3: Overview of escalation process**




Upon notification of a potential health emergency (either through the notification process or through departmental monitoring activities), the relevant functional lead (or delegate) will undertake an assessment process (see Figure 4) to determine the appropriate level of response.

The aim of the response is to contain or eradicate disease to minimise its impact in the community, or maximise health outcomes for individuals and communities impacted by an emergency.

Responsibilities and incident management structures for health emergency response are outlined in Section 6.4 Incident management arrangements.

The need to escalate or de-escalate should be continually reviewed as the situation changes or new information becomes available.

**Figure 4: Escalation process**

## SCALE

1. Assess the extent to which the incident has impacted, or may impact, the community's health on a small, medium, large or very large scale. Consider:

| SCALE | EXAMPLE INDICATORS |
|---|---|
| Number of people affected | • Volume of Triple Zero calls<br>• Volume of hospital presentations<br>• Number of presentations and volume of calls to GPs, community pharmacies and other health care service providers (such as NURSE-ON-CALL)<br>• Number of notifications of reportable disease or illness |
| Size of geographical area affected | • Location of Triple Zero calls<br>• Location of increased hospital presentations<br>• Location of notifications of reportable disease or illness<br>• Size of biological or radioactive incidents (actual and predicted)<br>• Extent of food or drinking water contamination |
| Potential increase in illness or injury (urgency) | • Degree of transmissibility and population vulnerability<br>• Number of individuals potentially impacted and unaccounted for<br>• Likely increase in exposure to threat or hazard<br>• Information from other agencies |

## CONSEQUENCE

2. Assess the extent (severity), or likely extent, of health consequences for incident for community members using the following scale:

| HEALTH CONSEQUENCE | DESCRIPTION |
|---|---|
| Minor | • Known and treatable illness or injury. Home management likely<br>• No mortality |
| Moderate | • Illness or injury requires or is likely to require treatment by pre-hospital or primary care services<br>• Minor increase or likely small increase in mortality |
| Significant | • Illness or injury requires or is likely to require treatment in hospital<br>• Moderate increase or likely moderate increase in mortality |
| Critical | • Illness or injury requires or is likely to require extended hospital treatment and rehabilitation<br>• Significant increase or likely significant increase in mortality |

## HEALTH IMPACT

3. Plot the likely scale and consequence of the incident within the following **Response Matrix** to determine the overall community impact:

| | | HEALTH CONSEQUENCE | | | |
|---|---|---|---|---|---|
| | | **Minor** | **Moderate** | **Significant** | **Critical** |
| **SCALE** | **Very large** (All or most of state impacted) | Major | Major | Severe | Severe |
| | **Large** (Several communities or regions impacted) | Medium | Major | Major | Severe |
| | **Medium** (Community impacted) | Low | Medium | Major | Major |
| | **Small** (Individuals impacted) | Low | Low | Medium | Major |

| IMPACT ON HEALTH SYSTEM | EFFECTIVE RESPONSE TO MAXIMISE HEALTH OUTCOMES FOR COMMUNITIES |
|---|---|
| **Low** | • This incident has had, or is likely to have, a low impact on health system operations.<br>• Response can be managed within business as usual arrangements. |
| **Medium** | • This incident has had, or is likely to have, a medium impact on health system operations.<br>• Response requires capacity or capability additional to the responding business unit.<br>• This will typically be a non-major emergency. |
| **Major** | • This incident has had, or is likely to have, a major impact on health system operations.<br>• Response requires additional capacity or capability across the health system and multiple government departments/agencies.<br>• This may be a major emergency, and may be recognised as a Class 2 health emergency. |
| **Severe** | • This incident has had, or is likely to have, a severe impact on health system operations.<br>• The State's capacity or capability to respond has been, or is likely to be, exceeded. Additional capacity or capability is required through multi-jurisdictional and/or international support.<br>• This will be a major emergency and will be recognised as a Class 2 health emergency. |

**Figure 4: Escalation process (continued)**

## FURTHER CONSIDERATIONS

4. Do any complexities and consequences of this incident change the assessment? Consider the following and adjust (potentially moving one or more columns to the right) on the response matrix:

| CONSIDERATION | EXAMPLE |
|---|---|
| Complexities | • Concurrent emergencies<br>• Unprecedented response required (no plan exists or plan untested)<br>• Multi-sectoral consequences requiring significant coordination<br>• Multi-jurisdictional or Commonwealth involvement<br>• Specialised technical knowledge and skills required<br>• Security issues<br>• Accessibility difficulties |
| Context | • Level of community resilience or vulnerability<br>• Need for public information and warnings<br>• Need for communications in relation to the incident<br>• Level of community concern<br>• Level of health system resources required to support response<br>• Level of loss or incapacitation of health structures<br>• Duration of incident |

The impact on normal health system operations identified in the response matrix (refer to **Figure 4**) informs a number of decisions by the relevant functional lead (or delegate) to ensure the health system can effectively respond and mitigate the adverse health consequences of an incident. This includes decisions on:

- tiers of operation to be activated (state, regional, incident)
- capacity and capability required of Incident Management Team(s) at relevant tiers (Level 1, 2 or 3, detailed at Table 3)
- functions that need to be established or scaled (up or down)
- notifications, warnings and public information to be issued
- readiness activities in anticipation of a health emergency.

