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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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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.


BENDIGO HOSPITAL

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

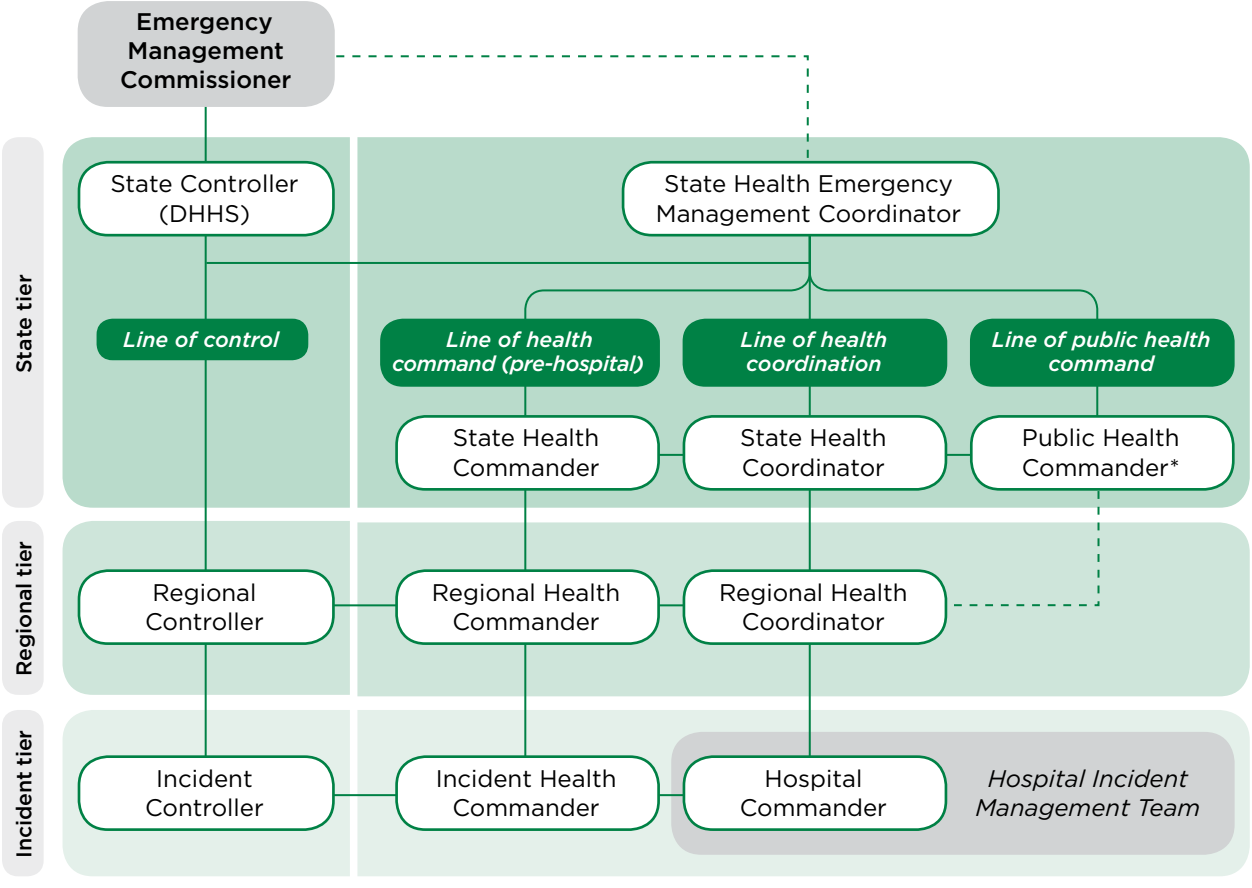
Under the EMMV Part 7 – Emergency Management Agency Roles, DHHS is the nominated control agency for specified health emergencies in Victoria (refer to Section 1).

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. 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: • 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) • 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. The State Controller is responsible for the following initial decisions and actions, in consultation with the appropriate internal and external stakeholders: • verify the relevant response assessment (refer to Section 6.3.3) • determine the strategic objectives for response • determine the incident management model or activate pre-agreed plans for the initial response • establish incident management team(s) (as applicable) • ensure timely and appropriate public information and warnings are provided to the community • notify the EMC, support agencies and relevant health system service providers. The State Controller may appoint a Deputy Controller. 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. Under these arrangements, the lead of the State Health Incident Management Team where DHHS is a support agency is: • the State Health Coordinator, where coordination of emergency response activities across the health system is required (including hospitals, primary health and other acute services); • 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. 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. 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). 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). 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*. In performing this function, the Public Health Commander will liaise directly with the State Health Commander and State Health Coordinator. 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. 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. 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). 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. 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 • respond to requests for pre-hospital emergency care, triage patients, determine treatment priority and provide pre-hospital clinical care • transport and distribute patients to appropriate medical care • provide health support to patients undergoing decontamination • manage additional medical and nursing capacity, such as FEMO and VMAT teams, where required • notify receiving hospitals of patients • support evacuations of vulnerable people • 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. • liaise with Public Health Commander and Health Coordinator.
DET	• provide emergency notifications and reporting services between schools and emergency services • 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 • in collaboration with the whole-of-government, lead the coordination of public information and warnings for major emergencies • lead the coordination of consequence management for major emergencies • 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 • provide early warnings to EMV and agencies of significant incidents, detected through triple zero information channels • maintain support and management of multi-agency operational communication systems.
EPA	• assess the environmental impact of the emergency • advise the emergency services on the properties and environmental impacts of hazardous materials • provide Air Monitoring capability in emergencies to support analyses of community health impacts in accordance with air monitoring protocols • provide environmental public health surveillance, risk assessment and initial response in accordance with environmental public health protocols and MOUs between EPA and DHHS • 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 • facilitate the delivery of warnings to the community and the provision of information to the public and media • support investigations and control of illness outbreaks and other public health incidents.

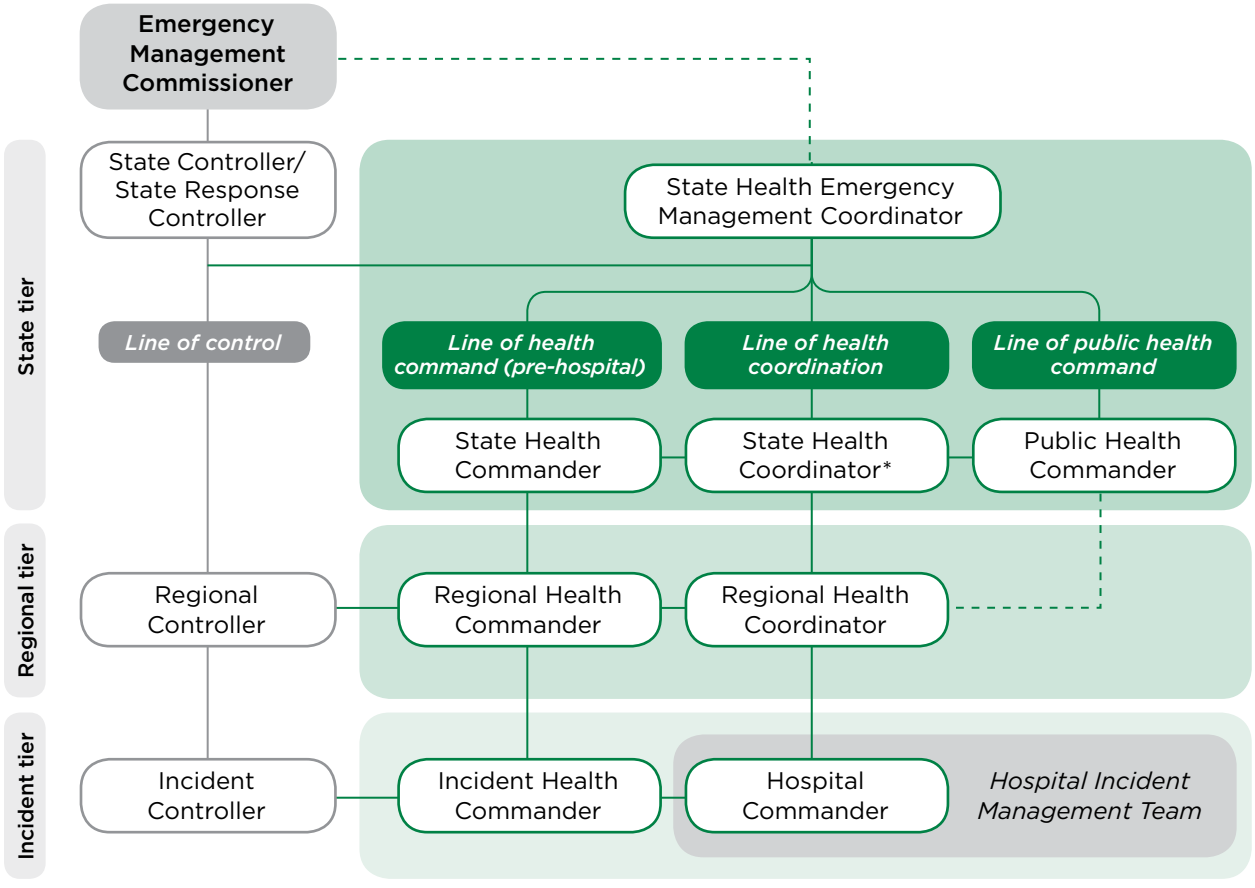
6.2.1 Agency roles and responsibilities for health emergency response (where DHHS is operating as a support agency)

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:

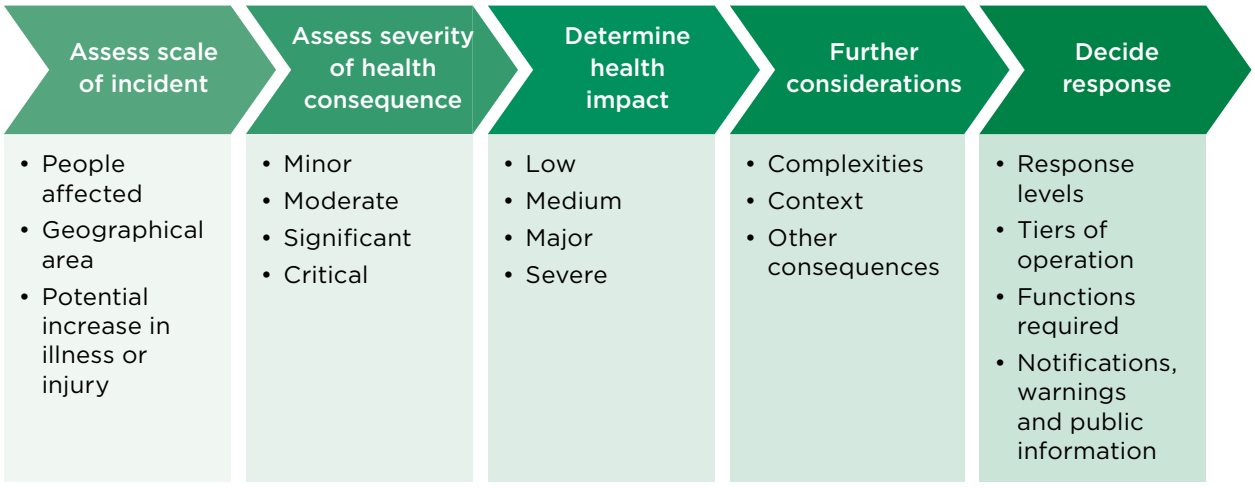
- a single point of contact that is monitored at all times for receiving DHHS notifications
- a plan to escalate their response if and as required.

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 • Volume of hospital presentations • Number of presentations and volume of calls to GPs, community pharmacies and other health care service providers (such as NURSE-ON-CALL) • Number of notifications of reportable disease or illness
Size of geographical area affected	• Location of Triple Zero calls • Location of increased hospital presentations • Location of notifications of reportable disease or illness • Size of biological or radioactive incidents (actual and predicted) • Extent of food or drinking water contamination
Potential increase in illness or injury (urgency)	• Degree of transmissibility and population vulnerability • Number of individuals potentially impacted and unaccounted for • Likely increase in exposure to threat or hazard • 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 • No mortality
Moderate	• Illness or injury requires or is likely to require treatment by pre-hospital or primary care services • Minor increase or likely small increase in mortality
Significant	• Illness or injury requires or is likely to require treatment in hospital • Moderate increase or likely moderate increase in mortality
Critical	• Illness or injury requires or is likely to require extended hospital treatment and rehabilitation • 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. • 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. • Response requires capacity or capability additional to the responding business unit. • 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. • Response requires additional capacity or capability across the health system and multiple government departments/agencies. • 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. • 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. • 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 • Unprecedented response required (no plan exists or plan untested) • Multi-sectoral consequences requiring significant coordination • Multi-jurisdictional or Commonwealth involvement • Specialised technical knowledge and skills required • Security issues • Accessibility difficulties
Context	• Level of community resilience or vulnerability • Need for public information and warnings • Need for communications in relation to the incident • Level of community concern • Level of health system resources required to support response • Level of loss or incapacitation of health structures • 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. They are typically small and simple incidents, with low overall community impact. Level 1 incidents will have a low-to-medium impact on normal health system operations. 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: • 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. 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. Level 2 incidents will have a medium-to-high impact on normal health system operations. 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: • The need for more complex management of emergency response in size, resources or risk • The need for deployment of additional resources/subject matter experts to perform dedicated functions due to the levels of complexity • 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. 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. Level 3 incidents will have a high-to-very high impact on normal health system operations. 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: • The need for more complex management of emergency response in size, resources, communications or risk • The need to coordinate concurrent response and relief and recovery arrangements • The need for deployment of additional resources/subject matter experts to perform the full range of dedicated functions due to the levels of complexity • Establishment of a State Health Incident Management Team and multiple agencies involved • Activation of the State Control Centre where necessary • 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.

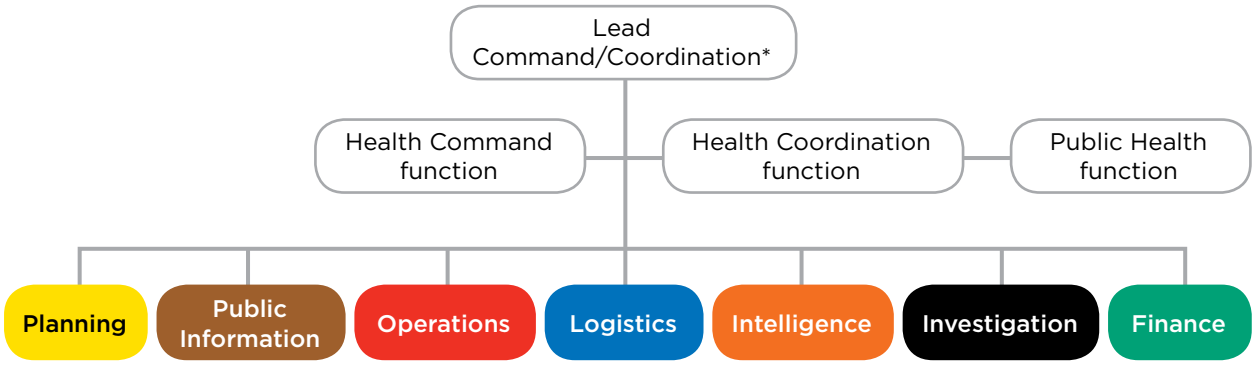
There are seven core functions that can be established within an Incident Management Team to manage an incident. These are: planning, public information, operations, logistics, intelligence, investigation and finance.

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 • sets the strategic context of the readiness, response, relief and recovery phases.	EMC and/or Chief Commissioner for Police (CCP) State Controller – Health Emergency Chief Health Officer State Health Coordinator Senior Police Liaison Officer (SPLO) State Relief and Recovery Manager (SRRM) DHHS State Liaison Officer (DHHS SLO) State Consequence Manager (SCM) Others as determined by EMC/CCP
State Control Team (SCT)	• oversees the control functions and responsibilities on behalf of the EMC • implements the strategic context of the readiness, response, and where appropriate relief and recovery phases.	State Controller – Health Emergency EMC Chief Health Officer State Health Commander Chief Officer CFA or State Agency Commander (SAC) Chief Fire Officer DELWP or SAC Chief Officer MFB or SAC Chief Officer Operations SES or SAC SPLO SCM SRRM DHHS SLO 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 CCP State Controller – Health Emergency Chief Health Officer State Health Coordinator State Health Commander SPLO SRRM SACs (CFA, DELWP, MFB, SES, VicPol, AV) 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 • sets priorities for EMJPIC in communications and engagement.	EMC Assistant Commissioner VicPol Director Relief and Recovery EMV Executive Director Communications DPC Executive Director Communications and Media DHHS Executive Director Communications VicPol Executive Director Communications DELWP Director Emergency Management Resilience EMV EMJPIC Chair (General Manager Media and Communication, EMV) Executive Director, Strategic Communications DEDJTR Executive Director, Strategic Communication DJR Executive Director, Communications, DET Executive Director, Communications, DTF Others as determined by EMC / EMJPIC Executive
EMJPIC	• coordinates all public emergency messaging • for operational readiness, response and recovery.	General Manager Media and Communication, EMV Executive Director Communications and Media DHHS 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:* Class 1 emergency means— (a) a major fire; or (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:* Class 2 emergency means a major emergency which is not— (a) a Class 1 emergency; or (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 (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:* '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: (a) an earthquake, flood, wind-storm or other natural event; and (b) a fire; and (c) an explosion; and (d) a road accident or any other accident; and (e) a plague or an epidemic; and (f) a warlike act, whether directed at Victoria or part of Victoria or at any other State or Territory of the Commonwealth; and (g) a hi-jack, siege or riot; and (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:* Major emergency means— (a) a large or complex emergency (however caused) which— i. has the potential to cause or is causing loss of life and extensive damage to property, infrastructure or the environment; or ii. has the potential to have or is having significant adverse consequences for the Victorian community or a part of the Victorian community; or iii. requires the involvement of 2 or more agencies to respond to the emergency; or (b) a Class 1 emergency; or (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: • biological and radioactive incidents • retail food contamination • food and water contamination • 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: • frail, and/or physically or cognitively impaired; and • 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: • electricity supply disruption • information technology disruption • structural damage • staffing and overcrowding emergencies • 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: • aircraft crash • structural collapse • explosion.
Code Orange	Evacuation	Requirement to evacuate patients, staff and visitors to a designated assembly area due to an emergency, for example: • fire • bomb threat • structural damage.

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Concept of Operations

Department of Health and Human Services as a Control Agency and as a Support Agency in emergencies

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1. Contents

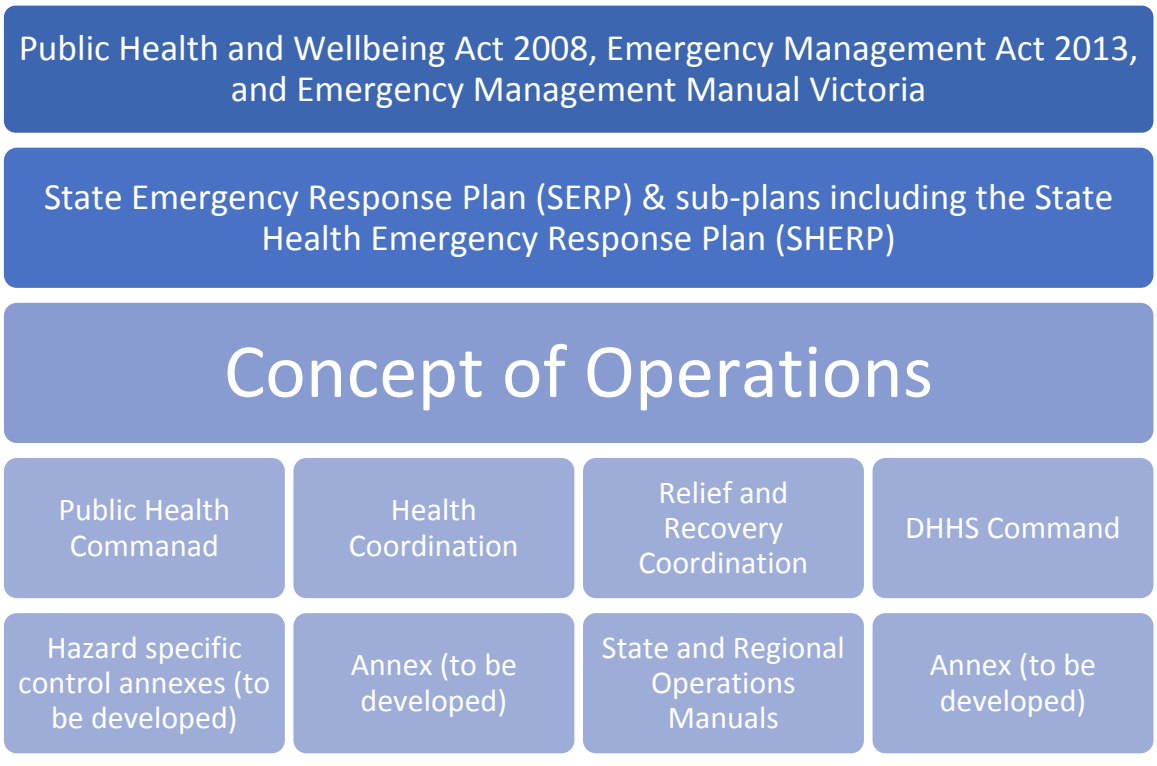
2. Purpose

This Concept of Operations provides guidance to staff working for the Department of Health and Human Services (the department) in emergency-related roles. It explains the department's incident management structure and arrangements used to effectively exercise its emergency-related responsibilities as a **control** and **support** agency, across its key functions:

- Public Health Command
- Departmental Command
- Health Coordination
- Relief and Recovery Coordination and services.

It recognises the department's responsibilities in the Public Health and Wellbeing Act 2008, the Emergency Management Act 2013, the Emergency Management Manual Victoria, and the health specific incident management and escalation arrangements founded in the State Health Emergency Response Plan (SHERP).

This Concept of Operations also provides the foundation arrangements for hazard-specific response plans for which the department is the control agency, which are detailed in annexes.



3. Scope

This Concept of Operations document:

- Outlines the department's operational functions, roles, key activities and deliverables at the state and regional tiers across all types of emergencies. Similar elements at the incident level will be detailed in annexes, where relevant.
- Describes the Concept of Operations for public health emergencies (class two emergencies where the department is the designated control agency) and for emergencies where the department is a support and/or coordination agency.
- Provides guidance on governance and other arrangements to inform further operational plans and annexes to this document, for health coordination, relief and recovery coordination and services, and managing public health emergencies due to:*
  - communicable disease;

  - foodborne illness;
  - drinking water contamination;
  - radiation; and
  - other causes of human disease.
- Inform other agencies involved in making operational decisions and supporting the department in relation to emergencies, by clearly describing the Concept of Operations in place within the department.

**Note the Emergency Management Manual of Victoria Part 7 indicates that the department is the control agency when the major effect of an emergency is due to:*

- *Accidents involving biological materials (including leaks or spills);*
- *Accidents involving radioactive materials (including leaks or spills);*
- *Retail food contamination;*
- *Food / drinking water contamination; and*
- *Human disease.*

These obligations are translated into two types of plans: hazard-specific plans such communicable disease plans, and plans related to vehicles of transmission of hazards, such as foodborne illness plans.

4. Principles

Principles for the Department acting as a control agency

A public health emergency can start abruptly, such as a radiation emergency or an epidemic thunderstorm asthma event, or it can build over days, weeks or months such as a communicable disease outbreak that is eventually recognised as a pandemic. In both situations, as soon as it is determined to be an emergency and the department is determined to be the control agency, the department's response will be guided by the following principles and critical actions:

- Manage the response in line with the State Emergency Management Priorities (noting these are currently subject to consultation):
  - Safety of department and emergency services personnel.
  - Safety of community members including vulnerable community members and visitors/tourists located within the incident area.
  - Issuing of community information and community warnings detailing incident information that is timely, relevant and tailored to assist community members make informed decisions about their safety.
  - Protection of critical infrastructure and community assets that supports community resilience.
  - Protection of residential property as a place of primary residence.
  - Protection of assets supporting individual livelihoods and economic production that supports individual and community financial sustainability.
  - Protection of environmental and conservation assets that considers the cultural, biodiversity and social values of the environment.
- Identify a Controller (Class 2) with the ability to coordinate a whole-of-government response to the consequences from the emergency, beyond the scope of human health, as determined by the State Health Emergency Management Coordinator (SHEMC) as per the State Health Emergency Response Plan.
- The responsibilities or ability of the Chief Health Officer (and staff) or ability to fulfil their obligations under relevant legislation, are not compromised through the appointment and subsequent decisions of the Controller (Class 2), if that person is not also the Chief Health Officer.
- Establish or modify its incident management structure to accommodate a greater emphasis on managing the hazard directly.
- Continue to perform all support and coordination agency responsibilities while it also takes on responsibility as the nominated control agency.

Principles for the Department acting as a support and coordination agency

The principles to guide the department's response as a support and coordination agency include:

- Maintain clarity about when the department is advising other agencies or authorities, and when the department is responsible for delivering a specific function. For example, in an emergency for which the department is a support agency, the public health command function is coordinated through a Public Health Advice Cell, chaired by the public health commander.
- Maintain vigilance for when there is a hazard requiring controls, that may require consideration of proposing the department as a control agency.

Concepts of command, control and coordination

Control refers to the overall direction of response activities in an emergency and operates horizontally across agencies.

Coordination is the bringing together of agencies and resources to ensure an effective response to, and recovery from, an emergency.

Command refers to the concept of an individual leading a hierarchy within an organisation and directing people and resources**.**

5. Functions, roles and key activities

Overview of functions, leadership roles and key activities

In an emergency, the department undertakes a number of key activities at the state and regional levels to meet its emergency management and public health responsibilities. ***Key activities*** of like kind are grouped together under a descriptive umbrella referred to as a ***function***. Each *function* is led by a ***leadership role***, who is the person allocated to this role responsible for ensuring each of the key activities within their function are effectively carried out, as part of the department's broader response to the emergency. These are summarised in Table 1 (state) and Table 2 (region). State and Regional Health Command is the responsibility of Ambulance Victoria and has been included to acknowledge the interdependencies between the agencies under SHERP.

Table 1. The department's state-level functions, leadership roles and key activities.

Function	Public Health Command	Departmental Command	Health Coordination	Relief & Recovery Coordination and Services	Control (Class 2)	State Health Command (Ambulance Victoria)
Leadership role	**Public Health Commander**	**State Departmental Commander**	**State Health Coordinator**	**State Departmental Commander**	**Controller**	**State Health Commander**
Key activities	Command the public health activities of an emergency response (including the investigation, management of public health risk, and communication of risk) Undertake actions to reduce pressure on the health system through control measures and advice Monitor the impacts of an emergency on public health Authorise public health communication to the public	Monitor the impacts of an emergency on the department's clients and funded services Undertake activities that support the safe deployment of DHHS personnel to acquit responsibilities of the department Coordinate activities to manage the consequence of these impacts on clients, funded services and DHHS staff Authorise public communications about impacts to departmental services	Monitor state-level impacts of an emergency across the health system Coordinate health sector emergency response activities to support the health system (including hospitals and primary health) Authorise health system impact communication to the public	Coordinate the provision of financial assistance to affected communities Coordinate the provision of emergency accommodation to affected communities Coordinate the provision of psychosocial support to affected communities Authorise relief and recovery public communications	Ensure implementation of control measures for the identified hazard(s) Manage the emergency consequences across government Authorise public information and warnings to the public Support the Emergency Management Commissioner, and the sector	Command the pre-hospital and field response to an emergency at the state tier (including ambulance services, first responder assistance, and spontaneous volunteers)

Decision-making	Chief Health Officer/Public Health Commander	Department Incident Management Team (D-IMT)* leadership group Department Executive Board (BC/surge)	State Health Incident Management Team	D-IMT leadership group	State Control Team	State Health Incident Management Team
State EM Committees	State Control Team State Coordination Team	N/A	State Control Team State Coordination Team State Emergency Management Team	State Relief & Recovery Team State Control Team State Coordination Team State Emergency Management Team	State Coordination Team State Emergency Management Team	State Control Team State Coordination Team State Emergency Management Team

Note: The Public Health Commander and Health Coordinator are detailed in SHERP, along with State Health Commander (Ambulance Victoria), which has not been included as it sits outside the department

*See page 8 for details

Table 2. The department's regional level functions, leadership roles and key activities

Function	Public Health Command	Departmental Command	Health Coordination	Relief & Recovery Coordination and Services	Control (Class 2)	Regional Health Command
Leadership role	**Regional DHHS Commander**	**Regional DHHS Commander**	**Regional Health Coordinator**	**Regional DHHS Commander**	**N/A**	**Regional Health Commander**
Key activities	Working with local government authorities and public health commander, monitor and report on the impacts of an emergency on public health. Act as a liaison to all regional tiers and agencies to assist implementation of controls and to facilitate information exchange.	Monitor the impacts of an emergency on the department's clients and funded services within the relevant Operations Division Undertake activities that support the safe deployment of DHHS Operations Division personnel to acquit responsibilities of the department Coordinate activities to manage the	Monitor regional-level impacts of an emergency across the health system Coordinate regional health sector emergency response activities to support the health system (including hospitals and primary health)	Coordinate regional relief and recovery activities Coordinate the provision of financial assistance to affected communities Coordinate the provision of emergency accommodation to affected communities Coordinate the provision of		Command the pre-hospital and field response to an emergency at the regional tier (including ambulance services, first responder assistance, and spontaneous volunteers)

		consequence of these impacts on clients, funded services and DHHS staff within the relevant Operations Division Authorise public communication about impacts to departmental services		psychosocial support to affected communities Provide input into relief and recovery public communications		
Decision-making	Chief Health Officer/Public Health Commander	Department Incident Management Team (D-IMT)* leadership group Operations Division Executive (BC/surge)	State Health Incident Management Team Regional Health Incident Management Team (where required)	Post Incident Regional Relief and Recovery Committee	N/A	Regional Health Incident Management Team
Regional EM committees	Regional Emergency Management Team		Regional Control Team Regional Emergency Management Team	Regional Emergency Management Team	Regional Control Team Regional Emergency Management Team	Regional Emergency Management Team

6. Further description of activities and deliverables

Below is a description that breaks up the key activities from Table 1 into discrete deliverables, activities or sectors, under an incident management system at the incident, regional and/or/state level/s).

When an emergency is identified, it is likely that there will be a need for rapid establishment of operational units led by functional lead officers. There is value in mapping a possible set of activities in supporting each departmental function in advance, that a leadership role is responsible for.

Key activities under each function are shown below, noting this is an indication only, is not exhaustive, and may vary. Appendix 2 provides one possible initial grouping of activities under functional lead officers, established in the incident management system for a complex public health emergency. Not all activities will be required, depending on the hazard, and the grouping of activities can flex and change to meet the needs of the emergency and other considerations, such as span of control.

Health Coordination activities are:

- Monitoring capacity of hospitals to receive patients, including those requiring specialised care
- Prioritising and coordinating patient distribution
- Activation of health coordination protocols and arrangements, including Field Emergency Medical Officers, Victorian Medical Assistance Teams, Field Care Clinics and activation of casualty data collection and monitoring
- Activation of protocols and liaison with hospitals including Code Brown and Private Hospitals Protocol
- Public information on health system impacts and treatment options.

Relief and Recovery Coordination and Services activities are:

- Financial assistance coordination and delivery
- Social recovery planning and coordination
- Emergency accommodation coordination
- Psychosocial support coordination
- Regional relief and recovery coordination
- Advice to State Recovery Coordinator
- Public information on support services.

Departmental Command activities are:

- Client and funded service impact monitoring
- Coordinate client and funded services
- Oversight of deployed DHHS staff
- Supporting coordination of business continuity across the department
- Public information on clients and services impacted.

Public Health Command activities are:

- Relating to incident control:
  - Discharge of statutory powers under Acts
  - Determination of required public health control measures
  - Representing the department on national response committees.
- Relating to planning and intelligence:
  - Rapid literature review and options analysis
  - Human health risk assessment (hazard, exposure, hypothesis)
  - Health impact assessment (morbidity and mortality)

  - Specialist functions (toxicology, infection control, infectious diseases, radiation protection, others)
  - Epidemiological analysis (environmental, descriptive human epidemiology, analytical human epidemiology)
  - Situational analysis and communication (briefings, PPQs)
  - Public health advice to councils, agencies and health services.
- Relating to operations:
  - Case management
  - Contact management
  - Clinical investigation
  - Laboratory and testing arrangements
  - Infection prevention and control
  - Field investigation and control
  - Local government advice and liaison
  - Agency liaison.
- Relating to public information:
  - Public information and advice to the community on health risks and mitigations
  - Coordinate public information with local, state and national government, and other responding agencies
  - Represent the department on the Victorian Emergency Management Joint Public Information Committee and the National health emergency media response network (Commonwealth Department of Health).
- Relating to logistics:
  - Providing a call centre and supporting field investigation teams
  - Providing countermeasures (medicines, vaccines, personal protective equipment)
  - Supporting the D-IMT, and any Public Health Advice Cell (PHAC), for meetings and through minutes and agendas
  - Rosters, accommodation, catering, on-boarding protocols, off-boarding protocols
  - Incident debriefing and health protection practice improvement.

Note: State Health Command is an Ambulance Victoria (AV) function, which undertakes a number of roles under SHERP. This function is represented by a Senior AV Officer who provides pre-hospital intelligence to the incident management team. While not a direct departmental activity, state health command is strongly connected under SHERP to departmental decision making. Key activities are:

- Community Health Assessment Centres
- Field clinics of any description
- Field Emergency Medical Officer response
- Victorian Medical Assistance Team response (in association with State Health Coordinator)
- First aid response
- Ambulance services response
- Public information on impacts to ambulance services.

7. Decision-making– Departmental Incident Management Team

Role of the Departmental Incident Management Team (D-IMT)

During an emergency, whether in control, support or coordinating, the department will convene a single body to inform decision-making by leadership roles irrespective of the type of hazard that has precipitated the emergency. For the purpose of the SHERP, the departmental incident management team fulfils the function, and will operate as the State Health Incident Management Team under SHERP when required.

The D-IMT determines the strategic priorities for the department, and in some cases the health and human services and emergency management sectors, in responding to emergencies across all functions. The D-IMT provides guidance on required decision-making, across the span of strategic, tactical and operational decisions. The D-IMT provides direction for functional lead officers in the discharge of all key activities and activities for which the department is accountable.

For example, a D-IMT that is managing a public health emergency, which is two confirmed Ebola cases with 30 dispersed close contacts across Victoria, may need to set priorities, guide critical individual decisions on how to quarantine contacts and give advice to the Public Health Commander through to the Controller (Class 2) on social distancing and closure interventions, and appropriate public information and relief activities to support the overall objectives and the affected communities.

Activation of the D-IMT

A D-IMT may be called by any of the leadership roles, following a risk assessment. For example, the SHERP outlines many of the factors that are relevant for identifying whether a public health emergency may be present. A request for a D-IMT by a leadership role may occur at the outset of an emergency, or at some point after its occurrence where it is deemed that the scale, complexity and impact on the community has grown such that there is benefit in the D-IMT being established to inform collective decision making where required for the relevant emergency management function (health, relief and/or recovery).

Membership of the D-IMT

All leadership roles are members of the D-IMT as are functional lead officers and a representative DHHS Regional Commander (if regions are active). Inclusion of functional lead officers ensures leadership roles have access to intelligence, key issues and problems to be solved, and is efficient by avoiding parallel briefings and meetings for functional lead officers.

However, it may be necessary to act quickly in a rapid onset emergency, and it would be appropriate for the Chair of the D-IMT to hold a meeting of the leadership roles and functional lead officers already on roster (such as the Public Information Officer) as required.

All leadership roles are also represented on Emergency Management committees, as noted in Tables 1 and 2.

Chairing the D-IMT

The principle is that the chair of the D-IMT is the leadership role responsible for the most significant or complex consequences of the emergency that need to be managed. Where the department is the control agency it will be the Public Health Commander, and where the department is the support agency, or the predominant Emergency Management function is to address relief and recovery, this will be the State Departmental Commander.

The priorities of the D-IMT will be actioned through the DHHS State Operations incident management structure which operates according to AIIMS principles and incorporates the relevant functions for a particular emergency. Consistent with the principle of unity of command, there will be one role leading this structure. This will be the chair of the D-IMT. For example, in an emergency where the most significant consequence relates to significant strain on Victoria's public health services, the State Health Coordinator may be the chair of the D-IMT and will perform the leadership role for DHHS State Operations. However, all other leaderships roles remain accountable for their functions.

Representation of regional responsibilities on the D-IMT

The lead departmental officer in each region during an emergency is the DHHS Regional Commander, and this role is usually undertaken by the relevant Operating Division Director Emergency Management and Health Protection.

Irrespective of whether the department is the control, support or coordination agency in an emergency, the regional response has four overall components:

- To act as a point of liaison and connection in relation to the public health command function (which is a centralised function in Victoria);
- To deliver key activities of the DHHS Regional Commander function in that region;
- To deliver key activities of the health coordination function in that region;
- To deliver key activities of relief and recovery in that region.

The D-IMT is structured so that for every key activity or deliverable under the overall functions of the department, there is a functional lead officer with carriage of those functions for the state. For example, the Operations Officer has carriage of emergency accommodation activity and contact tracing activity (see Appendix 2). The functional lead officer at the state level will have a regional functional lead officer they can work with, situated in the relevant Operations Division (likely in the Regional Emergency Operations Centre).

The Regional DHHS Commander and other response agencies will need to be closely supported in any initial period by the public health command function in a public health emergency where a regional field presence is required.

An example is a radiation emergency, where in the initial period, expertise or public health resources will be mobilising and will be *en route* from Melbourne to the location of the emergency. Regional DHHS Commander(s) (if activated) will also be represented on the D-IMT directly.

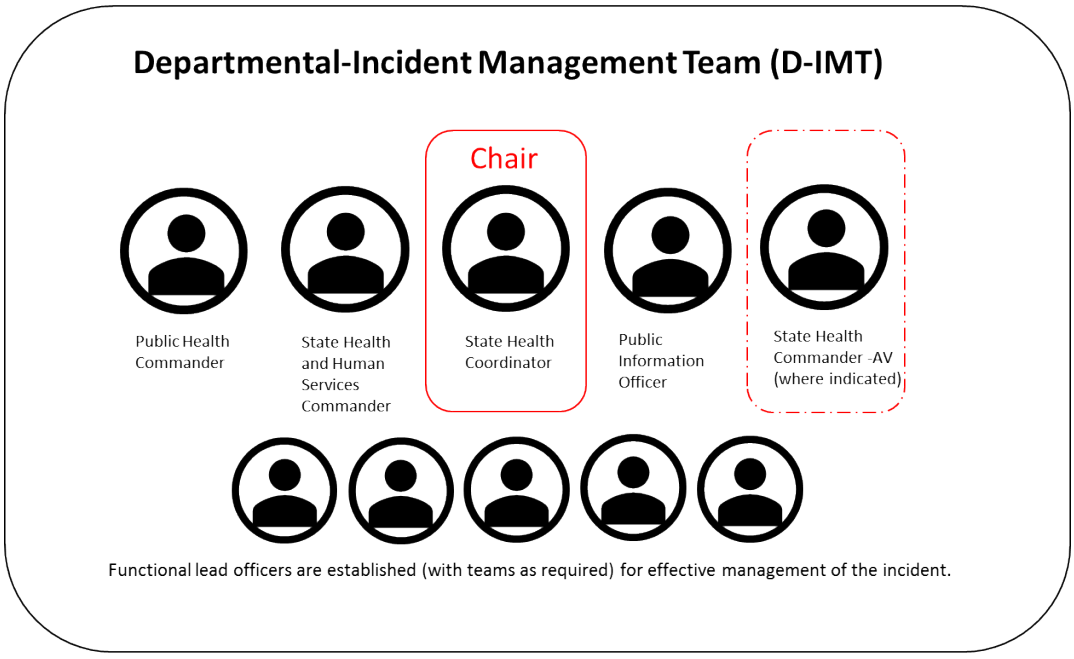
Initial actions for the D-IMT

At its first meeting the D-IMT will:

- Confirm a chair
- Apply the SHERP escalation or relevant process to determine tiers of activation and incident management structure required, including location of functions, for example in the State Emergency Management Centre, the State Control Centre, or Regional Emergency Operations Centre
- Determine the strategic priorities for the department across all functions.

An example agenda for a D-IMT is shown at **Appendix 1**.

Figure 1. An example Health Coordination-led D-IMT acting as a SHIMT under SHERP



8. Functional lead officer roles

Functional lead officers will be responsible for all functions within their unit, as per the DHHS State Operations structure and determined by the nature and consequences of the emergency. Depending on the scale and complexity of the emergency there may be cells (teams) formed under a functional lead officer to address functions. Staff to fulfil all activities will be drawn from the Emergency Management branch, Health Protection branch, subject matter experts within DHHS business areas and departmental emergency management surge workforce. Functional lead officers are likely to be staff from Emergency Management and Health Protection Branches when the department is the control agency, or when there are significant public health impacts of an emergency where the department is a support and coordination agency.

Where the department is the nominated control agency, DHHS State Operations structures are likely to vary for different hazard types. One example is provided at Appendix 2.

9. Departmental - Incident Management Team summary

When	In anticipation of, or in response to, an emergency that threatens to, or has, resulted in significant consequences for communities that are the responsibility of the department of health and human services sectors to manage.
Purpose	• To set the strategic priorities relating to the management of consequences on: – The health system – The community including public health, and relief and recovery services – The department's clients and funded services. • Provide expert advice to the Controller (Class 2) for the establishment of control strategies, where activated. • To provide direction to DHHS State Operations, health and human services sectors and Executive Board.

Membership	Membership will be: • State Health Coordinator • State Health and Human Services (Departmental) Commander • Public Health Commander • State Health Commander (as required) • Regional Commanders (as required) • Functional lead officers

10. Transition to recovery

The State Departmental Commander will take on the role of chair (if not already) within the D-IMT once the response phase nears transition to recovery. During this phase, membership of the D-IMT may begin to source appropriate expertise for decision making for recovery.

Where an emergency has transitioned to recovery, new members may be included in the D-IMT membership from across the department to coordinate services directly to support regions, councils and communities affected by the emergency.

11. De-escalation of the emergency management response

As the emergency de-escalates, the membership of the D-IMT will be continuously reviewed, and transition as agreed by the leadership roles.

During this time, the work will be transitioned to the functional unit's business area to manage and report on through standing business (non-emergency) arrangements.

12. Interface with national arrangements

The governance of an emergency may involve engagement with national governance arrangements, national agencies and other jurisdictions. Usually this will be through Victorian representation on national committees.

Inter-jurisdictional health arrangements are typically described in national plans overseen by the Australian Government Department of Health, and often describe the obligations of jurisdictional public health authorities / health departments alongside the obligations and role of national departments or agencies.

The Australian Government acts as the World Health Organisation Focal Point for the purposes of obligations and reporting under the *International Health Regulations 2005*, which outline how member states work together to manage risk from specified international hazards, particularly communicable diseases like pandemic influenza or Ebola virus disease.

Inter-jurisdictional social recovery arrangements are in place under the Social Recovery Reference Group, of which Victoria is the chair. This may see additional DHHS State Operations functions to coordinate inter-jurisdictional deployment to or from other states or the Commonwealth government.

A list of critical national plans that are relevant to the department is shown below in Table 3:

Table 3: National arrangements relevant to emergencies

National Arrangement	Functional focus	Key committee	Victorian representative

National Arrangement	Functional focus	Key committee	Victorian representative
AUSTRAUMAPLAN	Health coordination	National Health Emergency Management Standing Committee	Deputy Director Strategy and Policy Emergency Management branch
HEALTH CBRN Plan	Health coordination	National Crisis Committee	DHHS NHEMS rep
CDPLAN	Public health command	Australian Health Protection Principal Committee	Chief Health Officer
SRRG – Interjurisdictional Assistance Guidelines	Relief and Recovery Command	Social Recovery Reference Group	Director, Emergency Management

In a public health emergency with national response arrangements activated, the department will be actively represented on the following national response structures depending on the hazard causing the emergency:

- Australian Health Protection Principal Committee – by the Chief Health Officer
- Communicable Diseases Network Australia – by the Public Health Commander
- enHealth – by the Public Health Commander
- National Health Emergency Media Response Network – by the Public Information Officer.

13. Interface with state arrangements

Roles for the department at the State Control Centre when acting as a control agency

For all emergencies, the department is represented through its leadership roles on State Emergency Management committees (see Table 1).

When the department is a control agency and the emergency is a public health emergency, an appropriate Class 2 controller will be recommended by the State Health Emergency Management Coordinator (Deputy Secretary Regulation Health Protection and Emergency Management) to the department's Secretary for appointment. In keeping with SHERP, the Chief Health Officer will normally be appointed the Class 2 Controller for identified public health emergencies, and when that occurs the Chief Health Officer will delegate the Public Health Commander role to the Deputy Chief Health Officer relevant to the main hazard or consequence. The Public Health Commander will then be the chair of the D-IMT.

For 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 Class 2 Controller. In this case, the State Health Coordinator function will be delegated.

The Class 2 controller and the State Departmental Commander (as the State Health Coordinator and the Senior Liaison Officer, unless the roles are separated) will be on the State Control Team, State Coordination Team and the State Emergency Management Team. The State Departmental Commander will also be a member of State Relief and Recovery Team. The Chief Health Officer will also be on the State Coordination Team and the State Emergency Management Team.

The State Health Emergency Management Coordinator and the Chief Health Officer will attend with the Minister for Health on the Security and Emergencies Management Committee (SEMC) of Cabinet.

The Public Information Officer will attend the Emergency Management Joint Public Information Committee (EMJPIC). The Class 2 controller can request activation of the State Control Centre Public Information Section to support the department's response. A departmental deputy public information officer or a public information liaison officer can work from the SCC public information section.

Table 3: State Arrangements relevant to emergencies

State Arrangement	Functional focus	Key committee	Representative/s
Cabinet	WoVG coordination	Security and Emergencies Management Committee (SEMC) of Cabinet.	Minister for Health and Ambulance Services
Emergency Management Sector	State Emergency Management Coordination	State Control Team, State Coordination Team, State Emergency Management Team State Relief and Recovery Team (SRRT)	See Table 1.
Public Communication and Warnings	Public Communications	Emergency Management Joint Public Information Committee	Public Information Officer

Roles for the department at the SCC when acting as a support agency

When the department is a support agency, the department is represented as above with the exception that the Chief Health Officer is not currently a member of the State Control Team.

Relocation of other functions to the SCC

When the department is the control agency for an emergency, key staff may relocate to the SCC. The timing of any relocation will be determined by the rapidity of onset of the emergency and the need to access the SCC resources or location to support the department to fulfil its emergency management responsibilities. The D-IMT is likely to meet initially at the level 1 State Emergency Management Centre at 50 Lonsdale Street, and to put an incident management structure in place at that location in the first instance.

Relocation of roles to the SCC may be required when:

- The scale of the consequences is large, and the coordination of the emergency response is complex, for example when multiple sectors are affected, and multiple agencies or departments are responding
- When the Class 2 controller or Emergency Management Commissioner request such a relocation
- When the department determines it is necessary e.g. for the public information function

There may be circumstances when the department chooses to relocate roles to the SCC when the department is acting as a support agency. For example, in a class 3 deliberate-release emergency when there is a substantial amount of health risk assessment, management and public information required to support the control agency to manage the hazard or consequences.

Options for location

At a minimum, the relevant leadership roles will attend the SCC for meetings of State Emergency Management committees, as per the committee membership.

Once DHHS becomes a control agency, the Class 2 controller and the Senior Liaison Officer will be based at the SCC.

A further escalation may involve the movement of other roles to the SCC, noting for SCC tier 3, a departmental Emergency Management Liaison officer is always required.

14. Appendix 1 – Example Agenda for D-IMT

1. Welcome, apologies, confirmation of chair (first meeting and as required)
2. Situation
3. Strategic priorities for the department.
4. SHIMT - Public health command decisions (if required)
5. SHIMT - State health command decisions (if required)
6. SHIMT - State health coordination decisions (if required)
7. DHHS command decisions (if required)
8. State relief and recovery decisions (if required).
9. Recap of critical actions from the D-IMT, and any outstanding actions from previous meeting
10. Recap of internal and external communication / liaison of external communication / liaison required
11. Date and time of next meeting

15. Appendix 2 - Potential functions for functional lead officers when department is the control agency

In an emergency for which the department is the control agency, the following functions / activities / deliverables could be overseen by each functional lead officer, in additional to the roles in the State Operations Manual. The type and span of functions will be different depending on the hazard.

The likely source of each functional lead officer in an emergency for which the department is the control agency is:

- Planning Officer: Emergency Management Branch
- Intelligence Officer: Health Protection Branch
- Operations Officer: Health Protection Branch
- Logistics Officer: Emergency Management Branch
- Public Information Officer: Communications Branch

Note: many of these functions will be required when the department is a support agency or to support relief and recovery coordination and services. When the department is a support agency, the Emergency Management branch will source an Operations Officer.

Relevant leadership roles could oversee:

- Discharge of statutory powers under Acts
- Determination of required public health control measures
- Representing the department on national response committees.

Planning Officer could oversee:

- Develop plans
- Client and funded service impact monitoring
- Situational analysis and communication (briefings, PPQs).

Intelligence Officer could oversee:

- Sector impact monitoring including casualty data collection
- Rapid literature review and options analysis
- Human health risk assessment (hazard, exposure, hypothesis)
- Health impact assessment (morbidity and mortality)
- Specialist functions (toxicology, infection control, infectious diseases, radiation protection, others)
- Epidemiological analysis (environmental, descriptive human, analytical human).

Operations Officer could oversee a range of functions including:

- Health coordination-related operations functions:
  - Service coordination including Code Brown, Private Hospitals Activation
  - Health service alert coordination
- Relief and recovery-related operations functions:
  - Emergency accommodation coordination
  - Psychosocial support coordination
  - Financial assistance coordination.
- DHHS Command-related operations functions:
  - Coordinate changes to client and funded services
  - Business continuity
  - surge staff.
- Public health command-related functions:

  - Case management
  - Contact management
  - Laboratory and testing arrangements
  - Clinical investigation
  - Infection prevention and control
  - Field investigation and control
  - Local government advice and liaison
  - Public health advice to councils, agencies and the community.

Logistics Officer could oversee:

- Oversight of deployed DHHS staff including transport and accommodation
- Response team safety (D-IMT)
- Providing a call centre and supporting field investigation teams
- Providing countermeasures (medicines, vaccines, personal protective equipment)
- Supporting the D-IMT, any Public Health Advice Cell (meetings and minutes and agendas)
- Rosters, accommodation, catering, onboarding protocols, off-boarding protocols
- Scheduling of incident debriefing

Public Information Officer could oversee:

- The department's public information response covering public health advice; health coordination and health system impacts; relief and recovery support services and impacts to the department's clients and services
- Issue public information and warnings through the Victorian warning system and via the department's communication channels
- Represent the department on EMJPIC and the NHEMRN to ensure coordinated public information across local, state and national governments; and other responding agencies
- Work with the State Control Centre to develop a whole of Victorian Government incident specific communications plan
- Develop a suite of public information and communications materials i.e. key messages, factsheets, FAQs.

16. Appendix 3 – Daily schedule

An initial, default ‘battle rhythm’ for frequency of key governance group meetings is proposed below for a public health emergency where the department is confirmed to be the control agency:

0730-0830	State Control Team
0830-0900	Each lead officer identifies decisions and issues within their function requiring report or decision from D-IMT;
0900-0930	State Coordination Team
0930-1000	D-IMT
1000-1045	State Emergency Management Team
1045-1130	State Relief and Recovery Team
1130	Emergency Management Joint Public Information Committee (EMJPIC)
1200	Census point for daily situation reporting data if relevant;
1300	Media lines and public data authorised and released if relevant;
1400-1430	Each functional lead officer identifies decisions and issues within their function requiring report or decision from D-IMT;
1500-1530	Additional D-IMT meeting if required;
1700	Situation Report authorised and released.

17. Appendix 4 – Processes and Instruments of delegations for Controller (Class 2)

These will be identified and added after further work on this Concept of Operations.

18. Appendix 5 - Scenario testing examples

This Concept of Operations will be reviewed and amended by testing through the following scenarios.

Emergency descriptor	D-IMT Chair
Example 1 (DHHS as Support agency) – e.g. significant power outage at a service agency • Minimal consequences to be managed across the health system • Minimal public health impacts • **Significant** impacts to clients and funded services • **Significant** relief and recovery coordination responsibilities • Public health advice is through the Public Health Advice Cell (PHAC) chaired by the Public Health Commander, who is also on the D-IMT	D-IMT Chair: State Departmental Commander
Example 2 (DHHS as Support agency) – e.g. significant water damage to a large funded service building requiring relocation • Minimal consequences to be managed across the health system • Minimal public health impacts • Minimal impacts to clients and funded services • **Significant** relief and recovery coordination responsibilities • Public health advice is through the Public Health Advice Cell (PHAC) chaired by the Public Health Commander	D-IMT Chair: State Departmental Commander (no S-HIMT within the D-IMT)
Example 3 (DHHS as Support agency) – e.g. major road trauma emergency • **Significant** consequences to be managed across the health system • Minimal public health impacts • Minor impacts to clients, funded services or relief and recovery coordination responsibilities • Public health advice is through the Public Health Advice Cell (PHAC) chaired by the Public Health Commander, who is also on the D-IMT	D-IMT Chair: State Health Coordinator
Example 4 (DHHS as Control agency) – e.g. large legionella outbreak • Minimal consequences to be managed across the health system • **Significant** public health impacts to manage • Minor impacts to clients, funded services or relief and recovery coordination responsibilities • Public Health Commander will chair the D-IMT as a 'Public Health Incident', which will also provide advice to the control agency	D-IMT Chair: Public Health Commander

Example 5 (DHHS as Support agency) – e.g. major smoke impacts from fires • **Significant** impacts on the health system • **Significant** public health impacts to manage • Minor impacts to clients, funded services • **Significant** relief coordination responsibilities • Public health advice is through the Public Health Advice Cell (PHAC) chaired by the Public Health Commander, who is also on the D-IMT	D-IMT Chair: Public Health Commander or State Health Coordinator
Example 6 (DHHS as Support agency) – e.g. major smoke impacts from fires with some evacuations of clients required • **Significant** impacts on the health system • **Significant** public health impacts to manage • **Significant** impacts to clients, funded services • **Significant** relief and recovery coordination responsibilities to be managed • Public health advice is through the Public Health Advice Cell (PHAC) chaired by the Public Health Commander, who is also on the D-IMT	D-IMT Chair: Public Health Commander or State Health Coordinator or State Departmental Commander
Example 7 (DHHS as Control agency) – e.g. pandemic influenza, MERS outbreak, major foodborne disease outbreak • **Significant** impacts on the health system • **Significant** public health impacts to manage • **Significant** impacts to clients, funded services &/or relief and recovery coordination responsibilities to be managed	D-IMT Chair: Public Health Commander **Plus –** Controller (Class 2) - Class 2
Example 8 (DHHS as Control agency and Support Agency) – e.g. major floods at same time as foodborne disease outbreak • **Significant** impacts on the health system • **Significant** public health impacts to manage • **Significant** impacts to clients, funded services &/or relief and recovery coordination responsibilities to be managed	D-IMT Chair: Public Health Commander (foodborne disease outbreak) and State Departmental Commander (flood relief and recovery) **Plus –** Controller (Class 2) - Class 2

Public Health and Wellbeing Act 2008

Instrument of delegation

Interpretation

In this instrument:

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

duties, functions and powers means the duties of the Chief Health Officer under the provisions of the Act specified in column 1 of the Schedule.

Limitations means the Limitations specified in column 4 of the Schedule.

Officer means the person occupying or acting in the positions in the Department of Health and Human Services that are specified in column 3 of the Schedule.

Schedule means the Schedule attached to this instrument.

Description

The descriptions in column 2 of the attached Schedule are for ease of reference only. They do not affect the interpretation nor limit the powers contained in each of the provisions identified in column 1 of the Schedule.

Delegation

I, **Brett Sutton**, Chief Health Officer, appointed under Section 20 of the Act and 22 of the Act:

(a) **DELEGATE** my duties and powers to the Officer specified in column 3 of the Schedule, subject to the Limitations specified in column 4 of the Schedule; and

(b) **REVOKE** the previous instrument of delegation made by the Chief Health Officer under the Act dated 19 June 2017.

Commencement

This instrument commences on the date it is signed.

Signed at Melbourne in the State of Victoria

This 8th day of November 2019

Dr Brett Sutton
Chief Health Officer
Department of Health and Human Services

VICTORIA State Government | Health and Human Services

Schedule

COLUMN 1 Provisions	COLUMN 2 Descriptions	COLUMN 3 Delegate	COLUMN 4 Limitations
Section 113(1)	Power to make an examination and testing order	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 113(3)	Power to include specified items in an order or make the order subject to any conditions	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 114(4)	Duty to revoke an examination and testing order	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 117(1)	Power to make a public health order	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 118(3)	Duty to revoke a public health order	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 118(4)	Power to vary a public health order	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 118(5)	Power to extend a public health order	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	

COLUMN 1 Provisions	COLUMN 2 Descriptions	COLUMN 3 Delegate	COLUMN 4 Limitations
Section 118(6)	Power to extend a public health order as many times as considered necessary	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 121(3)	Duty to review a public health order	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 125	Duty to facilitate reasonable request for communication	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 134(1)	Power to make an order for a test if incident has occurred	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 134(3)	Power to make an application to a Magistrates' Court for an order	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 134(5)	Power to make an order for a person who is dead	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 134(8)	Power to include any conditions on an order	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	

COLUMN 1 Provisions	COLUMN 2 Descriptions	COLUMN 3 Delegate	COLUMN 4 Limitations
Section 134(9)	Power to vary or revoke an order	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 135(2)	Power to authorise the testing of a sample of blood or urine	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 136(1)	Power to examine or require the provision of health information	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 136(4)	Power to disclose health information	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 139(1)	Power to receive test results conducted under an order or authorisation	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 139(2)	Duty to give notice of test results	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 139(4)	Duty of to give notice of positive test results	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	

COLUMN 1 Provisions	COLUMN 2 Descriptions	COLUMN 3 Delegate	COLUMN 4 Limitations
Section 141(1)	Power to give directions	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 156(1)	Power to require a registered medical practitioner to carry out an autopsy on a body	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 156(2)	Duty to comply with section 157 in relation to an autopsy	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 156(3)	Power to order that possession of a body be given to a registered medical practitioner	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 157(1)	Duty to give a notice of decision to perform an autopsy to next of kin	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 188(1)	Power to direct a person to provide information in relation to a direction to provide information	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 188(4)(a)	Duty to warn a person	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	

COLUMN 1 Provisions	COLUMN 2 Descriptions	COLUMN 3 Delegate	COLUMN 4 Limitations
Section 188(4)(b)	Duty to inform a person in relation to a direction to provide information	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 189	Power to authorise authorised officers to exercise public health risk powers	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 191(4)	Power to extend period of authorisation to exercise public health risk powers	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 229(2)	Power to authorise a person or Council to take action under public health risk powers	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	Except in relation to emergency powers: • a direction or requirement under section 200; and • an improvement or prohibition notice issued in respect of a contravention to which section 203 applies.

Public Health and Wellbeing Regulations 2019

Instrument of delegation

Interpretation

In this instrument:

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

Chief Health Officer means the person appointed in accordance with section 20 of the Act.

duties, functions and powers means the duties, functions and powers of the Chief Health Officer under the provisions of the Regulations specified in column 1 of the Schedule.

Officers means the person(s) occupying or acting in the positions in the Department of Health and Human Services that are specified in column 3 of the Schedule.

Regulations means the Public Health and Wellbeing Regulations 2019.

Schedule means the Schedule attached to this instrument.

Description

The descriptions in column 2 of the attached Schedule are for ease of reference only. They do not affect the interpretation nor limit the powers contained in each of the provisions identified in column 1 of the Schedule.

Delegation

I, **Brett Sutton**, Chief Health Officer, acting under section 22 of the Act, **DELEGATE** my duties, functions and powers to the Officers specified in column 3 of the Schedule.

Commencement

This instrument commences on the date it is signed.

Signed at Melbourne in the State of Victoria

This 11th day of December 2019

Dr Brett Sutton
Chief Health Officer
Department of Health and Human Services

VICTORIA State Government | Health and Human Services

Schedule

COLUMN 1 Provisions	COLUMN 2 Descriptions	COLUMN 3 Description
Reg 19	Power to issue disease vector control notice	• Deputy Chief Health Officer (Communicable Disease) • Deputy Chief Health Officer (Environment)
Reg 111(2)	Power to direct the person in charge of a primary school or children's services centre to exclude an at-risk child	• Deputy Chief Health Officer (Communicable Disease) • Deputy Chief Health Officer (Environment)
Reg 111(4)	Power to direct that, for a child to whom the direction applies, attendance can be resumed	• Deputy Chief Health Officer (Communicable Disease) • Deputy Chief Health Officer (Environment)
Column 4 of item 5 of the Table in Schedule 7 of the Regulations	Power to clear a child who has come into contact with a member of their family or household infected with diphtheria to return to primary school, an education and care service premises or children's services centre	• Deputy Chief Health Officer (Communicable Disease) • Deputy Chief Health Officer (Environment)
Column 4 of item 15 of the Table in Schedule 7 of the Regulations	Power to determine whether a child who has come into contact with a person infected with influenza or an influenza like illness needs to be excluded	• Deputy Chief Health Officer (Communicable Disease) • Deputy Chief Health Officer (Environment)
Column 3 of item 16 of the Table in Schedule 7 of the Regulations	Power to approve the return to primary school, an education and care service premises or children's services centre of a child infected with leprosy	• Deputy Chief Health Officer (Communicable Disease) • Deputy Chief Health Officer (Environment)
Column 4 of item 26 of the Table in Schedule 7 of the Regulations	Power to determine whether a child who has come into contact with a person infected with Severe Acute Respiratory Syndrome (SARS) needs to be excluded	• Deputy Chief Health Officer (Communicable Disease) • Deputy Chief Health Officer (Environment)
Column 3 of item 27 of the Table in Schedule 7 of the Regulations	Power to require the exclusion of a child infected with Shiga toxin or verotoxin producing *Escherichia coli* (STEC or VTEC) and to specify the exclusion period	• Deputy Chief Health Officer (Communicable Disease) • Deputy Chief Health Officer (Environment)
Column 3 of item 30 of the Table in Schedule 7 of the Regulations	Power to approve the return to primary school, an education and care service premises or children's services centre of a child infected with typhoid fever (including paratyphoid fever)	• Deputy Chief Health Officer (Communicable Disease) • Deputy Chief Health Officer (Environment)

COLUMN 1 Provisions	COLUMN 2 Descriptions	COLUMN 3 Description
Column 4 of item 30 of the Table in Schedule 7 of the Regulations	Power to determine whether a child who has come into contact with a person infected with typhoid fever (including paratyphoid fever) needs to be excluded	• Deputy Chief Health Officer (Communicable Disease) • Deputy Chief Health Officer (Environment)

Public Health and Wellbeing Act 2008

Instrument of authorisation under section 199

Interpretation

In this instrument:

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

Authorisation

I, **Adjunct Clinical Professor Brett Sutton**, **Chief Health Officer of Department of Health and Human Services** authorise Dr Annaliese van Diemen, Deputy Chief Health Officer (Communicable Disease), an authorised officer appointed by the Secretary to the Department of Health and Human Services, to exercise any of the public risk powers and emergency powers under the Act.

I believe it is necessary to grant the authorisation to eliminate or reduce a serious risk to public health.

That serious risk to public health exists arises from Novel Coronavirus 2019 (2019-nCov), and exists throughout the State of Victoria.

This authorisation is given under section 199 in Part 10, Division 3 of the Act.

There are no restrictions or limitations of the public health risk powers or emergency powers that may be exercised under the authorisation.

Commencement

This instrument commences on 17 March 2020 and continues in force until 13 April 2020.

Signed at Melbourne in the State of Victoria

This 17th day of March 2020

Time: 9.47 pm

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

COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan

Confidential and internal draft plan

4 April 2020 – 17:00

Contents

Background

In Victoria, the term ‘physical distancing’ will be used, in preference to the term ‘social distancing’.

A recent summary of the value of social distancing in relation to the COVID-19 emergency was given as:

“Social distancing is one of the key measures currently being utilised to contribute to Australia’s ability to severely limit transmission of COVID-19. This reduces the burden of disease in the community, and importantly, will ensure healthcare capacity is not overwhelmed at any given time. The health sector must continue to undertake its core functions, as well as maintain the capacity to support those with COVID-19 who require more intensive care.

The overarching goal of our recommendations is to slow the spread of the virus and flatten the epidemic curve. We all have both a community and individual responsibility to maintain social distancing and minimise interactions in order to protect the people we love. The aim is a population response, to reduce transmission to protect vulnerable populations.”

Purpose

This plan intends to:

- Provide clarity to all parts of the Department of Health and Human Services’ (the department’s) physical distancing response to coronavirus disease 2019 (COVID-19);
- Describe the strategy and protocols for the physical distancing response;
- Describe the compliance and enforcement policy for all directions, including mandatory detention policy;
- Inform internal and external communications collateral around physical distancing.

Scope

In scope for this policy are:

- Physical distancing interventions in Victoria;
- Quarantine and isolation interventions in Victoria implemented for any reason.

Authorising environment

Chief Health Officer and Deputy Chief Health Officer

Under a state of emergency declared by the Victorian Government, he Chief Health Officer and Deputy Chief Health Officer have exercised powers to make a range of Directions that reflect physical distancing controls in Victoria, as described in Annexes to this plan.

Emergency Management Commissioner and State Controller

State Controller (Class 2) is appointed to coordinate the overall response, working within the emergency management arrangements.

National Cabinet

National Cabinet for COVID-19 has released statements of policy on social distancing (physical distancing). These are reported to have been based on advice from the Australian Health Protection Principal Committee (AHPPC). The AHPPC releases its advice in statements which are published online.

Victoria Police

Advice has been sought from Legal Services as to the role of Victoria Police. As of 31 March 2020, Victoria Police will undertake a greater role in managing compliance in the community including issuing of infringement notices. As a result, the role of DHHS authorised officers in specific support to Victoria Police around compliance checks will

reduce as Victoria Police have a range of powers considered sufficient to investigate, including to issue infringements and fines.

Governance of physical distancing policy within the DIMT

A Physical Distancing Cell will be chaired by the Deputy Public Health Commander – Planning, on behalf of the Deputy Chief Health Officer (Public Health Commander). This will include:

- a communications lead;
- an enforcement and compliance lead, and
- an evidence and policy lead.

Policy on control measures for physical distancing

AHPPC recommendations to National Cabinet

Statements by AHPPC

The Australian Health Protection Principal Committee (AHPPC) have made a number of statements on the matter of physical distancing (social distancing). These are available at TRIM location HHSF/20/7891, and on the web at https://www.health.gov.au/news/latest-statement-from-the-australian-health-protection-principal-committee-ahppc-on-coronavirus-covid-19-0

The most recent AHPPC statement was 30 March 2020.

National requirements from National Cabinet

The National Cabinet has made announcements through the Prime Minister, including a statement relating to social distancing on 24 March and as recently as 30 March 2020.

Legal directions under emergency powers in Victoria

Directions work within legal services

A team within the department's Legal Services Branch has been established, including order to draft Directions under the state of emergency, for the Chief Health Officer and Deputy Chief Health Officer. The Legal Services Branch is not available to provide third party legal advice on Directions and their compliance or otherwise.

Process for creating Directions

The process involves a number of steps, some of which are iterative as the policy underlying the Direction is developed.

These steps include – but are not limited to –

- Policy area develops a need for a Direction under the state of emergency;
- Legal services commence work to create instructions;
- Secretary finalises required directions content to Legal Services;
- Legal Services instructs parliamentary counsel to draft instructions;
- Final check undertaken with Chief Health Officer or Deputy Chief Health Officer;
- Direction is signed;
- Direction is published on the webpage;
- A communications approach is initiated, including a press release and frequently asked questions.

Critical step in creation of Directions

The Deputy Chief Health Officer has identified a minimum requirement for an evidence-informed policy rationale to be recorded prior to the issuing of directions, and that this evidence-informed rationale extends beyond the general observation of a state of emergency having been declared. Such a short evidence summary could be produced by the Intelligence function.

Directions

At the current time, Directions and detention orders are generally signed by Dr Annaliese van Diemen (Deputy Chief Health Officer) as authorised by the Chief Health Officer.

Consideration is being given to expanding the list of authorised officers who can sign directions to include other Senior Medical Advisors within the response who are Authorised Officers.

List of Directions

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

- *Direction on airport arrivals (Annex 1) – 18 March 2020 (revoked 30 March 2020 - still displayed for reference);*
- *Direction on cruise ships docking (Annex 2) – 19 March 2020 (revoked 30 March 2020 - still displayed for reference);*
- Direction on aged care (Annex 4) – 21 March 2020;
- Direction on hospital visitors (Annex 6) – 23 March 2020;
- Direction on isolation (diagnosis) – 25 March 2020;
- Direction on revocation of airport arrivals and cruise ship directions – 28 March 2020;
- Direction on detention notice – Undated (first posted 28 March 2020);
- Direction on stay at home – 30 March 2020;
- Direction on restricted activity – 30 March 2020.

Summary of legally required actions in Victoria with a focus on physical distancing

The Directions in place are available online, and at the TRIM location HHSF/20/7901.

The summary of the key requirements in all seven active directions, across four themes, is below (linking to the Direction itself for more detail).

Directions on visitors to aged care facilities – 21 March 2020

- Prevents entering or visiting aged care facilities unless goods and services are necessary, and if the person meets criteria for a suspected case or is ill or is not up to date with vaccination or is under 16;
- Some exemptions including employee, care and support, end of life visit.

Directions on hospital visitors – 23 March 2020

- Prohibits non-essential visits to hospitals, including for categories of patients, workers and visitors;
- Exceptions include patients. Exemptions can be granted.
- Prohibits non-essential business operation from noon on 23 March 2020, including for pubs, hotels, gyms,

Directions on isolation – 25 March 2020

- Prohibits movement out of isolation until a person is not longer required to be in isolation by DHHS but allows a person not in their home to go directly there after diagnosis.

Direction – detention notice – 27 March 2020

- Orders the detention of all persons who arrive into Victoria from overseas on or after midnight on 28 March 2020, requiring they be detained in a specified room in a hotel, with only limited reasons wherein leaving the room can be allowed.

Direction on stay at home – 30 March 2020

- Restricts the way by which people can leave their home making an effective requirement to stay at home except in certain circumstances, restricts gatherings to two people in most instances with some exceptions.

Direction on restricted activity – 30 March 2020.

- Expands restrictions on certain businesses and undertakings put in place as part of non-essential activities restrictions, for example to include playgrounds.

Directions that have been revoked

The following Directions have been issued but have been revoked. Information is included for reference.

Direction on airport arrivals -18 March 2020

- *Anyone who arrives at an airport in Victoria on a flight that originated from a place outside Australia, or on a connecting flight from a flight that originated from a place outside Australia must self-quarantine for 14 days after arrival, if arrived after 5pm on 18 March 2020;*
- *Sets rules on being in quarantine – cannot leave home except in an emergency and cannot allow people to enter unless they live there.*

Directions on cruise ship docking – 19 March 2020

- *Anyone who disembarks at a port in Victoria from an international cruise ship or an Australian cruise ship (which is on a voyage from a port outside Australian territory) must self-quarantine for 14 days after arrival.*
- *Allows for some exceptions (goes interstate directly, or to hospital).*

Directions on mass gatherings – 21 March 2020

- *Non-essential mass gatherings are prohibited (not allowed to be organised, allowed or attended). A mass gathering means:*
  - *A gathering of five hundred or more persons in a single undivided outdoor space at the same time;*
  - *A gathering of one hundred (100) or more persons in a single undivided indoor space at the same time.*
- *In addition, the total number of persons present in the indoor space at the same time does not exceed the number calculated by dividing the total area (measured in square metres) of the indoor space by 4, meaning a limit of one person per four square metres (2x2m).*
- *Many specified exemptions, including for some forms of transport, schools, prisons, Parliament or where CHO or DCHO issue an exemption.*

Directions on non-essential business closure – 23 March 2020

- *Prohibits non-essential business operation from noon on 23 March 2020, including for pubs, hotels, gyms, places of worship, other specified businesses;*
- *No exemptions process is specified – it is an inclusive list.*

Directions on prohibited gatherings – 25 March 2020

- *Non-essential gatherings are prohibited from midnight on 25 March 2020 – not to be organised, allowed or attended.*
- *Adds two additional prohibited mass gatherings which are social sport gatherings and weddings and funerals.*
- *Specifies a density quotient, with examples.*
- *A mass gathering means:*
  - *A gathering of five hundred or more persons in a single undivided outdoor space at the same time;*
  - *A gathering of one hundred (100) or more persons in a single undivided indoor space at the same time.*
- *Many specified exemptions, including social sport gatherings (two or more people), weddings, and funerals (no more than 10 people – indoors or outdoors), some forms of transport, schools, prisons, Parliament or where CHO or DCHO issue an exemption.*
- *Allows for exemptions to be asked for and granted.*

Directions on non-essential activities – 25 March 2020

- *Prohibits categories of non-essential activity;*
- *Adds requirement for signage, cleaning and disinfection on businesses that remain open;*
- *Includes prohibition on licensed premises, personal training facilities, outdoor personal training limited to ten persons, entertainment facilities, non-essential retail facilities, food and drink facilities, accommodation facilities, swimming pools, animal facilities, auctions;*
- *Exceptions include essential public services such as food banks, wedding venues, recording of performances, time-limited haircuts, delivery of goods, densely packed markets (density rule), food and drink facilities in certain places (hospitals for example); some types of accommodation facility.*

Announced stages of restrictions in Victoria

Stage 1 restrictions

Victoria announced 'stage 1 restrictions' on 22 March 2020 and 23 March 2020 and implemented effective midday 23 March 2020. These included:

- Bringing school holidays forward to commence starting on Tuesday 24 March;
- Ceasing non-essential business activity including:
  - pubs, bars or clubs, or hotels (other than to operate a bottleshop, take-away meals or accommodation),
  - gyms,
  - indoor sporting centres,
  - the casino,
  - cinemas,
  - nightclubs or entertainment venues of any kind,
  - restaurants or cafes, other than to the extent that it provides takeaway meals or a meal delivery service
  - places of worship, other than for the purposes of a wedding or funeral.

https://www.premier.vic.gov.au/statement-from-the-premier-32/

https://www.premier.vic.gov.au/statement-from-the-premier-33/

https://www.premier.vic.gov.au/wp-content/uploads/2020/03/200323-Statement-From-The-Premier-1.pdf (this includes a copy of the Deputy Chief Health Officer direction)

Stage 2 restrictions

Stage 2 restrictions were announced on 25 March 2020. Further to the stage 1 restrictions, these further restrictions include:

- Ceasing operation of:
  - Recreation facilities (indoor and recreation facilities, personal training facilities, community centres and halls, libraries, galleries and museums, youth centres and play centres (other than for essential public services);
  - Entertainment facilities (in addition to entertainment facilities already covered in stage 1, stage 2 added theatres, music and concert halls, auditoriums, arenas, stadiums, convention centres, arcades, amusement parks, gambling businesses, brothels, sex on premises venues, and strip clubs);
  - Non-essential retail facilities (beauty and personal care, auction houses, market stalls - other than for the provision of food and drink and subject to density provisions);
  - Food and drink facilities (in addition to stage 1, stage 2 added fast food stores, cafeteria's and canteens, and food courts) but maintaining the ability to provide take away;
  - Camping grounds and caravan parks;
  - Swimming pools (other than private pools not for communal use);
  - Animal facilities (zoos including petting zoos, wildlife centres, aquariums or animal farms not for food production);

  - Real estate auctions (other than remotely) and inspections (other than by appointment);
- Introduced a density quotient for retail facilities of 1 per 4m2 and increased cleaning requirements;
- Introduced a restriction social sport gatherings;
- Limited attendees at weddings (5 people) and funerals (10 people).

Prohibits operation of non-essential businesses and undertakings to slow spread. Cafes and food courts must stop providing table service, but may continue to offer delivery and takeaway. Cafes and canteens may continue to operate at: hospitals, care homes and schools, prisons, military bases, workplaces (though only as a takeaway service). Auction houses, real estate auctions and open house inspections, non-food markets, beauty and personal care services.

https://www.premier.vic.gov.au/wp-content/uploads/2020/03/200325-Statement-From-The-Premier-1.pdf

Stage 3 restrictions

These restrictions came into effect at midnight on 30 March 2020, and are:

- Gatherings are restricted to no more than two people except for members of your immediate household and for work or education purposes;
- Requirement to stay home will become enforceable;
- Playgrounds, skate parks and outdoor gyms will also close;
- There are only four reasons to be out:
  - Shopping for what you need – food and essential supplies;
  - Medical, care or compassionate needs;
  - Exercise in compliance with the public gathering requirements;
  - Work and study if you can't work or learn remotely;
- Moratorium on evictions introduced;
- Rules for weddings (no more than five people to attend) and funerals (no more than ten people can attend).

Essential services and non-essential services

A listing of the Victorian classification of essential compared to non-essential is under development.

Summary of strong recommendations in Victoria on physical distancing (should) – top lines

In addition to Directions, the Chief Health Officer provides a number of strong recommendations around physical distancing that are considered critical for suppressing any transmission of COVID-19 in Victoria at the current time.

The top lines at the present time are:

- Play your part and do the right thing or Victorians will die.
- Wash your hands.
- Cough into your elbow.
- Keep your distance from other people. Keep 1.5 metres between yourself and others
- Stay at home.
- If you can stay home, you must stay home.
- Stay in your own house and do not go to someone else's house.
- If you don't need to go out, don't go out.
- Do not go out if you are sick except to seek medical care.
- Shop for what you need, when you need it – do not go shopping unless you have to.
- If you can work from home, you should work from home.
- If you go to work, you must follow all the social distancing rules.
- Keep a distance of 1.5 metres is between yourself and others.
- Stop shaking hands, hugging or kissing as a greeting.

- Work from home where possible.
- If you have had close contact with a confirmed case of COVID-19 in the previous 14 days you must self-isolate and must not participate in community gatherings including community sport.
- Stay home if you are sick and don't expose others. If you are unwell with flu-like symptoms, do not go outside your property or home, do not go to work, school or shops unless it is essential – for example to seek medical care.
- Do not travel interstate, overseas or take a cruise. Avoid unnecessary travel.
- Everyone should avoid crowds if possible. If you must be in a crowd, keep the time short.

Policy development and decision-making

Evidence for physical distancing policies

Physical distancing between people aims to minimise interactions between people to limit the opportunities for disease to spread from an infected person to an un-infected person. Measures to bring about physical distancing amongst populations have been utilised in previous efforts to control influenza epidemics and pandemics.

Observational and modelling studies have provided evidence to help guide the use of physical distancing measures for influenza. Although these can provide some insight into how we might expect physical distancing to influence the progression of the COVID-19 pandemic, COVID-19 has its own disease characteristics which will influence the impact of physical distancing measures.

Evidence of the impact of social distancing is beginning to emerge from countries in which the epidemic commenced earlier than in Australia, particularly China. Additionally, modelling studies using information on the epidemiological features of COVID-19 are estimating the impact of different physical distancing measures.

To ensure that Victoria's approach to physical distancing is informed by the best-available evidence, an evidence summary will be produced and updated as new results emerge from the global scientific community. The current summary of evidence for physical distancing is at **Appendix 2**. This will be updated regularly.

International and national comparisons

Reports outlining the physical distancing interventions in place in other Australian states and internationally will be developed and updated on an ongoing basis. These will be updated weekly in the first instance, however the current summary of comparisons for physical distancing is at **Appendix 6**.

Evaluation of physical distancing policies

A range of measures to evaluate the efficacy of all interventions will be developed. In the first instance, these measures will include those suggested by the AHPPC:

- Evidence for efficacy of strengthened border measures/ travel advisories: reduction in the number of imported cases detected over time;
- Evidence of efficacy of the reduction in non-essential gatherings and mixing group sizes: reduction in the average number of secondary infections per case, based on contact tracing;
- Evidence for the combined efficacy of case finding and contact quarantine measures augmented by social distancing: reduction in the rate of growth of locally acquired infected cases;
- Evidence for the effectiveness of isolation: time from symptom onset to isolation.

The Intelligence function will develop a framework for monitoring and advising on progress with the effectiveness of physical distancing interventions in Victoria, to inform understanding of the Chief Health Officer and other colleagues, including decision-makers.

Next steps for physical distancing interventions

Scenario modelling and factors determining scaling back of physical distancing will be considered and incorporated in this section of the Plan.

Initial draft considerations relating to scaling back physical distancing interventions have considered – but not determined – whether factors like those listed below might prompt consideration.

Factors might include situations where:

- Societal tolerance of physical distancing measures is breached, or
- a vaccine is available and is being implemented, or
- underlying immunity (‘herd immunity’) is above a certain level (which is more than 70%, or calculated as 1/Ro, based on current reproductive number of around 2.4-2.7), or
- transmission will lead to manageable illness within an agreed intensive care unit capacity level, or
- transmission has been interrupted, mitigated, or stopped for a certain period.

Compliance and enforcement for physical distancing

Purpose of this section

The purpose of this compliance protocol is to set out the compliance approach in relation to Deputy Chief Health Officer (D/CHO) directions under *Public Health and Wellbeing Act 2008* (PHWA).

Scope of compliance and enforcement

The scope of enforcement and compliance activity will include persons and situations listed below:

- People under quarantine for any reason, including travel or close contact;
- People under isolation for any reason, including suspected cases and confirmed cases;
- Mass gatherings and any matter relating to any Direction relating to physical distancing, including visitation restrictions.

Chain of command for enforcement and compliance

It has been agreed with the Chief Health Officer and Deputy Chief Health Officer that the chain of command for matters relating to physical distancing (especially and including enforcement and compliance actions) interventions – in particular the compliance and enforcement activities relating to directions - is:

- Chief Health Officer to
- Public Health Commander to
- Deputy Public Health Commander (Planning) to
- Director Health and Human Services Regulation and Reform to
- Manager Environmental Health Regulation and Compliance to (where necessary -
- Victoria Police).

Strategy for compliance and enforcement

Intended outcome of compliance and enforcement activity

The outcomes being sought are to reduce the transmission COVID-19 through a range of interventions, including: quarantine for 14 days of those returning from overseas, isolation of those suspected to have or confirmed to have COVID-19, application of restrictions on non-essential mass gatherings, restricted entry into aged care facilities where vulnerable populations reside and closure of non-essential business. Actions should focus on achieving outcomes, be risk-based and minimise transmission risks in the Victorian community.

Strategy for focus of compliance and enforcement activity

The focus of activity will be on:

- Implementation of a mandatory detention program for new arrivals from overseas;
- Spot checks by Victoria Police of people who should be in quarantine or isolation;
- Mass gathering compliance and enforcement by Victoria Police.

These priorities will change, and likely expand into specific and more targeted risk-based compliance for highest-risk individuals in quarantine or isolation.

The department will consider enhanced monitoring arrangements and consider indicating to Victoria Police that other methods are considered, such as tracking of individuals through mobile phones, or random sampling calls to mobile phones of individuals if agreed. These methods are not yet formally under consideration.

Approach to compliance and enforcement – prioritisation framework for compliance activities

This will be based on a risk framework, based on public health risk.

An initial frame for Victoria Police was provided on 25 March 2020 and was:

- Cases diagnosed after midnight tonight.
- Passengers who have disclosed country visited in one of the higher risk countries? Which ones?
- Random selection of age cohorts from passenger list (of those who arrived less than 14 days ago) so that we can start to gauge which cohorts are the most likely to not comply.
- Pubs/clubs etc. (should be fairly easy to gauge with overnight crews.)
- Any allegations received from DHHS or VicPol Police Assistance Line.
- Selection of commercial premises mentioned in latest direction.

The proposed new preliminary order for focus of compliance and enforcement based on a public health risk assessment is (highest priority is first) from 26 March 2020 and updated 1 April 2020:

- Returned travellers from overseas who are in mandatory quarantine;
- Returned travellers from overseas who have indicated they do not intend to adhere to quarantine (self-isolation);
- Mass gatherings that are underway where there is alleged non-compliance with Directions;
- Cruise ships where there is potential or alleged non-compliance with Directions;
- Non-essential businesses where there is potential or alleged non-compliance with Directions;
- Confirmed cases who indicate they do not intend to isolate or are suspected not to be isolating;
- Known close contacts who indicate they do not intend to isolate or are suspected not to be isolating;
- Individuals where there is a report that a person is not adherent to quarantine or isolation;
- All other confirmed cases in relation to isolation Direction;
- All other close contacts;
- Prohibited gatherings (other than mass gatherings) that are underway or alleged non-compliance with Directions;
- Non-essential activities that are alleged to be non-compliant with Directions.

The Director of health and Human Services Regulation and Reform will communicate these priorities as a control agency advice to Victoria Police on a daily basis or as updated.

Linking members of the public to compliance action by Victoria Police

Linking occurs by:

- Callers may select the social distancing advice line between 8am and 8pm at DHHS by calling 1800 675 398 and selecting option 2.
- Callers may speak to Victoria Police by calling 1800 675 398 and selecting option 4.
- Callers who come through to any other line should be referred to the 1800 675 398 line and advised to select option 4.
- Members of the public are encouraged to call the phone line, rather than emailing their concerns.
- If concerns are emailed from the public about compliance with directions excluding those that are about close contacts and confirmed cases, the email should be forwarded to the Victoria Police complaints inbox, which is COVID-19.vicpol@dhhs.vic.gov.au

Department of Health and Human Services Liaison to Victoria Police

The department has established a roster of Emergency Management Liaison Officers at the State Control Centre, associated with the Police Operations Centre. The roster for the EMLO is on the board at the State Emergency Management Centre.

The EMLO is provided with the details of the DHHS oncall Authorised Officer each day to pass onto the Victoria Police SPOC for the overnight periods when the EMLO position is unstaffed.

Department of Health and Human Services initiation of compliance activity

If concerns are emailed from the public about compliance by close contacts and confirmed cases, the Operations Officer should oversee an investigation by the case and contact management team. If the case and contact management team assess that compliance action is required, they should contact the DHHS EMLO on the roster to agree how Victoria Police can assist, and may need to email details to the COVID-19 Victoria Police DHHS email address, which is COVID-19.vicpol@dhhs.vic.gov.au

Peer influence, education and community awareness to guide approach

It is anticipated that there will be high levels of voluntary compliance by those impacted by the Directions. This is due to high levels of community awareness, strong community support for measures to prevent transmission of COVID-19.

Exercising a Direction and considerations of enforcement

DHHS authorised officers are empowered to direct a person to comply with a D/CHO Direction (exercising the emergency powers). Victoria Police can assist an authorised officer to exercise a direction. Victoria Police are now undertaking a range of actions, including enforcement actions such as infringements.

Consideration of enforcement action, such as a prosecution under the PHWA, should generally only be pursued where there is a deliberate intention to not comply and/or repeated failure to comply with a direction.

Victoria Police COVID 19 Taskforce Sentinel

A Victoria Police taskforce of 500 officers will promote and assess compliance with directions and perform spot-checks, such as visiting those who have recently returned from overseas. The taskforce is coordinated through the Police Operations Centre. Information for spot checks can be provided directly to through Victoria Police SPOC.

Victoria Police support to DHHS compliance activity

Victoria Police (VicPol) will support DHHS to respond to allegations of non-compliance with the directions. This includes:

- receiving reports of non-compliance with directions through the Victoria Police Assistance Line (1800 675 398 – option 4);
- seeking to influence compliance and address non-compliance through spot checks, reiterating obligations, providing education and issuing infringements;
- where required, assisting DHHS authorised officers to provide a direction to a member/s of the public.

Contacting the Victoria Police Special Operations Centre

Victoria Police Special Operations Centre private number REDACTED if a senior officer in DHHS needs to contact the SPOC directly for an urgent reason.

The DHHS EMLO to Victoria Police is available through a roster in the SEMC.

Infringements

On 28 March 2030, the Public Health and Wellbeing Regulations 2019 were amended to create four new infringement offences to strengthen enforcement specifically around the emergency and public health risk powers. These are:

- hinder or obstruct an authorised officer exercising a power without reasonable excuse (5 penalty units);
- refuse or fail to comply with a direction by CHO to provide information made under s.188(10 without a reasonable excuse (10 penalty units for natural person and 30 penalty units for body corporate);
- refuse or fail to comply with a direction given to, or a requirement made or, a person in the exercise of a public health risk powers (10 penalty units for natural person and 60 penalty units for body corporate);
- refuse or fail to comply with a direction, or a requirement made of, a person in the exercise of a powers under a authorisation (10 penalty units for natural person and 60 penalty units for body corporate).

Data management to support compliance and enforcement

Department obtaining data on travellers for compliance

Authorised officers are responsible for uploading information to the business system which will then inform an upload to PHESS so that all persons in mandatory detention are recorded in PHESS for compliance and monitoring and surveillance purposes. This upload will occur under the accountability of the Director of Health Regulation and Reform. Final arrangements being confirmed

Provision of data on agreed priority groups to Victoria Police for enforcement and compliance purposes

On the direction of the Chief Health Officer, the Intelligence Officer has established a secure data portal for DHHS-Victoria Police data secure data sharing and provided a limited number of named Victoria Police officers in the COVID-19 response access. Information is being uploaded from Isolation Declaration Cards to a spreadsheet and then provided to the Intelligence Officer, who are then providing that information to Victoria Police for compliance purposes by a secure portal, on a daily basis. In conjunction with the priorities for compliance, Victoria Police can then take directed action. An information sharing agreement is under development.

Twice each day, the Intelligence Officer or delegate will upload the following to the data portal:

- Instructions on the use of the data;
- All active close contacts;
- All non-recovered confirmed cases;
- All new arrivals via scanned and uploaded Isolation Declaration Cards.

In coming days, data will be widened to include other groups if authorised by the Chief Health Officer. Further work is required to formally provide information on other categories for priority compliance activity

Specific procedures to support compliance and enforcement

Personal protective equipment for authorised officers is provided though the PPE Taskforce and the Equipment and Consumables Sector of the response. This plan will specify source.

Digital platforms to aid contact tracing and enforcement and compliance

The department will be implementing a new contact system to send daily health monitoring SMS messages to close contacts of confirmed COVID-19 cases and recently returned travellers who must isolate for fourteen days.

This system will use an Australian based system called Whispr to send messages to contacts in the department's public health monitoring systems.

People who receive these messages will be required to check in daily to:

- Confirm that they are in quarantine
- Whether they are well or experiencing COVID-19 symptoms
- Whether they have been tested and waiting for results.

Close contacts and returned travellers who are not isolating will be flagged by the system and can be further followed up as required.

This system became active from 26 March 2020.

Further work is underway to explore other systems for automating case and contact tracing.

Management of advice and exemption requests not relating to mandatory quarantine

There is no exemption clause in the Restricted Activity Direction (formerly Essential Services Direction). There is an area where exemptions occur which is in clause 11 of the Hospital Visitor Direction.

Exemptions can only be considered when there is a provision within the Direction to allow an exemption to be considered.

The Directions and Detention order give rise, broadly, to three kinds of request for advice or consideration by individuals and the public –

- Permission to leave detention requests from people in detention in Victoria;
- Exceptional circumstances requests for people seeking to not be ordered into detention (who have not yet arrived in Victoria from overseas); and
- All other requests for advice in relation to Victoria's Directions (including exemption requests for certain parts of Directions).

Only this last category will be dealt with in this part of the Plan (all other requests for advice in relation to Victoria's Directions). The other two categories will be dealt with in the Mandatory Quarantine section of this Plan.

To be specific, requests in relation to the mandatory quarantine (detention) orders or permission to leave (for people in detention) should be rapidly reviewed by staff in the call centre function if they occur, and there should generally be a presumption that these requests are forwarded immediately (within two hours) to the COVID-19.vicpol@dhhs.vic.gov.au email address for review by an Authorised Officer working directly to the Compliance Lead, as these are a high priority category of requests. The Authorised Officer will then follow the process outlined in a subsequent section of this Plan.

Process for seeking advice or requesting exemptions in relation to the Hospital Visitor Direction or other Direction

The Authorised Officer should provide advice to the requestor consistent with the *COVID -19 DHHS Physical Distancing Plan* and the Directions that are in force. The Plan is an internal document and is not for provision to members of the public. Instructions in the Directions should generally be emphasised.

Further information and consultation for an exemption relating to a direction can be undertaken by calling 1800 675 398.