### 6.3.4 Response levels

There are three levels of health emergency response:

**Table 3: Incident response level**

| INCIDENT LEVEL | DESCRIPTION | KEY CONSIDERATIONS |
|---|---|---|
| Level 1 | Level 1 incidents are characterised by being able to be resolved through the use of local or initial response resources only.<br>They are typically small and simple incidents, with low overall community impact.<br>Level 1 incidents will have a low-to-medium impact on normal health system operations.<br>Examples of Level 1 incidents include: routine food recalls; a localised outbreak of infectious disease; localised severe weather events with a limited number of associated health complaints. | The response to Level 1 incidents should consider:<br>• Establishment of a Hospital Incident Management Team or an Incident-tier Health Incident Management Team |
| Level 2 | Level 2 incidents may be more complex either in size, resources or risk.<br>They are typically larger in area and more complex than Level 1 incidents, and involve multiple agencies and resources, require public information and medium to major community overall health impact is possible.<br>Level 2 incidents will have a medium-to-high impact on normal health system operations.<br>Examples of Level 2 incidents include: moderate level outbreak of infectious disease; water supply contamination in a small rural town; significant number of injuries/illness at a mass gathering or public event. | The response to Level 2 incidents should consider:<br>• The need for more complex management of emergency response in size, resources or risk<br>• The need for deployment of additional resources/subject matter experts to perform dedicated functions due to the levels of complexity<br>• Establishment of a Health Incident Management Team at the appropriate tier/s |
| Level 3 | Level 3 incidents are characterised by high degrees of complexity requiring substantial response management.<br>Complexities of Level 3 incidents might include size, resources, duration, risks and/or difficulty to control. Level 3 incidents may also have high community and media interest and/or require longer-term response operations. They may have major to severe overall community health impact.<br>Level 3 incidents will have a high-to-very high impact on normal health system operations.<br>Examples of Level 3 incidents include: major disease outbreak or pandemic; actual or suspected terrorist attack with mass casualties; significant chemical, biological radiation incidents creating significant risk to communities and involving multiagency response. | The response to Level 3 incidents should consider:<br>• The need for more complex management of emergency response in size, resources, communications or risk<br>• The need to coordinate concurrent response and relief and recovery arrangements<br>• The need for deployment of additional resources/subject matter experts to perform the full range of dedicated functions due to the levels of complexity<br>• Establishment of a State Health Incident Management Team and multiple agencies involved<br>• Activation of the State Control Centre where necessary<br>• Develop an action plan outlining objectives, strategies and resource allocations |

### 6.3.5 Stand down

Stand down is the return to business-as-usual operations when deployment of resources and personnel is no longer required. For Class 2 health emergencies, the relevant incident controller is responsible for notifying the health system to stand down operations. Agencies involved in a response may consider undertaking one or more stand down activities. These activities may include but are not limited to:

- notifying relevant public health services, private hospitals, the primary health sector and other health sector stakeholders of incident site stand down
- hot debrief of all participants to learn from the emergency management experience
- peer support advice and information for personnel involved in a response, such as access to employee assistance programs.

For any major emergencies, a review of this plan and supporting plans and standard operating procedures will be required (refer to Section 1.9).

### 6.3.6 Transition to relief and recovery

Emergency response coordinators are responsible for advising all agencies involved in the health emergency of the termination of the emergency response.

Once the emergency response activities have concluded and where relief and recovery activities need to continue, the arrangements for managing the emergency will transition from the arrangements under this plan to the arrangements for managing recovery as outlined in the EMMV Part 4 – State Emergency Relief and Recovery Plan.

## 6.4 Incident management arrangements

The SERP outlines the arrangements for the management of all emergencies in Victoria. The SERP uses a three-tiered approach to emergency management, with the key control, command and coordination functions performed at the incident, regional and state tiers of emergency response.

Class 2 health emergencies can have unique characteristics such as:

- geographically dispersed and widespread, with no identifiable ‘incident site’
- largely invisible
- communicable
- unfamiliar or unknown.