The process is:

- Members of the public can submit requests to the COVID Directions inbox, including in relation to asking for advice on directions, requesting an exemption in relation to the Hospitals Visitor Direction (although that is unlikely) or in relation to asking to not have a detention order applied, or requesting a grant of leave (permission) from detention;
- Requests for advice (or Hospital Visitor exemptions) that are considered are logged on the secure MS Teams site established by Legal Services in a manner that can be audited and reviewed by any party in this compliance chain;
- The Director of Health Protection and Emergency Management who oversees the inbox and team managing this process assesses the merits of the individual proposal – including through delegates - and applies judgment as to whether advice should be provided verbally or whether advice is appropriate in writing to resolve the request, noting legal advice can be sought at any time;
- Requests are then assigned into three categories –
  - Priority 1 requests – where there is a same day urgency and importance is high;
  - Priority 2 requests – where there is complexity, lower urgency and / or medium urgency;
  - Priority 3 requests – where the authorised officer has determined that advice is given by the call centre function or staff with no further action, preferably verbally or in some rarer cases in writing;
- For priority 3 requests or where the call centre lead determines the matter is clear, if advice in writing is deemed appropriate, a written response should generally only be provided using an agreed template response, as it is preferable that advice is generally verbal in relation to directions (**Appendix 6**);
- For priority 2 requests and only where the call centre lead needs further advice, these should be batched and provided as a set of emails including a recommendation in each to an informal panel of the Deputy Public Health Commander, Compliance Lead and Legal Services to be convened every 24 hours if needed;

- For priority 1 requests, the call centre lead should email through details and a recommendation and call the Authorised Officer working directly to the Compliance Lead and discuss, and can initiate calls to the Compliance Lead at the time;
- If a request is deemed reasonable to meet, the Compliance Lead submits the proposal to the Deputy Public Health Commander Planning with a recommendation, and may call the Deputy PHC Planning to discuss and alert the DPHC to the request, including legal service advice as needed;
- The Deputy Public Health Commander assesses the recommendation and then recommends the outcome required by the Public Health Commander;
- The Public Health Commander communicates the outcome and the Compliance Lead is authorised to enact the outcome.
- Police will then be advised where any exemption is are granted by the Public Health Commander via the COVID-19.vicpol@dhhs.vic.gov.au that have relevance for enforcement and compliance by Victoria Police.

The Authorised Officer should then notify the requestor in writing the outcome of the decision of the Public Health Commander.

Formal documentation placed into the TRIM folder by the Deputy Public Health Commander or a tasking officer.

An audit of requests to check responses will be undertaken in due course, including a review of how advice was communicated publicly, if at all.

Protocols for investigating and managing potential breaches of Directions

Information is included here for reference, as Victoria Police have assumed a more independent role as to undertaking compliance and enforcement activity, with strategic direction as to highest risk groups.

Action to achieve compliance and address non-compliance

Following advice that Victoria Police can enforce directions, from 30 March 2020 Victoria Police is the primary agency responsible for investigating allegations of non-compliance and undertaking enforcement action, including the issuing of infringement notices.

Prior to this advice, existing arrangements involved referring alleged breaches to Victoria Police for investigation. If needed, Victoria Police would request DHHS authorised officer action and assistance, such as for issuing a direction.

Victoria Police may contact the DHHS Emergency Management Liaison officer seeking advice or clarification of particular circumstances

Reporting and evaluation of compliance and enforcement

The department proposes a range of checks or surveys of individuals who are directed to be in quarantine or isolation, including checks or surveys, and key metrics for evaluation. More detail will be developed in due course. Victoria Police provide a daily report on enforcement and compliance activity.

Plan for people returning from overseas to Victoria

Background to the mandatory quarantine (detention) intervention

A mandatory quarantine (detention) approach was introduced by creation of a policy that a detention order would be used for all people arriving from overseas into Victoria from midnight on Saturday 28 March 2020. An example detention order is available at https://www.dhhs.vic.gov.au/state-emergency

The objectives of the plan for people returning from overseas to Victoria are:

- To identify any instance of illness in returned travellers in order to detect any instance of infection;
- To ensure effective isolation of cases should illness occur in a returned traveller;
- To provide for the healthcare and welfare needs of returned travellers who are well or shown to be COVID-19 negative but are required to remain in quarantine for the required 14 days;
- To implement the direction of the Deputy Chief Health Officer through meeting:
  - A requirement to detain anyone arriving from overseas for a period of 14 days at a hotel in specific room for a specified period unless an individual determination is made that no detention is required;
  - A requirement to record provision of a detention notice showing that the order was served and to manage access to information on who is in detention using a secure database;
  - A requirement to undertake checks every 24 hours by an authorised officer during the period of detention;
  - A requirement to fairly and reasonably assess any request for permission to leave the hotel room / detention.

Governance and oversight of the mandatory quarantine (detention) intervention

Lead roles

The Chief Health Officer and Deputy Chief Health Officer have instituted a policy, in keeping with a conclusion from National Cabinet, that leads to issuance of detention orders for people returned from overseas.

The following lead roles are involved in the oversight of the mandatory detention intervention:

- Deputy Chief Health Officer – decision to issue a detention notice or not;
- Deputy Public Health Commander Planning – initial advice to DCHO/PHC on requests where a decision is needed whether to grant leave (permission);
- Director Health Regulation and Reform – is the Compliance Lead, for compliance and enforcement activity including authorised officer workforce – including the issuing and modification of detention orders (for example including moving a person from one room to another);
- Deputy State Health Coordinator – lead for healthcare provision to persons in detention;
- Director Health Protection and Emergency Management – lead for welfare and implementation of healthcare provision to persons in detention;
- Department of Health and Human Services Commander – lead for logistics for provision of mandatory detention involving transport and accommodation.

Information management for people in mandatory detention

A business system is being developed by BTIM to assist with the management of the healthcare and welfare for people included in this intervention.

That system articulates with the PHESS database through a common link key.

Critical information about people in mandatory detention will be uploaded to PHESS at two points in the day as a download from the business system to be used.

To be determined: the master source of who has exited the airport in mandatory detention.

To be completed: the build of the business system to support welfare and health needs of people in mandatory detention.

The Enforcement and Compliance section will ensure identities and basic compliance information of all persons in detention are entered onto PHESS through the twice daily upload process from the completed business system.

As a parallel system, Isolation Declaration Card (IDCs) are collected at the airport and batched and sent to an Australia Post call centre. The data is entered into a spreadsheet and sent to DHHS for cross entry into PHESS. This process takes approximately 24 hours. This can then be reconciled with any passenger list or people in detention list.

Enforcement and Compliance Command for Mandatory Quarantine

Deliverables of the enforcement and compliance function

The Director of Health Regulation and Compliance role is responsible for:

- Overall public health control of the detention of people in mandatory quarantine;
- Oversight and control of authorised officers administering detention;
- Administration of decisions to detain and decision to grant leave from detention.

Authorised officer* and Chief Health Officer obligations

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

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

Any AO that is unsure as to whether they been authorised under s.199 should contact administrative staff in the DHHS Health Protection Branch prior to enforcing compliance with the Direction and Detention Notice.

Exercising this power imposes several obligations on DHHS authorised officers including:

- producing their identity card for inspection prior to exercising a power under the PHWA
- before the person is subject to detention, explaining the reason why it is necessary to detain the person
- if it is not practicable to explain the reason why it is necessary to detain the person, doing so as soon as practicable
- before exercising any emergency powers, warning the person that refusal or failure to comply without reasonable excuse, is an offence
- facilitating any reasonable request for communication made by a person subject to detention
- reviewing, every 24 hours, whether continued detention of the person is reasonably necessary to eliminate or reduce a serious risk to health
- giving written notice to the Chief Health Officer (CHO) that a person:
  - has been made subject to detention
  - following a review, whether continued detention is reasonably necessary to eliminate or reduce the serious risk to public health.

The notice to the CHO must include:

- the name of the person being detained
- statement as to the reason why the person is being, or continues to be, subject to detention.

Following receipt of a notice, the CHO must inform the Minister as soon as reasonably practicable.

** DHHS Authorised Officer under the PHWA that has been authorised for the purposes of the emergency order.*

Required authorised officer actions at the airport

The lead for this situation is the Compliance Lead through a lead Authorised Officer.

DHHS Authorised Officers*:

- declare they are an Authorised Officer and show AO card [s.166] **(mandatory AO obligation)**
- must provide a copy of the Direction and Detention Notice to each passenger (notification to parent/guardian may need to be conducted over the phone and interpretation services may be required) and:
  - explain the reasons for detention [s. 200(2)] **(mandatory AO obligation)**
  - warn the person that refusal or failure to comply with a reasonable excuse is an offence and that penalties may apply [s. 200(4)] **(mandatory AO obligation)**
- ensure the Direction and Detention Notice:
  - contains the hotel name at which the person will be detained
  - states the name/s of the person being detained
- record issue and receipt of the notice through a scanned photograph and enter into business system
- if necessary, facilitate a translator to explain the reasons for detention
- facilitate any reasonable request for communication, such as a phone call or email [s. 200(5)] **(mandatory AO obligation)**
- provide a fact sheet about detention (what the detainee can and can't do, who to contact for further information)
- record any actions taken in writing, including the above mandatory obligations, use of translator and any associated issues.
- use the list of arriving passengers to check off the provision of information to each arrival. This will help ensure all arrivals have been provided the information in the Direction and Detention Notice.
- check the vehicle transporting detainees is safe (in accordance with the review of transport arrangements procedure)

If it is not practicable to explain the reason for detention prior to subjecting the person to detention, the AO must do so as soon as practicable. This may be at the hotel, however every effort should be made to provide the reason at the airport [s. 200(3)] **(mandatory AO obligation)**.

*DHHS Authorised Officer under the PHWA that has been authorised for the purposes of the emergency order.

Authorised Officer review of transport arrangements

AO should consider the following:

- All persons must have been issued a direction and detention notice to board transport
- Is there adequate physical distance between driver and detainees?
- If not wait for another suitable vehicle to be arranged by the hotel.
- Has the vehicle been sanitised prior to anyone boarding? If not then vehicle must be cleaned in accordance with DHHS advice (business sector tab).
- Ensure the driver required to wear PPE?
- Are the persons subject to detention wearing face masks? (Refer to Airport and transit process)
- Are there pens/welfare check survey forms available for each detainee to complete enroute or at the hotel?

People who are unwell at the airport

The lead for this situation is the Human Biosecurity Officer on behalf of the Deputy Chief Health Officer (Communicable Disease).

Any person who is unwell at the airport will be assessed by a DHHS staff member and biosecurity officer at the airport. After discussion with the human biosecurity officer, if it is determined that the person meets the criteria as a suspected case, the following actions should take place:

- The human biosecurity officer should organise an ambulance transfer to the Royal Melbourne Hospital or Royal Children's Hospital for testing and assessment;
- The authorised officer from DHHS at the airport should log the person as requiring mandatory quarantine at a specified hotel and then should follow-up with the hospital to update on whether the person has been found to be negative, so a transfer by (patient transfer/ambulance/ maxi taxi etc) can be organised to return to the hotel.
- If the person is unwell and requires admission, they should be admitted and the Compliance Lead informed;
- If the person is well enough to be discharged they should return to the hotel through an arrangement by the authorised officer, (comments as above) and be placed in a COVID-19 floor if positive, or in a general part of the hotel if tested negative for COVID-19.

Requirement for review each day

- DHHS AO must – at least once every 24 hours – review whether the continued detention of the person is reasonably necessary to protect public health [s. 200(6)] **(mandatory AO obligation).**
- DHHS AO will undertake an electronic review of detainment arrangements by viewing a Business system. This includes reviewing:
  - the date and time of the previous review (to ensure it occurs at least once every 24 hours)
  - number of detainees present at the hotel
  - duration each detainee has been in detention for, to ensure that the 14-day detention period is adhered to
  - being cleared of COVID-19 results while in detention, which may be rationale for discontinuing detention
  - determining whether continued detention of each detainee is reasonably necessary to eliminate or reduce a serious risk to health
  - any other issues that have arisen.

To inform decision-making, a DHHS AO must:

- consider that the person is a returned overseas traveller who is subject to a notice and that they are obliged to comply with detainment
- consider that detainment is based on expert medical advice that overseas travellers are of an increased risk of COVID-19 and form most COVID-19 cases in Victoria
- note the date of entry in Australia and when the notice was given
- consider any other relevant compliance and welfare issues the AO[1] becomes aware of, such as:
  - person's health and wellbeing
  - any breaches of self-isolation requirement
  - issues raised during welfare checks (risk of self-harm, mental health issues)
  - actions taken to address issues
  - being cleared of COVID-19 results while in detention
  - any other material risks to the person
- record the outcomes of their review (high level notes) for each detained person (for each 24-hour period) in the agreed business system database. This spreadsheet allows ongoing assessment of each detainee and consideration of their entire detention history. This will be linked to and uploaded to PHESS.

To ascertain any medical, health or welfare issues, AO will need to liaise with on-site nurses and welfare staff (are there other people on-site an AO can liaise with to obtain this information).

Additional roles of the AO

- AOs should check that security are doing some floor walks on the floors to ascertain longer-term needs and possible breaches
- AO going onto the floors with persons subject to detention must wear gloves and masks. There should be P2 masks for AO's at the hotels (in addition to the surgical masks).

- AO should provide a handover to the incoming AO to get an update of any problems or special arrangements. For example, some people are permitted to attend cancer therapy at Peter Mac etc.
- AO responsible for uploading information to the business system which will then inform an upload to PHESS so that all persons in mandatory detention are recorded in PHESS for compliance and monitoring and surveillance purposes.

Charter of Human Rights considerations in decision-making making process

AO should consider the Charter of Humans Rights when exercising emergency powers and reviewing a person's detention every 24 hours, namely:

- **Right to life** – This includes a duty to take appropriate steps to protect the right to life and steps to ensure that the person in detention is in a safe environment and has access to services that protect their right to life
- **Right to protection from torture and cruel, inhuman or degrading treatment –** This includes protecting detainees from humiliation and not subjecting detainees to medical treatments without their consent
- **Right to freedom of movement –** While detention limits this right, it is done to minimise the serious risk to public health as a result of people travelling to Victoria from overseas
- **Right to privacy and reputation** – This includes protecting the personal information of detainees and storing it securely
- **Right to protection of families and children –** This includes taking steps to protect facility and children and providing supports services to parents, children and those with a disability
- **Property rights –** This includes ensuring a detainee's property is protected
- **Right to liberty and security of person –** this includes only be detained in accordance with the PHWA and ensuring steps are taken to ensure physical safety of people, such as threats from violence
- **Rights to humane treatment when deprived of liberty** - This includes treating detainees with humanity

Mandatory reporting (mandatory AO obligation)

A DHHS AO must give written notice to the Chief Health Officer as soon as is reasonably practicable that:

- a person has been made subject to detention
- following a review, whether continued detention is reasonably necessary to eliminate or reduce the serious risk to public health.

The notice to the CHO must include:

- the name of the person being detained
- statement as to the reason why the person is being, or continues to be, subject to detention.

To streamline, the reporting process will involve a daily briefing to the CHO of new persons subject to detention and a database of persons subject to detention. The database will specify whether detention is being continued and the basis for this decision.

The CHO is required to advise the Minister for Health of any notice [s. 200(9)].

Grant of leave from the place of detention

This is a different legal test to that which applies after the notice is issued. It relates solely to the granting of leave (permission) and requires a different process and set of considerations.

The detention notice provides for a 24-hour review (which is required by legislation) to assess whether ongoing detention is needed, and, in addition, a person may be permitted to leave their hotel room on certain grounds, including compassionate grounds.

Any arrangements for approved leave would need to meet public health (and human rights) requirements. It will be important that the authorised officer balances the needs of the person and public health risk. For example, if the person needs immediate medical care, public health risks need to be managed appropriately, but the expectation is that the leave would automatically be granted. This would be more nuanced and complex when the request is

made on compassionate grounds where there is a question about how public health risks might be managed. However, again, human rights need to be considered closely.

Potential mechanisms for grant of leave from detention

Noting that there are broadly two mechanisms available to the authorised officer on behalf of the Compliance Lead / Public Health Commander to release a person from mandatory detention:

- The daily review by the authorised officer could find that detention is no longer required (with agreement of the Compliance Lead), or
- There could be permission given by the authorised officer (with agreement of the Compliance Lead) that a person has permission to leave the room in which they are detained.

The Public Health Commander could determine that detention should be served in an alternative location to a hotel, by writing a detention order to that effect.

Potential reasons for permission to grant leave from detention

There is a policy direction from the Deputy Chief Health Officer that permission to leave mandatory detention should be exceptional and always based on an individual review of circumstances.

In the following circumstances there could be consideration of permission grant after an application to the Deputy Chief Health Officer however this will require permission:

- A person who has a medical treatment in a hospital;
- A person who has recovered from confirmed COVID-19 infection and is released from isolation;
- An unaccompanied minor (in some circumstances – see below);
- Instances where a person has a reasonably necessary requirement for physical or mental health or compassionate grounds to leave the room, as per the detention notice.

Note that the last category is highly subjective. This means it is the expectation of the authorising environment that exemption applications on those grounds are made on exceptional circumstances.

Process for considering requests for permission to leave or not have detention applied

It is critical that any procedure allows for authorised officers to be nimble and able to respond to differing and dynamic circumstances impacting people who are detained, so that the detention does not become arbitrary. The process outlined here reflects their ability to make critical decisions impacting people in a timely manner.

Matters discussed with Legal Services on this matter should copy in REDACTED and [redacted]

Considerations

Any arrangements for approved leave would need to meet public health (and human rights) requirements. It will be important that the authorised officer balances the needs of the person and public health risk. For example, if the person needs immediate medical care, public health risks need to be managed appropriately, but the expectation is that the leave would automatically be granted. This would be more nuanced and complex when the request is made on compassionate grounds where there is a question about how public health risks might be managed. However, again, human rights need to be considered closely.

Requests in relation to the mandatory quarantine (detention) orders or permission to leave (for people in detention) should be rapidly reviewed by staff in the call centre function, and should always be funnelled through the COVID Directions inbox. That will allow that inbox to be a complete repository of all categories of requests for permission, exceptional circumstances requests and advice / exemption requests.

There should then be a presumption that these requests are forwarded immediately (within two hours) to COVID-19.vicpol@dhhs.vic.gov.au for review by an Authorised Officer working directly to the Director lead for compliance and enforcement, as these are a high priority category of request.

Temporary leave from the place of detention (Detention notice)

There are four circumstances in which permission may be granted:

1. **For the purpose of attending a medical facility to receive medical care**

- D/CHO or Public Health Commander will consider circumstances determine if permission is granted. See *Policy on permissions and application of mandatory detention*. AO must be informed so they are aware.
- In particular circumstances, an on-site nurse may need to determine if medical care is required and how urgent that care may be. DHHS AO officers and on-site nurse may wish to discuss the person's medical needs with their manager, on-site nurse and the Director, Regulation and Compliance officer to assist in determining urgency and whether temporary leave is needed
- Where possible, on-site nurses should attempt to provide the needed medical supplies.

2. **Where it is reasonably necessary for physical or mental health; or**

See policy on permissions and application of mandatory detention

- D/CHO or Public Health Commander will consider circumstances to determine if permission is granted. See *Policy on permissions and application of mandatory detention.*AO must be informed so they are aware.
- If approval is granted:
  - the AO must be notified
  - persons subject to detention are not permitted to enter any other building that is not their (self-isolating) premises
  - persons subject to detention should always be accompanied by an on-site nurse, DHHS authorised officer, security staff or a Victoria Police officer, and social distancing principles should be adhered to
- a register of persons subject to detention should be utilised to determine which detainees are temporarily outside their premises at any one time.

3. **On compassionate grounds;**

- D/CHO or Public Health Commander will consider circumstances to determine if permission is granted. *See Policy on permissions and application of mandatory detention*
- The AO must be notified if a detainee has been granted permission to temporarily leave their room and under what circumstances.

4. **Emergency situations must also be considered.**

- DHHS authorised officers and Victoria Police officers may need to determine the severity of any emergency (such as a building fire, flood, natural disaster etc) and the health risk they pose to detainees
- if deemed that numerous detainees need to leave the premises due to an emergency, a common assembly point external to the premises should be utilised; detainees should be accompanied at all times by a DHHS authorised officer or a Victoria Police officer, and infection control and social distancing principles should be adhered to
- the accompanying DHHS authorised officer or a Victoria Police officer should ensure that all relevant detainees are present at the assembly point by way of a register of detainees.

<u>The process for a person not yet in detention is:</u>

- Members of the public who wish to ask for detention not to be applied, or permission to be granted to leave, have the option of submitting a request in writing to the COVID Directions inbox;
- Authorised officers should also use the COVID Directions inbox to submit requests for detention not to be applied or permission to be assessed so that the COVID Directions inbox is a complete funnel for handling these requests;

- All requests for permission that are considered are logged on the secure MS Teams site established by Legal Services in a manner that can be audited and reviewed by any party in this compliance chain;
- The Director of Health Protection and Emergency Management (lead for COVID-19 Directions) who oversees the inbox and team managing this process assesses the merits of the individual proposal – including through delegates - and applies judgment as to whether the application should proceed to the next step. There is a policy view – outlined in this Plan – that exceptional circumstances are generally required for the Authorised Officer to NOT issue a notice of detention for an overseas arrival;
- If a request is determined to require to proceed, it should then be sent to COVID-19.vicpol@dhhs.vic.gov.au for review by the AO reporting directly to the Direct E+C;
- The Compliance Lead will seek legal advice and a discussion with the Deputy Public Health Commander urgently if required;
- The outcome will be recorded in writing and communicated back to the COVID Directions team and requestor in writing.

Policy on unaccompanied minors

Instances where an unaccompanied minor is captured by a detention order must be managed on a case by case basis.

In general, there is a presumption that there are no exemptions granted to mandatory quarantine. The issues in relation to mandatory quarantine of unaccompanied minors include: where this occurs, and with what adult supervision.

Preliminary legal advice is that the State could issue a detention order to a person under 18 years who is unaccompanied outside the home (a person in the care of the state) if certain conditions are met. These must include:

- AO has to check in regularly;
- Person can easily contact parent / guardian;
- Has adequate food;
- Remote education is facilitated.

A draft detention notice is being put together by Legal Services should this be required.

When an unaccompanied minor normally resides outside Victoria

It is proposed that where there is no clear alternative, an unaccompanied minor who normally resides outside of Victoria may be facilitated to undertake detention in their normal home state of residence, with appropriate risk management of any possible exposures to others on a domestic flight out of Victoria to that state. The department will need to be satisfied that the receiving state will take the person under 18 years and manage public health risks.

When an unaccompanied minor is normally resident in Victoria

It is proposed that an adult (who is not themselves a returned overseas traveller) who supervises a minor should join that minor at a place of detention. If that occurs, the adult should then remain with that person in quarantine although there is no legislative power to issue a direction to that adult to detain the adult.

If an unaccompanied minor who normally resides in Victoria is unable to be joined by a parent / guardian (for example because that parent / guardian has other caring duties and cannot thus join the minor in detention) then on a case by case basis, an assessment will be undertaken to identify whether detention is to be served in the home.

Whilst it may be acceptable for older children (16 – 18 year old) to be in quarantine without their parent(s) or guardian, it's likely to be unacceptable for younger children (12 or 13 years old or younger) and in that situation it's more appropriate to defer an alternative arrangement (i.e. parents join them in quarantine or quarantine at home).

If a child is quarantined at home with their parents, a detention notice should still be provided to the child and parents outlining the same requirements for children as if they were in quarantine in a hotel, together with the guidance about advice to close contacts in quarantine. Legal services will adapt notices for that purpose.

We'll need to ensure that authorised officers monitoring unaccompanied minors have current Working With Children Checks and understand their reporting requirements under the Reportable Conduct Scheme.

When a minor is detained at their home

If it is determined to be appropriate to detain a child at home after a risk assessment, the arrangement will involve:

- Issuing a detention order naming the specific home and / or parts of the home, and
- The detention order will be accompanied by advice on minimising risk of transmission to others in the home where the minor is detained (equivalent to advice to close contacts in quarantine); and
- An Authorised Officer will undertake a process to undertake a review each day in the manner required by the Act.

When an unaccompanied minor is detained in a hotel

If an unaccompanied minor is detained in a hotel without parents, a specific notice and process is below.

- A Detention Notice – Solo Children, is found at Appendix 7.
- A guideline for authorised officers in this respect is found at Appendix 8.

This is a more intensive process for the authorised officers, which is commensurate with the additional risk of quarantining a child because the child is subject to the care of the Chief Health Officer and department.

Working with Children Checks and Child Safe Standards

DHHS will work with Department of Justice and Community Safety to facilitate Working With Children Checks for Authorised Officers.

Escalation of issues

Should an AO become aware of any concern about a child, the AO must:

- contact DHHS welfare teams immediately
- contact after hours child protection team and Victoria police if AO thinks a child may be harmed

Release from mandatory quarantine (detention) after 14 days

The fourteen-day period is calculated from the day following arrival of the person in Australia and ends at midnight fourteen days later/

DHHS Authorised Officer prior to release should:

- review the case file and ensure the 14 day detention has been met.
- liaise with on-site nurse to check the detainee meets the following – i.e. no symptoms of COVID-19 infection;
- any physical checks of the room (damage, missing items, left items etc).

Supporting detainee to reach their preferred destination:

- DHHS organise for the detainee to be transported to their destination by completing a cab charge, Uber or appropriate mode of transport.
- Release from isolation criteria are as per current DHHS Victoria guidelines (based on the SoNG).

DHHS AO to update the business systems database with details of release.

Options to facilitate compliance

DHHS authorised officers should make every effort to inform the person of their obligations, facilitate communication if requested and explain the important rationale for the direction. The following graduated approach should guide an DHHS authorised officer:

- explain the important reasons for detention, that is this action is necessary to reduce the serious risk to public health **(mandatory obligation)**

- provide the person subject to detention with a fact sheet and give opportunity to understand the necessary action
- provide the person subject to detention opportunity to communicate with another person, including any request for a third-party communicator (such as translator), family member or friend (**mandatory obligation)**
- seek assistance from other enforcement agencies, such as Victoria Police, to explain the reason for detention and mitigate occupational health and safety concerns
- discuss matter with on-site nurse to ascertain if there are any medical issues that may require consideration or deviation from the intended course of action
- issue a verbal direction to comply with the Direction and Detention Notice
- advise that penalties may apply if persons do not comply with the Direction and Detention Notice
- recommend that Victoria Police issue an infringement notice if there is repeated refusal or failure to comply with a direction
- recommend Victoria Police physically detain the non-compliant individual for transfer to another site.

DHHS Authorised Officers should make contemporaneous notes where a person is uncooperative or breaches the direction.

Transfer of uncooperative detainee to secure accommodation (refer to Authorised Officer review of transport arrangements procedure)

It is recommended that a separate mode of transport is provided to uncooperative detainees to hotel or other for 14-day isolation.

Ensure appropriate safety measures are taken including child locks of doors and safety briefing for drivers etc.

Unauthorised departure from accommodation

If there is reason to believe a person subject to detention is not complying with the direction and detention notice, the DHHS authorised officer should:

- notify on-site security and hotel management
- organise a search of the facility
- consider seeking police assistance
- notify the Director, Regulatory Reform if the person subject to detention is not found

If the person is located, DHHS authorised officer should:

- seek security or Victoria Police assistance if it is determined the person poses a risk of trying to leave
- provide an opportunity for the person to explain the reason why they left their room
- assess the nature and extent of the breach, for example:
  - a walk to obtain fresh air
  - a deliberate intention to leave the hotel
  - mental health issues
  - escaping emotional or physical violence
- assess possible breaches of infection control within the hotel and recommend cleaning
- consider issuing an official warning or infringement through Victoria Police
- reassess security arrangements
- report the matter to the Director, Regulation Reform.

DHHS Authorised Officers should make contemporaneous notes where a person is uncooperative or breaches a direction.

Occupational health and safety for Authorised Officers

See **Appendix 9** for Occupational health and Safety measures.

Logistics for Mandatory Quarantine

Deliverables of the logistics function

The Director of the Office of the Secretary in DJPR role is responsible for:

- contract management with accommodation providers;
- transport arrangements from the airport;
- material needs including food and drink.

Airport and transit process

The lead for this situation is the DHHS Authorised Officer.

Passengers pass through immigration, customs and enhanced health checks before being transferred to their hotel.

- Every passenger is temperature checked by a registered nurse (RN) contracted by DHHS.
- Every passenger is handed a copy of the direction and a detention notice by a DHHS Authorised Officer (AO) authorised under the emergency provisions of the *Public Health and Wellbeing Act 2008*.
- Every passenger is provided an information sheet by DHHS.
- Passengers are met by VicPol/Border Force and escorted to organised buses for transport to the hotel.
- Every passenger is given a single-use facemask to wear while in transit to their hotel room.
- Every passenger is given a welfare survey to fill out on the bus or at the hotel.

Health and welfare for Mandatory Quarantine

Deliverables of the health and welfare function

The Deputy State Health Coordinator role is responsible for:

- provision of healthcare to detainees;
- provision of welfare to detainees through the Director Health Protection and Emergency Management.

Potential threats to health and wellbeing of people in mandatory detention

Potential risks associated with detention of returned travellers for compulsory 14-day quarantine can broadly be divided in physical or mental health risks.

Physical risks	**Mental health risks**
Transmission/development of COVID-19	Family violence
Transmission of other infectious diseases	Depression
Other medical problems	Anxiety
Diet – poor/imbalanced diet, food allergies/intolerances, over-consumption	Social isolation/loneliness
Lack of exercise	Claustrophobia
Lack of fresh air	Drug and alcohol withdrawal
Smoking – nicotine withdrawal, risk of smoking within rooms/fire hazard	

Tiers of risk for persons in mandatory detention

- Residents will be triaged into three tiers of risk. The type of welfare check will depend on the tier the passenger falls into.

- For phone calls (tier 1 and tier 2), translators must be available as needed. Language requirements should be recorded on arrival at the hotel and provisions made as required.
- Automated text messages are sent to all passengers in tier 3 via Whispir.
- Residents may be moved between risk tiers throughout their quarantine period as need dictates.

Risk Tier	Risk factors	Welfare check type
Tier 1	Residents with suspected or confirmed COVID-19 Families with children < 18 years Passengers aged > 65 years Aboriginal and Torres Strait Islander peoples Residents with underlying comorbidities (e.g. respiratory or cardiac conditions)	Daily phone call
Tier 2	Those who indicate they require a phone call but do not have any other risk factors. Residents who are by themselves.	Phone call every second day
Tier 3	Low risk – everyone else.	Daily text message (via Whispir)

Arrival at hotel – check in

At hotel check-in:

- Detainee provides Direction and Detention Notice to hotel staff; hotel staff to write on the notice:
  - room number
  - the date that the person will be detained until (14 days after arrival at place of detention).
- Detainee provides completed Direction and Detention Notice to AO to confirm that the following details on the notice are correct:
  - the hotel name;
  - hotel room number and arrival date, time and room on notice;
  - the date that the person will be detained until (14 days after arrival at place of detention).
- AO must take a photo of the person's Direction and Detention Notice and enters this into database.
- Following any medical and welfare check of the person, AO to liaise with nurses to identify detainees with medical or special needs.
- AO to note detainees with medical or special needs, such as prescription and medical appointments.

Persons will be sent to their allocated room and informed that a person will contact them in the afternoon or next AO to make themselves known to the security supervisor onsite.

Welfare and health service provision

- Residents will have a welfare check (as specified below) each day.
- DHHS welfare officers conducting welfare checks phone and email covid-19.vicpol@dhhs.vic.gov.au and AO individually to alert AO of medical and welfare issue.
- Residents will be provided with a resident satisfaction survey to complete each week.
- Residents can seek review by the nurse 24 hours a day if required.
- 24 hour on-call medical support will be available for on call subject to demand. This will initially be provided by a Field Emergency Medical Officer, and subsequently through a locum general practice service.
- Medical care is organised by Deputy State Health Coordinator. Deliverables include:

  - Primary care assessments;
  - Prescription provision;
  - 24 hour access to a general practitioner;
  - 24 hour access to nursing assessment.
- It is advisable that where possible, individuals who are in detention are linked to receive telehealth care from their normal general practice provider.

Conduct of a welfare check

A welfare check will allow passengers to be assessed for medical and social issues, and concerns flagged and responded to. These issues include but are not limited to health, mental health, safety and family violence concerns. A welfare check will be conducted by a DHHS officer which is included as a script at **Appendix 5.**

Safety / mental health

If there are concerns about the safety or mental health of passengers, the process is as follows:

- The nurse will review via phone (or in person if required with appropriate PPE).
- If escalation is required, the nurse will contact the Anxiety Recovery Centre Victoria for psychosocial support.
- Mental health triage at RMH/the Alfred can be contacted as a back-up.
- If the person is acutely unwell or at serious risk, urgent ambulance should be arranged by calling 000.
- Daily welfare check phone calls should be implemented thereafter if not already implemented.

Family violence (FV)

If there are concerns about family violence / the safety of women and children, the process is as follows:

- Case worker is called to review via phone initially or in person if required (with appropriate PPE).
- A separate room may need to be organised to facilitate the review away from the other family members.
- If deemed necessary, separate rooms should be organised to separate the family members.
- Case worker to review again as required.

Alcohol and other drugs

If there are concerns about alcohol or other substance abuse or withdrawal:

- Consider nurse/medical review.
- Provide numbers for support services (listed below).
- Preference for provision of standard drinks to a limit rather than prescribing diazepam for alcohol withdrawal.
- Prescriptions – Schedule 8 prescriptions for drug-dependent patients can only be provided after discussion with the DHHS Medicines and Poisons Branch.

Diet

- Ensure a well-balanced diet with options provided for those with specific dietary requirements.
- Ensure access to essentials within the room (e.g. snacks, tea and coffee) to limit the amount of interactions/contact required with staff.
- Ensure access to additional food if required.

Exercise and fresh air

- If the room has a balcony, ensure the residents can access it for fresh air.
- Advise residents to open windows/balconies where possible for fresh air and ventilation.
- If it is possible for residents to go outside to take some exercise for organised/supervised short periods of time, this should be facilitated where possible. Residents should ensure physical distancing is practised during this period. Only well residents from the same room should be able to go out to exercise at the same time.

- Residents should be provided with resources for exercise routines and yoga/mediation that they can perform safely within their rooms.

Procedure for a detainee / resident to leave their room for exercise or smoking

A person must be compliant and must not have symptoms before they could be allowed to have supervised exercise or a smoking break.

The steps that must be taken by the detainee are:

- Confirm they are well;
- Confirm they have washed their hands immediately prior to leaving the room;
- Don a single-use facemask (surgical mask);
- Perform hand hygiene with alcohol-based handrub as they leave;
- Be reminded to – and then not touch any surfaces internal to the hotel on the way out;

The procedure for the security escort is:

- Don a mask;
- Undertake hand hygiene with an alcohol-based handrub or wash hands in soapy water;
- Be the person who touches all surfaces if required such as the lift button, handles;
- Maintain a distance (1.5 metres) from the person;

There is no requirement to wear gloves and this is not recommended, as many people forget to take them off and then contaminate surfaces. If gloves are worn, remove the gloves immediately after the person is back in their room and then wash your hands.

Social and communications

- All residents should have access to **free** wifi/internet where at all possible.
- All residents should have access to entertainment such as television and streaming services (e.g. Netflix).
- All residents should have access to communications so that they can keep in regular contact with family and friends throughout the quarantine period.
- Toys and equipment should be provided for small children if possible.

Care packages for people in detention

A public health risk assessment has been conducted that indicates that care packages, such as food or toys, can be delivered for provision to people in detention. The care package should be provided to the hotel reception or other party for conveyance to the person in detention and should not be directly handed to the person in quarantine by the person gifting the care package. Ensuring the package passes to the person in detention without misdirection or tampering is essential. There is no public health reason for an inspection of any care package.

Smoking policy for people in detention

As part of the emergency response to COVID-19, individuals have been confined within hotels while under quarantine. The movement of these people has been restricted to hotel rooms, without access to outdoor spaces, where they can smoke.

Current laws

Under the *Tobacco Act 1987* (Tobacco Act), smoking is prohibited in an ”enclosed workplace”, however, Section 5A (2) (g), provides an exemption for the personal sleeping or living areas of a premises providing accommodation to members of the public for a fee. This means that, while a hotel is considered an enclosed workplace, the hotel could allow the occupants of the rooms to smoke if they choose.

In many cases, hotels have implemented their own smoke-free policies in rooms as the smoke is likely to enter the centralised air conditioning systems resulting in occupants of other rooms and staff being exposed to the smoke. Smoke also remains on the surfaces of the room and permeates soft furnishings meaning that it remains in the

room and exposes staff cleaning the room to the remaining residual smoke. The Department of Health and Human Services supports and encourages hotels to designate their rooms smoke-free.

If smokers were to be permitted to leave their rooms for supervised cigarette breaks, they would need to be taken to an area that does not constitute an enclosed workplace. This might be a balcony, roof top or other outdoor area. This area should preferably be away from open windows, doors and air conditioning intake points.

COVID-19 and smoking

The World Health Organization (WHO) has advised that any kind of tobacco smoking is harmful to the bodily systems, including the cardiovascular and respiratory systems, and puts smokers at greater risk in the context of COVID-19. Information from China, where COVID-19 originated, showed that people with cardiovascular and respiratory conditions, including those caused by smoking, were at higher risk of developing severe COVID-19 symptoms and death.

The Victorian Chief Health Officer has recommended that quitting smoking reduces the health risks associated with COVID-19.

Other examples of restricting access to smoking

There are some precedents of people being confined to facilities where they are unable smoke. This includes mental health facilities, prisons and, if people are unable to leave, hospitals. In these circumstances, individuals are supported to manage cravings using pharmacotherapies such as nicotine replacement therapies.

Victoria's Charter of Human Rights and Responsibilities

Removing the ability to smoke would be compatible with the *Charter of Human Rights and Responsibilities Act 2006 (the Charter)*, as it would be for the purposes of protecting the right to life. Section 9 of the Charter states that “Every person has the right to life and to not have their life taken. The right to life includes a duty on government to take appropriate steps to protect the right to life.”

Options

Option 1: Provide support for smokers to quit or manage cravings (Recommended)

The preferred option, for both the benefit of the individual and broader community would be to support smokers to quit or manage withdrawal while confined to their hotel room. This would mean that smokers be supported to manage cravings while they are unable to smoke but would not be forced to quit.

This could be easily managed through the provision of approved nicotine replacement therapies (NRT), with meal deliveries, accompanied by counselling through the Quitline. Quit Victoria has recommended a box of patches and an intermittent form of NRT such as a spray. These items are available for purchase without a prescription from a range of retailers including pharmacies and some big supermarkets.

Other pharmacotherapies, like zyban or champix, would require a prescription from a GP and are designed to help people completely quit as opposed to a short-term measure for people who are forced to stop smoking abruptly. These medications can take a while to take effect and, with champix, the advice is to continue smoking until it starts to impact on your cravings which means that it would not be an appropriate option for the circumstances.

Addiction to cigarettes includes both nicotine dependence and a behavioural and emotional dependence, which is why counselling plus pharmacotherapy is required. Someone who is heavily addicted will crave a cigarette every 45-60 minutes.

Telephone counselling is available via the Quitline - 13 78 48

Even if someone doesn’t want to quit, Quitline can help them reduce the number of cigarettes they smoke.

People can also contact their regular general practitioner via telehealth.

Option 2: Relax no smoking restrictions for the hotel rooms

While it would be legally possible to enable people in quarantine to smoke in their rooms, this option is not recommended. This would have an adverse impact on hotels and their staff and goodwill in the circumstances. It

would also increase the health risks of individuals potentially already at risk of COVID-19.When sharing a room with children, smoking should not be allowed.

Option 3: Accompany individuals to leave the room to smoke

While it would be possible to create a smoking area for people wishing to smoke, such as in an outdoor drinking area attached to a bar or restaurant facility, this option is not recommended. Allowing people to leave their hotel rooms to smoke undermines the quarantine restrictions being put in place. The individuals would need to be accompanied by security guards and might need to travel floors via lifts to access an outdoor area or leave the building.

Even if we assume, that the hotel is not currently operating for other customers, movement in the hotel creates an increased risk for staff and a need for greater vigilance in cleaning and maintaining distance.

Current policy for smokers in mandatory quarantine

The following actions should occur –

- Nicotine Replacement Therapy should be promoted strongly for smokers;
- Smoking restrictions should remain in relation to the room;
- Only where absolutely necessary, and in exceptional circumstances, a person in mandatory quarantine could be granted permission to leave their room under specific circumstances, where public health risk is managed:
  - The Authorised Officer is aware and grants permission;
  - They are accompanied by security, who are provided PPE to wear;
  - They are instructed to – and follow the instruction – not to touch surfaces en-route to the smoking area and coming back;
  - They return immediately to their hotel room.

Other health and wellbeing issues

- All residents should be given the contact information for support services such as Lifeline at the beginning of their quarantine period (the information sheet they are provided with at the airport should also have these contact numbers).
- Residents should have access to fresh bedlinen and towels as required.
- Care packages may be permitted for delivery to residents under certain circumstances and subject to checks by AOs.
- Residents can be provided with up to three standard drinks per day if there is a risk of alcohol withdrawal (this is in preference to prescribing benzodiazepines for withdrawal).
- Other residents can also request alcoholic drinks as part of their food and drink provisions.
- Smoking breaks or NRT should be offered to all smokers if feasible.

Actions to detect and test for COVID-19 amongst people in mandatory detention

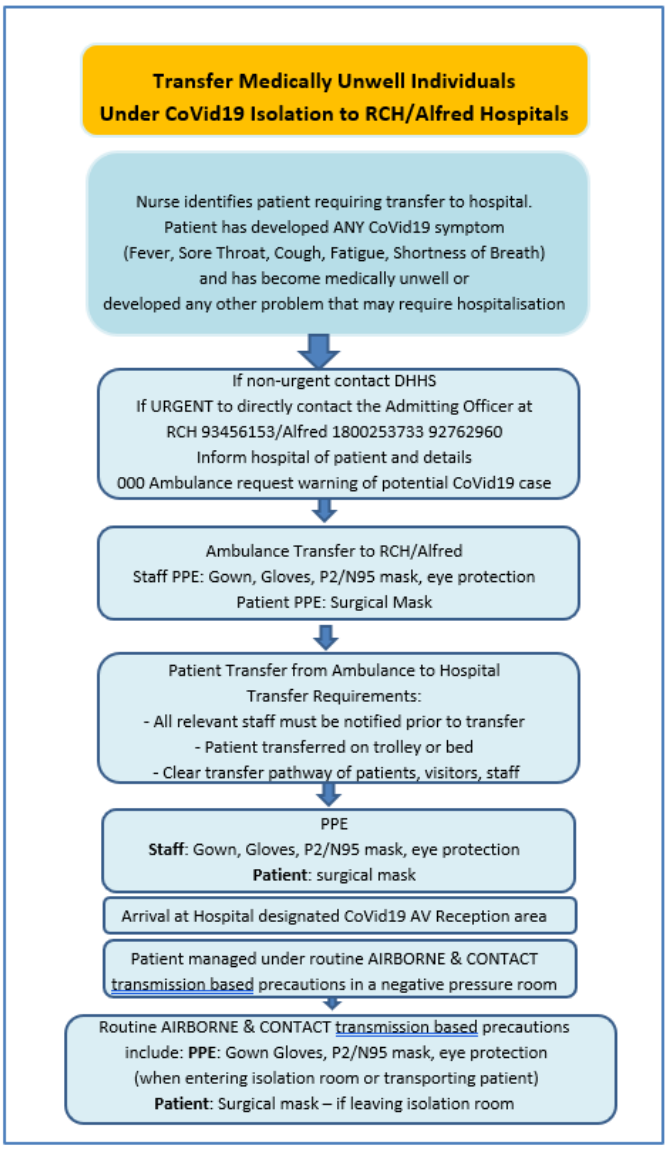
The following are the actions to enact this:

- Detainees will be asked daily (via phone or text) if they have symptoms consistent with COVID-19. These include but are not limited to fever, cough, shortness of breath and fatigue.
- The nurse onsite will be notified. The nurse will call the detainee (patient) and assess them over the phone. If face to face assessment is required, the nurse will assess them in the room with appropriate PPE.
- Security staff in PPE (masks and gloves) will accompany all nurses visiting hotel rooms. They will wait outside unless requested to enter by the nurses (full PPE is required to enter rooms).
- The nurse will assess the patient for symptoms of coronavirus. If deemed necessary, they will take swabs to test for COVID-19.
- If the patient is well enough, they can remain in quarantine at the hotel to await the test results. If they are sharing a room with another resident, they should be moved to a separate room if feasible and according to availability of rooms. If separation is not possible, they should practise physical distancing as far as is possible.

- If the test is positive and the patient is well, they can remain in quarantine at the hotel but should be moved to a separate section/floor of the hotel which is designated for confirmed cases. If they are sharing with other people, then arrangements such as a separate room or provision of PPE may be required, depending on the circumstances (for example it may not be feasible or appropriate to separate young children from parents).

Hospital transfer plan

- Passengers requiring hospital assessment/treatment for suspected or confirmed COVID-19 or other conditions, should be transferred to either the Royal Melbourne Hospital (RMH) or The Alfred Hospital, depending on proximity (**note children should be transferred to the Royal Children's Hospital**).
- If the hospital transfer is non-urgent, contact DHHS.
- If the hospital transfer is urgent, contact the Admitting Officer at RCH/RMH/the Alfred.
- Inform the hospital of patient and details.
- Call 000 to request ambulance and inform them that the passenger is a suspected (or confirmed) case of COVID-19.
- Staff should don full PPE and the passenger must wear a single-use surgical mask if tolerated.
- All relevant staff including AO must be notified prior to the transfer.
- AO must view appropriate authorisation.
- The passenger should be transferred on a trolley or bed from ambulance into the designated COVID-19 ambulance reception area.
- The patient should be managed under routine airborne and contact transmission-based precautions in a negative pressure room if available. The patient should wear a single-use surgical mask if leaving the isolation room.
- Ambulance services will list the hotels as an area of concern in case of independent calls and will ask on site staff to assess need for attendance in the case of low acuity calls.
- All residents who are: in high risk groups, unwell, breathless or hypoxic (O2 sats <95%) should be considered for hospital transfer.



Note P2 respirators are not required, but appear in this chart as an indicative mask, pending modification of this chart to reflect recommendation that a single use facemask is required.

Actions for confirmed cases of COVID-19 in people in mandatory detention

The following actions should be taken:

- Residents with confirmed COVID-19 should be accommodated / cohorted in a separate section/floor of the hotel, away from the non-COVID-19 infected passengers.

Personal protective equipment (PPE)

Staff who engage with monitoring or assisting persons in mandatory detention in person:

1. Apply standard infection prevention and control precautions at all times:
    a. maintain 1.5 metre distance
    b. wash your hands or use anti-bacterial agents frequently
    c. avoid touching your face.
2. Every situation requires a risk assessment that considers the context and client and actions required.

3. If you are not able to maintain a 1.5 metre distance and the person has symptoms (for example coughing) or is known to be a COVID-19 case use:
    a. fluid-resistant surgical mask (replace when moist or wet)
    b. eye protection
    c. disposable gloves.
4. If you need to be in a confined space (<1.5 metre) with a known COVID-19 case for more than 15 minutes, wear a single use facemask, eye protection and gloves.

Cleaning of rooms

Housekeeping services will not be provided routinely to residents. Fresh linen, towels and additional amenities can be left outside of rooms for residents to then collect. Biohazard bags can be left for residents to place dirty linen in and to leave outside their rooms for collection. Terminal cleaning is required on vacation of each room.

Reporting and evaluation on mandatory quarantine

A report will be prepared to summarise the activity of the program, and provided to the Deputy Chief Health Officer on a regular basis in confidence.

Communication and education

A communications plan for physical distancing is being developed to ensure the public receive timely, tailored and relevant advice on physical distancing measures.

The current collateral for the Victorian public and health sector to communicate on physical distancing requirements in Victoria includes items on the web and other locations:

Stay at home and restrictions:

- Coronavirus website homepage tile and webpage with detailed information on restrictions:
- www.dhhs.vic.gov.au/stay-home-and-restricted-activities-directions-frequently-asked-questions

Physical distancing and transmission reduction measures:

- Coronavirus website homepage tile and webpage with general information on physical distancing.
- www.dhhs.vic.gov.au/coronavirus-covid-19-transmission-reduction-measures
- Uploadable Victorian physical distancing document in keeping with that tile's web content, located at TRIM HHSD/20/142098

State of emergency and directions:

- Coronavirus website tile and webpage with PDFs of the signed Directions.
- www.dhhs.vic.gov.au/state-emergency

About coronavirus general information:

- Coronavirus website tile and webpage with general hygiene and physical distancing information.
- www.dhhs.vic.gov.au/victorian-public-coronavirus-disease-covid-19

Media (proactive and reactive):

- Daily interviews and press conferences by the Chief Health Officer, Premier, Minister for Health and Ambulance and the Public Health Commander
- Announcements will be made by the Premier/Minister/CHO at a media conference.
- A daily media release from the department will contain latest information on measures.

Social media posts on physical distancing

- Daily posts on DHHS and VicEmergency social media accounts.
- Live streams of press conferences on Facebook
- Social media FAQs for responding to community via social media channels

Videos on physical distancing

- Series of Chief Health Officer videos on self-isolation, quarantine and physical distancing

Appendix 1 - Standard emails and letter advice for compliance and enforcement

The following templates are generic and educative in nature. DHHS officers should adapt the tone and content according to risk and individual circumstances.

Airport arrivals

Dear (insert name),

As you may be aware, Victoria's Minister for Health has declared a state of emergency throughout Victoria in response to the coronavirus or COVID-19 situation. Following this declaration, Victoria's Deputy Chief Health Officer has exercised emergency powers under the *Public Health and Wellbeing Act 2008* to make a direction to eliminate or reduce the serious risk to public health posed by COVID-19.

We are contacting you as Department of Health and Human Services has received information that you may be not complying with the Airport Arrivals direction issued by Victoria's Deputy Chief Health Officer.

Please be aware that: a person who arrives between 5 pm on 18 March 2020 and midnight on 13 April 2020 at an airport in Victoria on a flight that originated from a place outside Australia, or on a connecting flight from a flight that originated from a place outside Australia:

- must travel from the airport to a premises that is suitable for you to reside in for 14days; and/or
- except in exceptional circumstances, must reside in a suitable premises for the period beginning on the day of your arrival and ending at midnight on the fourteenth (14th) day after arrival);
- must not leave the premises except:
  - for the purposes of obtaining medical care or medical supplies
  - in any other emergency situation circumstances where it is possible to avoid close contact with other persons; and
- must not permit any other person to enter the premises unless that other person usually lives at the premises, or the other person is also complying with this direction for the same 14 day period, or for medical or emergency purposes also complying with the CHO direction, or for medical or emergency purposes).

This email/letter seeks to inform you of your obligations. A copy of the direction and a fact sheet is attached to this email/letter.

Why it is important to comply with the Chief Health Officer's direction

The Victorian Government is very concerned about the serious, and potentially catastrophic, risk to public health arising from COVID-19 throughout Victoria.

Persons entering Victoria are at an increased risk of COVID-19. That is why a person entering Victoria from overseas must self-isolate for a period of 14 days in accordance with the Deputy Chief Health Officer's direction. Failure to self-isolate in accordance with the Deputy Chief Health Officer's direction may increase transmission of COVID 19 within our community.

All Victorians play an important role in minimising the impact of COVID-19. We strongly encourage you to comply with the CHO's direction and appreciate your co-cooperation.

Mass gatherings

Dear (insert name)

As you may be aware, Victoria's Minister for Health has declared a state of emergency throughout Victoria in response to the coronavirus or COVID-19 situation. Following this declaration, Victoria's Deputy Chief Health Officer has exercised emergency powers under the *Public Health and Wellbeing Act 2008* to make a direction to eliminate or reduce the serious risk to public health posed by COVID-19.

We are contacting you as Department of Health and Human Services has received information that you may be not complying with the Mass Gatherings direction issued by Victoria's Deputy Chief Health Officer.

Please be aware that:

- A person who owns, controls o operates premises in Victoria must not allow a mass gathering to occur on premises
- A person must not organise a mass gathering on premises in Victoria.

A mass gathering means:

- A gathering of five gendered (500) or more persons in a single undivided outdoor space at the same time; or
- A gathering of one hundred (100) or more persons in a single undivided indoor space at the same time.

A number of exclusions exist such as at an airport and a hotel, motel or other accommodation facility that is necessary for the normal operation of accommodation services.

This email/letter seeks to inform you of your obligations. A copy of the direction and a fact sheet is attached to this letter/email.

Why it is important to comply with the Deputy Chief Health Officer's direction

The Victorian Government is very concerned about the serious, and potentially catastrophic, risk to public health arising from COVID-19 throughout Victoria.

The restrictions are designed to limit transmission of COVID in places where there is high density of individuals in close proximity. This is because many individuals have been identified as being infected with COVID-19 and more cases are expected.

All Victorians play an important role in minimising the impact of COVID-19. We strongly encourage you to comply with the CHO's direction and appreciate your co-cooperation.

Appendix 2 – Evidence on physical distancing interventions for reducing impact of COVID-19

Last updated 27 March 2020

This document provides a review of evidence regarding the effectiveness of physical distancing interventions on the COVID-19 epidemic. As evidence is rapidly emerging this document may not contain all relevant available information. It also contains some references to reports and pre-prints that have not undergone peer-review. Therefore, caution should be taken in interpretation. Furthermore, as new evidence emerges the picture of the effectiveness will change. This document will be updated to reflect the changing evidence base.

Introduction

Physical distancing between people aims to minimise interactions between people to limit the opportunities for disease to spread from an infected person to an un-infected person. It is an example of a non-pharmaceutical intervention (NPI) that can be employed to control a disease outbreak. Measures to bring about physical distancing amongst populations have been utilised in previous efforts to control influenza epidemics and pandemics.

Observational and modelling studies have provided evidence to help guide the use of physical distancing measures for influenza. Although these can provide some insight into how we might expect physical distancing to influence the progression of the COVID-19 pandemic, COVID-19 has its own disease characteristics which will influence the impact of physical distancing measures. Evidence of the impact of social distancing is beginning to emerge from countries in which the epidemic commenced earlier than in Australia, particularly China. Additionally, modelling studies using information on the epidemiological features of COVID-19 are estimating the impact of different physical distancing measures.

This review consists of three parts:

- A review of the epidemiological features of COVID-19 and their implications for physical distancing in COVID-19
- A review of modelling analyses estimating the effects of physical distancing on the COVID-19 epidemic
- A review of evidence regarding physical distancing measures in the setting of pandemic influenza

1. Epidemiological features of COVID-19 that impact the effectiveness of physical distancing measures

1.1 Reproductive number

The basic reproductive number (R_0) is the number of individuals a single infected individual will infect in an otherwise fully susceptible population. This value will be influenced by features inherent to the pathogen, and characteristics of the population, such as population density and the nature and frequency of human-human interactions. As such, there is no single true value of R_0 for any disease, including COVID-19, as it will be influenced by population-specific factors.

Published estimates of R_0 for COVID-19 have ranged between 2.1 and 3.58. (1–6)

1.2 Modes of transmission

Early evidence suggests that SARS-CoV-2 (the virus that causes COVID-19) is primarily transmitted via respiratory droplets transmitted during close contact, and via fomites. (7) However, there is evidence of viral shedding in faeces (8) and viral persistence in aerosols (9,10), suggesting that aerosol and faecal-oral transmission may also occur. Transmission may also be possible via ocular surfaces. (11)

1.3 Timing of transmission

Analyses of viral shedding suggest that the time of peak viral load is early in the course of illness, around the time that symptoms develop, and that viral load then reduces over time. (10) The median duration of detected viral shedding of 191 patients in Wuhan was 20.0 days (IQR: 17.0-24.0 days) in survivors. (12) Importantly, these measurements of viral load cannot distinguish infectious from non-infectious virus. Although the two types of virus

are often correlated early in influenza, we cannot say for sure for whether the same holds for COVID-19 at this stage.

Evidence from case and cluster reports (13–15), and several epidemiological analyses (16–19) suggest that COVID-19 can be transmitted prior to the onset of symptoms.

1.4 Incubation period

An analysis of 55,924 laboratory-confirmed cases, found the mean incubation period was estimated to be 5.5 days. (7) Another analysis of 181 confirmed cases outside of Hubei Province found the mean incubation period to be 5.1 days (95% CI: 4.5-5.8 days). (20)

1.5 Duration of illness

An analysis of the clinical course of 52 critically ill adult patients with SARS-CoV-2 pneumonia who were admitted to the intensive care unit (ICU) of a Chinese hospital in late December 2019 and January 2020, found the median time from symptom onset to death was calculated to be 18 days. (21)

1.6 Demographic features of COVID-19

In general, COVID-19 causes a much more severe illness in older people, with case-fatality rates increasing with age, particularly for those aged 80 years and older. (7,22)

Children have thus far accounted for few cases of COVID-19 and are unlikely to have severe illness. (23) However, the role of children in transmission of COVID-19 remains unclear. In a pre-print analysis of household contacts of cases, it was found that children were infected at the same rate as older household contacts. (24) In the report of the WHO-China joint mission it was noted that children accounted for 2.4% of cases, that infected children had largely been identified through contact tracing, and there was no recollection of episodes of transmission from child to adult. (7)

1.7 Overview of the impact of key epidemiological features for physical distancing interventions

Key points arising from these epidemiological features are:

- COVID-19 is highly transmissible, and although close contact is more likely to result in transmission, transmission may be possible from minor contact, or through contact with infectious surfaces
- The COVID-19 epidemic in many areas is following exponential growth patterns, so case counts can be expected to rise rapidly
- As evidence suggests that people can transmit COVID-19 prior to the onset of symptoms, and because infectiousness appears to be highest at the time of symptom onset, isolating cases at the point of symptom onset may be inadequate to prevent transmission
- As there is a delay between infection and symptom onset and a delay between symptom onset and case detection, there will be a delay (of roughly 10 days) between implementation of an intervention and seeing its impact on case counts
- As there is a delay between symptom onset and death, there will be an even longer delay to seeing the impact of interventions on death rates (up to two weeks)
- The role of children in COVID-19 transmission remains unclear and would have significant implications for the effect of school closures on the epidemic

2. Modelling studies evaluating potential impact of physical distancing interventions for COVID-19

2.1 Modelling the impact of physical distancing interventions

This will be updated.

2.1.1 Imperial College report on non-pharmaceutical interventions

Ferguson et al of Imperial College published a report estimating the impact of a range of non-pharmaceutical interventions (physical distancing interventions) on the COVID-19 epidemic in the UK and the US. (26) Effects of different combinations of population-level interventions were reviewed. The report describes two alternative strategies: suppression and mitigation. It describes suppression as aiming to reduce the R value to less than 1, resulting in transmission ceasing in the population. Mitigation, however, aims to reduce the impact of the epidemic, whilst infection builds up in the community, rather than causing transmission to cease. Actions towards mitigation would include preventing infection amongst those most vulnerable to severe disease and slowing the rate of infection.

The report suggests that an approach of mitigation would result in the critical care capacity being overwhelmed many times over, resulting in hundreds of thousands of deaths. Only a combination of very strong measures taken together (including case isolation, household quarantine, general social distancing, school and university closure) is predicted to avoid critical care capacity being overwhelmed.

The report suggested that if suppression is being pursued, then earlier implementation is better, but if mitigation is being pursued then it is better to implement interventions closer to the peak of the epidemic. School closures were estimated to have a greater role on a suppression strategy, rather than mitigation. The modelling also suggested that relaxing the intervention whilst the population remained susceptible would result in a later, large peak that would also overwhelm critical care capacity, suggesting that policies may need to remain until a vaccine was available.

The report concluded that suppression seemed the only viable option, given that mitigation would result in health care capacity being overwhelmed many times over. However, they noted the uncertainty in whether a suppression approach could be achieved, as well as the uncertainty in modelling estimates.

2.1.2 Early modelling analysis from Australia

A modelling analysis, published as a pre-print, conducted by Australian researchers, Chang et al (27)suggested that the best intervention strategy is a combination of restriction on international arrivals to Australia, case isolation, and social distancing with at least 80-90% compliance for a duration of 13 weeks. They noted that compliance levels below this would lengthen the duration of required suppression measures. They also note that resurgence of disease is possible once interventions cease, and their analysis does not attempt to quantify the impact of measures beyond the 28-week horizon of analysis.

Another Australian pre-print analysis by Di Lauro et al (28) reviewed the optimal timing for “one shot interventions”, interventions that are assumed to only be able to implemented once in the course of an epidemic and for a finite time period. This suggested that optimal timing depended on the aim of the intervention; that to minimise the total number infected the intervention should start close to the epidemic peak to avoid rebound once the intervention is stopped, while to minimise the peak prevalence, it should start earlier, allowing two peaks of comparable size rather than one very large peak.

2.1.3 Modelling the impact of physical distancing interventions in China

Using a stochastic transmission model and publicly available data, Kucharski et al (29), estimated the effect of the distancing interventions introduced in China on the 23rd of January. the median daily reproduction number (Rt) in Wuhan declined from 2·35 (95% CI 1·15–4·77) 1 week before travel restrictions were introduced on Jan 23, 2020, to 1·05 (0·41–2·39) 1 week after.

An pre-print analysis by Lai et al (30) suggested that without the non-pharmaceutical intervention implemented in China (early detection and isolation of cases, travel restrictions and reduction of interpersonal interactions) the number of infections in Wuhan would have been many fold higher. They suggested that had the NPIs been conducted one week, two weeks, or three weeks earlier in China, cases could have been reduced by 66%, 86%, and 95%, respectively. They also suggested that social distancing interventions should be continued for the next few months to prevent case numbers increasing again after travel restrictions were lifted on February 17, 2020.

A pre-print analysis by Prem et al (31) reviewed the impact of China's interventions on social-mixing patterns and estimated the effects of different approaches to lifting the interventions. They suggested that control measures aimed at reducing social mixing can be effective in reducing the magnitude and delaying the epidemic peak. They suggested the interventions would have the most impact if continued until April, and if return to work was staggered. These results were sensitive to the duration of infectiousness and the infectiousness of children.

2.2 Modelling the potential impact of case isolation and contact tracing

An analysis by Hellewell et al (32) considered the possibility of controlling a COVID-19 outbreak with contact tracing and case isolation alone. Under some parameter assumptions it was possible to control the outbreak without the need for physical distancing measures. However, the probability of controlling the outbreak in this way decreased with an R0 of 2.5 or 3.5, when there was a larger initial infectious population, a longer delay to case detection and a larger proportion of pre-symptomatic transmission. The study concludes that "in most plausible outbreak scenarios, case isolation and contact tracing alone is insufficient to control outbreaks, and that in some scenarios even near perfect contact tracing will still be insufficient, and further interventions would be required to achieve control."

A pre-print analysis by Kretzschmar et al (33), suggests it is unlikely that case isolation and contact tracing alone could control a COVID-19 outbreak. They note that if delay between onset of infectiousness and isolation is more than 4 to 6 days, or the proportion of asymptomatic cases is greater than 40% the outbreak cannot be controlled even with perfect tracing. However, they note that contact tracing efforts can still be a valuable tool in mitigating the epidemic impact.

2.3 Modelling the impact of school closures for COVID-19

An early report from Di Domenico et al (34), used data from three French towns with COVID-19 outbreaks and assumed children had a susceptibility to COVID-19 of 20% relative to adults and relative infectiousness of 50%. With these assumptions they suggested that school closure alone would have limited benefit in reducing the peak incidence (less than 10% reduction with 8-week school closure for regions in the early phase of the epidemic). However, when coupled with 25% adults teleworking, 8-week school closure would be enough to delay the peak by almost 2 months with an approximately 40% reduction of the case incidence at the peak.

3. Evidence on physical distancing measures for pandemic influenza

There are important differences between the COVID-19 pandemic and previous influenza pandemics. Three important differences are:

- It is well established that school children play a major role in spreading influenza virus because of higher person-to-person contact rates, higher susceptibility to infection, and greater infectiousness than adults. In contrast, children have accounted for fewer cases in the COVID-19 pandemic and their role in transmission is unclear.
- Pandemic influenza is thought to have a shorter incubation period (approximately 2 days) compared to COVID-19 (approximately 5 days).
- There is likely a greater proportion of severe and critical cases of COVID-19, than in pandemic influenza. (35)
- However, the evidence regarding physical distancing measures on influenza pandemics may still provide some insight into the role they may play in the response to COVID-19.

A recent review (prior to the COVID-19 outbreak) by Fong et al (36) surveyed the evidence for NPIs in pandemic influenza, in particular the effects of school closures, workplace measures and avoiding crowding.

3.1 School closures

They found compelling evidence that school closure can reduce influenza transmission, especially among school aged children. However, the duration and optimal timing of closure were not clear because of heterogeneity of data, and transmission tended to increase when schools reopened.

A correlation analysis between weekly mortality rates and interventions (which included school closure) during the 1918–19 pandemic in cities in the United States estimated that early and sustained interventions reduced mortality rates by ≤25%. (37)

Two studies conducted in Hong Kong as a public health response to the 2009 influenza A(H1N1) pandemic estimated that school closures, followed by planned school holidays, reduced influenza transmission. (38,39)

Two studies conducted in Japan estimated that due to reactive school closures the peak number of cases and the cumulative number of cases in the 2009 pandemic were reduced by ≈24% (40) and 20% (41). However, two studies (one evaluating the response to the 2009 pandemic and the other seasonal influenza) estimated that reactive school closures had no effect in reducing the total attack rate and duration of school outbreaks, and the spread of influenza. (42,43)

It is important to note that school closures can have a disproportionate impact on vulnerable groups (eg low-income families), particularly when meals are provided by schools. This could be ameliorated by dismissing classes but allowing some children to attend schools for meals or enable parents to work. It has also been noted that school closures may have an impact on health workforce availability, as health care workers may have to care for children.

3.2 Workplace interventions

A systematic review of workplace measures by Ahmed et al (44) concluded that there was evidence, albeit weak, to indicate that such measures could slow transmission, reduce overall attack rates or peak attack rates, and delay the epidemic peak. In this review, epidemiological studies reviewed the effects of segregating persons into small subgroups and working from home. Modelling studies most frequently simulated the effects of workplace measures as reducing contacts by 50%.

In this review, for studies modelling R0 ≤ 1.9, workplace social distancing measures alone (single intervention) showed a median reduction of 23% in the cumulative influenza attack rate in the general population. Workplace social distancing measures combined with other nonpharmaceutical interventions showed a median reduction of 75% in the general population. However, the effectiveness was estimated to decline with higher R0 values, delayed triggering of workplace social distancing, or lower compliance.

Paid sick leave could improve compliance with a recommendation to stay away from work while ill. (45,46)

3.3 Avoiding crowding

The review by Fong et al (36) identified three studies that assessed the effects of measures to avoid crowding (such as bans on public gatherings, closure of theatres) in pandemic influenza. These suggested that such measures helped to reduce excess mortality in the 1918 pandemic and a natural study comparing the effect of accommodating pilgrims for World Youth Day in smaller groups rather than a large hall reduced transmission in 2008.

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Appendix 3 – Physical distancing international comparison

This will be updated by REDACTED / REDACTED in due course.

Appendix 4 – Hotel Isolation Medical Screening Form

DHHS Hotel Isolation Medical Screening Form	
Registration Number:	
Full Name:	Male ☐ Female ☐ Other ☐
Address:	Indigenous ☐ Torres Strait Islander ☐
Phone Number:	Nationality:
Date of Birth:	Place of Birth:
Phone #:	Primary language:
Please provide the information requested below, as it may be needed in case of an emergency. This information does not modify the information on the emergency card.	
Allergies:	
Past Medical History: Alerts: Alcohol & Other Drugs Y/N Disability Y/N Significant Mental Health Diagnosis Y/N	
Medications:	
Regular Medical Clinic/Pharmacy:	
General Practitioner:	
Next of Kin	Contact Number:

Covid-19 Assessment Form

Name	DOB	Room	Date of Admission	mobile	

Ask patient and tick below if symptom present

Day	Date	Fever	Cough	SOB	Sore Throat	Fatigue	Needs further review (nurse assessment)	Reason (if needs further assessment)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								

Appendix 5 – Welfare Survey

Survey questions – daily check-in

Date:	
Time:	
Call taker name:	
Passenger location:	Hotel: Room number:
location (room number):	
Confirm passenger name:	
Passenger DOB:	
Contact number:	Mobile: Room:
Interpreter required:	Yes/no Language:

Script

Good morning / afternoon, I'm XXX. Can I confirm who I'm speaking with?

I am working with the Department of Health and Human Services to support people in quarantine following their arrival in Australia, and I'm giving you a call to check on your welfare. We know that this may be a stressful time for you, and our aim is to make sure that you are as comfortable as you can be during this quarantine period.

I am a Victorian Public Servant and any information that you provide to me is subject to privacy legislation.

We will be checking in with you and the people you have been travelling with every 24 hours to make sure that you are ok and to find out if you have any health, safety or wellbeing concerns that we can address.

There are 23 questions in total, and it should take only a few minutes to go through these with you. When you answer, we would like to know about you as well as any other occupants in your room.

If you have needs that require additional support, we will connect you with another team who can provide this support.

Introductory questions

1. Are you still in Room XXX at the hotel? Circle YES / NO

2. Are you a lone occupant in your hotel room? Yes/No if No:
   a. Who are your fellow occupants, including your partner or spouse, children or fellow travellers?

Name	Relationship	Age (children/dependents)

3. Have you or your fellow occupants had to leave your room for any reason? If so, what was the reason? YES /N0

Health questions

4. Have you had contact with a medical staff nurse whilst in quarantine? If yes, can you please provide details and is it being monitored?

5. Have you or your fellow occupants had any signs or symptoms of COVID-19, including fever, cough, shortness of breath, chills, body aches, sore throat, headache, runny nose, muscle pain or diarrhoea)?

6. Do you or anyone you are with have any medical conditions that require immediate support? (ie smokers requiring nicotine patches)

7. Do you, or anyone in your group (including children) have any immediate health or safety concerns?

8. Do you have any chronic health issues that require management?

9. Do you or anyone you are with have enough prescribed medication to last until the end of the quarantine period?

10. Are you keeping up regular handwashing?

11. What sort of things help you to live well every day? For example, do you exercise every day, do you eat at the same time every day?

Safety questions

12. How is everything going with your family or the people you are sharing a room with?

13. Is there anything that is making you feel unsafe?

14. Are there any concerns that you anticipate in relation to your own or other occupant's safety that might become an issue in the coming days?

If the person answers yes to either question 10 or the one above, you could say:

- You have identified safety concerns -would you like me to establish a safe word if you require additional support regarding your safety?

If yes…

- The word I am providing is <xxx> (different word for each individual). You can use that word in a conversation with me and I will know that you need immediate support/distance from other occupants in the room or may be feeling a high level of distress.

Where family violence, abuse or acute mental health is identified as an issue refer to specific guidance / escalate for specialist support.

Wellbeing questions

15. How are you and any children or other people that you are with coping at the moment?

16. Do you have any immediate concerns for any children / dependents who are with you?

17. Do you have any additional support needs that are not currently being met, including any access or mobility support requirements?

18. Have you been able to make and maintain contact with your family and friends?

19. What kind of things have you been doing to occupy yourself while you're in isolation, e.g. yoga, reading books, playing games, playing with toys?

20. Have you been able to plan for any care responsibilities that you have in Australia? Can these arrangements be maintained until the end of the quarantine period?

Final

21. What has the hotel's responsiveness been like? Have you had any trouble getting food, having laundry done, room servicing etc.?

22. Do you have any other needs that we may be able to help you with?

23. Do you have any other concerns?

End of survey

Thank you for your time today. We will contact you again tomorrow.

Office use only

1. Referral details

Nurse	
Authorised officer	
Complex Client Specialist	
Other	

2. NOTES:

3. Enter on spreadsheet

- Any referrals or issues
- Short or long survey for the next call contact (short may be by text message so they will need a mobile phone number)
- Safe word documented
- Make note of mobile number or if they don't have one.

Appendix 6 – Scripts for physical distancing call centre

Detail to be added about certain scenarios, including for funeral-related questions.

Appendix 7 – Direction and detention notice – Solo Children

DIRECTION AND DETENTION NOTICE

SOLO CHILDREN

Public Health and Wellbeing Act 2008 (Vic)

Section 200

1. Reason for this Notice

(2) You have arrived in Victoria from overseas, on or after midnight on 28 March 2020.

(3) A state of emergency has been declared under section 198 of the *Public Health and Wellbeing Act 2008* (Vic) (the **Act**), because of the serious risk to public health posed by COVID-19.

(4) In particular, there is a serious risk to public health as a result of people travelling to Victoria from overseas. People who have been overseas are at the highest risk of infection and are one of the biggest contributors to the spread of COVID-19 throughout Victoria.

(5) You will be detained at the hotel specified in clause 2 below, in the room specified in clause 2 below, for a period of 14 days, because that is reasonably necessary for the purpose of eliminating or reducing a serious risk to public health, in accordance with section 200(1)(a) of the Act.

(6) Having regard to the medical advice, 14 days is the period reasonably required to ensure that you have not contracted COVID-19 as a result of your overseas travel.

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

(8) The Chief Health Officer will be notified that you have been detained. The Chief Health Officer must advise the Minister for Health of your detention.

Note: These steps are required by sections 200(7) and (9) of the Act.

2. Place and time of detention

(9) You will be detained at:

Hotel: _____ *(to be completed at place of arrival)*

Room No: _____ *(to be completed on arrival at hotel)*

(10) You will be detained until: _____ on ____of _____2020.

3. Directions — transport to hotel

(11) You must **proceed immediately to the vehicle** that has been provided to take you to the hotel, in accordance with any instructions given to you.

(12) Once you arrive at the hotel, **you must proceed immediately to the room** you have been allocated above in accordance with any instructions given to you.

4. Conditions of your detention

(13) **You must not leave the room in any circumstances**, unless:

(c) you have been granted permission to do so:

(i) for the purposes of attending a medical facility to receive medical care; or

(ii) where it is reasonably necessary for your physical or mental health; or

(iii) on compassionate grounds; or

(d) there is an emergency situation.

(14) **You must not permit any other person to enter your room**, unless the person is authorised to be there for a specific purpose (for example, providing food or for medical reasons).

(15) Except for authorised people, the only other people allowed in your room are people who are being detained in the same room as you.

(16) You are permitted to communicate with people who are not staying with you in your room, either by phone or other electronic means.

Note: An authorised officer must facilitate any reasonable request for communication made by you, in accordance with section 200(5) of the Act.

(17) If you are under 18 years of age your parent or guardian is permitted to stay with you, but only if they agree to submit to the same conditions of detention for the period that you are detained.

5. Review of your detention

Your detention will be reviewed at least once every 24 hours for the period that you are in detention, in order to determine whether your detention continues to be reasonably necessary to eliminate or reduce a serious risk to public health.

Note: This review is required by section 200(6) of the Act.

6. Special conditions because you are a solo child

Because your parent or guardian is not with you in detention the following additional protections apply to you:

(a) We will check on your welfare throughout the day and overnight.

(b) We will ensure you get adequate food, either from your parents or elsewhere.

(c) We will make sure you can communicate with your parents regularly.

(d) We will try to facilitate remote education where it is being provided by your school.

(e) We will communicate with your parents once a day.

7. Offence and penalty

(19) It is an offence under section 203 of the Act if you refuse or fail to comply with the directions and requirements set out in this Notice, unless you have a reasonable excuse for refusing or failing to comply.

(20) The current penalty for an individual is $19,826.40.

_____

Name of Authorised Officer: _____

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

Appendix 8 – Guidelines for Authorised Officers (Unaccompanied Minors)

Guidelines for Authorised Officers - Ensuring physical and mental welfare of international arrivals in individual detention (unaccompanied minors)

Introduction

You are an officer authorised by the Chief Health Officer under section 199(2)(a) of the *Public Health and Wellbeing Act 2008* (Vic) to exercise certain powers under that Act. You also have duties under the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**Charter**).

These Guidelines have been prepared to assist you to carry out your functions in relation to Victorian unaccompanied minors who have arrived in Victoria and are subject to detention notices, requiring them to self-quarantine in a designated hotel room for 14 days in order to limit the spread of Novel Coronavirus 2019 (**2019-nCoV**) where no parent, guardian or other carer (**parent**) has elected to join them in quarantine (a **Solo Child Detention Notice**).

As part of your functions, you will be required to make decisions as to whether a person who is subject to a Solo Child Detention Notice should be granted permission to leave their room:

- for the purposes of attending a medical facility to receive medical care; or
- where it is reasonably necessary for their physical or mental health; or
- on compassionate grounds.

Authorised Officers are also required to review the circumstances of each detained person at least once every 24 hours, in order to determine whether their detention continues to be reasonably necessary to eliminate or reduce a serious risk to public health.

Your obligations under the *Charter of Human Rights and Responsibilities Act 2006*

You are a public officer under the Charter. This means that, in providing services and performing functions in relation to persons subject to a Detention Notice you must, at all times:

- act compatibly with human rights; and
- give 'proper consideration' to the human rights of any person(s) affected by your decisions.

How to give 'proper consideration' to human rights

'Proper consideration' requires you to:

- **first**, understand in general terms which human rights will be affected by your decisions (these rights are set out below under 'relevant human rights');
- **second**, seriously turn your mind to the possible impact of your decisions on the relevant individual's human rights, and the implications for that person;
- **third**, identify the countervailing interests (e.g. the important public objectives such as preventing the further spread of 2019-nCoV, which may weigh against a person's full enjoyment of their human rights for a period of time); and
- **fourth**, balance the competing private and public interests to assess whether restricting a person's human rights (e.g. denying a person's request to leave their room) is justified in the circumstances.

Relevant human rights

The following human rights protected by the Charter are likely to be relevant to your functions when conducting daily wellbeing visits and when assessing what is reasonably necessary for the physical and mental health of children who are subject to Solo Child Detention Notices:

- The right of **children** to such protection as is in their best interests (s 17(2)). As the Solo Child Detention Notices detain children in circumstances where no parent has elected to join them in quarantine, greater protection must be provided to these children in light of the vulnerability that this creates. Where possible the following additional protection should be provided:
    - You should undertake two hourly welfare checks while the child is awake and once overnight. You should ask the child to contact you when they wake each morning and let you know when they go to sleep so that this can be done.
    - You should ask the child if they have any concerns that they would like to raise with you at least once per day.
    - You should contact the child's parents once per day to identify whether the parent is having contact with the child and whether the parent or child have any concerns.
    - You should ensure that where the child does not already have the necessary equipment with them to do so (and their parent is not able to provide the necessary equipment) the child is provided with the use of equipment by the department to facilitate telephone and video calls with their parents. A child must not be detained without an adequate means of regularly communicating with their parents.
    - You should ensure that where the child does not already have the necessary equipment with them to do so (and their parent is not able to provide the necessary equipment) the child is provided with the use of equipment by the department to participate in remote education if that is occurring at the school they are attending. Within the confines of the quarantine you should obtain reasonable assistance for the child in setting up that computer equipment for use in remote education.
    - You should allow the child's parents to bring them lawful and safe items for recreation, study, amusement, sleep or exercise for their use during their detention. This should be allowed to occur at any time within business hours, and as many times as desired, during the detention.
- The rights to **liberty** (s 21) and **freedom of movement** (s 12), and the right to **humane treatment when deprived of liberty** (s 22). As the Solo Child Detention Notices deprive

children of liberty and restrict their movement, it is important that measures are put in place to ensure that the accommodation and conditions in which children are detained meet certain minimum standards (such as enabling parents to provide detained children with food, necessary medical care, and other necessities of living). It is also important that children are not detained for longer than is reasonably necessary.

- **Freedom of religion** (s 14) and **cultural rights** (s 19). Solo Child Detention Notices may temporarily affect the ability of people who are detained to exercise their religious or cultural rights or perform cultural duties; however, they do not prevent detained persons form holding a religious belief, nor do they restrict engaging in their cultural or religious practices in other ways (for example, through private prayer, online tools or engaging in religious or cultural practices with other persons with whom they are co-isolated). Requests by children for additional items or means to exercise their religious or cultural practices will need to be considered and accommodated if reasonably practicable in all the circumstances.
- The rights to **recognition and equality before the law**, and to **enjoy human rights without discrimination** (s 8). These rights will be relevant where the conditions of detention have a disproportionate impact on detained children who have a protected attribute (such as race or disability). Special measures may need to be taken in order to address the particular needs and vulnerabilities of, for example Aboriginal persons, or persons with a disability (including physical and mental conditions or disorders).
- The rights to **privacy, family and home** (s 13), **freedom of peaceful assembly** and **association** (s 16) and the **protection of families** (s 17). Solo Child Detention Notices are likely to temporarily restrict the rights of persons to develop and maintain social relations, to freely assemble and associate, and will prohibit physical family unification for those with family members in Victoria. Children's rights may be particularly affected, to the extent that a Solo Child Detention Notice results in the interference with a child's care and the broader family environment. It is important, therefore, to ensure children subject to Solo Child Detention Notices are not restricted from non-physical forms of communication with relatives and friends (such as by telephone or video call). Requests for additional items or services to facilitate such communication (e.g. internet access) will need to be considered and accommodated if reasonably practicable in all the circumstances.

Whether, following 'proper consideration', your decisions are compatible with each these human rights, will depend on whether they are reasonable and proportionate in all the circumstances (including whether you assessed any reasonably available alternatives).

General welfare considerations

All persons who are deprived of liberty must be treated with humanity and respect, and decisions made in respect of their welfare must take account of their circumstances and the particular impact that being detained will have on them. Mandatory isolation may, for some people, cause greater hardship than for others – when performing welfare visits you will need to be alert to whether that is the case for any particular person.

In particular, anxieties over the outbreak of 2019-nCoV in conjunction with being isolated may result in the emergence or exacerbation of mental health conditions amongst persons who are subject to Detention Notices. If you have any concerns about the mental health of a detained person, you should immediately request an assessment of mental health be conducted and ensure appropriate support is facilitated. Hotel rooms are not normally used or designed for detention, so you should be aware that a

person who is detained in a hotel room could have greater opportunity to harm themselves than would be the case in a normal place of detention.

Additional welfare considerations for children

Children differ from adults in their physical and psychological development, and in their emotional and educational needs. For these reasons, children who are subject to Solo Child Detention Notices may require different treatment or special measures.

In performing functions and making decisions with respect to a detained person who is a child, the best interests of the child should be a primary consideration. Children should be given the opportunity to conduct some form of physical exercise through daily indoor and outdoor recreational activities. They should also be provided with the ability to engage in age-appropriate activities tailored to their needs. Each child's needs must be assessed on a case-by-case basis. Requests for items or services to meet the needs of individual children will need to be considered and accommodated if reasonably practicable in all the circumstances. Where available, primary school age children should be allocated rooms that have an outside area where it is safe for active physical play to occur (not a balcony) and consideration should be given to allowing small children access to any larger outdoor areas that are available within the hotel, where possible within relevant transmission guidelines. Although each child's needs must be assessed daily and individually, it can be assumed that it will have a negative effect on a child's mental health to be kept in the same room or rooms for two weeks without access to an adequate outdoor area in which to play.

Balancing competing interests

However, the best interests of children and the rights of anyone who is subject to a Solo Child Detention Notice will need to be balanced against other demonstrably justifiable ends; for example, lawful, reasonable and proportionate measures taken to reduce the further spread of 2019-nCoV. It is your role to undertake this balance in your welfare checks, based on the information and advice that you have from the department and on the information provided to you by the children that you are assessing.

Appendix 9 – Authorised Officer Occupational Health and Safety

Purpose

The purpose of this document is to provide an occupational health and safety procedure for authorised officers when attending off site locations during the current State of Emergency.

Health Emergency

Coronaviruses are a large family of viruses that cause respiratory infections. These can range from the common cold to more serious diseases. COVID-19 is the disease caused by a new coronavirus. It was first reported in December 2019 in Wuhan City in China.

Symptoms of COVID-19 can range from mild illness to pneumonia. Some people will recover easily, and others may get very sick very quickly which in some cases can cause death.

Compliance Activity

On 16 March 2020 a State of Emergency was declared in Victoria to combat COVID-19 and to provide the Chief Health Officer with the powers he needs to eliminate or reduce a serious risk to the public.

Under a State of Emergency, Authorised Officers, at the direction of the Chief Health Officer, can act to eliminate or reduce a serious risk to public health by detaining people, restricting movement, preventing entry to premises, or providing any other direction an officer considers reasonable to protect public health.

Using a roster-based system, you will be placed on call to exercise your authorised powers pursuant to section 199 of the *Public Health and Wellbeing Act 2008* ***(Act)***. **Your compliance role is only to exercise the powers under section 199 of the Act, any arrests, including moving people into detainment or physical contact with an offender suspect must be manage by Victoria Police**.

OHS

Occupational Health and Safety is a shared responsibility of both the employer and the employee. Officers must raise hazards, concerns, incidents with: REDACTED REDACTED

One of the foremost issues associated with site attendance is the 'uncontrolled environment' that exists. Officers can be exposed to infectious diseases (such as COVID-19), confrontational and/or aggressive members of the public who may be drug affected, mentally ill or intellectually impaired. The very nature of this work is likely to be perceived as invasive and can provoke a defensive response.

Risks can be minimised by maintaining routine safe work practices and proper planning. Prior to any site visit, risks and hazards should be identified and assessed.

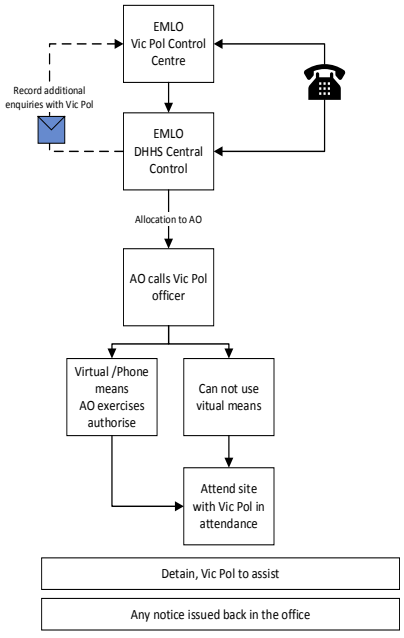
Officers and managers both have a shared responsibility for occupational health and safety. All employees have a responsibility to report and discuss hazards or perceived hazards, by bringing this to the managers attention.

Fatigue

Officers will be rostered on a rotating basis, with the aim of mitigating the risk of fatigue. Fatigue may impede decision making capability and when driving a motor vehicle to a location. When fatigue is identified please make this known to your manager.

To mitigate the risk of fatigue, officers should be aware of any fatigue they may have. A good tool to use to help officers identify their level of fatigue is to use the following calculator: http://www.vgate.net.au/fatigue.php

Officers are required to hold a valid motor vehicle license and are required to adhere to the requirements of the departments driving policy. Information about the departments policy can be found on the DHHS intranet site.



Risk assessment before attendance | Personal Protection

Officers must only take a direction to attend a site with the approval of the Central DHHS emergency Management Liaison Officer or DHHS duty manager. An officer must only attend a location where there is the confirmed attendance of the Victoria Police.

In the first instance, officers are required to use technology (i.e: mobile phone, Facetime, Skype) to exercise their authority. This aims to protect officers from attending an uncontrolled environment, where the risk of harm is increased.

Before attending a site, the officer should make themselves familiar with the recommendations produced by the Australian Government and the Department of Health and Human Services, in the protection against COVID-19.

Interventions are known as 'transmission reduction, or 'physical distancing' measures. Officers can take the following personal measure to reduce their risk of exposure to COVID-19. Officers with pre-existing medical conditions that put them more at risk of COVID-19, should discuss this with their medical practitioner and manager.

Personal measures to reduce risk the risk of exposure to COVID-19 include:

- Stay healthy with good nutrition, regular exercise, sensible drinking, sleeping well, and if you are a smoker, quitting.
- Wash your hands often with soap and water for at least 20 seconds, especially after you have been in a public place, or after blowing your nose, coughing, sneezing, or using the toilet. If soap and water are not readily available, use a hand sanitiser that contains at least 60 per cent alcohol.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Cover your nose and mouth with a tissue when you cough or sneeze. If you don't have a tissue, cough or sneeze into your upper sleeve or elbow.
- Stop shaking hands, hugging or kissing as a greeting.
- Ensure a **distance of 1.5 metres** is kept between yourself and others.
- Get vaccinated for flu (influenza) as soon as available. This could help reduce the risk of further problems. *Note: the department covers expenses for vaccines, speak to your manager for more details.*
- Clean and disinfect high touch surfaces regularly, for example: telephones, keyboards, door handles, light switches and, bench tops.

When an officer is called to attend a site, they should take a **risk-based approach** and assess the most suitable way to reduce harm to themselves. Before attending, the officer must obtain information such as:

- Is the offender(s) a positive case of COVID-19?
- Has the offender(s) been recently in close contact with a positive case of COVID-19?
- Has the offender(s) recently returned from overseas within the last 14 days?

Officers are required to use their discretion and take into account their own personal safety. The Department of Health and Human Services has provided the following PPE:

- Face mask (N95 or equivalent)
- Gloves
- Hand Sanitizer

The following is only a guide for officers to consider.

PPE	Guide
Face mask	When there is known case of COVID-19, or an offender has been recently been exposed to COVID-19
Gloves	Always
Hand Sanitizer / Soap	Always
Social Distancing of at least 1.5 meters	Always

Known risks and hazards

Hazard	Risk	Mitigate
COVID-19 infection	Serious illness / death	Follow personal protective measures
Fatigue	Impaired decisions / driving to site	In the first instance use virtual technology to perform duties Use fatigue calculator http://www.vgate.net.au/fatigue.php
Physical Injury	Low / Medium	Only attend a site with Victoria Police
Other infectious agen		Follow personal protective measures

COVID-19 Policy and procedures – Mandatory Quarantine (Direction and Detention Notice) V1

Authorised Officers under the *Public Health and Wellbeing Act 2008*

Working draft not for wider distribution @ 8/4/20

For URGENT operational advice contact

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VICTORIA State Government | Health and Human Services

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COVID-19 Policy and Procedure – Mandatory Quarantine (Direction and Detention Notice)

Authorised Officers under the *Public Health and Wellbeing Act 2008*

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Contents

Purpose

This policy and procedure intends to:

- provide clarity to all parts of the Department of Health and Human Services' (the department's) quarantine (mandatory detention) intervention as part of the response to coronavirus disease 2019 (COVID-19)
- describe the strategy and protocols for the quarantine (mandatory detention) intervention
- describe the compliance and enforcement policy and procedures for the mandatory detention directions for departmental authorised officers (AOs).

Direction and detention notice issued 27 March 2020

This notice orders the detention of all persons who arrive into Victoria from overseas on or after midnight on 28 March 2020, requiring they be detained in a hotel for a period of 14 days.

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

More information can be obtained from:

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

Background

Background to the mandatory quarantine (detention) intervention

A mandatory quarantine (detention) approach was introduced by the Victorian Government, consistent with the Commonwealth Government (Department of Health Information for International Travellers) through a policy that a detention order would be used for all people arriving from overseas into Victoria from midnight on Saturday 28 March 2020. An example detention order is available at https://www.dhhs.vic.gov.au/state-emergency

The objectives of the plan for people returning from overseas to Victoria are:

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

Enforcement and Compliance Command for Mandatory Quarantine

Deliverables of the enforcement and compliance function

The Director, Health and Human Services Regulation and Reform (Lead Executive – COVID-19 Compliance) is responsible for:

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

Authorised officer* and Chief Health Officer obligations

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

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

Any AO that is unsure as to whether they been authorised under s.199 should contact administrative staff in the department's Health Protection Branch prior to enforcing compliance with the Direction and Detention Notice.

Exercising this power imposes several obligations on departmental AOs including:

- producing their identity card for inspection prior to exercising a power under the PHWA
- before the person is subject to detention, explaining the reason why it is necessary to detain the person
- if it is not practicable to explain the reason why it is necessary to detain the person, doing so as soon as practicable
- before exercising any emergency powers, warning the person that refusal or failure to comply without reasonable excuse, is an offence
- facilitating any reasonable request for communication made by a person subject to detention
- reviewing, every 24 hours, whether continued detention of the person is reasonably necessary to eliminate or reduce a serious risk to health
- giving written notice to the Chief Health Officer (CHO) that a person:
  - has been made subject to detention
  - following a review, whether continued detention is reasonably necessary to eliminate or reduce the serious risk to public health.

The notice to the CHO must include:

- the name of the person being detained
- statement as to the reason why the person is being, or continues to be, subject to detention.

Following receipt of a notice, the CHO must inform the Minister as soon as reasonably practicable.

** A departmental Authorised Officer under the PHWA that has been authorised for the purposes of the emergency order*

Use of a Business System –Quarantine and Welfare System COVID-19 Compliance Application

The Quarantine and Welfare System is comprised of two applications:

- COVID-19 Compliance Application - This application supports Authorised Officers to maintain Detainee and Detention Order records
- COVID-19 Welfare Application (not part of Authorised Officer responsibilities).

A **User Guide** is available to guide Authorised Officers.
Support email for users:REDACTED
Support will be active between 8am and 8pm. You can email support for access issues, technical issues, application use questions. A **phone number** will also be provided shortly.