In some circumstances it will be appropriate to manage health emergencies at the incident tier (for example, an infectious disease outbreak limited to a single hospital facility).

However the management of public health incidents usually occurs centrally, at the state tier. This means that a Regional and/or Incident Controller may not be required. This does not remove the control agencies' responsibilities at either the incident or regional tiers. Therefore, for Class 2 health emergencies where there is no Regional or Incident Controller appointed, the State Controller is responsible for the incident, regional and/or state tiers. This may require the State Controller to appoint a Deputy Controller specifically focused on consequence management and liaison with incident and/or regional teams (as appropriate).

In the event of a major health emergency (Class 2), for example a complex geographically dispersed pandemic, it is expected that all three tiers will be fully operational in a manner consistent with the SERP.

The management of health emergency response to incidents other than Class 2 health emergencies may also be managed at the state level, with or without the support of regional and/or incident- tier incident management teams.

### 6.4.1 Health emergency incident management system

Health emergency response uses the operational methodologies and structures consistent with established incident management systems, such as Australasian Inter-Service Incident Management Systems (AIIMS), and their underpinning principles.

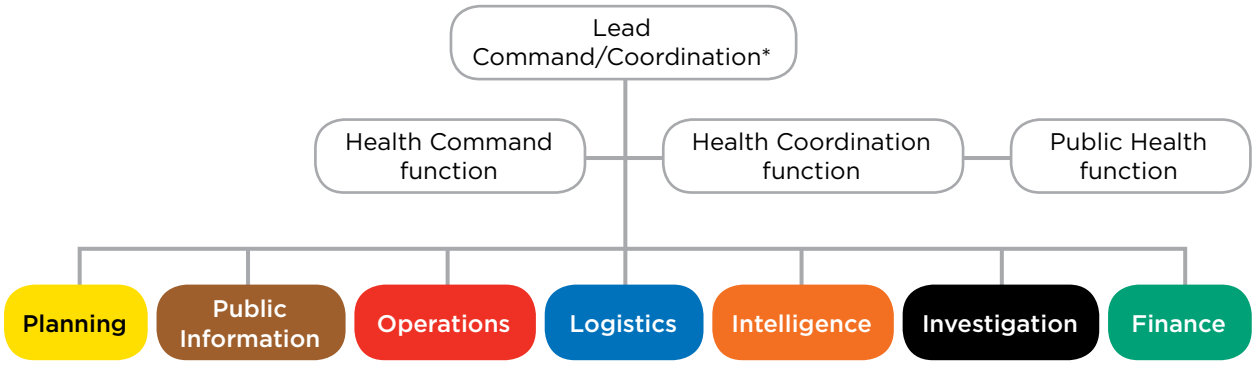
There are seven core functions that can be established within an Incident Management Team to manage an incident. These are: planning, public information, operations, logistics, intelligence, investigation and finance.

Importantly, this system is scalable, and functions can be expanded or reduced depending on the size and complexity of the incident. A Health Incident Management Team may be established at every tier, or one tier only, depending on what is needed to effectively respond to a health incident and mitigate the adverse consequences for individuals or communities. Likewise, a function should only be established where it is necessary and appropriate for the effective management of the incident.

The public information function will usually only be established at the state tier to facilitate consistent, timely and targeted provision of public information. The operations function will typically include a range of activities necessary for the effective response to a health emergency or the health consequences of an emergency. This may include coordination across ambulance, primary health, mental health, health services, aged care and public health. The intelligence function may be activated early to assist with situational awareness of a likely or unfolding incident. Often this information will originate from regional DHHS, Ambulance Victoria or EPA teams, or local health service providers. Investigation and finance functions are more likely to be required for larger or more complex health emergencies.

The response matrix will inform the decision as to which functions will be established and at which tier or tiers and at which locations.

**Figure 5: Example health incident management team structure**




* At the State tier, the lead is determined by whether DHHS is control or support agency and the nature of incident, as described in Table 1: Key functions in a health emergency. At the regional tier, the Health Coordination function is lead. At the incident tier, the Health Command function is lead.

### Health emergency response (where DHHS is operating as a support agency)

The relevant Commander or Coordinator will manage the health response to incidents or emergencies (other than Class 2 health emergencies) with health consequences that go beyond normal health system operations.

On advice from the State Health Commander, State Health Coordinator and the Public Health Commander, the State tier Incident Management Team lead is responsible for activating the State Emergency Management Centre and deploying a State tier Health Incident Management Team (S-HIMT), with functional sections as necessary and appropriate for the effective management of the incident.

### 6.4.2 State tier governance

The EMC coordinates the state response to major emergencies, including Class 2 health emergencies, through the following five key teams (refer to Table 5).