Authorised officers and powers

Authorisation under section 200 for the purposes of the emergency order

Only departmental AOs under the PHWA that have been authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the PHW can exercise emergency powers under section 200. The powers extend only to the extent of the emergency powers under section 200 and as set out in the PHWA.

Powers and obligations under the Public Health and Wellbeing Act 2008

The general powers are outlined under Part 9 of the PHWA (Authorised Officers). The following is an overview of powers and obligations. It does not reference all powers and obligations.

AOs are encouraged to read Part 9 and seek advice if they are unsure in the administration of their powers.

Authorised officer obligations:

Produce your identity card - s166

Before exercising powers provided to you under the PHWA:
At any time during the exercise of powers, if you are asked to show your ID card
As part of good practice, you should produce your identity card when introducing yourself to occupiers or members of the public when attending complaints or compliance inspections.

Inform people of their rights- s167

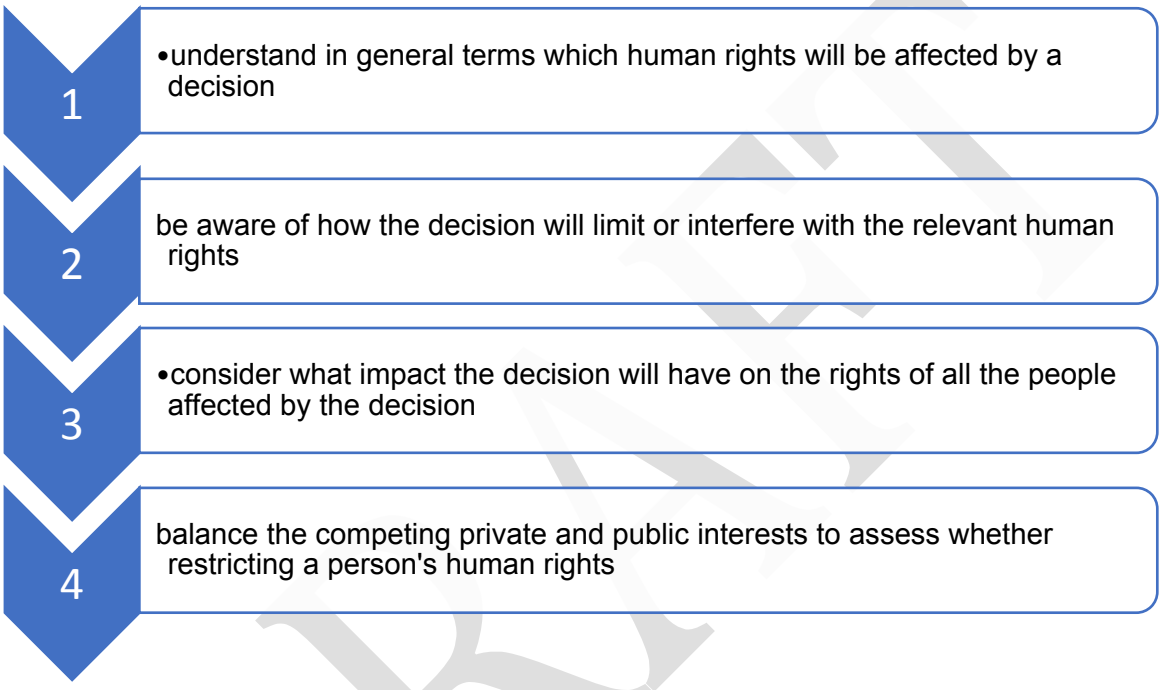
You may request a person to provide information if you believe it is necessary to investigate whether there is a risk to public health or to manage or control a risk to public health.
But you must first advise the person that they may refuse to provide the information requested.

Charter of Human Rights obligations

Department AO obligations under the *Charter of Human Rights and Responsibilities Act 2006*

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

How to give 'proper consideration' to human rights



The relevant Charter Human Rights that departmental AOs need to be aware of that may be affected by a decision:

- **Right to life** – This includes a duty to take appropriate steps to protect the right to life and steps to ensure that the person in detention is in a safe environment and has access to services that protect their right to life
- **Right to protection from torture and cruel, inhuman or degrading treatment –** This includes protecting persons in detentions from humiliation and not subjecting persons in detention to medical treatments without their consent
- **Right to freedom of movement –** while detention limits this right, it is done to minimise the serious risk to public health as a result of people travelling to Victoria from overseas
- **Right to privacy and reputation** – this includes protecting the personal information of persons in detention and storing it securely
- **Right to protection of families and children –** this includes taking steps to protect families and children and providing supports services to parents, children and those with a disability
- **Property rights –** this includes ensuring the property of a person in detention is protected
- **Right to liberty and security of person –** this includes only be detained in accordance with the PHWA and ensuring steps are taken to ensure physical safety of people, such as threats from violence
- **Rights to humane treatment when deprived of liberty** – this includes treating persons in detention humanely.

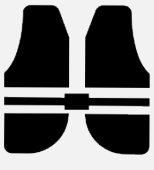
Airport

Key responsibilities

The following outlines required procedures at the airport for departmental Authorised officers.

Authorised Officers*:

Responsibility		Mandatory obligation	Section (PHWA)
	• must declare they are an Authorised Officer and show AO card	Yes	Section 166
	• must provide a copy of the Direction and Detention Notice to each passenger (notification to parent/guardian may need to be conducted over the phone and interpretation services may be required) and: – explain the reasons for detention – warn the person that refusal or failure to comply with a reasonable excuse is an offence and that penalties may apply	Yes. If it is not practicable to explain the reason for detention prior to subjecting the person to detention, the AO must do so as soon as practicable. This may be at the hotel, however every effort should be made to provide the reason at the airport [s. 200(3)] **(mandatory AO obligation)**.	Section 200(2) and 200(4)
	• ensure the Direction and Detention Notice: – states the name/s of the person being detained – states the name of AO – contains signature of person being detained – contains signature of AO – contains the hotel name at which the person will be detained – contains date the person will be detained till (14 days).		

Responsibility		Mandatory obligation	Section (PHWA)
	• record issue and receipt of the notice through a scanned photograph and enter into business system[1] • request person subject to detention present to AO at hotel		
	• facilitate any reasonable request for communication, such as a phone call or email and including if necessary, organising a translator to explain the reasons for detention (need to provide VITS number)	Yes	Section 200(5)
	• provide a fact sheet about detention (what a person in detention can and can't do, who to contact for further information)		
	• record any actions taken in writing, including the above mandatory obligations, use of translator and any associated issues.		
	• use the list of arriving passengers to check off the provision of information to each arrival. This will help ensure all arrivals have been provided the information in the Direction and Detention Notice.		
	• check the vehicle transporting a person in detention is safe (in accordance with the review of transport arrangements procedure).		

** DHHS Authorised Officer under the PHWA that has been authorised for the purposes of the emergency order*

[1] The Business system referred to here is the Quarantine and Welfare System COVID-19 Compliance Application

Additional roles

Authorised Officer review of transport arrangements to hotel

AO should consider the following:

- All persons must have been issued a direction and detention notice to board transport
- Is there adequate physical distance between driver and a person to be detained?
- If not wait for another suitable vehicle to be arranged by the hotel.
- Has the vehicle been sanitised prior to anyone boarding? If not then the vehicle must be cleaned in accordance with departmental advice (business sector tab).
- Ensure the driver required to wear personal protective equipment (PPE)? (clarify what PPE is needed?) TBC
- Are the persons subject to detention wearing face masks? (Refer to Airport and transit process)
- Are there pens/welfare check survey forms available for each person to be detained to complete enroute or at the hotel?

Other airport issues

People who are unwell at the airport

The Compliance lead for this situation is the Human Biosecurity Officer on behalf of the Deputy Chief Health Officer (Communicable Disease).

Any person who is unwell at the airport will be assessed by a departmental staff member and biosecurity officer at the airport. After discussion with the human biosecurity officer, if it is determined that the person meets the criteria as a suspected case, the following actions should take place:

- The human biosecurity officer should organise an ambulance transfer to the Royal Melbourne Hospital or Royal Children's Hospital for testing and assessment
- The department AO at the airport should log the person as requiring mandatory quarantine at a specified hotel and then should follow-up with the hospital to update on whether the person has been found to be negative, so a transfer by (patient transfer/ambulance/ maxi taxi etc) can be organised to return to the hotel
- If the person is unwell and requires admission, they should be admitted and the Compliance Lead informed
- If the person is well enough to be discharged they should return to the hotel through an arrangement by the authorised officer, (refer to points above) and be placed in a COVID-19 floor if positive, or in a general part of the hotel if tested negative for COVID-19.

Transfer of uncooperative person to be detained to secure accommodation (refer to Authorised Officer review of transport arrangements procedure)

It is recommended that a separate mode of transport is provided to a person who is to be detained who is uncooperative to a hotel or other location for the 14-day isolation.

Ensure appropriate safety measures are taken including child locks of doors and safety briefing for drivers etc.

Arrival at hotel – check in

Key responsibilities

At hotel check-in:

- Person to be detained provides Direction and Detention Notice to hotel staff; hotel staff to write on the notice:
  - room number
  - the date that the person will be detained until (14 days after arrival at place of detention).
- Person to be detained provides completed Direction and Detention Notice to AO to confirm that the following details on the notice are correct:
  - the hotel name;
  - hotel room number and arrival date, time and room on notice;
  - the date that the person will be detained until (14 days after arrival at place of detention).
- AO must take a photo of the person's Direction and Detention Notice and enters this into Quarantine and Welfare System COVID-19 Compliance Application.
- Following any medical and welfare check of the person, AO to liaise with nurses to identify persons being detained with medical or special needs.
- AO to note persons being detained with medical or special needs, such as prescription and medical appointments.

Persons being detained will be sent to their allocated room and informed that a person will contact them in the afternoon or next AO to make themselves known to the security supervisor onsite.

Additional roles of the AO

- AOs should check that security are doing some floor walks on the floors to ascertain longer-term needs and possible breaches
- AO should provide a handover to the incoming AO to get an update of any problems or special arrangements. For example, some people are permitted to attend cancer therapy at Peter Mac etc. This information should be also uploaded on the database/spreadsheet? Or is this covered below?
- AO responsible for uploading information to the business system which will then inform an upload to PHESS so that all persons in mandatory detention are recorded in PHESS for compliance and monitoring and surveillance purposes.

Regular review of detention

Requirement for review each day

- A lead AO will – at least once every 24 hours – review whether the continued detention of the person is reasonably necessary to protect public health [s. 200(6)] **(mandatory AO obligation).**
- The AO will undertake an electronic review of detainment arrangements by viewing Quarantine and Welfare System COVID-19 Compliance Application This includes reviewing:
  - the date and time of the previous review (to ensure it occurs at least once every 24 hours)
  - number of detainees present at the hotel
  - duration each detainee has been in detention for, to ensure that the 14-day detention period is adhered to
  - being cleared of COVID-19 results while in detention
  - determining whether continued detention of each detainee is reasonably necessary to eliminate or reduce a serious risk to health
  - consideration of the human rights being impacted – refer to 'Charter of Human Rights' obligations
  - any other issues that have arisen.

Decision making

To inform decision-making, the lead AO must:

- consider that the person is a returned overseas traveller who is subject to a notice and that they are obliged to comply with detainment
- consider that detainment is based on expert medical advice that overseas travellers are of an increased risk of COVID-19 and form most COVID-19 cases in Victoria
- note the date of entry in Australia and when the notice was given
- consider any other relevant compliance and welfare issues the AO becomes aware of, such as:
  - person's health and wellbeing
  - any breaches of self-isolation requirement
  - issues raised during welfare checks (risk of self-harm, mental health issues)
  - actions taken to address issues
  - being cleared of COVID-19 results while in detention
  - any other material risks to the person
- record the outcomes of their review (high level notes) for each detained person (for each 24-hour period) in the agreed business system database. This spreadsheet allows ongoing assessment of each detainee and consideration of their entire detention history. This will be linked to and uploaded to PHESS.

To ascertain any medical, health or welfare issues, AO will need to liaise with on-site nurses and welfare staff and specialist areas within the department. This is also available on the Quarantine and Welfare System COVID-19 Compliance Application.

Mandatory reporting (mandatory AO obligation)

A departmental AO must give written notice to the Chief Health Officer as soon as is reasonably practicable that:

- a person has been made subject to detention

- following a review, whether continued detention is reasonably necessary to eliminate or reduce the serious risk to public health.

The notice to the CHO must include:

- the name of the person being detained
- statement as to the reason why the person is being, or continues to be, subject to detention.

To streamline, the reporting process will involve a daily briefing to the CHO of new persons subject to detention and a database of persons subject to detention. The database will specify whether detention is being continued and the basis for this decision.

The CHO is required to advise the Minister for Health of any notice [s. 200(9)].

Possible release from detention based on review

The daily review by the lead AO could identify that detention may no longer be required (with the approval of the Compliance Lead and Public Health Commander.

In the first instance the AO should contact the specialist area if needed (i.e. Mental Health)

Based on specialist advise, there will be a recommendation to the Compliance Lead and Public Health Commander/CHO.

Grant of leave from detention

Considerations

Temporary leave from the place of detention (Detention notice)

Any arrangements for approved leave would need to meet public health (and human rights) requirements. It will be important that the AO balances the needs of the person and public health risk.

For example, if the person needs immediate medical care, public health risks need to be managed appropriately, but the expectation is that the leave would automatically be granted. This would be more nuanced and complex when the request is made on compassionate grounds where there is a question about how public health risks might be managed. However, again, human rights under the Charter need to be considered closely.

There are four circumstances in which permission may be granted:

1. For the purpose of attending a medical facility to receive medical care

AO should refer to the '*Permission for Temporary Leave from Detention'* guide at **Appendix 2.**

- AO will consider circumstances to determine if permission is granted.
- An on-site nurse may need to determine if medical care is required and how urgent that care may be. Departmental AOs and on-site nurse may wish to discuss the person's medical needs with their manager, on-site nurse and the Director, Health and Human Services Regulation and Reform (Lead Executive – COVID-19 Compliance) to assist in determining urgency and whether temporary leave is needed AO may need to seek specialist advise within the department
- Where possible, on-site nurses should attempt to provide the needed medical supplies.
- If AO recommends leave be granted, they should seek approval from the Director, Health and Human Services Regulation and Reform (Lead Executive – COVID-19 Compliance).
- AO to be informed of decision
- If approval is granted, AO should complete a Permission for Temporary Leave from detention form / enter in Quarantine and Welfare System COVID-19 Compliance Application **Appendix 1**
- AOs should follow the Hospital Transfer Plan below.

2. Where it is reasonably necessary for physical or mental health

AO should refer to the *'Permission for Temporary Leave from Detention'* guide at **Appendix 2.**

- AO will consider circumstances to determine if permission is granted.
- AO should request DHHS Welfare team perform a welfare check to assist decision-making.
- If AO recommends leave be granted, they should seek approval from the Director, Health and Human Services Regulation and Reform (Lead Executive – COVID-19 Compliance).
- If approval is granted, AO should complete a Permission for Temporary Leave from detention form / enter in Quarantine and Welfare System COVID-19 Compliance Application Permission for Temporary Leave from detention form and enter into business system, **Appendix 1**
- AO should complete a register for Permission Granted / enter in business system,
- If approval is granted:
  - the on-site AO must be notified
  - persons subject to detention are not permitted to enter any other building that is not their (self-isolating) premises

  - persons subject to detention should always be accompanied by an on-site nurse, the department's authorised officer, security staff or a Victoria Police officer, and social distancing principles should be adhered to[2]
- a register of persons subject to detention should be utilised to determine which persons are temporarily outside their premises at any one time.

3. On compassionate grounds:

AO should refer to the *'Permission for Temporary Leave from Detention'* guide at **Appendix 2.**

- AO will consider circumstances to determine if permission is granted.
- AO may request DHHS Welfare team perform a welfare check to assist decision-making.
- If AO recommends leave be granted, they should seek approval from the Director, Health and Human Services Regulation and Reform (Lead Executive – COVID-19 Compliance).
- If approval is granted, AO should complete a Permission for Temporary Leave from detention form / enter in Quarantine and Welfare System COVID-19 Compliance Application, **Appendix 1**

4. Emergency situations

- Department AOs and Victoria Police officers may need to determine the severity of any emergency (such as a building fire, flood, natural disaster etc) and the health risk they pose to persons in detention.
- If deemed that numerous persons in detention need to leave the premises due to an emergency, a common assembly point external to the premises should be utilised; persons in detention should be accompanied at all times by a department authorised officer or a Victoria Police officer, and infection prevention and control and social distancing principles should be adhered to
- The accompanying departmental AO or a Victoria Police officer should ensure that all relevant persons in detention are present at the assembly point by way of a register of persons in detention.
- AO's should make notes in Quarantine and Welfare System COVID-19 Compliance Application

Procedure for a person in detention / resident to leave their room for exercise or smoking

Infection prevention and control measures TBC

A person must be compliant and must not have symptoms before they could be allowed to have supervised exercise or a smoking break. Details must be entered into Quarantine and Welfare System COVID-19 Compliance Application

The steps that must be taken by the person in detention are:

- Confirm to the person who will escort them that they are well,
- Confirm to the person who will escort them that they have washed their hands immediately prior to leaving the room,
- Don a single-use facemask (surgical mask), to be supplied by the security escort prior to leaving the room,
- Perform hand hygiene with alcohol-based handrub as they leave, this will require hand rub to be in the corridor in multiple locations,
- Be reminded to – and then not touch any surfaces or people within the hotel on the way out, and then not actually do it.
- They return immediately to their hotel room

The procedure for the security escort is:

[2] See also Exercise and smoking procedure

- Don a single-use facemask (surgical mask);
- Perform hand hygiene with an alcohol-based handrub or wash hands in soapy water;
- Be reminded to – and then not touch any surfaces or people within the hotel on the way out, and then not actually do it
- Be the person who touches all surfaces if required such as the lift button or door handles (where possible using security passes and elbows rather than hands;
- Maintain a distance (1.5 metres) from the person;
- Perform hand hygiene with an alcohol-based handrub or wash hands in soapy water as the end of each break.

There is no requirement to wear gloves and this is not recommended, as many people forget to take them off and then contaminate surfaces. If gloves are worn, remove the gloves immediately after the person is back in their room and then wash your hands.

In addition:

- Family groups may be taken out in a group provided it is only 2 adults and less than 5 in total.
- They can be taken to an outside area with sunlight, for up to 15 minutes outside of the hotel.
- Smokers can take up to 2 breaks per day if staffing permits.
- Rostering to be initiated by the departmental staff/AO present.

Supporting smokers to quit smoking

Tthe preferred option is support smokers to quit or manage withdrawal while confined to their hotel room. This would mean that smokers be supported to manage cravings while they are unable to smoke but would not be forced to quit.

Further work to support to support this approach would include provision of approved nicotine replacement therapies (NRT), with meal deliveries, accompanied by counselling through the Quitline. DHHS to explore opportunities to incorporate provision of NRT and counselling

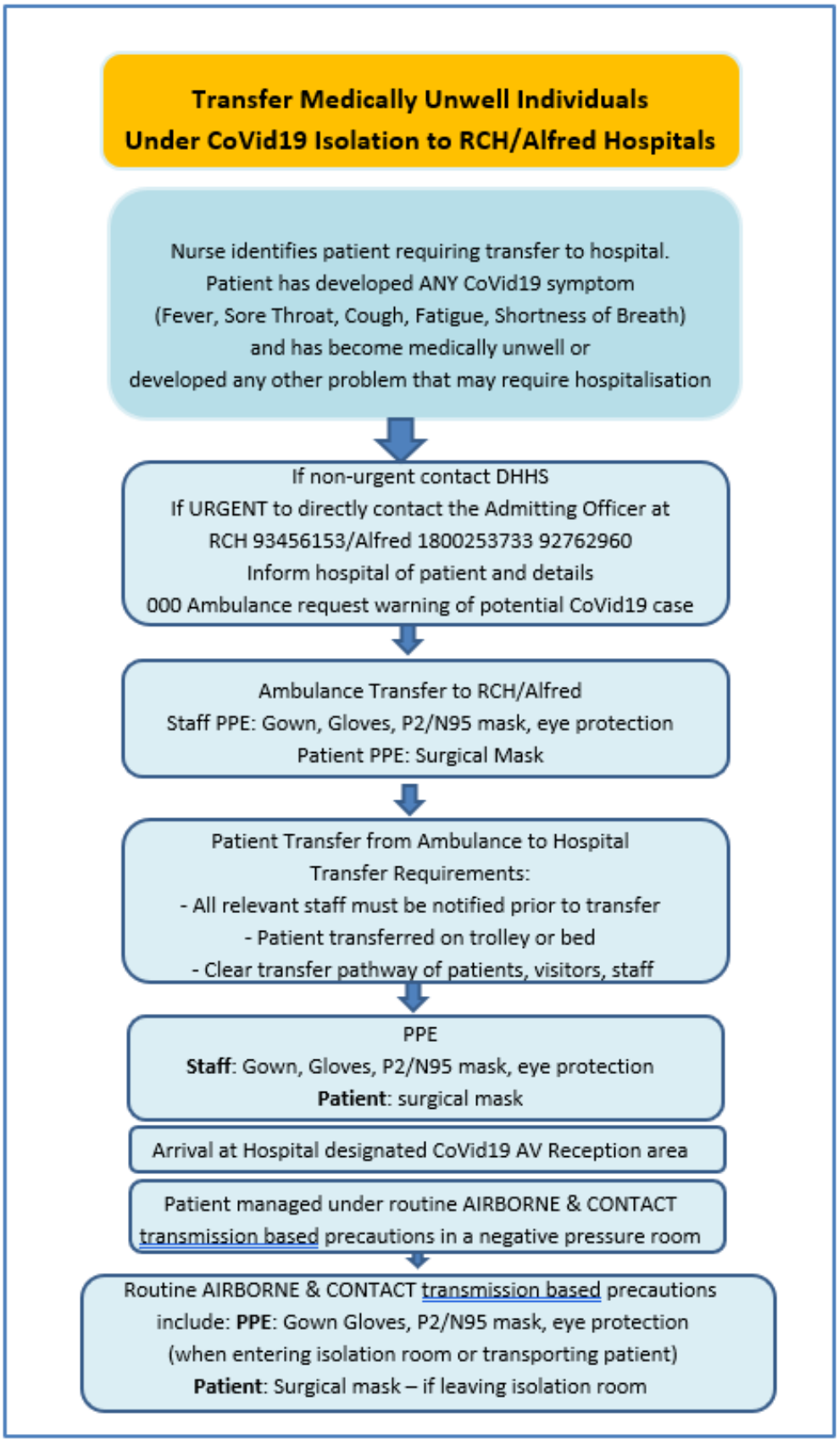
Hospital transfer plan

The following is a general overview of the transfer of a patient to hospital involving nurses, doctors, AOs, Ambulance Victoria (AV) and hospitals. The bold highlight AO interactions.

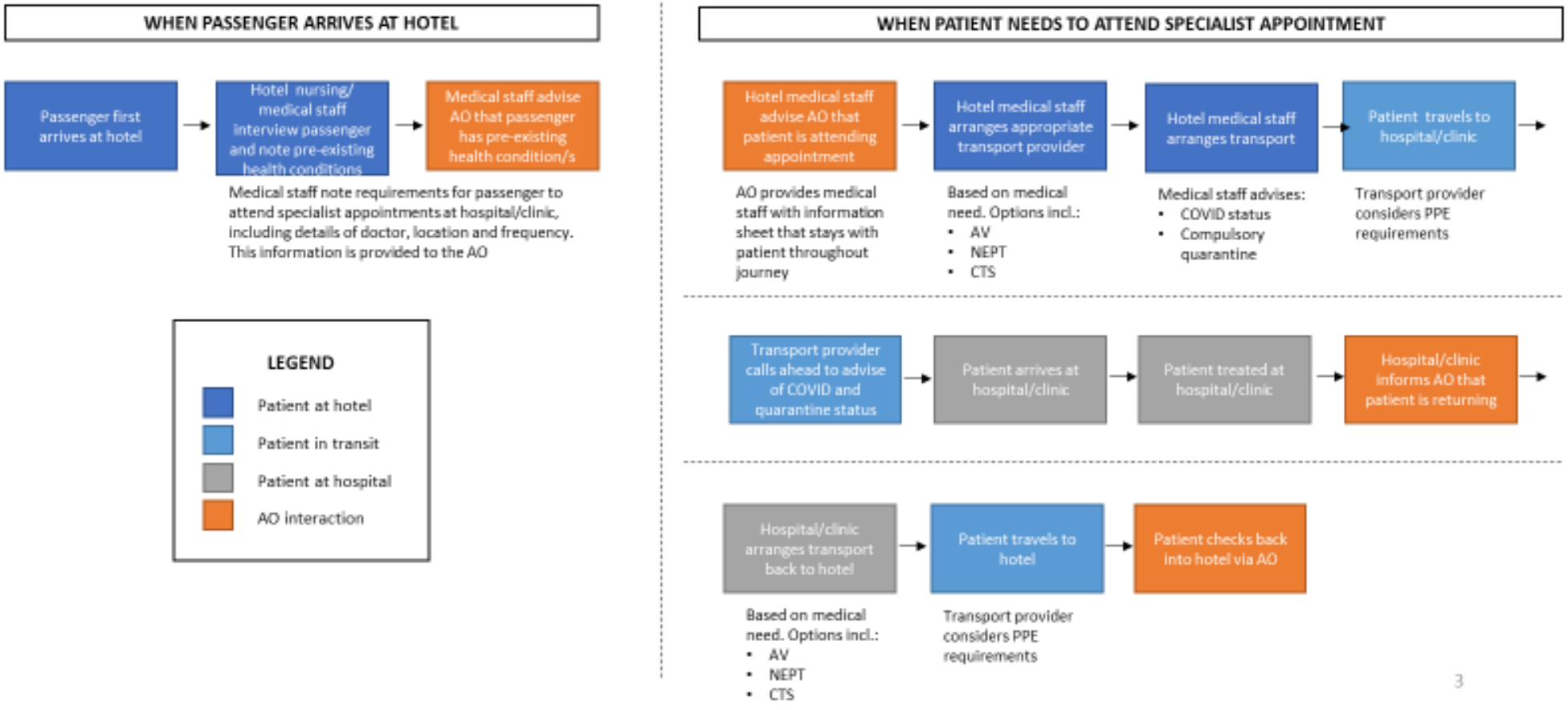
1. Nurse/doctor assess that patient requires hospital care
2. **There is also a one pager to explain to AO how to grant permission at Appendix 2 Permission to temporarily leave. Leave should be recorded on the business system or register.**
3. **All relevant staff including AO must be notified prior to the transfer.**
4. Patient is transferred to the appropriate hospital. Patients requiring hospital assessment/treatment for suspected or confirmed COVID-19 or other conditions, should be transferred to either the Royal Melbourne Hospital (RMH) or The Alfred Hospital, depending on proximity **(note children should be transferred to the Royal Children's Hospital).**
5. If the hospital transfer is urgent call 000 to request ambulance and inform them that the passenger is a suspected (or confirmed) case of COVID-19.
6. Contact the Admitting Officer at RCH/RMH/the Alfred, inform the hospital of patient and details.
7. Staff should don full PPE and the passenger must wear a single-use surgical mask if tolerated.
8. The passenger should be transferred on a trolley or bed from ambulance into the designated COVID-19 ambulance reception area.
9. The patient should be managed under routine airborne and contact transmission-based precautions in a negative pressure room if available. The patient should wear a single-use surgical mask if leaving the isolation room.
10. Ambulance services will list the hotels as an area of concern in case of independent calls and will ask on site staff to assess need for attendance in the case of low acuity calls.
11. All residents who are: in high risk groups, unwell, breathless or hypoxic (O2 sats <95%) should be considered for hospital transfer.
12. Assessment and diagnosis made as per medical care and plan made for either admission to same hospital or more appropriate medical care or for discharge. (receiving hospital ED)
13. Prior to any movement of the patient out of the ED a new plan or detention approval must be sought for either return or admission to different location in consultation with compliance team (receiving hospital and compliance team).
14. **Hospitals will need to contact the AO at hotels (a mobile will need to be sourced that stays at each hotel across shifts) then the AO Team lead will advise Lead Executive Compliance to obtain any necessary approvals)**

The flow diagrams below outline the processes, including interactions with AO for the transfer and return of a patient.

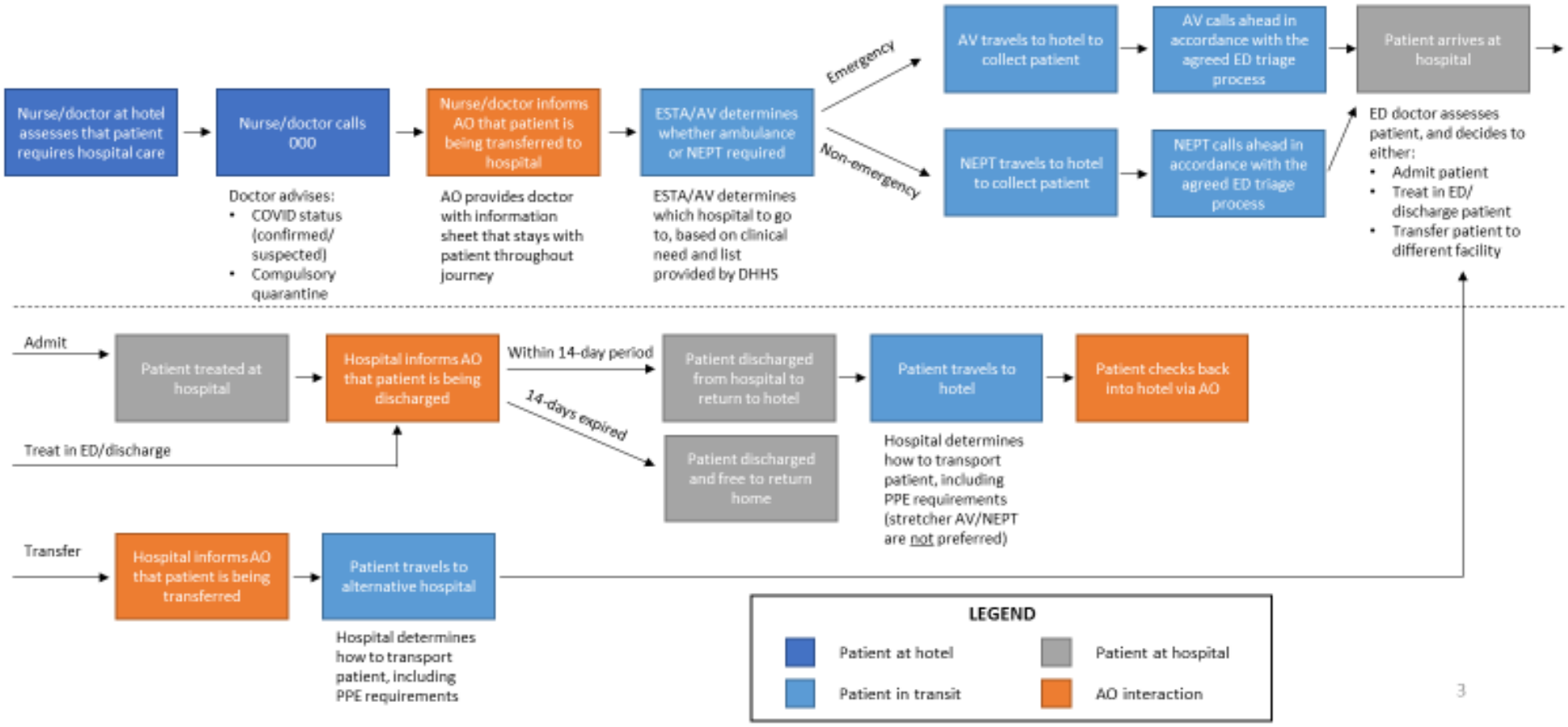
DHHS is endeavouring to organise patient transport arrangements.



Process to transfer passengers to hospital (planned)



Process to transfer passengers to hospital (unplanned)



Compliance

The role of an AO in compliance is only to exercise the powers under section 199 of the PHWA, any arrests, including moving people into detainment or physical contact with a person must be managed by Victoria Police.

Options to facilitate compliance

Department AOs should make every effort to inform the person of their obligations, facilitate communication if requested and explain the important rationale for the direction. The following graduated approach should guide AOs:

Explain	explain the important reasons for detention, that is this action is necessary to reduce the serious risk to public health **(mandatory obligation)**
Fact sheet	provide the person subject to detention with a fact sheet and give opportunity to understand the necessary action
Communicate	provide the person subject to detention opportunity to communicate with another person, including any request for a third-party communicator (such as translator),
Seek assistance	seek assistance from other enforcement agencies, such as Victoria Police, to explain the reason for detention and mitigate occupational health and safety concerns
Discuss with nurse	discuss matter with on-site nurse to ascertain if there are any medical issues that may require consideration or deviation from the intended course of action
Issue verbal direction	issue a verbal direction to comply with the Direction and Detention Notice
Inform of penalties	advise that penalties may apply if persons do not comply with the Direction and Detention Notice
Infringement notice	recommend that Victoria Police issue an infringement notice if there is repeated refusal or failure to comply with a direction
Physical detain	recommend Victoria Police physically detain the non-compliant individual for transfer to another site.
Make notes	Department AOs should make contemporaneous notes where a person is uncooperative or breaches the direction.

Unauthorised departure from accommodation

If there is reason to believe a person subject to detention is not complying with the direction and detention notice, the AO should:

- notify on-site security and hotel management
- organise a search of the facility
- consider seeking police assistance
- notify the Director, Regulatory Reform if the person subject to detention is not found

If the person is located, the AO should:

- seek security or Victoria Police assistance if it is determined the person poses a risk of trying to leave
- provide an opportunity for the person to explain the reason why they left their room
- assess the nature and extent of the breach, for example:
  - a walk to obtain fresh air
  - a deliberate intention to leave the hotel
  - mental health issues
  - escaping emotional or physical violence
- assess possible breaches of infection control within the hotel and recommend cleaning
- consider issuing an official warning or infringement through Victoria Police
- reassess security arrangements
- report the matter to the Director, Regulation Reform.

Departmental AOs should make contemporaneous notes where a person is uncooperative or breaches a direction.

Infringements

On 28 March 2020, the Public Health and Wellbeing Regulations 2019 were amended to create four new infringement offences. These are:

Table 1 List of infringements

Section (PHWA)	Description	Amount
s.183	Hinder or obstruct an authorised officer exercising a power without reasonable excuse (5 penalty units).	5 penalty units (PU)
s.188(2)	Refuse or fail to comply with a direction by CHO to provide information made under s.188(10 without a reasonable excuse.	10 PU natural person, 30 PU body corporate
s.193(1)	Refuse or fail to comply with a direction given to, or a requirement made or, a person in the exercise of a public health risk powers (10 penalty units for natural person and 60 penalty units for body corporate).	10 PU natural person, 30 PU body corporate
s.203(1)	Refuse or fail to comply with a direction given to, or a requirement made or, a person in the exercise of a public health risk powers (10 penalty units for natural person and 60 penalty units for body corporate).	10 PU natural person, 30 PU body corporate

Policy and procedure on unaccompanied minors

Instances where an unaccompanied minor is captured by a detention order must be managed on a case by case basis.

In general, there is a presumption that there are no exemptions granted to mandatory quarantine. The issues in relation to mandatory quarantine of unaccompanied minors include: where this occurs, and with what adult supervision.

Preliminary legal advice is that the State could issue a detention order to a person under 18 years who is unaccompanied outside the home (a person in the care of the state) if certain conditions are met. These must include:

- AO has to check in regularly
- Person can easily contact parent / guardian
- Has adequate food
- Remote education is facilitated.

A detention notice for minors to undertake detention outside of a hotel will be supplied in this protocol shortly.

There is guidance for AOs on how to comply with the Charter of Human Rights in relation to unaccompanied minors at Appendix 4.

When an unaccompanied minor normally resides outside Victoria

It is proposed that where there is no clear alternative, an unaccompanied minor who normally resides outside of Victoria may be facilitated to undertake detention in their normal home state of residence, with appropriate risk management of any possible exposures to others on a domestic flight out of Victoria to that state. The department will need to be satisfied that the receiving state will take the person under 18 years and manage public health risks.

When an unaccompanied minor is normally resident in Victoria

It is proposed that an adult (who is not themselves a returned overseas traveller) who supervises a minor should join that minor at a place of detention. If that occurs, the adult should then remain with that person in quarantine although there is no legislative power to issue a direction to that adult to detain the adult.

If an unaccompanied minor who normally resides in Victoria is unable to be joined by a parent / guardian (for example because that parent / guardian has other caring duties and cannot thus join the minor in detention) then on a case by case basis, an assessment will be undertaken to identify whether detention is to be served in the home.

An alternative arrangement (i.e. parents join them in quarantine or quarantine at home) to self detention is to be considered for an unaccompanied minor. Please also see **Appendix 3.**

If a child is quarantined at home with their parents, a detention notice should still be provided to the child and parents outlining the same requirements for children as if they were in quarantine in a hotel, together with the guidance about advice to close contacts in quarantine. Legal services will adapt notices for that purpose.

AOs monitoring unaccompanied minors should have current Working With Children Checks and understand their reporting requirements under the Reportable Conduct Scheme.

When a minor is detained at their home

If it is determined to be appropriate to detain a child at home after a risk assessment, the arrangement will involve:

- Issuing a detention order naming the specific home and / or parts of the home, and
- The detention order will be accompanied by advice on minimising risk of transmission to others in the home where the minor is detained (equivalent to advice to close contacts in quarantine); and
- An Authorised Officer will undertake a process to undertake a review each day in the manner required by the Act.

When an unaccompanied minor is detained in a hotel

If an unaccompanied minor is detained in a hotel without parents, a specific notice and process is below.

- A Detention Notice – Solo Children, is found at **Appendix 5.**
- A guideline for authorised officers in this respect is found at **Appendix 4**.

This is a more intensive process for the authorised officers, which is commensurate with the additional risk of quarantining a child because the child is subject to the care of the Chief Health Officer and the department.

Working with Children Checks and Child Safe Standards

The department will work with Department of Justice and Community Safety to facilitate Working with Children Checks for Authorised Officers.

Escalation of issues

Should an AO become aware of any concern about a child, the AO must:

- contact the department's welfare teams immediately. Child Protection contact details for each Division: https://services.dhhs.vic.gov.au/child-protection-contacts. West Division Intake covers the City of Melbourne LGA: REDACTED
- contact after hours child protection team on 13 12 78 if an AO thinks a child may be harmed and Victoria Police on 000 if the immediate safety of a child is at risk.

DRAFT for review - This process is under development.

Departure – release from mandatory detention

Background

Prior to release of a person being detained, they will be provided with an end of detention letter Appendix 7: End of Detention Notice or **Appendix 8:** End of Detention Notice (confirmed case or respiratory illness symptoms) that confirms release details and specifies requirements to follow other relevant directions post release, dependant of the outcome of their final health check. Detention is 14 days from the date of arrival and ends at 12am on the last day. No-one will be kept past their end of detention.

Responsibilities

Departmental staff/Department of Jobs, Precincts and Regions to notify the person in detention that:

- they will be due for release from detention in 48 hours
- a health check to determine their status is recommended
- provide information for people exiting quarantine on transport and other logistical matters.

Health check

- In accordance with section 200(6) of the PHWA, the daily health check will be used to review the persons continued detention. In order to assess whether the person has fulfilled their 14-day quarantine period as required under the direction and detention notice.
- The health checks on the second last day prior to the 14-day period ending must be used to make an assessment of whether the person is well, symptomatic or positive.
- Everyone will be offered a voluntary temperature and symptom check by a nurse around 24 hours before release.
- If people being detained have a temperature or other symptoms of coronavirus before leaving or at the health check, this will not affect the completion of their detention. They will not be detained for longer than the 14-day quarantine period, even if they have symptoms consistent with coronavirus. However, if they do have symptoms at the health check, when they are released, they will need to seek medical care and self-isolate as appropriate, as do all members of the community.

Checkout process

- The release process will consist of an organised check out procedure (the compliance check out). This will mean people being detained will be released in stages throughout a set time period on the day of release. Travelling parties will be brought down to reception in stages to complete the check out process. People being detained will also need to settle any monies owing to the hotel for additional meals and drinks if they have not already done so. Physical distancing must be maintained throughout this process.
- Prior to the departure of people being detained, they will be given a compliance form with their documented end date and time of detention. The DHHS authorised officer will confirm the period of detention with people being detained and will ask them to sign the compliance form. They need to be signed out by a DHHS authorised officer before you they can leave.
- Transportation will be organised for you.
- Further information is available in **Appendix 9**: Guidance Note

Occupational health and safety (OHS) for Authorised Officers

Purpose

The purpose of this section is to provide an occupational health and safety procedure for department AOs when attending off site locations during the current State of Emergency.

Health Emergency

Coronaviruses are a large family of viruses that cause respiratory infections. These can range from the common cold to more serious diseases. COVID-19 is the disease caused by a new coronavirus. It was first reported in December 2019 in Wuhan City in China.

Symptoms of COVID-19 can range from mild illness to pneumonia. Some people will recover easily, and others may get very sick very quickly which in some cases can cause death.

Compliance Activity

On 16 March 2020 a State of Emergency was declared in Victoria to combat COVID-19 and to provide the Chief Health Officer with the powers he needs to eliminate or reduce a serious risk to the public.

Under a State of Emergency, Authorised Officers, at the direction of the Chief Health Officer, can act to eliminate or reduce a serious risk to public health by detaining people, restricting movement, preventing entry to premises, or providing any other direction an officer considers reasonable to protect public health.

Using a roster-based system, AOs will be placed on call to exercise authorised powers pursuant to section 199 of the PHWA. **AOs compliance role is only to exercise the powers under section 199 of the Act, any arrests, including moving people into detainment or physical contact a person must be managed by Victoria Police**.

OHS

OHS is a shared responsibility of both the employer and the employee. Officers must raise hazards, concerns and incidents with REDACTED

One of the foremost issues associated with site attendance is the 'uncontrolled environment' that exists. AOs can be exposed to infectious diseases (such as COVID-19), confrontational and/or aggressive members of the public who may be drug affected, mentally ill or intellectually impaired. The very nature of this work is likely to be perceived as invasive and can provoke a defensive response.

Risks can be minimised by maintaining routine safe work practices and proper planning. Prior to any site visit, risks and hazards should be identified and assessed.

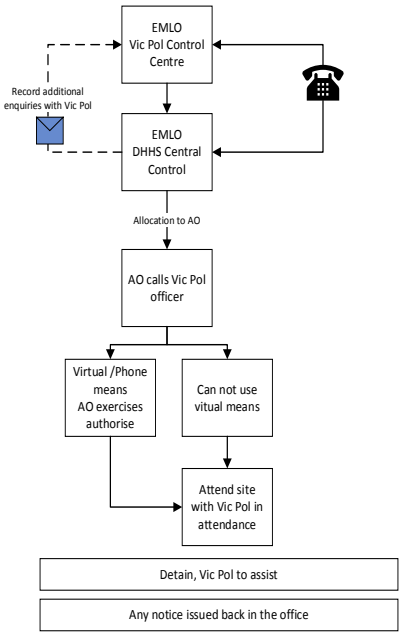
Officers and managers both have a shared responsibility for occupational health and safety. All employees have a responsibility to report and discuss hazards or perceived hazards, by bringing this to the managers attention.

Fatigue

AOs will be rostered on a rotating basis, with the aim of mitigating the risk of fatigue. Fatigue may impede decision making capability and when driving a motor vehicle to a location. When fatigue is identified please make this known to your manager.

To mitigate the risk of fatigue, AOs should be aware of any fatigue they may have. A good tool to use to help officers identify their level of fatigue is to use the following calculator:
http://www.vgate.net.au/fatigue.php

AOs are required to hold a valid motor vehicle licence and are required to adhere to the requirements of the department's driving policy. Information about this policy can be found on the DHHS intranet site.



Risk assessment before attendance | Personal Protection

Officers must only take a direction to attend a site with the approval of the Central DHHS emergency Management Liaison Officer or DHHS duty manager. An officer must only attend a location where there is the confirmed attendance of the Victoria Police.

In the first instance, officers are required to use technology (i.e: mobile phone, Facetime, Skype) to exercise their authority. This aims to protect officers from attending an uncontrolled environment, where the risk of harm is increased.

Before attending a site, whether an airport or a hotel, the officer should make themselves familiar with the recommendations produced by the Australian Government and the Department of Health and Human Services, in the protection against COVID-19.

Interventions are known as 'transmission reduction, or 'physical distancing' measures. Officers can take the following personal measure to reduce their risk of exposure to COVID-19. Officers with pre-existing medical conditions that put them more at risk of COVID-19, should discuss this with their medical practitioner and manager.

Personal measures to reduce risk the risk of exposure to COVID-19 include:

- Stay healthy with good nutrition, regular exercise, sensible drinking, sleeping well, and if you are a smoker, quitting.
- Wash your hands often with soap and water for at least 20 seconds, especially after you have been in a public place, or after blowing your nose, coughing, sneezing, or using the toilet. If soap and water are not readily available, use a hand sanitiser that contains at least 60 per cent alcohol.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Cover your nose and mouth with a tissue when you cough or sneeze. If you don't have a tissue, cough or sneeze into your upper sleeve or elbow.
- Stop shaking hands, hugging or kissing as a greeting.
- Ensure a **distance of 1.5 metres** is kept between yourself and others.
- Get vaccinated for flu (influenza) as soon as available. This could help reduce the risk of further problems. *Note: the department covers expenses for vaccines, speak to your manager for more details.*
- Clean and disinfect high touch surfaces regularly, for example: telephones, keyboards, door handles, light switches and, bench tops.

When an officer is called to attend the airport or a hotel to exercise powers in relation to the Direction and Detention notice they should take a **risk-based approach** and assess the most suitable way to reduce harm to themselves. Before attending, the officer must obtain information such as:

- Is the person being detained a positive case of COVID-19?
- Has the person being detained been recently in close contact with a positive case of COVID-19?
- Has the person being detained recently returned from overseas within the last 14 days?

Officers are required to use their discretion and take into account their own personal safety. The Department of Health and Human Services has provided the following PPE:

- Face mask (N95 or equivalent)
- Gloves
- Hand Sanitizer

- The following is only a guide for AOs to consider. AOs going onto hotel the floors with persons subject to detention must wear gloves and masks. There should be P2 masks for AO's at the hotels (in addition to the surgical masks).