During or following a large-scale emergency, the Victorian Government's Security and Emergency Management Committee of Cabinet (SEMC) may provide whole of government ministerial oversight.

The State Crisis and Resilience Council (SCRC) provides SEMC with assurance that the broad social, economic, built and natural environmental consequences of the emergency are being addressed at a whole of government level. SCRC also has responsibility for the oversight of the development of a whole of government communications strategy for the approval of SEMC.

**Table 4: Functions and membership of key state response teams**

| TEAM | ROLE/FUNCTION | MEMBERSHIP FOR CLASS 2 HEALTH EMERGENCY |
|---|---|---|
| State Coordination Team (SCOT) | • oversees the coordination functions and responsibilities on behalf of the EMC<br>• sets the strategic context of the readiness, response, relief and recovery phases. | EMC and/or Chief Commissioner for Police (CCP)<br>State Controller – Health Emergency<br>Chief Health Officer<br>State Health Coordinator<br>Senior Police Liaison Officer (SPLO)<br>State Relief and Recovery Manager (SRRM)<br>DHHS State Liaison Officer (DHHS SLO)<br>State Consequence Manager (SCM)<br>Others as determined by EMC/CCP |
| State Control Team (SCT) | • oversees the control functions and responsibilities on behalf of the EMC<br>• implements the strategic context of the readiness, response, and where appropriate relief and recovery phases. | State Controller – Health Emergency<br>EMC<br>Chief Health Officer<br>State Health Commander<br>Chief Officer CFA or State Agency Commander (SAC)<br>Chief Fire Officer DELWP or SAC<br>Chief Officer MFB or SAC<br>Chief Officer Operations SES or SAC<br>SPLO<br>SCM<br>SRRM<br>DHHS SLO<br>Others as determined by EMC/State Controller |

| TEAM | ROLE/FUNCTION | MEMBERSHIP FOR CLASS 2 HEALTH EMERGENCY |
|---|---|---|
| State Emergency Management Team (SEMT) | • oversees the management of strategic risks and consequences of the emergency situation. | EMC<br>CCP<br>State Controller – Health Emergency<br>Chief Health Officer<br>State Health Coordinator<br>State Health Commander<br>SPLO<br>SRRM<br>SACs (CFA, DELWP, MFB, SES, VicPol, AV)<br>Other emergency management functional roles across Government and agencies as appropriate |
| EMJPIC Executive | • oversees the media and communications functions and responsibilities on behalf of the EMC<br>• sets priorities for EMJPIC in communications and engagement. | EMC<br>Assistant Commissioner VicPol<br>Director Relief and Recovery EMV<br>Executive Director Communications DPC<br>Executive Director Communications and Media DHHS<br>Executive Director Communications VicPol<br>Executive Director Communications DELWP<br>Director Emergency Management Resilience EMV<br>EMJPIC Chair (General Manager Media and Communication, EMV)<br>Executive Director, Strategic Communications DEDJTR<br>Executive Director, Strategic Communication DJR<br>Executive Director, Communications, DET<br>Executive Director, Communications, DTF<br>Others as determined by EMC / EMJPIC Executive |
| EMJPIC | • coordinates all public emergency messaging<br>• for operational readiness, response and recovery. | General Manager Media and Communication, EMV<br>Executive Director Communications and Media DHHS<br>Communication officers from all agencies and departments |

### 6.4.3 Regional tier governance

The control, command and coordination of a health emergency response will not always be appropriate at the regional tier.

The response to public health incidents for example, will usually be centrally coordinated and led at the State level, but may rely on regional DHHS teams and regional liaison officers from other relevant agencies to distribute information, respond to community concerns and manage consequences.

If a health response at the regional tier is considered necessary and appropriate for the effective management of the incident, the Regional Health Coordinator will form a Regional tier Health Incident Management Team (R-HIMT). This may be on the recommendation of the Regional Health Commander.

### 6.4.4 Incident tier governance

All major emergencies (Class 1, 2 and 3) may be managed at the incident tier, and the health sector needs to be engaged at that tier to adequately support the health response.

Where health incidents are managed at the incident tier, for example, an incident at a hospital, which is contained to a single facility, it will involve the establishment of a Hospital Incident Management Team (HoIMT).

However as is the case with regional tier governance, control, command and coordination of a health emergency response will not always be appropriate at the incident tier, either because there is no incident 'site' (for example, epidemic thunderstorm asthma) or because the response is most appropriately coordinated centrally (using State tier arrangements).

If a response at the incident tier is considered necessary and appropriate for the effective management of the incident, the Incident Health Commander will form an Incident tier Health Incident Management Team (I-HIMT) with support from Hospital Commanders from affected facilities.

# 7 Appendices

## Appendix A: Glossary

| TERM | DEFINITION |
|---|---|
| Acute care | Victorian acute care includes admitted and non-admitted services such as critical care, surgical services, Hospital in the Home, specialist clinics, trauma and emergency services. |
| All communities, all emergencies approach | This approach to the planning, response to and recovery from an emergency, is one that is adaptable for a wide range of situations and considers the needs of different community groups. |
| Business continuity | The uninterrupted availability of all key resources supporting essential business function. Business continuity management provides for the availability of processes and resources in order to ensure the continued achievement of critical services objectives. |
| Casualty | A person who is sick, injured or killed in an emergency. |
| Chief Health Officer | The Chief Health Officer appointed under the *Public Health and Wellbeing Act 2008*. |
| Class 1 emergency | Definition from the *Emergency Management Act 2013:*<br>Class 1 emergency means—<br>(a) a major fire; or<br>(b) any other major emergency for which the Metropolitan Fire and Emergency Services Board, the Country Fire Authority or the Victorian State Emergency Service Authority is the control agency under the state emergency response plan. |
| Class 2 emergency | Definition from the *Emergency Management Act 2013:*<br>Class 2 emergency means a major emergency which is not—<br>(a) a Class 1 emergency; or<br>(b) a warlike act or act of terrorism, whether directed at Victoria or a part of Victoria or at any other State or Territory of the Commonwealth; or<br>(c) a hi-jack, siege or riot. |
| Class 3 emergency | Class 3 emergency is not a defined term in the *Emergency Management Act 2013.* For the purpose of this plan, a Class 3 emergency means a warlike act or act of terrorism, whether directed at Victoria or a part of Victoria or at any other State or Territory of the Commonwealth, or a hi-jack, siege or riot. |

| TERM | DEFINITION |
|---|---|
| Code Brown | Nationally recognised hospital code for an external emergency. |
| Command | Directing an agency's people and resources in the performance of its role and tasks. Authority is vertical within the agency. |
| Control | The overall direction of response activities in an emergency situation. Control acts horizontally across agencies, as it carries the responsibility for tasking other agencies. |
| Control Agency | An agency nominated through the authority of the EMMV to control response activities for a specific emergency. |
| Coordinate/ coordination | Bringing together agencies and elements to ensure and effective response to the emergency. It involves the systematic acquisition and application of resources (agencies, personnel and equipment). |
| EM-COP | The Emergency Management Common Operating Picture (EM-COP) is a web-based platform that enables the emergency management sector to create and publish community notifications and warnings. |
| Emergency | Definition from the *Emergency Management Act 1986:*<br>'An emergency due to the actual or imminent occurrence of an event which in any way engagers or threatens to endanger the safety or health of any person in Victoria, or which destroys or damages, or threatens to destroy or damage, any property in Victoria, or endangers or threatens to endanger the environment or an element of the environment in Victoria including, without limiting the generality of the foregoing:<br>(a) an earthquake, flood, wind-storm or other natural event; and<br>(b) a fire; and<br>(c) an explosion; and<br>(d) a road accident or any other accident; and<br>(e) a plague or an epidemic; and<br>(f) a warlike act, whether directed at Victoria or part of Victoria or at any other State or Territory of the Commonwealth; and<br>(g) a hi-jack, siege or riot; and<br>(h) a disruption to an essential service.' |
| Emergency management | Measures taken in response to particular hazards, incidents or disasters. |
| Escalation | The act of moving to a higher level of response for appropriate management of the emergency incident. Escalation is based on the risk factors associated with the incident including factors such as size, resources or media interest. |
| Hazard | A condition or event potentially harmful to the community or environment. |
| Health Commander | The person responsible for directing the pre-hospital health emergency operations. At each tier the Health Commander will be an appropriate ambulance manager. Otherwise, the appointment is made by the SHEMC. |
| Health Coordinator | An emergency management role, within the regional and state tiers, responsible for representing and coordinating the activities of DHHS in response to an emergency at that tier. |