• PPE	Guide
• Face mask	When there is known case of COVID-19, or an a person subject to detenti has been recently exposed to COVID-19
• Gloves	Always
• Hand Sanitizer / Soap	Always
• Social Distancing of at • least 1.5 meters	Always

Known risks and hazards

Hazard	Risk	Mitigate
COVID-19 infection	Serious illness / death	Follow personal protective measures
Fatigue	Impaired decisions / driving to site	In the first instance use virtual technology to perform duties Use fatigue calculator http://www.vgate.net.au/fatigue.php
Physical Injury	Low / Medium	Only attend a site with Victoria Police
Other infectious agents		Follow personal protective measures

Appendix 1 - Permission for temporary leave from detention

PERMISSION FOR TEMPORARY LEAVE FROM DETENTION

Public Health and Wellbeing Act 2008 (Vic)

Section 200

An Authorised Officer has granted you permission to leave your room based on one of the grounds set out below. This is temporary. You will be supervised when you leave your room. You must ensure you comply with all the conditions in this permission and any directions an Authorised Officer gives you. You must return to your room at the time specified to finish your detention. Speak to your supervising Authorised Officer if you require more information.

Temporary leave

(1) You have arrived in Victoria from overseas, on or after midnight on 28 March 2020 and have been placed in detention, pursuant to a Direction and Detention Notice that you were provided on your arrival in Victoria (**Notice**).

(2) This Permission for Temporary Leave From Detention (**Permission**) is made under paragraph 4(1) of the Notice.

Reason/s for, and terms of, permission granting temporary leave

(3) Permission for temporary leave has been granted to: _____ _____ [insert name] for the following reason/s [tick applicable]:

(a) for the purpose of attending a medical facility to receive medical care:

☐ **Name of facility:** _____

Time of admission/appointment:_____

Reason for medical appointment:_____

☐ (b) where it is reasonably necessary for physical or mental health:

Reason leave is necessary:_____

Proposed activity/solution:_____

☐ (c) on compassionate grounds:

Detail grounds:_____

(4) The temporary leave starts on _____

and ends on _____ [insert date and time].

_____ **Signature of Authorised Officer**

Name of Authorised Officer: _____

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

Conditions

(5) You must be supervised **at all times**/may be supervised *[delete as appropriate]* while you are out of your room. You are not permitted to leave your hotel room, even for the purpose contained in this Permission, unless you are accompanied by an Authorised Officer.

(6) While you are outside your room you must practice social distancing, and as far as possible, maintain a distance of 1.5 metres from all other people, including the Authorised Officer escorting you.

(7) When you are outside your room you must refrain from touching communal surfaces, as far as possible, such as door knobs, handrails, lift buttons etc.

(8) When you are outside your room you must, **at all times**, wear appropriate protective equipment to prevent the spread of COVID-19, if directed by the Authorised Officer escorting you.

(9) When you are outside your room you must, **at all times**, comply with any direction given to you by the Authorised Officer escorting you.

(10) At the end of your temporary leave, you will be escorted back to your room by the Authorised Officer escorting you. You must return to your room and remain there to complete the requirements under the Notice.

(11) Once you return to the hotel, **you must proceed immediately to the room** you have been allocated above in accordance with any instructions given to you.

(12) You must comply with any other conditions or directions the Authorised Officer considers appropriate.

(Insert additional conditions, if any, at Annexure 1)

Specific details

(13) Temporary leave is only permitted in limited circumstances, to the extent provided for in this Permission, and is subject to the strict **conditions** outlined at paragraph 3. You must comply with these conditions **at all times** while you are on temporary leave. These conditions are reasonably necessary to protect public health, in accordance with section 200(1)(d) of the *Public Health and Wellbeing Act 2008* (Vic).

(14) Permission is only granted to the extent necessary to achieve the **purpose** of, and for the **period of time** noted at paragraph 2 of this Permission.

(15) Nothing in this Permission, invalidates, revokes or varies the circumstances, or period, of your detention, as contained in the Notice. The Notice continues to be in force during the period for which you are granted permission for temporary leave from detention. The Notice continues to be in force until it expires.

Offences and penalties

(16) It is an offence under section 203 of the Act if you refuse or fail to comply with the conditions set out in this Permission, unless you have a reasonable excuse for refusing or failing to comply.

(17) The current penalty for an individual is $19,826.40.

Appendix 2 Guidance Note: Permission for Temporary Leave from Detention

How do you issue a Permission for Temporary Leave from Detention?

It is recommended that Authorised Officers take the following steps when issuing a Permission for Temporary Leave from Detention:

Before you provide the Permission for Temporary Leave from Detention

- carefully consider the request for permission and consider the grounds available under paragraph 4(1) of the Direction and Detention Notice – which include:
  - for the purposes of attending a medical facility to receive medical care; or
  - where it is reasonably necessary for your physical or mental health; or
  - on compassionate grounds.
- complete all sections of the Permission, including clearly documenting the reasons for the Permission, date and time when the temporary leave is granted from and to, and whether the person will be supervised by the authorised officer during the temporary leave
- ensure the reference number is completed.

When you are provide the Permission for Temporary Leave from Detention

- you must warn the person that refusal or failure to comply without reasonable excuse, is an offence;
- explain the reason why it is necessary to provide the Permission and the conditions which apply to the temporary leave (including that the person is still subject to completing the remainder of the detention once the temporary leave expires, and the Permission is necessary to protect public health);
- provide a copy of the Permission to the person, provide them with time to read the Permission and keep the completed original for the department's records.

NB If it is not practicable to explain the reason why it is necessary to give the Permission, please do so as soon as practicable after Permission has been exercised.

What are the requirements when you are granting a permission to a person under the age of 18?

The same requirements set out above apply when issuing a Permission to an unaccompanied minor. However, the supervising Authorised Officer must have Working With Children Check, have regard to the special conditions in the Direction and Detention Notice as well as the person's status as a child.

What other directions can you give?

Section 200(1)(d) of the PHWA sets out an emergency power that allows an authorised officer to give any other direction that the authorised officer considers is reasonably necessary to protect public health.

What are your obligations when you require compliance with a direction?

Exercising this power imposes several obligations on departmental authorised officers including that an authorised officer must, before exercising any emergency powers, warn the person that refusal or failure to comply without reasonable excuse, is an offence.

Appendix 3 Guidance: Exemptions under Commonwealth law

Australian Government
Department of Health

Coronavirus disease (COVID-19)

Exemptions to the 14 day mandatory quarantine period for international travellers

The Australian Health Protection Principal Committee (AHPPC) recognise that there should be some exemptions from quarantine requirements for specific industry groups, provided they adhere to specified risk mitigations measures. These specific exemptions are recommended because of the industry infection prevention requirements, training these groups have undergone, and the vital role of these industries in Australia.

While these are national recommendations, mandatory quarantine is enforced under state and territory public health legislation. Individual states and territories may choose to implement additional requirements at the point of arrival.

Some jurisdictions may also have additional quarantine requirements upon entry to the state or territory. Depending on the jurisdiction, this could mean that an international traveller is required to go into mandatory quarantine at the first point of arrival into Australia, and further quarantine upon entry to another jurisdiction.

The following groups are recommended to be exempt from the 14 day mandatory quarantine requirements when entering Australia. While these groups are exempt from mandatory quarantine, **all** arrivals into Australia **must** continue to practise social distancing, cough etiquette and hand hygiene. Other requirements, such as self-isolation, may still apply and are outlined below.

Aviation crew

International flight crew (Australian residents/citizens)

- Are not required to undertake 14 days of mandatory quarantine on arrival.
- Are not required to complete the Isolation Declaration Card.
- Are not required to self-isolate.

International flight crew (foreign nationals)

- Are not required to undertake 14 days of mandatory quarantine on arrival.
- Are not required to complete the Isolation Declaration Card.
- Must self-isolate in their hotel on arrival until their next flight.
- Must use privately organised transport to transfer to and from hotels between flights.
- May fly domestically to their next point of departure from Australia if required.

Domestic flight crew

- Exempt from self-isolation requirements *except when a state or territory specifically prohibits entry.*

Maritime crew (excluding cruise ships)

- Are not required to undertake 14 days of mandatory quarantine on arrival into Australia. They are therefore not required to complete the Isolation Declaration Card.
- Must proceed directly to the vessel on arrival.

- If access to the vessel is not immediate, crew must self-isolate at their accommodation during any lay-over period.
- May travel domestically and/or take a domestic flight to meet their vessel at the next point of departure if required.
- At the completion of their shifts, they are not required to go into mandatory 14 days quarantine, but must undertake 14 days self-isolation.
- Time at sea counts towards the 14 days of self-isolation if no illness has been reported on-board. Therefore crew signing off commercial vessels that have spent greater than 14 days at sea, with no know illness on-board, do not need to self-isolate on arrival.

Unaccompanied minors

Unaccompanied minors will be allowed to travel domestically after entering Australia to self-quarantine with a parent or guardian at their home.

Transit passengers

- International transit passengers arriving into Australia are able to depart on another international flight if the following conditions are met:
  - If the individual has up to 8 hours until the departing international flight, they must remain at the airport and be permitted to onward travel, maintaining social distancing and hand hygiene.
  - If 8-72 hours before the departing flight, they must go to mandatory quarantine at the state designated facility until the time of the departing flight.
- No domestic onward travel is allowed, even if this is to meet a departing international flight. These people should go into mandatory quarantine at the state designated facility at the first point of arrival.

Diplomats

- Australia has legal obligations under the Vienna Convention to ensure diplomats freedom of movement and travel, and protection from detention. Diplomats are not required to undertake 14 days of mandatory quarantine on arrival into Australia. They are therefore not required to complete the Isolation Declaration Card.
- Diplomats should self-isolate at their mission or in their usual place of residence on arrival for 14 days.
- Diplomats must continue to practise social distancing, cough etiquette and hand hygiene.

Compassionate or medical grounds

Applications on medical or compassionate grounds should be submitted to the relevant state or territory who will consider requests on a case-by-case basis.

Contact details for state or territory public health agencies are available at www.health.gov.au/state-territory-contacts.

Where can I get more information?

For the latest advice, information and resources, go to www.health.gov.au.

Call the National Coronavirus Helpline on 1800 020 080. This line operates 24 hours a day, seven days a week. If you require translating or interpreting services, call 131 450.

Appendix 4 - Guidance note: Ensuring physical and mental welfare of international arrivals in individual detention (unaccompanied minors)

Introduction

You are an officer authorised by the Chief Health Officer under section 199(2)(a) of the *Public Health and Wellbeing Act 2008* (Vic) to exercise certain powers under that Act. You also have duties under the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**Charter**).

These Guidelines have been prepared to assist you to carry out your functions in relation to Victorian unaccompanied minors who have arrived in Victoria and are subject to detention notices, requiring them to self-quarantine in a designated hotel room for 14 days in order to limit the spread of Novel Coronavirus 2019 (**2019-nCoV**) where no parent, guardian or other carer (**parent**) has elected to join them in quarantine (a **Solo Child Detention Notice**).

As part of your functions, you will be required to make decisions as to whether a person who is subject to a Solo Child Detention Notice should be granted permission to leave their room:

- for the purposes of attending a medical facility to receive medical care; or
- where it is reasonably necessary for their physical or mental health; or
- on compassionate grounds.

Authorised Officers are also required to review the circumstances of each detained person at least once every 24 hours, in order to determine whether their detention continues to be reasonably necessary to eliminate or reduce a serious risk to public health.

Your obligations under the Charter of Human Rights and Responsibilities Act 2006

You are a public officer under the Charter. This means that, in providing services and performing functions in relation to persons subject to a Detention Notice you must, at all times:

- act compatibly with human rights; and
- give 'proper consideration' to the human rights of any person(s) affected by your decisions.

How to give 'proper consideration' to human rights

'Proper consideration' requires you to:

- **first**, understand in general terms which human rights will be affected by your decisions (these rights are set out below under 'relevant human rights');
- **second**, seriously turn your mind to the possible impact of your decisions on the relevant individual's human rights, and the implications for that person;
- **third**, identify the countervailing interests (e.g. the important public objectives such as preventing the further spread of 2019-nCoV, which may weigh against a person's full enjoyment of their human rights for a period of time); and
- **fourth**, balance the competing private and public interests to assess whether restricting a person's human rights (e.g. denying a person's request to leave their room) is justified in the circumstances.

Relevant human rights

The following human rights protected by the Charter are likely to be relevant to your functions when conducting daily wellbeing visits and when assessing what is reasonably necessary for the physical and mental health of children who are subject to Solo Child Detention Notices:

- The right of children to such protection as is in their best interests (s 17(2)). As the Solo Child Detention Notices detain children in circumstances where no parent has elected to join them in quarantine, greater protection must be provided to these children in light of the vulnerability that this creates. Where possible the following additional protection should be provided:
- You should undertake two hourly welfare checks while the child is awake and once overnight. You should ask the child to contact you when they wake each morning and let you know when they go to sleep so that this can be done.
- You should ask the child if they have any concerns that they would like to raise with you at least once per day.
- You should contact the child's parents once per day to identify whether the parent is having contact with the child and whether the parent or child have any concerns.
- You should ensure that where the child does not already have the necessary equipment with them to do so (and their parent is not able to provide the necessary equipment) the child is provided with the use of equipment by the department to facilitate telephone and video calls with their parents. A child must not be detained without an adequate means of regularly communicating with their parents.
- You should ensure that where the child does not already have the necessary equipment with them to do so (and their parent is not able to provide the necessary equipment) the child is provided with the use of equipment by the department to participate in remote education if that is occurring at the school they are attending. Within the confines of the quarantine you should obtain reasonable assistance for the child in setting up that computer equipment for use in remote education.
- You should allow the child's parents to bring them lawful and safe items for recreation, study, amusement, sleep or exercise for their use during their detention. This should be allowed to occur at any time within business hours, and as many times as desired, during the detention.
- The rights to liberty (s 21) and freedom of movement (s 12), and the right to humane treatment when deprived of liberty (s 22). As the Solo Child Detention Notices deprive children of liberty and restrict their movement, it is important that measures are put in place to ensure that the accommodation and conditions in which children are detained meet certain minimum standards (such as enabling parents to provide detained children with food, necessary medical care, and other necessities of living). It is also important that children are not detained for longer than is reasonably necessary.
- Freedom of religion (s 14) and cultural rights (s 19). Solo Child Detention Notices may temporarily affect the ability of people who are detained to exercise their religious or cultural rights or perform cultural duties; however, they do not prevent detained persons form holding a religious belief, nor do they restrict engaging in their cultural or religious practices in other ways (for example, through private prayer, online tools or engaging in religious or cultural practices with other persons with whom they are co-isolated). Requests by children for additional items or means to exercise their religious or cultural practices will need to be considered and accommodated if reasonably practicable in all the circumstances.
- The rights to recognition and equality before the law, and to enjoy human rights without discrimination (s 8). These rights will be relevant where the conditions of detention have a disproportionate impact on detained children who have a protected attribute (such as race or disability). Special measures may need to be taken in order to address the particular needs and vulnerabilities of, for example Aboriginal persons, or persons with a disability (including physical and mental conditions or disorders).
- The rights to **privacy, family and home** (s 13), **freedom of peaceful assembly** and **association** (s 16) and the **protection of families** (s 17). Solo Child Detention Notices are likely to temporarily

restrict the rights of persons to develop and maintain social relations, to freely assemble and associate, and will prohibit physical family unification for those with family members in Victoria. Children's rights may be particularly affected, to the extent that a Solo Child Detention Notice results in the interference with a child's care and the broader family environment. It is important, therefore, to ensure children subject to Solo Child Detention Notices are not restricted from non-physical forms of communication with relatives and friends (such as by telephone or video call). Requests for additional items or services to facilitate such communication (e.g. internet access) will need to be considered and accommodated if reasonably practicable in all the circumstances.

Whether, following 'proper consideration', your decisions are compatible with each these human rights, will depend on whether they are reasonable and proportionate in all the circumstances (including whether you assessed any reasonably available alternatives).

General welfare considerations

All persons who are deprived of liberty must be treated with humanity and respect, and decisions made in respect of their welfare must take account of their circumstances and the particular impact that being detained will have on them. Mandatory isolation may, for some people, cause greater hardship than for others – when performing welfare visits you will need to be alert to whether that is the case for any particular person.

In particular, anxieties over the outbreak of 2019-nCoV in conjunction with being isolated may result in the emergence or exacerbation of mental health conditions amongst persons who are subject to Detention Notices.

If you have any concerns about the mental health of a detained person, you should immediately request an assessment of mental health be conducted and ensure appropriate support is facilitated. Hotel rooms are not normally used or designed for detention, so you should be aware that a person who is detained in a hotel room could have greater opportunity to harm themselves than would be the case in a normal place of detention.

Additional welfare considerations for children

Children differ from adults in their physical and psychological development, and in their emotional and educational needs. For these reasons, children who are subject to Solo Child Detention Notices may require different treatment or special measures.

In performing functions and making decisions with respect to a detained person who is a child, the best interests of the child should be a primary consideration. Children should be given the opportunity to conduct some form of physical exercise through daily indoor and outdoor recreational activities. They should also be provided with the ability to engage in age-appropriate activities tailored to their needs.

Each child's needs must be assessed on a case-by-case basis. Requests for items or services to meet the needs of individual children will need to be considered and accommodated if reasonably practicable in all the circumstances.

Where available, primary school age children should be allocated rooms that have an outside area where it is safe for active physical play to occur (not a balcony) and consideration should be given to allowing small children access to any larger outdoor areas that are available within the hotel, where possible within relevant transmission guidelines. Although each child’s needs must be assessed daily and individually, it can be assumed that it will have a negative effect on a child’s mental health to be kept in the same room or rooms for two weeks without access to an adequate outdoor area in which to play.

Balancing competing interests

However, the best interests of children and the rights of anyone who is subject to a Solo Child Detention Notice will need to be balanced against other demonstrably justifiable ends; for example, lawful, reasonable and proportionate measures taken to reduce the further spread of 2019-nCoV.

It is your role to undertake this balance in your welfare checks, based on the information and advice that you have from the department and on the information provided to you by the children that you are assessing.

Appendix 5 Direction and Detention Notice – Solo Children

To be added

Appendix 6 Other issues

Welfare and health service provision

- DHHS Welfare team to conduct a welfare check (as specified below) each day.
- DHHS welfare officers conducting welfare checks phone and email REDACTED and AO individually to alert AO of medical and welfare issue.
- Residents will be provided with a resident satisfaction survey to complete each week.
- Residents can seek review by the nurse 24 hours a day if required.
- 24 hour on-call medical support will be available for on call subject to demand. This will initially be provided by a Field Emergency Medical Officer, and subsequently through a locum general practice service.
- Medical care is organised by Deputy State Health Coordinator. Deliverables include:
  - Primary care assessments;
  - Prescription provision;
  - 24 hour access to a general practitioner;
  - 24 hour access to nursing assessment.
- It is advisable that where possible, individuals who are in detention are linked to receive telehealth care from their normal general practice provider.

Safety / mental health

If there are concerns about the safety or mental health of passengers, the process is as follows:

- The nurse will review via phone (or in person if required with appropriate PPE).
- If escalation is required, the nurse will contact the Anxiety Recovery Centre Victoria for psychosocial support.
- Mental health triage at RMH/the Alfred can be contacted as a back-up.
- If the person is acutely unwell or at serious risk, urgent ambulance should be arranged by calling 000.
- Daily welfare check phone calls should be implemented thereafter if not already implemented.

Family violence (FV)

If there are concerns about family violence / the safety of women and children, the process is as follows:

- Case worker is called to review via phone initially or in person if required (with appropriate PPE).
- A separate room may need to be organised to facilitate the review away from the other family members.
- If deemed necessary, separate rooms should be organised to separate the family members.
- Case worker to review again as required.

Alcohol and other drugs

If there are concerns about alcohol or other substance abuse or withdrawal:

- Consider nurse/medical review.
- Provide numbers for support services (listed below).
- Preference for provision of standard drinks to a limit rather than prescribing diazepam for alcohol withdrawal.
- Prescriptions – Schedule 8 prescriptions for drug-dependent patients can only be provided after discussion with the DHHS Medicines and Poisons Branch.

Exercise and fresh air

- If the room has a balcony, ensure the residents can access it for fresh air.
- Advise residents to open windows/balconies where possible for fresh air and ventilation.
- If it is possible for residents to go outside to take some exercise for organised/supervised short periods of time, this should be facilitated where possible. Residents should ensure physical distancing is practised during this period. Only well residents from the same room should be able to go out to exercise at the same time.

Appendix 7: End of Detention Notice

Public Health and Wellbeing Act 2008 (Vic)

Section 200

Subject to the conditions below, this Notice is evidence that this detainee has completed their period of detention under a *Direction and Detention Notice* issued to reduce or eliminate the serious public health risk posed by COVID-19.

Detention Notice

You have arrived in Victoria from overseas, on or after midnight on 28 March 2020 and have been placed in detention, pursuant to a Direction and Detention Notice that you were provided on your arrival in Victoria (**Notice**).

Details of Detention Notice

Name of Detainee:_____

Date of Detainment and Detention Notice:_____

Place of Detention:_____

End of Detention Notice

In accordance with section 200(6) of the *Public Health and Wellbeing Act 2008,* I have reviewed your continued detention.

On review of the Notice, I have made the following findings:

you will have served the required detention period by _____[*insert date*]; and

you have not started exhibiting any symptoms of COVID-19.

In consideration of the above circumstances, I have decided that your continued detention is not reasonably necessary to eliminate or reduce a serious risk to public health.

I advise that your detention pursuant to section 200(1)(a) of the *Public Health and Wellbeing Act 2008* (Vic) and the Notice will end on _____ [*insert date*] after you have been discharged by an Authorised Officer from _____ [*insert place of detention*] and have commenced transportation to your ordinary residence.

[*If lives in Victoria*] Although you are no longer to be detained pursuant to the Notice, you are required to comply with all directions currently in force in Victoria. This includes the Stay at Home Directions (No 2) (**Direction**), as amended from time to time. Pursuant to the Direction, you are required to travel directly to the premises where you ordinarily reside within Victoria, and remain there unless you are leaving for one of the reasons listed in the Direction.

[*If lives outside Victoria*] I note that you are ordinarily a resident in _____ [*insert State or Territory*] and that arrangements have been made for you to return home. While you remain in the State of Victoria, you are required to comply with all directions in operation in Victoria. Once you have returned home, you are required to comply with the Directions and/or Orders in place in your home jurisdiction, including any directions that may require you to isolate for a further 14 day period.

In the event that you start to experience symptoms of COVID-19, it is important that you self-isolate and, if necessary, contact your General Practitioner or local Public Health Unit.

End of Detention Instructions

Your detention **does not end** until the time stated in paragraph 0 of this notice. Until that time, at which you will be discharged from detention, you must continue to abide by the requirements of your detention, as contained in the Notice.

You **must not** leave your hotel room until you have been collected by an Authorised Officer [*OR*] You **must not** leave your hotel room until _____ [*insert time and date*], at which time you are permitted to travel to the hotel lobby to meet an Authorised Officer to be discharged from detention.

When leaving detention you **must** adhere to the following safeguards:

if provided to you, you **must** wear personal protective equipment;

you **must** refrain, as far as possible, from touching communal surfaces, such as handrails, elevator buttons and door handles;

you **must** where possible, engage in social distancing, maintaining a distance of 1.5 metres from other people; and

upon leaving your hotel room, you **must** go straight to the foyer for discharge and then immediately after travel to your transportation and travel directly to your ordinary residence.

These steps are to ensure your protection, and reduce the risk of you becoming infected with COVID-19 by any persons detained in the hotel, or in the community, who may have COVID-19.

Until your detention has concluded, you must follow instructions from Authorised Officer/s and any other conditions set out.

2 Offence and penalty

(1) It is an offence under section 203 of the Act if you refuse or fail to comply with the directions set out in this notice, unless you have a reasonable excuse for refusing or failing to comply.

(2) The current penalty for an individual is $19,826.40.

_____ **Signature of Authorised Officer**

Name of Authorised Officer: _____

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

Appendix 8: End of Detention Notice (confirmed case or respiratory illness symptoms)

Public Health and Wellbeing Act 2008 (Vic)

Section 200

An Authorised Officer has decided to end your Direction and Detention Notice. This decision has been made following the mandatory review of your Direction and Detention Notice because you [*have returned a positive test for COVID-19*] *or* [*have started displaying symptoms of respiratory illness*].

Detention Notice

You have arrived in Victoria from overseas, on or after midnight on 28 March 2020 and have been placed in detention, pursuant to a Direction and Detention Notice that you were provided on your arrival in Victoria (**Notice**).

Details of End of Detention Notice

Name of Detainee:_____

Date Notice Made:_____

Date Notice Expires:_____

Place of Detention:_____

Medical Facility:_____

(if medical care is required)

COVID-19 Status or respiratory illness symptoms [tick applicable]:

COVID-19 confirmed*:* _____ *[insert date of test]*	☐	coughing	☐
fever or temperature in excess of 37.5 degrees	☐	sort throat	☐
congestion, in either the nasal sinuses or lungs	☐	body aches	☐
runny nose	☐	fatigue	☐

End of Detention Notice

In accordance with section 200(6) of the *Public Health and Wellbeing Act 2008,* I have reviewed your continued detention.

On review of the Notice, I have noticed that you [have been diagnosed with COVID-19] or [have exhibited the symptoms of respiratory illness, as outlined above at paragraph 2(8) *[delete as applicable*].

In consideration of the above, I do not believe that continued detention is reasonably necessary to eliminate or reduce a serious risk to public health because:

(a) [*if applicable*] You have been confirmed to have COVID-19 and will be required to self-isolate in accordance with the Isolation (Diagnosis) Direction, in a premises that is suitable for you to reside in, or a medical facility, until such a time you are notified that you no longer need to self-isolate and a clearance from isolation (self-isolation) is given;

(b) [*if applicable*] You are showing symptoms of respiratory illness and will be required to self-isolate in accordance with the Stay at Home Direction currently in force in Victoria and will need travel directly to your ordinary residence once you leave detention, and remain there unless you are permitted to leave for a reason specified in the Stay at Home Direction; and

(c) You are ordinarily a resident in Victoria.

(3) Compliance with Directions made by the Deputy Chief Health Officer is required to reduce or eliminate the serious risk to public health posed by COVID-19. It is essential that you [self-isolate in accordance with the Isolation (Diagnosis) Direction until such time as you are notified that you no longer need to self-isolate and a clearance from self-isolation is given] OR [return to your ordinary residence and remain there unless you are permitted to leave for a reason specified in the Stay at Home Direction. Please monitor your symptoms and seek appropriate medical care if required]. *[delete as applicable*].

(4) The Notice is ended subject to the directions below under paragraph 4. Non-compliance with these directions is an offence.

3 Conditions

You will be transited from the hotel where you have been detained to your ordinary residence / Premises for Isolation pursuant to Isolation (Diagnosis) Direction / medical facility [*delete as appropriate*] by an Authorised Officer. You may / will [*delete as appropriate*] be supervised during transit.

While you are transiting to your ordinary residence / Premises for Isolation pursuant to Isolation (Diagnosis) Direction / medical facility [*delete as appropriate*], you must refrain from touching communal surfaces, as far as possible, such as door knobs, handrails, lift buttons etc.

When you are transiting to your ordinary residence / Premises for Isolation pursuant to Isolation (Diagnosis) Direction / medical facility [*delete as appropriate*], you must, **at all times**, wear appropriate protective equipment to prevent the spread of COVID-19, if directed by the Authorised Officer.

You must practice social distancing, and as far as possible, maintain a distance of 1.5 metres from all other people, including any Authorised Officer escorting you.

When you are transiting to your ordinary residence / Premises for Isolation pursuant to Isolation (Diagnosis) Direction / medical facility [*delete as appropriate*], you must, **at all times**, comply with any direction given to you by any Authorised Officer escorting you.

4 Offence and penalty

(1) It is an offence under section 203 of the Act if you refuse or fail to comply with the directions and requirements set out in this notice and/or the Isolation (Diagnosis) Direction *[if applicable*], unless you have a reasonable excuse for refusing or failing to comply.

(2) The current penalty for an individual is $19,826.40.

_____ **Signature of Authorised Officer**

Name of Authorised Officer: _____

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

Appendix 9: Guidance Note

How to conclude a person's detainment under a *Direction and Detainment Notice* if they have served the required period of detainment, become a confirmed case of COVID-19 or have symptoms of respiratory illness

What do you have to do before you issue an End of Detention Notice?

- if the person has served 14 days of detention you must decide how to administer the completion of that person's detention arrangements:
  - selecting a time for the person to attend a foyer after the 14 day period has concluded - it is recommended that this occur in small groups of people who are practicing appropriate social distancing and with sufficient time between groups to avoid crowds. This will ensure Authorised Officers can safely discharge each detainee
  - collecting a person from their hotel room after the 14 day period has concluded – this approach should be carefully administered to ensure Authorised Officers can safely discharge and escort each person to their transport
- if a person's detainment is concluding because they have a confirmed case of COVID-19 or symptoms of respiratory illness they must be discharged when it is safe to do so – e.g. when other detained people are in their rooms, under full supervision etc.
- complete all sections of the Notice, including clearly documenting the reasons for the end of detention and the details recorded on the Direction and Detention Notice
- update all the registers and relevant records about the person's detainment arrangements
- ensure the reference number is completed.

When should you issue an End of Detention Notice?

- It is preferable that an End of Detention Notice be issued the day before a person's detainment is set to conclude – this will give the person adequate time to prepare (e.g. to pack their belongings) and ensure the orderly discharge of large groups of people.
- A notice may be provided earlier but it creates a risk that a person may develop COVID-19 symptoms before the day the detainment period must end.

What do you have to do when you issue an End of Detention Notice?

When you issue an End of Detention Notice you must:

- explain the reason why detention has ceased and is no longer necessary to eliminate or reduce a serious risk to public health
- advise that person of the arrangements being made for their discharge from detention (e.g. at an allocated time at the foyer; when they are escorted from their room etc)
- notify they person that although they are no longer subject to detention when they are discharged and leave the premises of their detention, they are still subject to the directions which are in force in Victoria, including
  - if they are ordinarily resident in Victoria, they are required to return immediately to their ordinary residence, where they must remain, in accordance with the Stay at Home Directions (No 2)
  - if they have a confirmed case of COVID-19, they must isolate at home in accordance with the Isolation (Diagnosis) Direction
- if the person is ordinarily resident outside of Victoria, notify the person of their travel arrangements and that they are to immediately travel to the airport to leave the State.

ANNEX 1

COVID-19 Compliance policy and procedures – Detention authorisation

Authorised Officers under the *Public Health and Wellbeing Act 2008*

Document Details

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Contents

Appendices

1 Purpose and background

1.1 Purpose

This purpose of this annex is to outline the compliance and enforcement functions and procedures for the direction and detention direction issued under the *Public Health and Wellbeing Act 2008* (PHWA).

This is an annex to the State plan 'Operation Soteria: Mandatory Quarantine for All Victorian Arrivals' which describes the overarching system in operation.

1.2 Background

A mandatory quarantine (detention) approach was introduced by the Victorian Government, consistent with the Commonwealth Government (Department of Health Information for International Travellers) through a policy that a detention order would be used for all people arriving from overseas into Victoria.

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

The policy is given effect through a direction and detention notice under the *Public Health and Wellbeing Act 2008.* The directions are displayed on the department's website at https://www.dhhs.vic.gov.au/state-emergency and were made by the Deputy Chief Health Officer or Chief Health Officer:

1.2.1 Objectives

The objectives of the plan for people returning from overseas to Victoria are:

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

2 Enforcement and Compliance command / roles and responsibilities / Business system

2.1 Enforcement and Compliance command structure

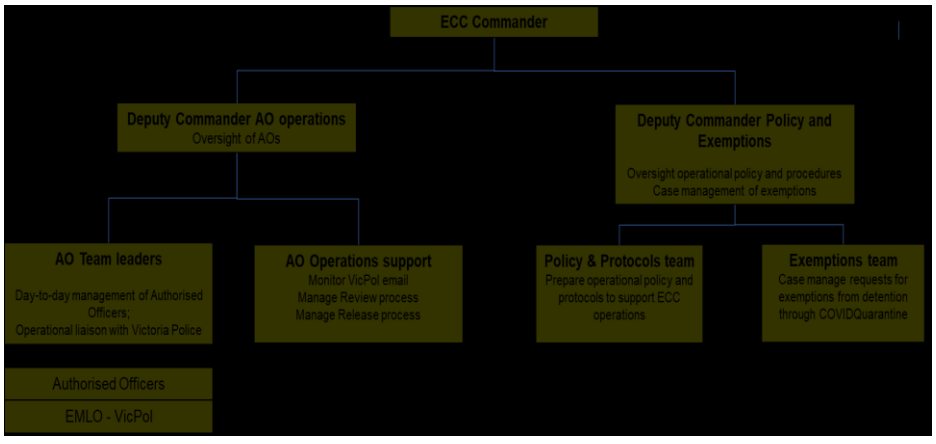

Figure { SEQ Figure * ARABIC }: Compliance command structure

2.2 Compliance cell roles and responsibilities

Table 1 Compliance cell roles

Role	Responsibilities
Enforcement and Compliance Commander	• Lead and provide oversight to compliance matters under all Public Health Directions. • Provide advice and input into complex compliance matters. • Provide advice and support to the Chief Health Officer and their delegate on compliance. • Daily review of those subject to detention
Deputy Commander AO operations	• Provide oversight to Authorised officers • Lead the provision of guidance to the AO Team Leaders. • Report on daily review of people being detained.
AO Operations support	• Undertake rostering, recruiting and onboarding of AOs • Monitor VicPol email address • Manage Review and Release Process
Senior AO	• Provide leadership to AOs. • First point of call for approving permissions.
AO	Primary responsible for: • administration of, and ensuring compliance with, the Direction and Detention Notices (27 March 2020 and 13 April 2020) • meeting obligations under the Public Health and Wellbeing Act
EMLO VicPol	• Liaise with Victoria Police
Deputy Commander Policy and Exemptions	• Oversight of operational policy and procedures • Case management of exemptions
Policy and Protocols team	• Prepare operational policy and protocols to support enforcement and compliance
Exemptions team	• Case manage requests for exemptions from detention • Manage COVIID Quarantine inbox.

2.3 Roles and responsibilities for other non-compliance cell staff involved in compliance

Table 2 Non-compliance cell staff at hotel

Role	Responsibility
DHHS Team Leader	• Supports the health and well-being of staff. • Liaises with airport command and staff from the Department of Jobs Precincts and Regions represented at the hotel. • Provides situational awareness and intelligence to inform transport providers, state-level emergency management arrangements and airport operations. • Provides a point of reference to all site-staff to help resolve operations, logistics or site-related issues and / or escalations required. • Ensures appropriate records management processes are in place.
DHHS and DJPR concierge staff	• Capture client personal needs, e.g. dietary, medication, allergies, personal hygiene needs. • Deliver hyper-care (concierge) services onsite. • Manage contracts with accommodation providers. • Manage transport arrangements from the airport and other locations detainees as permissioned by AOs. • Manage material needs including food and drink.
Nursing staff	• Provide 24 hour on-call medical support subject to demand. • Provide welfare to detainees through a daily welfare check — DHHS welfare officers email \COVIDQuarantine@dhhs.vic.gov.au and phone the site AO individually to alert AO of medical and welfare issues. • Provide a satisfaction survey for residents to complete each week.
Security	• Assist AOs in ensuring detainees comply with notices and permissions. This includes ensuring detainees do not leave hotel rooms, assisting with movement of detainees where they have permission to leave rooms, and assisting with release from detention.

2.4 COVID-19 Quarantine and Welfare System Compliance Application

The COVID-19 Quarantine and Welfare System is currently comprised of two elements:

- COVID-19 Compliance Application - This application supports AOs to maintain Direction and Detention notice and permissions records.
- COVID-19 Welfare Application (not part of Authorised Officer responsibilities and will partially accessible to certain senior team members).

A third element is under development for nursing staff to be able to enter health assessment data (partially accessible certain senior team members).

A **User Guide** is available to guide Authorised Officers.
Support email for users: **ComplianceandWelfareApplicationSupport@dhhs.vic.gov.au**
Support will be active between 8am and 8pm. You can email support for access issues, technical issues, application use questions. A **phone number** will also be provided shortly.

3 Authorised officers and powers

3.1 Key points

- Only AO's additionally authorised for the purposes of the public health risk and emergency powers can undertake administration and enforcement of the direction and detention notice.
- AOs must undertake several obligations before exercising powers.

3.2 Authorisation under the Public Health and Wellbeing Act for the purposes of the emergency order

Only VPS employees and council environmental health officers that are AOs under the PHWA and also authorised by the Chief Health Officer under section 199(2)(a) of the PHWA can exercise public health risk and emergency powers.

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

Note: Any AO that is unsure as to whether they have been authorised under s. 199 should contact the AO Operations support team prior to enforcing compliance with the Direction and Detention Notices.

While exercising their powers and monitoring compliance, AOs should be cognisant that persons subject to detention may be tired, emotional and stressed. AOs may need to use conflict negotiation, mediation skills and compassion to help persons settle into the new environment.

3.2.1 Emergency Powers and Offences

The Direction and detention notice is issued under s 200 of the PHW Act (emergency powers).

It is an offence under s 203 of the HPW Act if a person refuses or fails to comply with the direction in the direction and detention notice (unless there is a reasonable excuse for failing to comply). The maximum court penalty for an individual is 120 penalty units and 600 penalty units for a body corporate.

3.3 Authorised officer1 and Chief Health Officer obligations

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

3.3.1 Mandatory obligations for AOs

AOs have mandatory obligations that must be followed when carrying out functions. The table below summarises mandatory obligations.

Table { SEQ Table * ARABIC }: Mandatory obligations of AOs

Legislation	Obligations
Emergency powers and general powers in the *Public Health and Wellbeing Act 2008*	• AO must show ID card before carrying out actions/exercising powers
	• AO must explain to the person the reason why it is necessary to detain them – if not practicable, it must be done as soon as practicable
	• AO must warn the person that refusal or failure to comply without reasonable excuse, is an offence before carrying out actions/exercising powers
	• AO must facilitate a reasonable request for communication
	• AO must review every 24 hours, whether continued detention of the person is reasonably necessary to eliminate or reduce a serious risk to health (undertaken by Deputy Commander AO operations with support from Operations Support Team)
	• AO must give written notice to the Chief Health Officer (CHO) that detention has been made and if it is reasonably necessary to continue detention to eliminate or reduce the serious risk to public health.[1]
In addition, AOs must comply with the Charter of Human Rights (see also appendix 10)	• AO must act compatibly with human rights
	• AO must give 'proper consideration' to the human rights of any person(s) affected by a department AO's decision.

The notice to the CHO must include:

- the name of the person being detained
- statement as to the reason why the person is being, or continues to be, subject to detention.

Following receipt of a notice, the CHO must inform the Minister as soon as reasonably practicable.

[1] *And Authorised Officer under the PHWA that has been authorised for the purposes of the emergency order*

3.3.2 General powers and obligations under the Public Health and Wellbeing Act 2008 (PHWA)

The general powers of Authorised Officers are outlined under Part 9 of the PHWA (Authorised Officers). The following is an overview of powers and obligations. It does not reference all powers and obligations.

AOs are encouraged to read Part 9 and seek advice from the Deputy Commander AO Operations if they are unsure about the administration of their powers.

3.3.3 Authorised officer obligations:

Produce your identity card - s166

- **Before** exercising powers provided to you under the PHWA;
- At any time during the exercise of powers, if you are asked to show your ID card
- As part of good practice, you should produce your identity card when introducing yourself to occupiers or members of the public when attending complaints or compliance inspections.

Inform people of their rights and obligations

- You may request a person to provide information if you believe it is necessary to investigate whether there is a risk to public health or to manage or control a risk to public health.
- Before exercising any emergency powers, you must, unless it is not practicable to do so, warn the person that a refusal or failure to comply without a reasonable excuse, is an offence.

4 AO responsibilities at airport

AOs issue Direction and Detention notices to people arriving in Victoria (airports and seaports)[2] from overseas and them they must go into immediate compulsory quarantine for 14 days. This is because international arrivals present a high-risk of further transmission of the COVID-19 virus and detention is necessary to reduce or eliminate the serious risks to public health associated with the virus.

All passengers will be transported free of change to a designated hotel accommodation, where they must undertake a strict 14-day quarantine period.

The airport is the first point of contact for an AO, who must undertake several obligations to administer the direction and detention notice issued under the PHWA.

4.1 Key points

- AO must fulfil mandatory obligations (e.g. show ID card and explain reason for detention, etc).
- AO must check that a direction and detention notice is filled in properly.
- AO must provide factsheet and privacy collection notice to person.

4.2 Key responsibilities

Table 4 – AO responsibilities at the airport

Step	AO responsibilities	Mandatory obligation	Section (PHWA)
Identify pre-approved exemptions	1. Exemptions for flights will be provided to the by the Exemptions Team Lead to the AO rostered at the airport as well as Airport Operations Command prior to passenger disembarkation 2. Any queries in relation to the exemption should be directed to the Exemption team lead 3. AO to check exemption paperwork and identify on passenger manifest sheet 'exemption'		
Flight arrival	4. Inform flight crew of AO action and request translation of script3. 5. Declare you are an Authorised officer and show your identification card. 6. Read script (attachment 1), which: i. explains the reasons for detention ii. warns returning passengers that refusal or failure to comply without a reasonable excuse is an offence and that penalties may apply iii. reminds passengers they must keep their detention notice. 7. Repeat twice. 8. Flight crew read script in all relevant languages.	Yes	Sections 166, 200(2),200(4) and 202(1)

[2] Noting some exemptions apply for maritime crew – see exemptions section

[4] The Business system referred to here is the Quarantine and Welfare System COVID-19 Compliance Application.

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Issue notice immediately after disembarkation	9. Serve the approved Direction and Detention Notice to each passenger. Unless advised otherwise, the approved notice is the general notice (attachment xx). Unaccompanied children who are detained must be served the solo child notice (attachment XX). (notification to parent/guardian may need to be conducted over the phone and interpretation services may be required). 10. If practicable at this time, provide the person with a copy of the department's privacy collection notice. If not practicable, this can be provided at the hotel.	Yes.	Section 200, 200(2) and 200(4)
Facilitate request for communication	11. Facilitate any reasonable request for communication, such as a phone call or email and including if necessary, organising a translator to explain the reasons for detention (call Victorian Interpretation and translation service on REDACT; PIN code is REDACT.	Yes	Section 200(5)
Confirm details	12. Ensure each direction and detention notice: i. states the full name of the person being detained, date of birth and mobile phone number (if applicable) ii. contains the signature of the person being detained or their guardian as receipt of the notice iii. states the name and signature of the AO iv. contains the hotel name at which the person will be detained v. contains the date of commencement of detention.		
Record issue of receipt	13. Take a photo of direction and detention notice and record issue and receipt of the notice in the COVID-19 Compliance and Welfare Application4. You may be assisted by a non-AO in this task. 14. Request person subject to detention present to AO at hotel		
Check with welfare team	15. Liaise with AO Team Leader and health team if the Health Check has identified passengers that need to transfer to hospital. 16. Issue leave permissions where required (e.g. in circumstances where a person needs to go to hospital) Refer to Section XX (Permissions) for further detail. 17. Ensure the detainee understands they must return to the hotel listed on the detention notice immediately after medical release in transport organised by DHHS.		

[4] The Business system referred to here is the Quarantine and Welfare System COVID-19 Compliance Application.

	18. (Note: a hospital information sheet is currently being developed to assist the hospital on required and contact details.)		
[redacted]	• **provide a fact sheet about detention (what a person in detention can and can't do, who to contact for further information)**		
Record	19. Record any actions in the COVID Compliance and Welfare App, including the above mandatory obligations, use of translator and any associated issues. 20.		

4.2.1 Transfer of uncooperative person to be detained

There may be circumstances where a person refuses to be cooperative. DHHS Operations staff at the airport may elect to organise a separate mode of transport for in such circumstances, noting Victoria Police may be requested to escort such individuals.

5 AO responsibilities at hotels

As part of meeting mandatory detention requirements in the direction and detention notice, the Victorian Government has arranged accommodation in numerous locations, primarily in the Melbourne CBD area. The purpose of this is to restrict the movement of international arrivals to limit the spread of COVID-19.

5.1 Key points

- AO reiterates detention requirements, explains reasons for detention and the penalties for non-compliance.
- AO oversees and provides advice on compliance and works with security, hotel staff, and medical and other staff.
- AOs are responsible for detention release following the mandatory 14 day detention

5.2 Shift change over

Table { SEQ Table * ARABIC }: Key steps and AO roles and responsibilities during shift change over

Step	AO roles and responsibilities	Mandatory obligation	Section (PHWA)
Introduction	1. Introduce yourself to: • hotel/duty manager • head of security • DHHS Team Leader • DJPR site manager (if on site) • medical staff.		
Handover	2. Obtain a handover from the previous AO (verbal and high-level information) to: • understand detainee issues, early releases, exemptions and permissions • ascertain location of records and template forms • Any hotel operational issues (eg physical exercise space unavailable, changes to operational policies like food delivery) • ensure COVID-19 Compliance Application has been updated • if exits from detention expected, ensure AO team and release team aware of plans and location of documentation.		

5.3 Hotel check-in

The purpose of hotel check-in is to:

- enable hotel staff to provide people being detained with a room number and key
- reiterate obligations for those being detained.

Table { SEQ Table * ARABIC }: Key steps and AO roles and responsibilities – hotel check-in

Step	AO roles and responsibilities	Mandatory obligation	Section (PHWA)
Check-in	1. Ensure person to be detained provides Direction and Detention Notice to hotel staff; hotel staff to write on the notice: i. room number ii. the date that the person will be detained until (14 days after arrival at place of detention).		
Check and reiterate Direction and detention notice	2. Show identification and introduce yourself 3. Check completed Direction and Detention Notice to confirm that the following details have been correctly recorded on the notice and in the compliance app: • the hotel name • hotel room number and arrival date and time • the date that the person will be detained until (14 days after arrival at place of detention). 4. Return the notice to the person being detained (note that this must occur). AO's should reiterate: • the reason for detention • warn the person that refusal or failure to comply without a reasonable excuse is an offence and that penalties may apply • facilitate any reasonable request for communication.		Sections 166, 200(2), 200(4) and 203(1)
Liaise with medical and welfare staff	5. Liaise with nurses to identify persons that might require permissions for temporary leave (e.g. for medical treatments).		