| TERM | DEFINITION |
|---|---|
| Health emergency | Health emergency in the context of this plan includes an incident or emerging risk to the health of community members, from whatever cause, and requires a significant and coordinated effort to ensure the health system can effectively respond and mitigate the adverse health consequences for communities. |
| Health response | The significant and coordinated management of pre-hospital and hospital response to a health emergency. |
| Health service | Relates to public health services, denominational hospitals, metropolitan hospitals and public hospitals, as defined by the *Health Services Act 1988,* with regard to acute and subacute services provided within a hospital or a hospital-equivalent setting. |
| Health system | For the purposes of this plan, references to the health system include acute, public and primary health service providers. |
| Incident management system | A flexible, scalable organisational management structure that includes the functions of operations, planning, logistics, administration/finance and public affairs to facilitate efficient management of an incident. |
| Major emergency | Definition from the *Emergency Management Act 2013:*<br>Major emergency means—<br>(a) a large or complex emergency (however caused) which—<br>i. has the potential to cause or is causing loss of life and extensive damage to property, infrastructure or the environment; or<br>ii. has the potential to have or is having significant adverse consequences for the Victorian community or a part of the Victorian community; or<br>iii. requires the involvement of 2 or more agencies to respond to the emergency; or<br>(b) a Class 1 emergency; or<br>(c) a Class 2 emergency. |
| Mass casualty situation | An emergency involving such number and severity of casualties for which normal local resources for response may be inadequate. |
| Operational debrief | A meeting held during or at the end of an operation to assess its conduct or results. Final debriefing needs to be delayed until all information and data are available to inform the operational debrief. |
| Operational response plan | A plan prepared by an agency/organisation or functional area which describes the operations carried out to support the control agency during health emergency response operations. It is an action plan describing how the agency/organisation or functional area is to be coordinated in order to carry out allocated roles and responsibilities. |
| Pre-hospital | A functional component of health emergency response, from response at the scene of an incident, to the receiving hospital or other healthcare facility. |
| Preparedness | The action to minimise loss of life and damage, and the organisation and facilitation of timely, effective rescue, relief and rehabilitation in case of an emergency. |
| Primary health | The care received at the first point of contact with the healthcare system, for example, when someone sees a physiotherapist because they have a sore back. It is traditionally delivered in community health centres or through private allied health providers. |

| TERM | DEFINITION |
|---|---|
| Public health | The organised response by society to protect and promote health of the population as a whole, and to prevent illness, injury and disability. |
| Public Health Commander | The public health command functional lead performed by the Chief Health Officer (or delegate). |
| Public health emergency | Public health emergencies (for which DHHS is the control agency) include:<br>• biological and radioactive incidents<br>• retail food contamination<br>• food and water contamination<br>• human disease |
| Situation report | A brief report that is published and updated periodically during an emergency that outlines the details of the emergency, the health tasks generated, and the responses undertaken as they become known. |
| Stand down | The return to business-as-usual operations when deployment of resources and personnel is no longer required. |
| Standard Operating Procedures | The internal response procedures which document operational and administrative procedures to be used. |
| State Control Centre (SCC) | Victoria's primary control centre for the management of emergencies. The purpose of the SCC is to provide a facility to support the EMC to meet the state control priorities and objectives. |
| State Emergency Management Centre | Used to coordinate the health and human services response and recovery operations of medium to large-scale emergencies. It is located on Level 1, 50 Lonsdale St, Melbourne. |
| State Health Emergency Management Coordinator | An executive-level public administration function performed by DHHS and appointed by the Secretary of the Department. |
| Support agency | An agency that provides essential services, personnel or material to support or assist a control agency or affected persons. Any agency may be requested to assist in any emergency if it has skills, expertise or resources that may contribute to the management of the emergency. |
| Tiers of operation | There are three tiers of incident control for emergency response in Victoria: incident, regional and state. |
| Triage | The process by which casualties are sorted, prioritised and distributed, according to their need for first aid, resuscitation, emergency transportation and appropriate care. |
| Vulnerable person | A vulnerable person under this plan refers to someone living in the community who is:<br>• frail, and/or physically or cognitively impaired; and<br>• unable to comprehend warnings and directions and/or respond in an emergency situation. |

# Appendix B: Relevant Victorian public health legislation

| | ADDITIONAL LEGISLATION RELATED TO THIS PLAN |
|---|---|
| 1 | *Ambulance Services Act 1958* |
| 2 | *Health Records Act 2001* |
| 3 | *Health Services Act 1988* |
| 4 | *Local Government Act 1989* |
| 5 | *Occupational Health and Safety Act 2004* |
| 6 | *Safe Drinking Water Act 2003* |
| 7 | *Food Act 1984* |
| 8 | *Radiation Act 2005* |

# Appendix C: National plans relating to SHERP

| PLAN | DESCRIPTION |
|---|---|
| AEMA | The Australian Emergency Management Arrangements, which provide an overview of how Commonwealth, state, territory and local governments collectively approach the management of emergencies, including catastrophic disaster events. |
| AHMPPI | The Australian Health Management Plan for Pandemic Influenza, a national health plan for responding to an influenza pandemic based on international best practice and evidence. It outlines the measures that the health sector will consider in response to an influenza pandemic. This plan may call on elements of SHERP4 in support. |
| AUSASSISTPLAN | Outlines the coordination arrangements for the provision of Australian Government assistance, be it financial, technical or physical, to an overseas disaster in countries eligible for official development assistance (ODA) as well as for non ODA countries. |
| AUSTRAUMAPLAN | Provides an agreed framework and mechanisms for the effective national coordination, response and recovery arrangements for mass casualty incidents of national consequence resulting from trauma. Includes the Severe Burn Injury annex (AUSBURNPLAN). |
| COMDISPLAN | Coordination arrangements for the provision of Australian Government physical assistance to states and territories in the event of a disaster where the jurisdiction's own resources are exhausted or unavailable. |
| NatHealth arrangements | The National health emergency response arrangements, which direct how the Australian health sector (incorporating state and territory health authorities and relevant Commonwealth agencies) would work cooperatively and collaboratively to contribute to the response to, and recovery from, emergencies of national consequence. |
| National arrangements for mass casualty transport | The national arrangements to plan for and coordinate medical transport within Australia in response to a mass casualty event. |
| NATCATDISPLAN | Describes the national coordination arrangements for supporting states, territories and the Commonwealth governments in responding to and recovering from catastrophic natural disasters in Australia. |
| National counter terrorism plan | This plan outlines responsibilities, authorities and the mechanisms to prevent (or if they occur, manage) acts of terrorism and their consequences within Australia. |
| OSMASSCASPLAN | The National response plan for mass casualty incidents involving Australians overseas, which details the primary response arrangements to overseas incidents involving Australian nationals and other approved persons. |

# Appendix D: List of relevant operational response plans and supporting documents

Status correct at time of publication and subject to change

| PLAN | DESCRIPTION | STATUS |
|---|---|---|
| Communicable Disease Incident and Emergency Operational Response Plan | Outlines DHHS' arrangements for managing a response to communicable disease incidents and emergencies. This includes the roles and responsibilities of the relevant DHHS branch responsible for initiating and managing the response. | Under development |
| Food Incident and Emergency Operational Response Plan | Outlines DHHS' arrangements for managing a response to food contamination incidents and emergencies. This includes the roles and responsibilities of the relevant DHHS branch responsible for initiating and managing the response. | Under development |
| Water Incident and Emergency Operational Response Plan | Outlines DHHS' arrangements for managing a response to drinking water contamination incidents and emergencies. This includes the roles and responsibilities of the relevant DHHS branch responsible for initiating and managing the response. | Under development |
| CBRNE Incident and Emergency Operational Response Plan | Outlines DHHS' arrangements for managing a response to chemical, biological, radiological, nuclear and explosive incidents and emergencies. This includes the roles and responsibilities of the relevant DHHS branch responsible for initiating and managing the response. | Under development |
| Epidemic Thunderstorm Asthma Preparedness and Operational Response Plan | Describes the DHHS arrangements for preparing for and managing a response to an Epidemic Thunderstorm Asthma event. This includes arrangements for the forecasting and monitoring of epidemic thunderstorm in preparation for future pollen seasons. | Active (under revision) |
| Ambulance Victoria Emergency Response Plan | Outlines Ambulance Victoria's arrangements for the management of major incidents across Victoria. It describes key responsibilities and activities of AV including the role of personnel in the pre-hospital line of command, the management of communication and information, and the mobilisation of AV resource capability during a major incident. | Under revision |
| ESTA Critical Incident Response Plan (CIRP) | Provides a guideline for implementing various strategies that mitigate impacts to service delivery during periods of surge. It describes how ESTA escalates its response and manages critical incidents. | Active |
| Heat Health Plan for Victoria (2015) | Outlines a coordinated and integrated response to extreme heat in Victoria and sets out the actions and systems in place to support those most at risk during periods of extreme heat. | Active |