5.4 Monitoring compliance

The AO will provide oversight and ensure compliance with the direction and detention notice

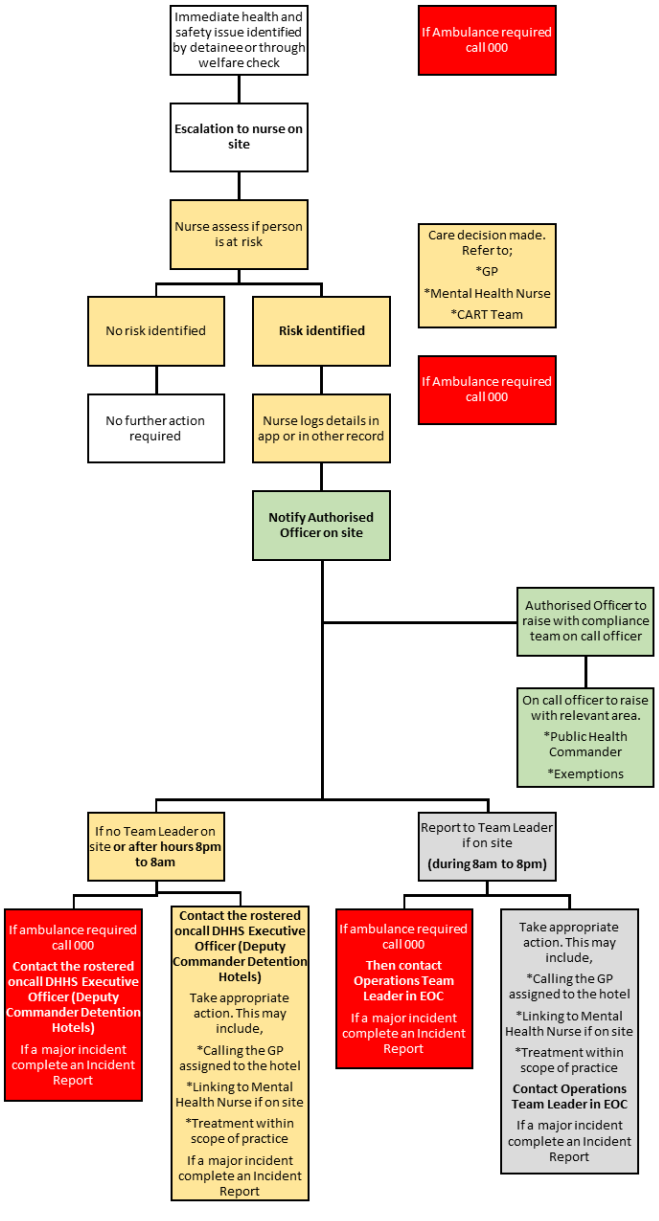
Table { SEQ Table * ARABIC }: Key steps and AO roles and responsibilities – monitoring compliance

Step	AO roles and responsibilities	Mandatory obligation	Section (PHWA)
Liaise with security	1. Check that security are undertaking floor walks to encourage compliance and deter non-compliance.		
Oversee compliance	2. Oversee and provide advice on compliance-related issues such as: • a person refusing to comply and a person demanding to be removed from detention • reminding a person the reason for the detention, their obligations under the detention and direction notice and the penalties if they do not comply • responding to requests from security to address compliance • answering questions from hotel staff, security and police as to what persons may be permitted or not permitted to do • seeking assistance from security or Victoria police to support compliance efforts • facilitating any reasonable requests for communication. For translation, call Victorian Interpretation and translation service d[redacted] PIN code is[redacted]		203(1)
Permissions	3. See Section 7 (Permissions). 4. Raise requests for permission to leave with AO Team Leader if there is not an authorised area for the detainee to exercise the permission or there is complexity in applying the transition (eg requires leaving the hotel site). All requests by detainees to leave the hotel site must be escalated to Deputy Command AO operations if not already approved. 5. Administer permission to leave and monitor compliance.		203(1)
Exemptions	6. See Section 7 (Exemptions). 7. Raise any exemption requests with AO Team Leader in the first instance. The AO Team Leader may then refer exemption requests to covidquarantine@dhhs.vic.gov.au,[or may request the AO to do so] for decision. 8. Issue Direction and Detention Notices for detention in alternate locations if ECC Commander approves an exemption request. In this case, a case manager from the Exemptions Team will contact the AO with details.		200(2),200(4) and 203(1)

Records	9. Make notes of compliance related issues and actions. The means of recording notes are dependent of the availability and use of technology and could include the COVID Compliance Application. 10. Record all permissions in the permissions register and Covid Compliance App 11. Upload photos of all amended direction notices issued while at the hotel to the COVID Compliance Application.		
Other issues	12. Inform nurse, medical practitioner, welfare staff or DHHS concierge staff of other matters you become aware of.		

5.5 Emergency health and welfare incidents

Where there is an immediate health and welfare issue identified at the hotel, the following process is to be followed.



5.6 Clarity about role of AO

AOs should be aware that their role and scope is related to administration of, and compliance with, the direction and detention notice under the PHWA. Activities outside the scope of the role of the AO include:

- transport. This is the responsibility of the DHHS Team Leader on-site. If a DHHS Team Leader is not on-site, please refer to the Emergency Operations Command at DHHSOpSoteriaEOC@dhhs.vic.gov.au and title the email "Referral to organise transport"
- physically moving COVID 19 patients. Please see procedure under 'Occupational Health and safety"
- retrieving luggage
- food quality
- inspecting care packs, removing items from care packs such as perishables and alcohol and ordering food such as Uber eats
- monitoring or ordering PPE or other supplies

If an AO becomes aware of these or other non-compliance related issues in a hotel, they should refer them to the DHHS Team Leader on-site for follow up. For medical and welfare issues, the AO should inform on-site medical and nursing staff in accordance with section 4.5 above.

5.7 Daily review and reporting by the AO Review Team

The daily review is a mandatory obligation to determine whether continued detention of a person is reasonably necessary to eliminate or reduce a serious risk to health. There are mandatory obligations for the AO to inform the Chief Health Officer (CHO) and the CHO to inform the Minister. This is the responsibility of the Deputy Command AO Operations who will be aided by the AO operations support team in fulfilling this task.

Table { SEQ Table * ARABIC }: Key steps and AO Review Team roles and responsibilities – daily review

Step	AO Review Team roles and responsibilities	Mandatory obligation	Section (PHWA)
Daily review	1. AO operations support Team will – at least once every 24 hours – review whether the continued detention of the person is reasonably necessary to protect public health.	Yes	S 200(6)
Review checks	2. Undertake an electronic review of detainment arrangements by viewing the COVID-19 Compliance Application. This includes: • reviewing the date and time of the previous review (to ensure it occurs at least once every 24 hours) • reviewing the number of detainees present at the hotel • reviewing the duration each detainee has been in detention for, to ensure that the 14-day detention period is adhered to • noting individuals who have been tested and cleared of COVID-19 by Public Health Command while in detention		

	3. Determine whether continued detention of each detainee is reasonably necessary to eliminate or reduce a serious risk to health 4. Consider the human rights being impacted – refer to 'Charter of Human Rights' obligations in Appendix XX 5. Consider any other issues that have arisen.		
Review considerations	6. Consider that the person is a returned overseas traveller who is subject to a notice and that they are obliged to comply with detainment. 7. Consider that detainment is based on expert medical advice that overseas travellers are of an increased risk of COVID-19 and form most COVID-19 cases in Victoria. 8. Consider any other relevant compliance and welfare issues, such as: • person's health and wellbeing • any breaches of self-isolation requirement • issues raised during welfare checks (risk of self-harm, mental health issues) • actions taken to address issues • a person having been tested and cleared of COVID-19 while in detention • any other material risks to the person.		
Possible release from detention	9. Review could identify that detention may no longer be required. These matters will be provided to the Deputy Command Policy and Exemptions for further consideration.		
Record	10. Record the outcomes of their review (high level notes) (for each 24-hour period) in the **COVID-19 Compliance Application**. This allows ongoing assessment of each detainee and consideration of their entire detention history.		
Prepare brief (Minister)	11. Prepare brief from CHO to Minister to advise of notice received about detention and review. The brief will serve as a written notice that: • a person has been made subject to detention • following a review, whether continued detention is reasonably necessary to eliminate or reduce the serious risk to public health. 12. The notice to the CHO must include: • the name of the person being detained • statement as to the reason why the person is being, or continues to be, subject to detention.		Sections 200(7) and (8) Section 200(9)

	13. Deputy Command AO operations to review and approve the Review and Brief 14. Report to be sent to Public Health Command, cc to ECC Commander and Deputy Command Policy and Exemptions		

5.8 Departure – release from mandatory detention

The purpose is to ensure and confirm the person being detained:

i. has completed their period of detention under the Direction and Detention notice
ii. is released in a timely and orderly manner.

5.8.1 Pre-check out

Prior to release of a person being detained, DHHS (with the help of hotel security) will provide each person being detained with either:

1. an End of Detention Notice, **Appendix 8;**
2. an End of Detention Notice (confirmed case or respiratory illness symptoms), **Appendix 9**
3. (to be supplied)

The notice provides information about the discharge process and the obligations of the detainees until they are discharged.

5.8.2 Health check

Health checks will be undertaken by medical staff on the second last day prior to the 14-day period ending to make an assessment of whether each person being detained is well, symptomatic or positive.

Everyone will be offered a voluntary temperature and symptom check by a nurse around 24 hours before release.

If people being detained have a temperature or other symptoms of coronavirus before leaving or at the health check, this will not affect the completion of their detention. They will not be detained for longer than the 14-day detention period, even if they have symptoms consistent with coronavirus. However, if they do have symptoms at the health check, when they are released, they will need to seek medical care and will be required to self-isolate (as is required as of all members of the community).

- If people have been diagnosed with COVID-19 during their quarantine, they will be subject to the Isolation (Diagnosis) directions and can only be released from these on receipt of a formal clearance letter from the Public Health Commander. These letters are sent to COVIDquarantine@dhhs.vic.gov.au for supply to the detainee. Once this letter has been received, the detainee should be released from detention even if this is before the end of the mandatory quarantine period with the appropriate form (appendix 9).
- If a confirmed case does not receive clearance before the end of the mandatory quarantine period, the public health operations team may permit them to travel home with appropriate PPE and transport precautions if they are Victorian residents. If they are residents of other states a further detention order may be issued in consultation with the public health and legal teams.

5.8.3 Day of release

Security will provide detainees approximately 1 hour notice of their exit time. Security will then bring detainees down at their scheduled exit time.

5.8.4 Check-out process overview (compliance check-out)

The release process will consist of an organised check-out procedure (the compliance check-out). This means people being detained will be released in stages throughout a set time period on the day of release.

Security will bring travelling parties down to reception in stages to complete the check-out process. People being detained will also need to settle any monies owing to the hotel for additional meals and drinks if they have not already done so. Physical distancing must be maintained throughout this process.

Table { SEQ Table * ARABIC }: Key steps, roles and responsibilities at check-out (AO role unless specified)

Step	Roles and responsibilities	Mandatory obligation	Section (PHWA)
Notification of COVID-19 cases of close contacts	1. ECC Operations Support Team, to inform AO of those with 2. confirmed COVID-19, suspects Covid cleared or close contacts. Public health will have contact each detainee in these categories to discuss arrangements post detention. 3. AO to note and to inform security that COVID-19 cases will need separate check-out time and implement extra precautionary measures.		
Check-out	4. Request to see identification (passport) and the End of Detention notice from each person 5. Cross check the person's identification details and room number with information on exit sheet 6. Sign the End of Detention notice and provide back to the person 7. Confirm the period of detention and explain detention period has ceased 8. Confirm self-isolation requirements for all confirmed COVID cases. 9. Detainee to sign discharge exit sheet as evidence they have received a notice and have been discharged		
Record	10. Provide exit list to a Release and Review team member on site for updating in the COVID-19 Compliance Application (note this may be a data entry update after the process has been completed). 11. All exit sheets are to be returned to the Operational Support team as soon as possible		

Where a person has been COVID-19 cleared, their detention release must be accompanied with a COIVD-19 Clearance letter provided by Public Health Command. This will be included in the release pack prepared by the AO Operations Support team.

6 Exemption requests

6.1 Key points

- AOs must be aware of how requests for exemption from detention are escalated.
- DHHS case manager from Exemptions and Permission Team will liaise with AO Team Leader regarding approved exemption request.

6.2 5.2 Exemption requests – overview

In limited circumstances, approval may be sought to undertake detention in another location, transit to another state/country or early release. **Generally, exemptions are not granted.**

Requests for exemption from mandatory hotel detention may be considered before a person commences detention or while in detention. Public Health Commander is responsible for approving and granting approvals to alter the way in which mandatory quarantine applies. The PH Commander may delegate approvals to the ECC Commander in accordance with *Guidance Note — Exceptions to the General Quarantine Policy*

While each exemption request must be considered on its own merits, the following circumstances have been identified as open for consideration of early release or change of detention location. These include:

- Unaccompanied minors in transit to another state
- Unaccompanied minors where a parent or guardian does not agree to come into the hotel
- Foreign diplomats coming into the country
- ADF staff travelling for essential work
- People with a terminal illness
- People whose health and welfare cannot be accommodated in a hotel environment (e.g. mental health or requirements for in-facility health treatment)
- People who are transiting directly to another country (and who do not need to travel domestically first)
- Air crew
- Maritime workers who have come off a boat and will be leaving by boat
- Maritime workers who have come off a plane and will be leaving by boat within the quarantine period.

Any approval must consider the public health risk and must ensure the individual is not showing symptoms of covid or may be release into an environment where a highly vulnerable person may be a close contact.

There is no blanket exemption approval

Table { SEQ Table * ARABIC }: Key steps, roles and responsibilities for exemptions prior to commencing, and during, detention

Step	Roles and responsibilities	Mandatory obligation	Section (PHWA)
Request	1. covidquarantine@dhhs.vic.gov.au receives a request for exemption5. 2. Person confirms flight details and arrival information before the matter is assessed.		
Assessment and decisions	3. Exemptions Team will consider the request and refer to the ECC Commander for decision 4. Exemptions case manager to: • inform the AO Operation Lead if an exemption is granted so that relevant AO Airport Team Leader and AOs are informed (including correspondence) • Inform the EOC to arrange transport • Inform the CART team if required • arrange for compliance oversight with Victoria police • contact other jurisdictions (if transiting through Victoria). • Record all actions and supporting paperwork in the case management tool		
AO to issue Notice of Direction and Detention	5. The exemption team will provide guidance to the AO about issuing the exemption paperwork 6. AO will: • issue a Notice of Direction and Detention for those permitted to undertake detention at an alternative location in accordance with x.x • permit international transit for those issued a letter • record details in COVID-19 Compliance Application		200(2) and (4) 203(1)
International transit passenger process	7. To facilitate an exemption given to a person for international transit, the AO Team Leader will notify Airport AO and Australian Border Forces (ABF) prior to their arrival at the airport via a specific email with a specific subject title to: • "map.border.clearance@abf.gov.au" with a cc to "NorthandWest.EOC@dhhs.vic.gov.au. A template email is below.		

[5] An onsite nurse or welfare staff can recommend the exemption for a person via covidquarantine email and outline why they believe an exemption should be considered. Unless impracticable the person on whose behalf the request has been made should be consulted

	• Email to be titled *Transit Passenger from Quarantine Hotel (DHHS)* and request assistance to collect released detainee for connecting transit flight to XXX. Email should include: • full name (as per passport) • passport number • flight departure time • flight number • arrival time at T2 international departure.		

6.3 Unaccompanied minors

Unaccompanied minors will be considered on a case-by-case basis. If an unaccompanied minor is detained in a hotel without a parent or guardian, a specific process must apply.

There are three options:

i. Unaccompanied minor to undertake detention at an alternate location with parent or guardian
ii. Unaccompanied minor to undertake detention in hotel with parent. The parent or guardian will be required to agree to the mandatory detention arrangements
iii. Unaccompanied minor to undertake detention in hotel with welfare support provided by DHHS

In general, there is a presumption that there are no exemptions granted to mandatory quarantine. The issues associated with mandatory quarantine of unaccompanied minors include:

1. where this occurs, and
2. with what adult supervision.

The State can issue a detention order to a person under 18 years who is unaccompanied outside the home (a person in the care of the state) if certain conditions are met. However, this is not preferred because of the welfare obligations imposed.

There is guidance for AOs on how to comply with the Charter of Human Rights in relation to unaccompanied minors at Appendix 4.

Table { SEQ Table * ARABIC }: Key steps, roles and responsibilities for managing unaccompanied minors

Step	Roles and responsibilities	Mandatory obligation	Section (PHWA)
When an unaccompanied minor normally resides outside Victoria			
AO to request approval if not already sought	1. If Exemptions team has not granted approval, AO to escalate to the Deputy Command Policy and Exemptions and cc covidquarantine		
Assessment and decision	2. Exemptions case manager to: • inform the AO Operation Lead and AO Airport Team Leader of approval or rejection • contact other jurisdictions (if transiting to a location outside Victoria)		

	• Advise requesting party of the risk management obligations on a domestic flight out of Victoria and seek confirmation it can be achieved.		
AO to issue Notice of Direction and Detention	3. AO will: • issue a Notice of Direction and Detention to undertake detention at an alternative location in Victoria in accordance with the instructions and templates provided by the Exemptions case manager • permit transit to another state if minor normally resides outside Victoria • record details in COVID-19 Compliance Application.	**Yes**	200(2),(4) and **203**(1)
When minor resides in Victoria			
AO to request approval if not already sought	4. If Exemptions team has not granted approval, AO to escalate to Deputy Command Policy and Exemptions and cc covidquarantine		
Assessment and decision	5. Exemptions case manager to: • inform the AO Operation Lead and AO Airport Team Leader of approval • alert the EOC to arrange transport • arrange for compliance oversight with Victoria police.		
AO to issue Notice of Direction and Detention	6. AO to issue direction and detention notice to child through their guardian for: • alternate location (home and / or parts of the home); or • Provide advice on minimising risk of transmission to others in the home where the minor is detained (equivalent to advice provided to close contacts in quarantine),	**Yes**	200(2), (4) and **203**(1)

6.3.1 Escalation of issues

Should an AO become aware of any concern about a child, the AO must:

- contact the department's welfare teams immediately. Child Protection contact details for each Division are available from: https://services.dhhs.vic.gov.au/child-protection-contacts. West Division Intake covers the City of Melbourne LGA: REDACT.
- if it is after hours, contact the after-hours child protection team on REDACT if the AO thinks a child may be harmed, and Victoria Police on 000 if the immediate safety of a child is at risk.

7 Permissions

7.1 Key points

- AOs can make decisions in consultation with their AO Team Leader or Deputy Commander AO Operations for simple requests.
- AO must complete a permission for temporary leave form and enter details in COVID-19 Compliance Application.

There are four circumstances under the Direction and Detention Notice in which permission to leave the room may be granted:

- for the purpose of attending a medical facility to receive medical care
- where it is reasonably necessary for physical or mental health
- on compassionate grounds
- emergency situations.

AOs should refer to the 'Permission for Temporary Leave from Detention' guide at **Appendix 2.**

7.2 AO to make decisions on certain permission requests on case-by-case basis

An AO in consultation with their AO Team Leader or Deputy Commander AO operations can make certain straightforward decisions about the following scenarios on a case-by-case basis:

- attendance at a funeral
- medical treatment
- seeing family members who have a terminal illness, (noting that there are directions on visiting care facilities and hospitals which must be complied with).
- smoke breaks where people are suffering extreme anxiety and where it is safe to do so from a public health/infection control perspective.
- exercise breaks where it is safe to do so.

Not all leave requests can accommodated and may be site and resource dependent. Any arrangement for leave would need to meet public health, human rights requirements and balance the needs of the person.

It is expected that those with medical needs, seeking to attend a funeral or with family members who are about to pass away are granted leave. The AO should confirm appropriate details before issuing permission to leave (refer to Table 12 for further details).

If medical care is deemed urgent by an on-site nurse or medical practitioner, the AO should prioritise and approve leave immediately.

AOs are not responsible for transport arrangements. This is the responsibility of the DHHS Team Leader on-site. If a DHHS Team Leader is not on-site, please refer to the Operation Soteria Emergency Operations Centre at DHHSOpSoteriaEOC@dhhs.vic.gov.au and title the email "Referral to organise transport".

Table { SEQ Table * ARABIC }: Key steps, roles and responsibilities for temporary leave

Step	Roles and responsibilities	Mandatory obligation	Section (PHWA)
Assess site for suitability	1. AO Team Leader to assess site for suitability of exercise and fresh air breaks. 2. AO to consider safety and security and obtain agreement from Security and DHHS Team Leader on suitable site 3. Site Map to be put on the Team Sharepoint site and attached as an attachment to this protocol following Deputy Command AO Operations approval.		
Request for temporary leave	4. Person may seek permission directly from the AO or may email covidquarantine@dhhs.vic.gov.au and explain the grounds for temporary leave		
Referral to AO	5. Permission and Exemptions team to triage and forward to AO for decision 6. Permission and Exemptions team to assess complex cases and inform AO		
AO assessment and decision	7. AO to make decision and consider: • those that require exercise or fresh air break or those who may be at risk without these breaks (this is the most important consideration for fresh air and exercise breaks) • willingness and availability of security to oversee and facilitate exercise or other fresh air break (the number of security officers will determine how many people can undertake temporary leave, as well as the ability to ensure small groups by room are distanced accordingly • site layout, safety and capability to ensure persons are in a cordoned off area • maintaining infection control, such as ensuring persons do not touch door handles or lift buttons • adherence to exercise and smoking procedures 8. In considering a request for a person to visit a terminally ill family member in hospital, the AO will need to first check whether the medical facility will accept the person, noting the Hospital Visitors Direction.		
Issue permission for temporary leave	9. AOs to: • instruct security on the dates and times permitted for leave • provide procedural guidance to security and the person in detention, such as exercising in a		s.203(1)

	cordoned off area not accessed by members of the public • request the medical facility or hospital inform the AO prior to return (for medical temporary leave) • prepare a Permission for Temporary Leave from Detention form (see Appendix 2), and issue to the detainee and explain the leave obligations. For example: - a person attending a funeral must not attend the wake, must practice physical distancing and return immediately within stipulated timeframes - an exercise break is for a certain time and the person must return to their room following exercise or fresh air break • warn the person that failure to comply with these directions is an offence • ensure the person checks back into the hotel at specified time • seek feedback on implementation of temporary leave and note any issued raised		
Record	10. If AO approves leave be granted, the AO: • must keep records of the Permission for Temporary Leave from Detention form for the person, Appendix 2 and the Register of permissions granted under 4(1) of the Directions and Detention Notice, Appendix 11, and • enter details in COVID-19 Compliance Application.		

7.3 Emergency situations

Table { SEQ Table * ARABIC }: Key steps, roles and responsibilities for emergency leave

Step	Roles and responsibilities	Mandatory obligation	Section (PHWA)
Determine risk	1. AOs and Victoria Police officers may need to determine the severity of any emergency (such as a building fire, flood, natural disaster etc) and the health risk they pose to persons in detention.		
Evacuation	2. Assist with immediate evacuation to common assembly point 3. Contact Victoria police, emergency services and Deputy Commander AO operations to support 4. Promote infection prevention and control and physical distancing principles if possible		

	5. Account for all persons being detained at the assembly point by way of the register of persons in detention/COVID-19 compliance application		

7.4 Procedure for a person in detention / resident to leave their room for exercise or smoking

A person must be compliant and must not have symptoms before they could be allowed to have supervised exercise or a smoking break. Only well residents from the same room should be able to go out to exercise at the same time.

7.5 Guidance for safe movement associated with permissions

7.5.1 Guidance for person in detention

The steps that must be taken by the person in detention are:

- Confirm to the person who will escort them that they are well.
- Confirm to the person who will escort them that they have washed their hands immediately prior to leaving the room.
- Don a single-use facemask (surgical mask), to be supplied by the security escort prior to leaving the room.
- Perform hand hygiene with alcohol-based hand sanitiser as they leave, this will require hand sanitiser to be in the corridor in multiple locations.
- Be reminded to – and then not touch any surfaces or people within the hotel on the way out, and then not actually do it.
- Return immediately to their hotel room following the break.

7.5.2 Guidance for security escort

Security escort should:

- Don a single-use facemask (surgical mask) if a distance of >1.5 metres cannot be maintained when escorting the person;
- Perform hand hygiene with an alcohol-based hand sanitiser or wash hands in soapy water before each break;
- Remind the person they are escorting to not touch any surfaces or people within the hotel on the way out or when coming back in
- Be the person who touches all surfaces if required such as the lift button or door handles (where possible using security passes and elbows rather than hands);
- Wherever possible, maintain a distance (at least 1.5 metres) from the person;
- Perform hand hygiene with an alcohol-based hand sanitiser or wash hands in soapy water at the end of each break and when they go home
- Ensure exercise is only undertaken in a cordoned off area with no public access or interaction.

7.5.3 Infection control considerations

Points to remember when using a single-use facemask (surgical mask):

- Always perform hand hygiene before donning the mask.
- Mould the metal clip over the bridge of the nose and ensure the bottom of the mask fits snuggly under the chin.
- Avoid touching or adjusting the mask once it has been donned.
- Unless damp or soiled, masks may be worn for the duration of a shift for up to four hours.
- Masks must be removed and disposed of for breaks and then replaced if needed.
- Masks must never be partially removed (for example, top tie undone and left dangling around the neck) and then re-worn.
- Perform hand hygiene immediately before and after removal of the mask.

There is no requirement to wear gloves and this is not recommended, as many people forget to take them off and then contaminate surfaces. Hand hygiene is one of the most effective ways to prevent the spread of infection and gloves should not be seen as a substitute for hand hygiene. If gloves are worn, remove the gloves immediately after the person is back in their room and then wash your hands.

In addition:

Family groups may be taken out in a group provided it is only 2 adults and less than 5 in total.

They can be taken to an outside area with sunlight, for up to 15 minutes outside of the hotel.

Smokers can take up to 2 breaks per day if staffing permits.

Rostering to be initiated by the departmental staff/AO present.

8 Compliance

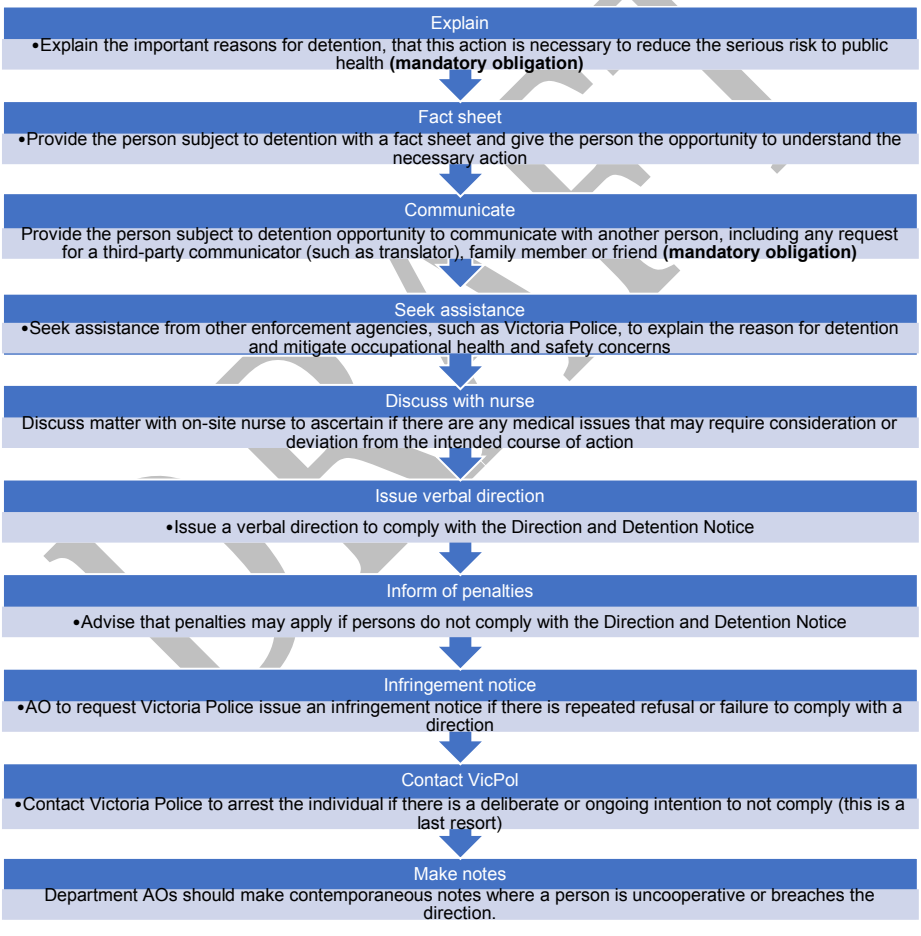
8.1 Key points

- AOs to apply a graduated approach to compliance.
- Police and security can assist in compliance and enforcement activities

8.2 Options to facilitate compliance

AOs should make every effort to inform the person of their obligations, facilitate communication if requested and explain the important rationale for the direction. Non-compliance could take the form of a person refusing to comply with the direction at the airport or hotel.

The following graduated approach should guide AOs:



8.3 Unauthorised departure from accommodation

Table { SEQ Table * ARABIC }: Key steps, roles and responsibilities for managing unauthorised departure from accommodation

Step	Roles and responsibilities	Mandatory obligation	Section (PHWA)
Notify and search	1. AO to notify AO Team Leader, on-site security and hotel management and request search.		
Contact Victoria police	2. AO to seek police assistance and notify the Deputy Commander AO Operations if the person is not found.		
Identification and compliance	3. If the person is located, AO to: • seek security or Victoria Police assistance if it is determined the person poses a risk of trying to leave • provide an opportunity for the person to explain the reason why they left their room • assess the nature and extent of the breach, for example: - a walk to obtain fresh air - a deliberate intention to leave the hotel - mental health issues - escaping emotional or physical violence. • consider issuing an official warning or infringement through Victoria Police • reassess security arrangements.		s.203(1)

8.4 Infringements

There are four infringement offences applicable to detention arrangements. These are:

Table 1 List of infringements

Section (PHWA)	Description	Amount
s.183	Hinder or obstruct an authorised officer exercising a power without reasonable excuse (5 penalty units).	5 penalty units (PU)
s.188(2)	Refuse or fail to comply with a direction by CHO to provide information made under s.188(10 penalty units for a natural person and 30 penalty units for a body corporate without a reasonable excuse).	10 PU natural person, 30 PU body corporate
s.193(1)	Refuse or fail to comply with a direction given to, or a requirement made or, a person in the exercise of a public health risk powers (10 penalty units for natural person and 60 penalty units for body corporate).	10 PU natural person, 30 PU body corporate

s.203(1)	Refuse or fail to comply with a direction given to, or a requirement made or, a person in the exercise of a public health risk powers (10 penalty units for natural person and 60 penalty units for body corporate).	10 PU natural person, 30 PU body corporate

9 Occupational health and safety (OHS) for Authorised Officers

The purpose of this section is to provide an occupational health and safety procedure for AOs when attending off site locations during the current State of Emergency.

9.1 Key points

- OHS is a shared responsibility of both the employer and the employee. AOs must raise hazards, concerns and incidents with the AO Team Leader or the Deputy Commander AO operations.
- AOs must take steps to protect themselves from transmission of COVID-19 and adhere to physical distancing protocols wherever possible

9.2 Health Emergency

Coronaviruses are a large family of viruses that cause respiratory infections. These can range from the common cold to more serious diseases. COVID-19 is the disease caused by a new coronavirus. It was first reported in December 2019 in Wuhan City in China.

Symptoms of COVID-19 can range from mild illness to pneumonia. Some people will recover easily, and others may get very sick very quickly which in some cases can cause death.

9.3 OHS

OHS is a shared responsibility of both the employer and the employee. Officers must raise hazards, concerns and incidents with the rostered AO Team Leader.

One of the foremost issues associated with site attendance is the 'uncontrolled environment' that exists. AOs can be exposed to infectious diseases (such as COVID-19), confrontational and/or aggressive members of the public who may be drug affected, mentally ill or intellectually impaired. The very nature of this work is likely to be perceived as invasive and can provoke a defensive response.

Risks can be minimised by maintaining routine safe work practices and proper planning. Prior to any site visit, risks and hazards should be identified and assessed.

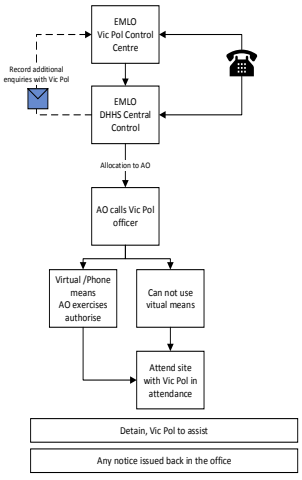
Officers and managers both have a shared responsibility for occupational health and safety. All employees have a responsibility to report and discuss hazards or perceived hazards, by bringing this to the managers attention.

9.4 Fatigue

AOs will be rostered on a rotating basis, with the aim of mitigating the risk of fatigue. Fatigue may impede decision making capability and when driving a motor vehicle to a location. When fatigue is identified please make this known to your AO Team Leader or Deputy Commander AO operations.

To mitigate the risk of fatigue, AOs should be aware of any fatigue they may have. A good tool to use to help officers identify their level of fatigue is to use the following calculator:
http://www.vgate.net.au/fatigue.php

AOs are required to hold a valid motor vehicle licence and are required to adhere to the requirements of the department's driving policy. Information about this policy can be found on the DHHS intranet site.



9.5 Risk assessment before attendance -Personal Protection

Officers must only take a direction to attend a site with the approval of the Central DHHS Emergency Management Liaison Officer and a AO Team leader or the Deputy Commander AO operations or DHHS management.

In the first instance, officers are required to use technology (i.e: mobile phone, Facetime, Skype) to exercise their authority. This aims to protect officers from attending an uncontrolled environment, where the risk of harm is increased.

Before attending a site, whether an airport or a hotel, the officer should make themselves familiar with the recommendations produced by the Australian Government and the Department of Health and Human Services, in the protection against COVID-19.

Interventions are known as 'transmission reduction, or 'physical distancing' measures. Officers can take the following personal measures to reduce their risk of exposure to COVID-19. Officers with pre-existing medical conditions that put them more at risk of COVID-19, should discuss this with their medical practitioner and manager.

9.6 Personal measures to reduce risk the risk of exposure to COVID

9.6.1 General

AOs must take steps to protect themselves from transmission of COVID-19 and adhere to physical distancing protocols wherever possible. For example,:

- Stay healthy with good nutrition, regular exercise, sensible drinking, sleep well, and if you are a smoker, quit.
- Wash your hands often with soap and water for at least 20 seconds, especially after you have been in a public place, or after blowing your nose, coughing, sneezing, or using the toilet. If soap and water are not readily available, use a hand sanitiser that contains at least 60 per cent alcohol.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Cover your nose and mouth with a tissue when you cough or sneeze. If you don't have a tissue, cough or sneeze into your upper sleeve or elbow.
- Stop shaking hands, hugging or kissing as a greeting.
- Ensure a **distance of 1.5 metres** is kept between yourself and others.
- Get vaccinated for flu (influenza) as soon as available. This could help reduce the risk of further problems. *Note: the department covers expenses for vaccines, speak to your AO team leader for more details.*
- Clean and disinfect high touch surfaces regularly, for example: telephones, keyboards, door handles, light switches and, bench tops.

When an officer is called to attend the airport or a hotel to exercise powers in relation to the Direction and Detention notice they should take a **risk-based approach** and assess the most suitable way to reduce harm to themselves. Before attending, the officer must obtain information such as:

- Is the person being detained a suspected or confirmed case of COVID-19?
- Has the person being detained been recently in close contact with a confirmed case of COVID-19?
- Has the person being detained recently returned from overseas within the last 14 days?

Officers are required to use their discretion and take into account their own personal safety. The Department of Health and Human Services has provided the following PPE:

- Single-use surgical mask
- Gloves
- Hand Sanitiser.

9.6.2 AOs going onto floors of hotel

AOs going onto hotel floors with persons subject to detention must wear a surgical mask. There will be surgical masks for AO's at the hotels.

AO's should not enter the room in which a person is being detained. Communication should be from the corridor or outside the room.

9.6.3 Relocating a confirmed case of COVID-19

All COVID confirmed cases will be transferred to a Covid hotel. The AO should amend the detention notice with the new location details prior to the detainee leaving the premises. Gloves and mask should be work when amending the notice and advising the detainee of the amendment.

Companions of the confirmed covid case may wish to remain with the confirmed covid detainee and transfer to the covid hotel. Their detention notice will also need to be amended.

Transfer of the detainee is the responsibility of the EOC.

The room or location change must be recorded in the compliance app by the AO

9.7 Measures and guides to enhance occupational health and safety

PPE/measure	Guide
Single-use face mask (surgical mask)	When there is suspected or confirmed case of COVID-19, or a person subject to detention has been recently exposed to COVID-19 and a distance of at least 1.5 metres cannot be maintained.
Gloves	If contact with the person or blood or body fluids is anticipated.
Hand hygiene / Hand Sanitizer Soap and water	Always
Physical distancing of at least 1.5 meters	Always

9.8 Known risks and hazards

Hazard	Risk	Mitigate
COVID-19 infection	Serious illness / death	Follow personal protective measures
Fatigue	Impaired decisions / driving to site	In the first instance use virtual technology to perform duties Use fatigue calculator http://www.vgate.net.au/fatigue.php
Physical Injury	Low / Medium	Only attend a site with Victoria Police or with security.
Other infectious agents		Follow personal protective measures

Appendix 1 – Script for plane/arrival

Required script before issuing a direction and detention notice

My Name is XXXX, I work for the Department of Health and Human Services Victoria and I am an Authorised Officer under the Public Health and Wellbeing Act. I am also authorised for the purposes of the emergency and public health risk powers in Victoria's current State of Emergency.

Because you have arrived in Victoria from overseas, when you disembark off this plane you will be issued with a direction and detention notice, which requires you to quarantine for a 14-day period at the hotel nominated on the notice.

Many of Victoria's cases of covid-19 originate from overseas and international travellers so this action is necessary to ensure we reduce the serious risk to public health posed by COVID 19.

Refusal or failure to comply without reasonable excuse is an offence. There are penalties for not complying with the notice.

Once you have been issued with the notice, please keep it with you at all times.

We greatly appreciate your co-operation and assistance in these challenging times. Thank you again.

Appendix 2 - Permission for temporary leave from detention

PERMISSION FOR TEMPORARY LEAVE FROM DETENTION

Public Health and Wellbeing Act 2008 (Vic)

Section 200

An Authorised Officer has granted you permission to leave your room based on one of the grounds set out below. This is temporary. You will be supervised when you leave your room. You must ensure you comply with all the conditions in this permission and any directions an Authorised Officer gives you. You must return to your room at the time specified to finish your detention. Speak to your supervising Authorised Officer if you require more information.

Temporary leave

(1) You have arrived in Victoria from overseas, on or after midnight [on 28 March 2020 or 13 April 2020] and have been placed in detention, pursuant to a Direction and Detention Notice that you were provided on your arrival in Victoria (**Notice**).

(2) This Permission for Temporary Leave From Detention (**Permission**) is made under paragraph 4(1) of the Notice.

Reason/s for, and terms of, permission granting temporary leave

(3) Permission for temporary leave has been granted to: _____ _____ [insert name] for the following reason/s [tick applicable]:

☐ (a) for the purpose of attending a medical facility to receive medical care:

Name of facility: _____

Time of admission/appointment:_____

Reason for medical appointment:_____

☐ (b) where it is reasonably necessary for physical or mental health:

Reason leave is necessary:_____

Proposed activity/solution:_____

☐ (c) on compassionate grounds:

Detail grounds:_____

(4) The temporary leave starts on _____

and ends on _____ [insert date and time].

_____ **Signature of Authorised Officer**

Name of Authorised Officer: _____

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

Conditions

(5) You must be supervised **at all times**/may be supervised *[delete as appropriate]* while you are out of your room. You are not permitted to leave your hotel room, even for the purpose contained in this Permission, unless you are accompanied by an Authorised Officer.

(6) While you are outside your room you must practice social distancing, and as far as possible, maintain a distance of 1.5 metres from all other people, including the Authorised Officer escorting you.

(7) When you are outside your room you must refrain from touching communal surfaces, as far as possible, such as door knobs, handrails, lift buttons etc.

(8) When you are outside your room you must, at all times, wear appropriate protective equipment to prevent the spread of COVID-19, if directed by the Authorised Officer escorting you.

(9) When you are outside your room you must, at all times, comply with any direction given to you by the Authorised Officer escorting you.

(10) At the end of your temporary leave, you will be escorted back to your room by the Authorised Officer escorting you. You must return to your room and remain there to complete the requirements under the Notice.

(11) Once you return to the hotel, you must proceed immediately to the room you have been allocated above in accordance with any instructions given to you.

(12) You must comply with any other conditions or directions the Authorised Officer considers appropriate.

(Insert additional conditions, if any, at Annexure 1)

Specific details

(13) Temporary leave is only permitted in limited circumstances, to the extent provided for in this Permission, and is subject to the strict conditions outlined at paragraph 3. You must comply with these conditions at all times while you are on temporary leave. These conditions are reasonably necessary to protect public health, in accordance with section 200(1)(d) of the Public Health and Wellbeing Act 2008 (Vic).

(14) Permission is only granted to the extent necessary to achieve the purpose of, and for the period of time noted at paragraph 2 of this Permission.

(15) Nothing in this Permission, invalidates, revokes or varies the circumstances, or period, of your detention, as contained in the Notice. The Notice continues to be in force during the period for which you are granted permission for temporary leave from detention. The Notice continues to be in force until it expires.

Offences and penalties

(16) It is an offence under section 203 of the Act if you refuse or fail to comply with the conditions set out in this Permission, unless you have a reasonable excuse for refusing or failing to comply.

(17) The current penalty for an individual is $19,826.40.

Appendix 3 Guidance Note: Permission for Temporary Leave from Detention

How do you issue a Permission for Temporary Leave from Detention?

It is recommended that Authorised Officers take the following steps when issuing a Permission for Temporary Leave from Detention:

- **Before you provide the Permission for Temporary Leave from Detention**

- carefully consider the request for permission and consider the grounds available under paragraph 4(1) of the Direction and Detention Notice – which include:
  - for the purposes of attending a medical facility to receive medical care; or
  - where it is reasonably necessary for the person's physical or mental health; or
  - on compassionate grounds.
- complete all sections of the Permission, including clearly documenting the reasons for the Permission, date and time when the temporary leave is granted from and to, and whether the person will be supervised by the authorised officer during the temporary leave
- ensure the reference number is completed.

- **When you are provide the Permission for Temporary Leave from Detention**

- you must warn the person that refusal or failure to comply without reasonable excuse, is an offence;
- explain the reason why it is necessary to provide the Permission and the conditions which apply to the temporary leave (including that the person is still subject to completing the remainder of the detention once the temporary leave expires, and the Permission is necessary to protect public health);
- provide a copy of the Permission to the person, provide them with time to read the Permission and keep the completed original for the department's records.

NB If it is not practicable to explain the reason why it is necessary to give the Permission, please do so as soon as practicable after Permission has been exercised.

- **What are the requirements when you are granting a permission to a person under the age of 18?**

The same requirements set out above apply when issuing a Permission to an unaccompanied minor. However, the supervising Authorised Officer must have Working With Children Check, have regard to the special conditions in the Direction and Detention Notice as well as the person's status as a child.

- **What other directions can you give?**

Section 200(1)(d) of the PHWA sets out an emergency power that allows an authorised officer to give any other direction that the authorised officer considers is reasonably necessary to protect public health.

What are your obligations when you require compliance with a direction?

Exercising this power imposes several obligations on departmental authorised officers including that an authorised officer must, before exercising any emergency powers, warn the person that refusal or failure to comply without reasonable excuse, is an offence.

Appendix 4 Guidance: Exemptions under Commonwealth law

Please note that Victoria may vary from this guidance

Exemptions to the 14 day mandatory quarantine period for international travellers

The Australian Health Protection Principal Committee (AHPPC) recognise that there should be some exemptions from quarantine requirements for specific industry groups, provided they adhere to specified risk mitigations measures. These specific exemptions are recommended because of the industry infection prevention requirements, training these groups have undergone, and the vital role of these industries in Australia.

While these are national recommendations, mandatory quarantine is enforced under state and territory public health legislation. Individual states and territories may choose to implement additional requirements at the point of arrival.

Some jurisdictions may also have additional quarantine requirements upon entry to the state or territory. Depending on the jurisdiction, this could mean that an international traveller is required to go into mandatory quarantine at the first point of arrival into Australia, and further quarantine upon entry to another jurisdiction.

The following groups are recommended to be exempt from the 14 day mandatory quarantine requirements when entering Australia. While these groups are exempt from mandatory quarantine, **all** arrivals into Australia **must** continue to practise social distancing, cough etiquette and hand hygiene. Other requirements, such as self-isolation, may still apply and are outlined below.

Aviation crew

International flight crew (Australian residents/citizens)

- Are not required to undertake 14 days of mandatory quarantine on arrival.
- Are not required to complete the Isolation Declaration Card.
- Are not required to self-isolate.

International flight crew (foreign nationals)

- Are not required to undertake 14 days of mandatory quarantine on arrival.
- Are not required to complete the Isolation Declaration Card.
- Must self-isolate in their hotel on arrival until their next flight.
- Must use privately organised transport to transfer to and from hotels between flights.
- May fly domestically to their next point of departure from Australia if required.

Domestic flight crew

- Exempt from self-isolation requirements *except when a state or territory specifically prohibits entry.*

Maritime crew (excluding cruise ships)

- Are not required to undertake 14 days of mandatory quarantine on arrival into Australia. They are therefore not required to complete the Isolation Declaration Card.
- Must proceed directly to the vessel on arrival.

Exemptions to the 14 day mandatory quarantine period, version 2 (06/04/2020)
Coronavirus Disease (COVID-19) 1

- If access to the vessel is not immediate, crew must self-isolate at their accommodation during any lay-over period.
- May travel domestically and/or take a domestic flight to meet their vessel at the next point of departure if required.
- At the completion of their shifts, they are not required to go into mandatory 14 days quarantine, but must undertake 14 days self-isolation.
- Time at sea counts towards the 14 days of self-isolation if no illness has been reported on-board. Therefore crew signing off commercial vessels that have spent greater than 14 days at sea, with no know illness on-board, do not need to self-isolate on arrival.

Unaccompanied minors

Unaccompanied minors will be allowed to travel domestically after entering Australia to self-quarantine with a parent or guardian at their home.

Transit passengers

- International transit passengers arriving into Australia are able to depart on another international flight if the following conditions are met:
  - If the individual has up to 8 hours until the departing international flight, they must remain at the airport and be permitted to onward travel, maintaining social distancing and hand hygiene.
  - If 8-72 hours before the departing flight, they must go to mandatory quarantine at the state designated facility until the time of the departing flight.
- No domestic onward travel is allowed, even if this is to meet a departing international flight. These people should go into mandatory quarantine at the state designated facility at the first point of arrival.