| PLAN | DESCRIPTION | STATUS |
|---|---|---|
| State Smoke Framework (2016) | Describes a cross-government approach to smoke events that impact air quality and the health of communities and outlines the strategies and tools for smoke management measures. | Active |
| Victorian Medical Assistance Team Policy (2015) | Describes the authorising environment, resilience activity, deployment arrangements, response and mobilisation at incident level for VMAT operations. The policy specifies the health services nominated to maintain VMAT capability. | Active |
| Victorian Medical Assistance Team Protocol (2016) | Describes the selection, training, equipping, deployment and administrative arrangements for VMAT. It lists the various major, metropolitan and regional trauma centres at which VMATs have been established, the composition of each VMAT team, training and exercising requirements, and the process by which VMAT assistance may be activated. | Active |
| DHHS Public Information and Warnings Business Rules and Decision-making Guide (2017) | Outlines the roles and responsibilities for issuing public information and warnings for health emergencies, to the extent that these differ to the arrangements in the SHERP. | Active |
| DHHS First Wave Notification | Outlines the consideration for issuing a first wave notification and the process by which one is sent. A first wave notification provides a means of alerting the health sector about incidents (actual or potential) that may result in widespread or catastrophic consequences on the Victorian community or health infrastructure. | Active |
| Epidemic Thunderstorm Asthma Warnings Protocol | Outlines the procedures for the Chief Health Officer and the Emergency Management Commissioner to approve thunderstorm asthma warnings. | Active (under revision) |
| Guidelines for multiple burns casualties (2015) | Outlines the response strategies required for an incident resulting in multiple burn casualties in Victoria. In particular, it describes the means by which the State's two burn services will support and respond to an incident involving multiple burn casualties. | Active |
| Victorian health management plan for pandemic influenza (2014) | Provides a framework for government and the health sector to minimise transmissibility, morbidity and mortality associated with an influenza pandemic, and to manage the impact of a pandemic on the community and the health system. | Active |
| Mass Casualty and Pre-hospital Operational Response Plan | Provides additional detail for managing a health emergency response involving mass casualties and pre-hospital arrangements. It describes the leadership and management arrangements for a health emergency response within the incident tier of operations. | Under development |

| PLAN | DESCRIPTION | STATUS |
|---|---|---|
| Additional Capability and Capacity Operational Response Plan | Outlines scalable arrangements to mobilise additional capability and capacity across the health sector. This includes arrangements to engage first aid agencies, general practitioners (GPs), community pharmacists, and Field Emergency Medical Officers or coordinators in a health emergency response. The aim of this plan is to improve health sector preparedness for emergencies by increasing system wide capacity and capability enabling greater scalability, availability, and accessibility of required resources in the event of an emergency. | To be developed |
| Regional Health Emergency Operational Response Plan | Provides additional detail for managing a regional health emergency response. It describes the leadership and management arrangements for a health emergency response within the regional tier of operations. | Under development |
| **SUPPORTING DOCUMENTS** | | |
| Public Events and Mass Gatherings Guidelines | Provides information to assist event organisers in their health emergency preparedness activities. Includes a checklist to assist in planning a health emergency response. | Under development |
| Code Brown Guidelines | Provides information to assist health services prepare Code Brown Plans. The guidelines aims to clarify the purpose of Code Brown plans and highlights some key steps to take before, during and after an external emergency. | Active |
| Emergency Incident Casualty Data Collection Protocol | Describes the procedures for the provision of emergency incident information between health services and DHHS. The protocol applies to all Victorian public and private health services with an Emergency Department or Urgent Care Centre. Its objective is to collate reliable, accurate, timely and consistent information on presentations to health services resulting from an emergency incident. | Active |
| Key Function Descriptions | Describes the roles, responsibilities and functions of the State Health Emergency Management Coordinator (SHEMC), Public Health Commander, State Health Coordinator and State Health Commander. It also describes the key attributes, qualification and/or training required to fulfil the role of the SHEMC, Public Health Commander, State Health Coordinator and State Health Commander. | Under revision |
| Primary Health Networks Guidelines | Provides information to assist primary health networks to prepare for and respond to emergencies. | Under development |

# Appendix E: Summary of relevant health care facility emergency codes

The following codes are based on *Australian Standard (AS) 4083 – 2010 Planning for emergencies – Health care facilities.*

| CODE COLOUR | DESCRIPTOR | DESCRIPTION OF EMERGENCY |
|---|---|---|
| **Code Red** | Fire / smoke | Fire or smoke emergency |
| **Code Blue** | Medical emergency | Medical emergency (for example cardiac arrest) |
| **Code Purple** | Bomb threat | Bomb threat or suspicious item / mail |
| **Code Yellow** | Infrastructure and other internal emergencies | Any internal emergency that affects service delivery, for example:<br>• electricity supply disruption<br>• information technology disruption<br>• structural damage<br>• staffing and overcrowding emergencies<br>• bushfires and cyclones. |
| **Code Black** | Personal threat | Person threatening or attempting to harm self or others. Includes Code Black Alpha for infant or child abduction |
| **Code Brown** | External emergency | A multi-casualty incident that stretches or overwhelms the available health resources, for example:<br>• aircraft crash<br>• structural collapse<br>• explosion. |
| **Code Orange** | Evacuation | Requirement to evacuate patients, staff and visitors to a designated assembly area due to an emergency, for example:<br>• fire<br>• bomb threat<br>• structural damage. |

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