Diplomats

- Australia has legal obligations under the Vienna Convention to ensure diplomats freedom of movement and travel, and protection from detention. Diplomats are not required to undertake 14 days of mandatory quarantine on arrival into Australia. They are therefore not required to complete the Isolation Declaration Card.
- Diplomats should self-isolate at their mission or in their usual place of residence on arrival for 14 days.
- Diplomats must continue to practise social distancing, cough etiquette and hand hygiene.

Compassionate or medical grounds

Applications on medical or compassionate grounds should be submitted to the relevant state or territory who will consider requests on a case-by-case basis.

Contact details for state or territory public health agencies are available at www.health.gov.au/state-territory-contacts.

Where can I get more information?

For the latest advice, information and resources, go to www.health.gov.au.

Call the National Coronavirus Helpline on [redacted]. This line operates 24 hours a day, seven days a week. If you require translating or interpreting services, call [redacted].

Appendix 5 - Guidance note: Ensuring physical and mental welfare of international arrivals in individual detention (unaccompanied minors)

Introduction

You are an officer authorised by the Chief Health Officer under section 199(2)(a) of the *Public Health and Wellbeing Act 2008* (Vic) to exercise certain powers under that Act. You also have duties under the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**Charter**).

These Guidelines have been prepared to assist you to carry out your functions in relation to Victorian unaccompanied minors who have arrived in Victoria and are subject to detention notices, requiring them to self-quarantine in a designated hotel room for 14 days in order to limit the spread of Novel Coronavirus 2019 (**2019-nCoV**) where no parent, guardian or other carer (**parent**) has elected to join them in quarantine (a **Solo Child Detention Notice**).

As part of your functions, you will be required to make decisions as to whether a person who is subject to a Solo Child Detention Notice should be granted permission to leave their room:

- for the purposes of attending a medical facility to receive medical care; or
- where it is reasonably necessary for their physical or mental health; or
- on compassionate grounds.

Authorised Officers are also required to review the circumstances of each detained person at least once every 24 hours, in order to determine whether their detention continues to be reasonably necessary to eliminate or reduce a serious risk to public health.

Your obligations under the Charter of Human Rights and Responsibilities Act 2006

You are a public officer under the Charter. This means that, in providing services and performing functions in relation to persons subject to a Detention Notice you must, at all times:

- act compatibly with human rights; and
- give 'proper consideration' to the human rights of any person(s) affected by your decisions.

How to give 'proper consideration' to human rights

'Proper consideration' requires you to:

- **first**, understand in general terms which human rights will be affected by your decisions (these rights are set out below under 'relevant human rights');
- **second**, seriously turn your mind to the possible impact of your decisions on the relevant individual's human rights, and the implications for that person;
- **third**, identify the countervailing interests (e.g. the important public objectives such as preventing the further spread of 2019-nCoV, which may weigh against a person's full enjoyment of their human rights for a period of time); and
- **fourth**, balance the competing private and public interests to assess whether restricting a person's human rights (e.g. denying a person's request to leave their room) is justified in the circumstances.

Relevant human rights

The following human rights protected by the Charter are likely to be relevant to your functions when conducting daily wellbeing visits and when assessing what is reasonably necessary for the physical and mental health of children who are subject to Solo Child Detention Notices:

- The right of children to such protection as is in their best interests (s 17(2)). As the Solo Child Detention Notices detain children in circumstances where no parent has elected to join them in quarantine, greater protection must be provided to these children in light of the vulnerability that this creates. Where possible the following additional protection should be provided:
- You should undertake two hourly welfare checks while the child is awake and once overnight. You should ask the child to contact you when they wake each morning and let you know when they go to sleep so that this can be done.
- You should ask the child if they have any concerns that they would like to raise with you at least once per day.
- You should contact the child's parents once per day to identify whether the parent is having contact with the child and whether the parent or child have any concerns.
- You should ensure that where the child does not already have the necessary equipment with them to do so (and their parent is not able to provide the necessary equipment) the child is provided with the use of equipment by the department to facilitate telephone and video calls with their parents. A child must not be detained without an adequate means of regularly communicating with their parents.
- You should ensure that where the child does not already have the necessary equipment with them to do so (and their parent is not able to provide the necessary equipment) the child is provided with the use of equipment by the department to participate in remote education if that is occurring at the school they are attending. Within the confines of the quarantine you should obtain reasonable assistance for the child in setting up that computer equipment for use in remote education.
- You should allow the child's parents to bring them lawful and safe items for recreation, study, amusement, sleep or exercise for their use during their detention. This should be allowed to occur at any time within business hours, and as many times as desired, during the detention.
- The rights to liberty (s 21) and freedom of movement (s 12), and the right to humane treatment when deprived of liberty (s 22). As the Solo Child Detention Notices deprive children of liberty and restrict their movement, it is important that measures are put in place to ensure that the accommodation and conditions in which children are detained meet certain minimum standards (such as enabling parents to provide detained children with food, necessary medical care, and other necessities of living). It is also important that children are not detained for longer than is reasonably necessary.
- Freedom of religion (s 14) and cultural rights (s 19). Solo Child Detention Notices may temporarily affect the ability of people who are detained to exercise their religious or cultural rights or perform cultural duties; however, they do not prevent detained persons form holding a religious belief, nor do they restrict engaging in their cultural or religious practices in other ways (for example, through private prayer, online tools or engaging in religious or cultural practices with other persons with whom they are co-isolated). Requests by children for additional items or means to exercise their religious or cultural practices will need to be considered and accommodated if reasonably practicable in all the circumstances.
- The rights to recognition and equality before the law, and to enjoy human rights without discrimination (s 8). These rights will be relevant where the conditions of detention have a disproportionate impact on detained children who have a protected attribute (such as race or disability). Special measures may need to be taken in order to address the particular needs and vulnerabilities of, for example Aboriginal persons, or persons with a disability (including physical and mental conditions or disorders).

- The rights to **privacy, family and home** (s 13), **freedom of peaceful assembly** and **association** (s 16) and the **protection of families** (s 17). Solo Child Detention Notices are likely to temporarily restrict the rights of persons to develop and maintain social relations, to freely assemble and associate, and will prohibit physical family unification for those with family members in Victoria. Children's rights may be particularly affected, to the extent that a Solo Child Detention Notice results in the interference with a child's care and the broader family environment. It is important, therefore, to ensure children subject to Solo Child Detention Notices are not restricted from non-physical forms of communication with relatives and friends (such as by telephone or video call). Requests for additional items or services to facilitate such communication (e.g. internet access) will need to be considered and accommodated if reasonably practicable in all the circumstances.

Whether, following 'proper consideration', your decisions are compatible with each these human rights, will depend on whether they are reasonable and proportionate in all the circumstances (including whether you assessed any reasonably available alternatives).

General welfare considerations

All persons who are deprived of liberty must be treated with humanity and respect, and decisions made in respect of their welfare must take account of their circumstances and the particular impact that being detained will have on them. Mandatory isolation may, for some people, cause greater hardship than for others – when performing welfare visits you will need to be alert to whether that is the case for any particular person.

In particular, anxieties over the outbreak of 2019-nCoV in conjunction with being isolated may result in the emergence or exacerbation of mental health conditions amongst persons who are subject to Detention Notices.

If you have any concerns about the mental health of a detained person, you should immediately request an assessment of mental health be conducted and ensure appropriate support is facilitated. Hotel rooms are not normally used or designed for detention, so you should be aware that a person who is detained in a hotel room could have greater opportunity to harm themselves than would be the case in a normal place of detention.

Additional welfare considerations for children

Children differ from adults in their physical and psychological development, and in their emotional and educational needs. For these reasons, children who are subject to Solo Child Detention Notices may require different treatment or special measures.

In performing functions and making decisions with respect to a detained person who is a child, the best interests of the child should be a primary consideration. Children should be given the opportunity to conduct some form of physical exercise through daily indoor and outdoor recreational activities. They should also be provided with the ability to engage in age-appropriate activities tailored to their needs.

Each child's needs must be assessed on a case-by-case basis. Requests for items or services to meet the needs of individual children will need to be considered and accommodated if reasonably practicable in all the circumstances.

Where available, primary school age children should be allocated rooms that have an outside area where it is safe for active physical play to occur (not a balcony) and consideration should be given to allowing small children access to any larger outdoor areas that are available within the hotel, where possible within relevant transmission guidelines. Although each child's needs must be assessed daily and

individually, it can be assumed that it will have a negative effect on a child's mental health to be kept in the same room or rooms for two weeks without access to an adequate outdoor area in which to play.

Balancing competing interests

However, the best interests of children and the rights of anyone who is subject to a Solo Child Detention Notice will need to be balanced against other demonstrably justifiable ends; for example, lawful, reasonable and proportionate measures taken to reduce the further spread of 2019-nCoV.

It is your role to undertake this balance in your welfare checks, based on the information and advice that you have from the department and on the information provided to you by the children that you are assessing.

Appendix 6 Direction and Detention Notice – Solo Children

DIRECTION AND DETENTION NOTICE

SOLO CHILDREN

Public Health and Wellbeing Act 2008 (Vic)
Section 200

Reason for this Notice

You have arrived in Victoria from overseas, on or after midnight on 28 March 2020 or on or after 13 April 2020..

A state of emergency has been declared under section 198 of the *Public Health and Wellbeing Act 2008* (Vic) (the **Act**), because of the serious risk to public health posed by COVID-19.

In particular, there is a serious risk to public health as a result of people travelling to Victoria from overseas. People who have been overseas are at the highest risk of infection and are one of the biggest contributors to the spread of COVID-19 throughout Victoria.

You will be detained at the hotel specified in clause 2 below, in the room specified in clause 2 below, for a period of 14 days, because that is reasonably necessary for the purpose of eliminating or reducing a serious risk to public health, in accordance with section 200(1)(a) of the Act.

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

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

The Chief Health Officer will be notified that you have been detained. The Chief Health Officer must advise the Minister for Health of your detention.

Note: These steps are required by sections 200(7) and (9) of the Act.

Place and time of detention

You will be detained at:

Hotel: _____ *(to be completed at place of arrival)*

Room No: _____ *(to be completed on arrival at hotel)*

You will be detained until: _____ on ____of _____2020.

Directions — transport to hotel

You must **proceed immediately to the vehicle** that has been provided to take you to the hotel, in accordance with any instructions given to you.

Once you arrive at the hotel, **you must proceed immediately to the room** you have been allocated above in accordance with any instructions given to you.

Conditions of your detention

You must not leave the room in any circumstances, unless:

you have been granted permission to do so:

for the purposes of attending a medical facility to receive medical care; or

where it is reasonably necessary for your physical or mental health; or

on compassionate grounds; or

there is an emergency situation.

You must not permit any other person to enter your room, unless the person is authorised to be there for a specific purpose (for example, providing food or for medical reasons).

Except for authorised people, the only other people allowed in your room are people who are being detained in the same room as you.

You are permitted to communicate with people who are not staying with you in your room, either by phone or other electronic means.

Note: An authorised officer must facilitate any reasonable request for communication made by you, in accordance with section 200(5) of the Act.

(18) If you are under 18 years of age your parent or guardian is permitted to stay with you, but only if they agree to submit to the same conditions of detention for the period that you are detained.

Review of your detention

Your detention will be reviewed at least once every 24 hours for the period that you are in detention, in order to determine whether your detention continues to be reasonably necessary to eliminate or reduce a serious risk to public health.

Note: This review is required by section 200(6) of the Act.

Special conditions because you are a solo child

Because your parent or guardian is not with you in detention the following additional protections apply to you:

We will check on your welfare throughout the day and overnight.

We will ensure you get adequate food, either from your parents or elsewhere.

We will make sure you can communicate with your parents regularly.

We will try to facilitate remote education where it is being provided by your school.

We will communicate with your parents once a day.

Offence and penalty

It is an offence under section 203 of the Act if you refuse or fail to comply with the directions and requirements set out in this Notice, unless you have a reasonable excuse for refusing or failing to comply.

The current penalty for an individual is $19,826.40.

_____

Name of Authorised Officer: _____

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

Appendix 7: End of Detention Notice

Public Health and Wellbeing Act 2008 (Vic)

Section 200

Subject to the conditions below, this Notice is evidence that this detainee has completed their period of detention under a *Direction and Detention Notice* issued to reduce or eliminate the serious public health risk posed by COVID-19.

Detention Notice

You have arrived in Victoria from overseas, on or after midnight on 28 March 2020 and have been placed in detention, pursuant to a Direction and Detention Notice that you were provided on your arrival in Victoria (**Notice**).

Details of Detention Notice

Name of Detainee: **<<FIRST NAME>> <<LAST NAME>>**

Date of Detainment and Detention Notice: <<DETENTION START DATE>>

Place of Detention: <<HOTEL>> <<ROOM>>

End of Detention Notice

In accordance with section 200(6) of the *Public Health and Wellbeing Act 2008,* I have reviewed your continued detention.

On review of the Notice, I have made the following findings:

you will have served the required detention period by <<DETENTION END DATE>>; and

you have not started exhibiting any symptoms of COVID-19.

In consideration of the above circumstances, I have decided that your continued detention is not reasonably necessary to eliminate or reduce a serious risk to public health.

I advise that your detention pursuant to section 200(1)(a) of the *Public Health and Wellbeing Act 2008* (Vic) and the Notice will end on <<**DETENTION END DATE**>> at _____after you have been discharged by an Authorised Officer and have commenced transportation to your ordinary residence.

Although you are no longer to be detained pursuant to the Notice, you are required to comply with all directions currently in force in Victoria. This includes the Stay at Home Directions (No 3) (**Direction**), as amended from time to time. Pursuant to the Direction, if you live in Victoria you are required to travel directly to the premises where you ordinarily reside, and remain there unless you are leaving for one of the reasons listed in the Direction.

If you are a resident of another state arrangements will be made for you to return home. While you remain in the State of Victoria, you are required to comply with all Directions in operation in Victoria. Once you have returned home, you are required to comply with the Directions and/or Orders in place in your home jurisdiction, including any directions that may require you to isolate for a further 14 day period.

In the event that you start to experience symptoms of COVID-19, it is important that you self-isolate and, if necessary, contact your General Practitioner or local Public Health Unit.

End of Detention Instructions

You must not leave your hotel room until you have been collected by Security at which time you are permitted to travel to the hotel lobby to meet an Authorised Officer who will **sight your identification** and discharge you from detention. **Security will give you approximately an hour notice of when they will collect you.**

Your detention **does not end** until the time stated in paragraph 0 of this notice which will be filled in by an authorised officer when you are discharged from detention. Until that time you must continue to abide by the requirements of your detention, as contained in the Notice.

When leaving detention you **must** adhere to the following safeguards:

if provided to you, you **must** wear personal protective equipment;

you **must** refrain, as far as possible, from touching communal surfaces, such as handrails, elevator buttons and door handles;

you **must** where possible, engage in social distancing, maintaining a distance of 1.5 metres from other people; and

upon leaving your hotel room, you **must** go straight to the foyer for discharge and then immediately after travel to your transportation and travel directly to your ordinary residence.

These steps are to ensure your protection, and reduce the risk of you becoming infected with COVID-19 by any persons detained in the hotel, or in the community, who may have COVID-19.

Until your detention has concluded, you must follow instructions from Authorised Officer/s and any other conditions set out.

2 Offence and penalty

(1) It is an offence under section 203 of the Act if you refuse or fail to comply with the directions set out in this notice, unless you have a reasonable excuse for refusing or failing to comply.

(2) The current penalty for an individual is $19,826.40.

_____ **Signature of Authorised Officer**

Name of Authorised Officer: _____

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

Appendix 8: End of Detention Notice (confirmed case or respiratory illness symptoms)

Public Health and Wellbeing Act 2008 (Vic)

Section 200

An Authorised Officer has decided to end your Direction and Detention Notice. This decision has been made following the mandatory review of your Direction and Detention Notice because you [*have returned a positive test for COVID-19*] *or* [*have started displaying symptoms of respiratory illness*].

1. Detention Notice

You have arrived in Victoria from overseas, on or after midnight on 28 March 2020 or on or after midnight on 13 April 2020 and have been placed in detention, pursuant to a Direction and Detention Notice that you were provided on your arrival in Victoria (**Notice**).

2. Details of End of Detention Notice

Name of Detainee:_____

Date Notice Made:_____

Date Notice Expires:_____

Place of Detention:_____

Medical Facility:_____
(if medical care is required)

COVID-19 Status or respiratory illness symptoms [tick applicable]:

COVID-19 confirmed*:* _____ *[insert date of test]*	☐	coughing	☐
fever or temperature in excess of 37.5 degrees	☐	sort throat	☐
congestion, in either the nasal sinuses or lungs	☐	body aches	☐
runny nose	☐	fatigue	☐

3. End of Detention Notice

In accordance with section 200(6) of the Public Health and Wellbeing Act 2008, I have reviewed your continued detention.

On review of the Notice, I have noticed that you [have been diagnosed with COVID-19] or [have exhibited the symptoms of respiratory illness, as outlined above at paragraph 2(8) *[delete as applicable*].

In consideration of the above, I do not believe that continued detention is reasonably necessary to eliminate or reduce a serious risk to public health because:

a) [*if applicable*] You have been confirmed to have COVID-19 and will be required to self-isolate in accordance with the Isolation (Diagnosis) Direction, in a premises that is suitable

for you to reside in, or a medical facility, until such a time you are notified that you no longer need to self-isolate and a clearance from isolation (self-isolation) is given;

b) [*if applicable*] You are showing symptoms of respiratory illness and will be required to self-isolate in accordance with the Stay at Home Direction currently in force in Victoria and will need travel directly to your ordinary residence once you leave detention, and remain there unless you are permitted to leave for a reason specified in the Stay at Home Direction; and

c) You are ordinarily a resident in Victoria.

Compliance with Directions made by the Deputy Chief Health Officer is required to reduce or eliminate the serious risk to public health posed by COVID-19. It is essential that you [self-isolate in accordance with the Isolation (Diagnosis) Direction until such time as you are notified that you no longer need to self-isolate and a clearance from self-isolation is given] OR [return to your ordinary residence and remain there unless you are permitted to leave for a reason specified in the Stay at Home Direction. Please monitor your symptoms and seek appropriate medical care if required]. *[delete as applicable*].

The Notice is ended subject to the directions below under paragraph 4. Non-compliance with these directions is an offence.

4. Conditions

- You will be transited from the hotel where you have been detained to your ordinary residence / Premises for Isolation pursuant to Isolation (Diagnosis) Direction / medical facility [*delete as appropriate*] by an Authorised Officer. You may / will [*delete as appropriate*] be supervised during transit.
- While you are transiting to your ordinary residence / Premises for Isolation pursuant to Isolation (Diagnosis) Direction / medical facility [*delete as appropriate*], you must refrain from touching communal surfaces, as far as possible, such as door knobs, handrails, lift buttons etc.
- When you are transiting to your ordinary residence / Premises for Isolation pursuant to Isolation (Diagnosis) Direction / medical facility [*delete as appropriate*], you must, **at all times**, wear appropriate protective equipment to prevent the spread of COVID-19, if directed by the Authorised Officer.
- You must practice social distancing, and as far as possible, maintain a distance of 1.5 metres from all other people, including any Authorised Officer escorting you.
- When you are transiting to your ordinary residence / Premises for Isolation pursuant to Isolation (Diagnosis) Direction / medical facility [*delete as appropriate*], you must, **at all times**, comply with any direction given to you by any Authorised Officer escorting you.

5. Offence and penalty

It is an offence under section 203 of the Act if you refuse or fail to comply with the directions and requirements set out in this notice and/or the Isolation (Diagnosis) Direction *[if applicable*], unless you have a reasonable excuse for refusing or failing to comply.

The current penalty for an individual is $19,826.40.

_____ **Signature of Authorised Officer**

Name of Authorised Officer: _____

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

Appendix 9:End of detention guidance note

How to conclude a person's detainment under a *Direction and Detainment Notice* if they have served the required period of detainment, become a confirmed case of COVID-19 or have symptoms of respiratory illness

What do you have to do before you issue an End of Detention Notice?

- if the person has served 14 days of detention you must decide how to administer the completion of that person's detention arrangements:
  - selecting a time for the person to attend a foyer after the 14 day period has concluded - it is recommended that this occur in small groups of people who are practicing appropriate social distancing and with sufficient time between groups to avoid crowds. This will ensure Authorised Officers can safely discharge each detainee
  - collecting a person from their hotel room after the 14 day period has concluded – this approach should be carefully administered to ensure Authorised Officers can safely discharge each person
- if a person's detainment is concluding because they have a confirmed case of COVID-19 or symptoms of respiratory illness they must be discharged when it is safe to do so – e.g. when other detained people are in their rooms, under full supervision etc.
- complete all sections of the Notice, including clearly documenting the reasons for the end of detention and the details recorded on the Direction and Detention Notice
- update all the registers and relevant records about the person's detainment arrangements
- ensure the reference number is completed.

When should you issue an End of Detention Notice?

It is preferable that an End of Detention Notice be issued the day before a person's detainment is set to conclude – this will give the person adequate time to prepare (e.g. to pack their belongings) and ensure the orderly discharge of large groups of people.

A notice may be provided earlier but it creates a risk that a person may develop COVID-19 symptoms before the day the detainment period must end.

What do you have to do when you issue an End of Detention Notice?

When you issue an End of Detention Notice you must:

- explain the reason why detention has ceased and is no longer necessary to eliminate or reduce a serious risk to public health
- advise that person of the arrangements being made for their discharge from detention (e.g. at an allocated time at the foyer; when they are escorted from their room etc)
- notify they person that although they are no longer subject to detention when they are discharged and leave the premises of their detention, they are still subject to the directions which are in force in Victoria, including
  - if they are ordinarily resident in Victoria, they are required to return immediately to their ordinary residence, where they must remain, in accordance with the Stay at Home Directions (No 2)
  - if they have a confirmed case of COVID-19, they must isolate at home in accordance with the Isolation (Diagnosis) Direction

Appendix 10: Charter of Human Rights obligations

Key points

- AO must act compatibly with human rights.
- AO must give 'proper consideration' to the human rights of any person(s) affected by an AO's decision.

Department AO obligations under the Charter of Human Rights and Responsibilities Act 2006

Department AOs are public officials under the Charter of Human Rights. This means that, in providing services and performing functions in relation to persons subject to the Direction and Detention Notice, department AOs must, at all times: act compatibly with human rights; and

give 'proper consideration' to the human rights of any person(s) affected by a department AO's decisions.

How to give 'proper consideration' to human rights

1. ••understand in general terms which human rights will be affected by a decision
2. •be aware of how the decision will limit or interfere with the relevant human rights
3. ••consider what impact the decision will have on the rights of all the people affected by the decision
4. •balance the competing private and public interests to assess whether restricting a person's human rights

The relevant Charter Human Rights that departmental AOs need to be aware of that may be affected by a decision:

Charter Right	Obligation
Right to life	• This includes a duty to take appropriate steps to protect the right to life and steps to ensure that the person in detention is in a safe environment and has access to services that protect their right to life

Right to protection from torture and cruel, inhuman or degrading treatment	• This includes protecting persons in detentions from humiliation and not subjecting persons in detention to medical treatments without their consent
Right to freedom of movement	• while detention limits this right, it is done to minimise the serious risk to public health as a result of people travelling to Victoria from overseas
Right to privacy and reputation	• this includes protecting the personal information of persons in detention and storing it securely
Right to protection of families and children	• this includes taking steps to protect families and children and providing supports services to parents, children and those with a disability
Property Rights	• this includes ensuring the property of a person in detention is protected
Right to liberty and security of person	this includes only be detained in accordance with the PHWA and ensuring steps are taken to ensure physical safety of people, such as threats from violence
Rights to humane treatment when deprived of liberty	this includes treating persons in detention humanely.

Appendix 11 Register of permissions granted under 4(1) of the *Direction and Detention Notice*

Authorised officer:_____

Ref No.	Date	Name of detained person	Reason	Time-Out	Time-In

Appendix 12 Guidance Note — Exceptions to the General Quarantine Policy

Summary

You are [an officer authorised by the Chief Health Officer under section 199(2)(a) of the *Public Health and Wellbeing Act 2008* (Vic) (**PHW Act**) to exercise certain powers under that Act] [or a delegate of the Chief Health Officer under section 22 of the PHW Act] [**Note: however, only registered medical practitioners can be delegates under s 22**]. You also have duties under the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**Charter**).

This guidance note has been prepared to assist you to carry out your functions in determining whether individual persons arriving in Victoria from overseas should be exempt from being made subject to a detention notice requiring them to self-quarantine in a designated hotel room for 14 days in order to limit the spread of Novel Coronavirus 2019 (**2019-nCoV**) (the **general quarantine policy**). This policy is in place because people returning from overseas are at increased risk of infection from 2019-nCoV and may inadvertently transmit it to others upon their return and because the earlier requirement to isolate at home was not uniformly complied with.

As part of your functions, you are required to make decisions as to whether an exception to the general quarantine policy is warranted in particular cases that have been escalated to you by authorised officers. If you decide that an exception applies, you must subsequently decide whether the person in question should be:

1. released from quarantine in Victoria (because they are medically cleared or will be subject to another jurisdiction's regime); or
2. required to complete their quarantine in another location in Victoria (at home or in another facility), in which case they would be subject to the same conditions that apply to other international arrivals under the standard direction and detention notice, including monitoring and penalties for non-compliance.

This guidance note sets out the following **six categories of exceptions** to the general quarantine policy and provides a checklist of relevant factors to be considered when determining whether each exception applies:

1. International transit (for example, transit in Victoria from New Zealand en route to Europe or vice versa).
2. Interstate transit (with the approval of the receiving jurisdiction, usually for compassionate reasons or as an unaccompanied minor).
3. Unaccompanied minors whose legal guardians are unable to reside with them at the hotel (for example, due to other caring responsibilities).
4. Compassionate or medical grounds (for example, if the person suffers from anaphylaxis).
5. Previous confirmed cases with medical clearance who no longer require quarantine.
6. Key workers.

It also provides guidance on how to fulfil your obligations under the Charter for each exception. Those obligations are to act compatibly with human rights and to give 'proper consideration' to the relevant human rights of any person(s) affected by your decisions. The relevant factors and human rights considerations will differ depending on the applicable exception.

We note that, although it is important that the exceptions are reasonably transparent and communicated clearly to people arriving in Victoria from overseas, this must be balanced against the need to ensure that the categories of exceptions are appropriately circumscribed so as not to undermine the general quarantine policy. Further, although this guidance note has been developed in the interests of ensuring consistency and clarity in the application of the exceptions, you must determine each request on a case-by-case basis.

Your obligations under the Charter

You are a public officer under the Charter. This means that, in deciding whether an exception to the general quarantine policy is warranted in any particular case, you must give 'proper consideration' to the human rights of *any person* affected by the decision, including the person who would otherwise be subject to the detention notice, the person(s) who they may quarantine with if they were to quarantine at home, and members of the community.

'Proper consideration' requires you to:

- **first**, understand in general terms which human rights will be affected by your decision (these rights are set out below and differ depending on the exception);
- **second**, seriously turn your mind to the possible impact of your decision on the relevant individual's human rights, and the implications for that person;
- **third**, identify the countervailing interests (e.g. the important public objectives such as preventing the further spread of 2019-nCoV, which may weigh against a person's full enjoyment of their human rights for a period of time); and
- **fourth**, balance the competing private and public interests to assess whether restricting a person's human rights is justified in the circumstances.

Exceptions [*Ensure consistency with Aus Government policy re exceptions to mandatory quarantine*]

1. International transit

Description of category

Relevant factors

[DHHS to please provide]

Relevant human rights

2. Interstate transit

Description of category

[*Refer to letter to diplomat re exception to travel to Canberra*]

Relevant factors

[DHHS to please provide]

Relevant human rights

3. Unaccompanied minors whose legal guardians are unable to reside with them at the hotel

Description of category

Relevant factors

[DHHS to please provide]

Relevant human rights

4. Compassionate or medical grounds

Description of category

[*Refer to previous assessments for* [redacted]

Relevant factors

[DHHS to please provide]

Relevant human rights

5. Previous confirmed cases with medical clearance who no longer require quarantine

Description of category

Relevant factors

[DHHS to please provide]

Relevant human rights

6. Key workers

Description of category

[*Refer to letter from Minister Hunt re exception for key workers*]

Relevant factors

[DHHS to please provide]

Relevant human rights

[Note: do we possibly need a 'miscellaneous' / catch-all category, to capture cases that may warrant an exception but do not fall squarely into one of the above categories?]

ANNEX 1

COVID-19 Compliance policy and procedures – Detention authorisation

Authorised Officers under the *Public Health and Wellbeing Act 2008*

Document Details

Version	Status	Author	Reviewer	Authorised for Release	Date
1.0	Approved	REDACTED	Angie Bone	Meena Naidu	29/4/2020
2.0	Approved	REDACTED	Meena Naidu	Murray Smith	24/05202020

VICTORIA State Government | Health and Human Services

This document is not for public release and is classified as 'sensitive'.

Contents

Appendices

1 Purpose and background

1.1 Purpose

This purpose of this annex is to outline the compliance and enforcement functions and procedures for the Direction and Detention notice under the *Public Health and Wellbeing Act 2008* (PHWA).

This is an annex to the State plan 'Operation Soteria: Mandatory Quarantine for All Victorian Arrivals' which describes the overarching system in operation.

1.2 Background

A mandatory quarantine (detention) approach was introduced by the Victorian Government, consistent with the Commonwealth Government (Department of Health Information for International Travellers) through a policy that a detention order would be used for all people arriving from overseas into Victoria.

An initial notice was issued on 27 March 2020, which ordered the detention of all persons who arrive into Victoria from overseas on or after midnight on 28 March 2020, requiring they be detained in a hotel for a period of 14 days. A second notice (No 2) was issued on 13 April 2020 that requires the detention of all person who arrived into Victoria from overseas on or after midnight on 13 April 2020, requiring they be detained in a hotel for a period of 14 days A third notice (No 3) was issued on 11 May 2020, that requires the detention of all persons arriving in Victoria from overseas to be detained in a quarantine hotel for a period of 14 days (Appendix 1).

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

1.2.1 Objectives

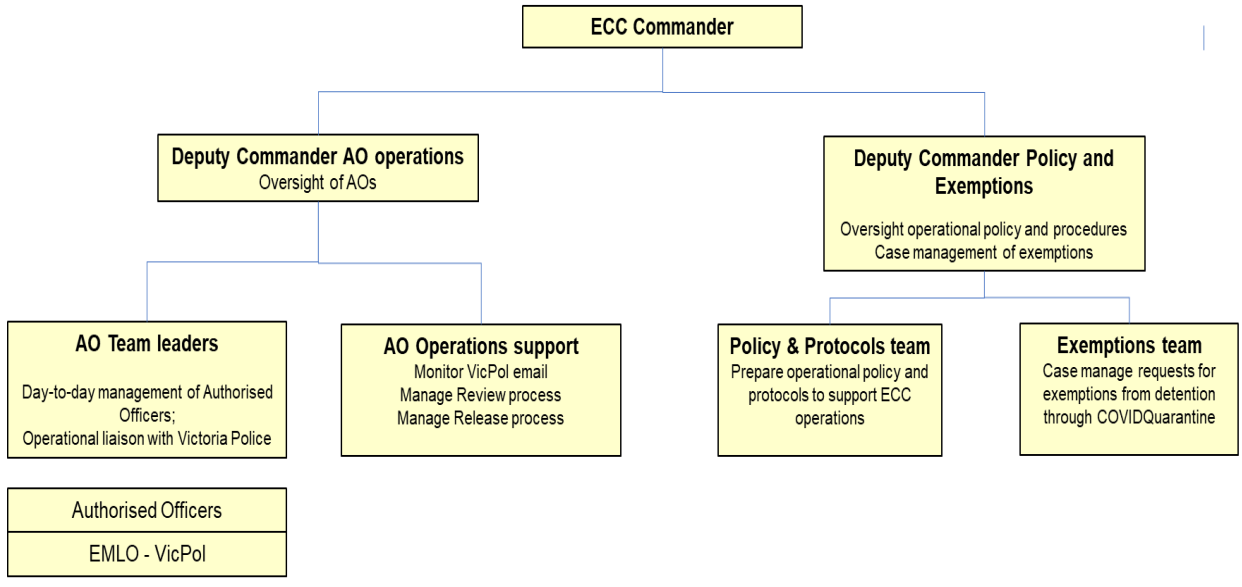
The objectives of the plan for people returning from overseas to Victoria are:

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

2 Enforcement and Compliance Command governance

2.1 Enforcement and Compliance Command structure

Figure 1. Enforcement and Compliance Command structure



2.2 ECC roles and responsibilities

Table 1. ECC cell roles

Role	Responsibilities
Enforcement and Compliance Commander	• Lead and provide oversight to compliance matters under all Public Health Directions. • Provide advice and input into complex compliance matters. • Provide advice and support to the Chief Health Officer and their delegate on compliance. • Address interagency issues • Approve requests for changes to alternative detention arrangements • Daily review of those subject to detention
Deputy Commander AO operations	• Provide oversight to Authorised officers • Ensure effective communication between AO operations, Command and Policy and Exemptions

	• Ensure operations are compliant with protocols • Engage with EOC as required around hotel operations and compliance • Lead the provision of guidance to the AO Team Leaders. • Report on daily review of people being detained.
AO Operations support	• Undertake rostering, recruiting and onboarding of ECC resources • Monitor VicPol email address • Manage daily review of detention process • Manage release from detention process.
Senior AO	• Provide leadership to AOs. • Monitor the approval of permissions • Support AOs through complex matters • Make exemption request where appropriate • Ensure appropriate parties are aware of complex matters
AO	Primary responsible for: • Issuing detention notices • Ensuring compliance with the notices • Issuing and managing permissions • Actioning approved exemptions • Actioning the release of detainees from hotels • Provide support to VicPol as required
EMLO VicPol	• Liaise with Victoria Police.
Deputy Commander Policy and Exemptions	• Oversight of operational policy and procedures. • Key liaison point with legal • Case management of exemptions.
Exemptions Managers	• Approve cases declined at Triage • Review cases to be approved by the Commander
Exemptions Team Leaders	• Support team members through complex cases • Ensure cases are appropriately closed out
Exemptions team	• Triage cases as they are received • Manage COVIDQuarantine inbox • Case manage requests for exemptions from detention. • Liaise with other parties as required to manage cases
Policy and Protocols team	• Prepare operational policy and protocols to support enforcement and compliance. • Prepare briefs, PPQs and other documents and reports as required

2.3 Roles and responsibilities for other staff

Table 2. Non-compliance cell staff at hotel

Role	Responsibility
DHHS Team Leader	• Supports the health and well-being of staff. • Liaises with airport command and staff from the Department of Jobs Precincts and Regions represented at the hotel. • Provides situational awareness and intelligence to inform transport providers, state-level emergency management arrangements and airport operations. • Provides a point of reference to all site-staff to help resolve operations, logistics or site-related issues and / or escalations required. • Ensures appropriate records management processes are in place.
DHHS and DJPR concierge staff	• Capture client personal needs, e.g. dietary, medication, allergies, personal hygiene needs. • Deliver hyper-care (concierge) services onsite. • Manage contracts with accommodation providers. • Manage transport arrangements from the airport and other locations detainees as permissioned by AOs. • Manage material needs including food and drink.
Nursing staff	• Provide 24 hour on-call medical support subject to demand. • Provide welfare to detainees through a daily welfare check — DHHS welfare officers email COVIDQuarantine@dhhs.vic.gov.au and phone the site AO individually to alert AO of medical and welfare issues. • Provide a satisfaction survey for residents to complete each week.
Security	• Assist AOs in ensuring detainees comply with notices and permissions. This includes ensuring detainees do not leave hotel rooms, assisting with movement of detainees where they have permission to leave rooms, and assisting with release from detention.

2.4 COVID-19 Quarantine Compliance and Welfare System

The COVID-19 Quarantine and Welfare System is the key recording and reporting system supporting the ECC. It supports quarantine arrangements by providing a common database for compliance health and welfare activities. The systems is protected for privacy reasons with different cohorts having access to specific part of the database through either an app or directly through the Customer Relationship Management (CRM) interface. The ECC has access to

- COVID-19 Compliance Application (Compliance App)- This application supports AOs to issue, maintain and record Direction and Detention notices and permissions as well as issue and record certain exemptions. .
- COVID-19 Exemptions – This tool enables the exemptions team to triage; case manage and close requests for exemptions. It is linked to the Compliance App so AOs are able to see the status of, request and action exemptions.

A Smart form for applications for exemptions is on the DHHS website for travellers or their representatives to request a change to the mandatory detention arrangements. The SMART form feeds directly into the CRM.

A **User Guide** is available to guide ECC team members.
Support email for users: **ComplianceandWelfareApplicationSupport@dhhs.vic.gov.au**
Support will be active between 8am and 8pm. You can email support for access issues, technical issues, application use questions. A **phone number** will also be provided shortly.

3 Authorised officers and powers

3.1 Key points

- Only AO's additionally authorised for the purposes of the public health risk and emergency powers can undertake administration and enforcement of the direction and detention notice
- AOs must meet legislative obligations around identification, warnings, communication and human rights when exercising powers.

3.2 Authorisation under the PHWA to exercise emergency powers

Only VPS employees and council environmental health officers that are AOs under the PHWA and also authorised by the Chief Health Officer under section 199(2)(a) of the PHWA can exercise public health risk and emergency powers.

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

Note: Any AO that is unsure as to whether they have been authorised under s. 199 should contact the AO Operations support team prior to enforcing compliance with the Direction and Detention Notices.

While exercising their powers and monitoring compliance, AOs should be cognisant that persons subject to detention may be tired, emotional and stressed. AOs may need to use conflict negotiation, mediation skills and compassion to help persons settle into the new environment.

3.2.1 Emergency powers and offences

Section 200(1) of the PHWA sets out the emergency powers, including detaining any person or group of persons in the emergency area for the period reasonably necessary to eliminate or reduce a serious risk to health.

The Direction and Detention notice is made pursuant to section 200 of the PHWA (emergency powers), Attachment 1.

It is an offence under section 203 of the PHWA if a person refuses or fails to comply with the directions and requirements set out in the Direction and Detention notice (unless there is a reasonable excuse for refusing or failing to comply). The maximum court penalty for an individual is 120 penalty units and 600 penalty units for a body corporate. There are infringement penalties of 10 penalty units for a natural person and 60 penalty units for a body corporate.

3.3 Authorised officer and Chief Health Officer obligations

Sections 200(2) – (8) of the PHWA set out several AO obligations in relation to detaining any person or group of persons in the emergency area for the period reasonably necessary to eliminate or reduce a serious risk to health.

3.3.1 Mandatory obligations for AOs

AOs have mandatory obligations that must be followed when exercising powers. Table 3 below summarises mandatory obligations.

Table 3. Mandatory obligations of AOs

Legislation	Obligations
Emergency powers and general powers in the *Public Health and Wellbeing Act 2008*	• AO must show ID card before carrying out actions/exercising powers
	• Before any person is detained, AO must briefly explain to the person the reason why it is necessary to detain them – if not practicable, it must be done as soon as practicable
	• Before any person is detained, AO must warn the person that refusal or failure to comply without reasonable excuse, is an offence.
	• AO must facilitate any reasonable request for communication
	• AO must review every 24 hours, whether continued detention of the person is reasonably necessary to eliminate or reduce a serious risk to health (undertaken by Deputy Commander AO operations with support from Operations Support Team)
	• AO must give written notice to the Chief Health Officer (CHO) that detention has been made and if it is reasonably necessary to continue detention to eliminate or reduce the serious risk to public health[1].
In addition, AOs must comply with the Charter of Human Rights (see also Appendix 16)	• AO must act compatibly with human rights
	• AO must give 'proper consideration' to the human rights of any person(s) affected by a department AO's decision.

The notice to the CHO must include:

- the name of the person being detained
- statement as to the reason why the person is being, or continues to be, subject to detention.

Following receipt of a notice, the CHO must inform the Minister as soon as reasonably practicable.

[1] An Authorised Officer under the PHWA that has been authorised to exercise public health risk and emergency powers

3.3.2 General powers and obligations under the Public Health and Wellbeing Act 2008 (PHWA)

The general powers of Authorised Officers are outlined under Part 9 of the PHWA (Authorised Officers). The following is an overview of powers and obligations. It does not reference all powers and obligations.

AOs are encouraged to read Part 9 and seek advice from the Deputy Commander AO Operations if they are unsure about the administration of their powers.

3.3.3 Authorised officer obligations:

Produce your identity card - s166

- **Before** exercising powers provided to you under the PHWA (unless impractival to do so):
- At any time during the exercise of powers, if you are asked to show your ID card
- As part of good practice, you should produce your identity card when introducing yourself to occupiers or members of the public when attending complaints or compliance inspections.

Inform people of their rights and obligations

- You may request a person to provide information if you believe it is necessary to investigate whether there is a risk to public health or to manage or control a risk to public health (s.167).
- Before exercising any emergency powers, you must, unless it is not practicable to do so, warn the person that a refusal or failure to comply without a reasonable excuse, is an offence.

4 AO responsibilities at port of arrival

AOs issue Direction and Detention notices to people arriving in Victoria (airports and seaports)[2] from overseas who must go into immediate compulsory quarantine for 14 days. This is because international arrivals present a high-risk of further transmission of the COVID-19 virus and detention is necessary to reduce or eliminate the serious risks to public health associated with the virus.

All passengers will be transported to a designated hotel accommodation, where they must undertake a strict 14-day quarantine period with the **day of arrival counted as day 0**.

The airport is the first point of contact for an AO, who must undertake several obligations to administer the direction and detention notice issued under the PHWA.

4.1 Key points

- AO must fulfil mandatory obligations (e.g. show ID card and explain reason for detention,).
- AO must check that a direction and detention notice is filled in properly and recorded.
- AO to provide factsheet and privacy collection notice to person.

4.2 Key responsibilities

Table 4. AO responsibilities at the airport

Step	AO responsibilities	Mandatory obligation	Section (PHWA)
Identify pre-approved exemptions	1. Prior to flight arrival the rostered Airport AO should check for any preapproved exemptions which may need to be actioned at the airport 2. Exemptions will be provided by the Exemptions Team Manager to the AO rostered at the airport as well as Airport Operations Command prior to passenger disembarkation. 3. Any queries in relation to the exemption should be directed to the Exemption team lead. 4. AO to check exemption paperwork and identify on passenger manifest sheet 'exemption'.		
Flight arrival	5. Inform flight crew of AO action and request translation of script[3]. 6. Declare you are an Authorised officer and show your identification card. 7. Read script (Appendix 2), which: i. explains the reasons for detention ii. warns returning passengers that refusal or failure to comply without a reasonable excuse is an offence and that penalties may apply iii. reminds passengers they must keep their detention notice.	Yes	Sections 166, 200(2),200(4) and 202(1)

[2] See exemptions section that describes circumstances and policies for maritime environment

[3] See suggested script at Attachment 1

	8. Repeat twice. 9. Flight crew read script in all relevant languages.		
Issue notice immediately after disembarkation	10. Show identification. 11. If the traveller is not a foreign diplomat or immediately transferring to an international flight leaving within 8 hours of arrival, serve the approved Direction and Detention Notice to each passenger. Unless advised otherwise, the approved notice is the general notice (Appendix 1). Unaccompanied children who are detained must be served the solo child notice (Appendix 3). (notification to parent/guardian may need to be conducted over the phone and interpretation services may be required). 12. Ask passenger/s if they understand the notice. If not, explain reasons for detention again, warn them that it is an offence to not comply and answer questions. 13. If practicable at this time, provide the person with a copy of the department's privacy collection notice. If not practicable, this can be provided at the hotel.	Yes.	Section 200, 200(2) and 200(4)
Facilitate request for communication	14. Facilitate any reasonable request for communication, such as a phone call or email and including if necessary, organising a translator to explain the reasons for detention **(call Victorian Interpretation and translation service on** REDACT **; PIN code is** REDAC TED	Yes	Section 200(5)
Confirm details	15. Ensure each direction and detention notice: i. states the full name of the person being detained, date of birth and mobile phone number (if applicable) ii. contains the signature of the person being detained or their guardian as receipt of the notice iii. states the name and signature of the AO iv. contains the hotel name at which the person will be detained v. contains the date of commencement of detention.		
Record issue of receipt	16. Take a photo of direction and detention notice and record issue and receipt of the notice in the COVID-19 Compliance and Welfare Application[4]. You may be assisted by a non-AO in this task.		

[4] The Business system referred to here is the Quarantine Compliance and Welfare System COVID-19 Compliance Application

	17. Request person subject to detention present to AO at hotel. Direct person to area for transport to hotel. 18. Provide a fact sheet about detention (what a person in detention can and can't do, who to contact for further information)		
Arrangements for diplomats and immediate transits	19. Foreign diplomats cannot be served a detention notice. The Exemptions team will provide a letter to give to the diplomat and will provide instruction. This will normally be done in advance of the flight arrival 20. Take a photo of the letter issued		
Arrangements for immediate transits (less than 8 hours between international flights)	21. Check onward ticket and that the traveller is not showing symptoms of covid. 22. Record the individual as a transit in the Compliance app. No document is required to be issued. 23. Advise traveller they are required to stay airside between flights at the designated transit area		
Check with welfare team	24. Liaise with Senior AO and health team if the Health Check has identified passengers that need to transfer to hospital. 25. Issue leave permissions where required (e.g. in circumstances where a person needs to go to hospital) Refer to Section 7 (Permissions) for further detail. 26. Ensure the person subject to detention understands they must return to the hotel listed on the detention notice immediately after medical release in transport organised by DHHS. 27. Make a note in the Compliance app and ensure the AO at the relevant hotel and Deputy Command AO operations is aware a permission has been granted. 28. Complete the hospital fact sheet and provide a copy to the driver to be given to the hospital on detainee arrival.		
Record	29. Record any actions in the COVID Compliance Application, including the above mandatory obligations, use of translator and any associated issues.		

4.2.1 Transfer of uncooperative person to be detained

There may be circumstances where a person refuses to be cooperative. DHHS Operations staff at the airport may elect to organise a separate mode of transport for in such circumstances, noting Victoria Police may be requested to escort such individuals.

5 AO responsibilities at hotels

As part of meeting mandatory detention requirements in the Direction and Detention notice, the Victorian Government has arranged accommodation in numerous locations, primarily in the Melbourne CBD area. The purpose of this is to restrict the movement of international arrivals to limit the spread of COVID-19.

5.1 Key points

- AO oversees and provides advice on compliance and works with security, hotel staff, and medical and other staff.
- AOs are responsible for detention release following the mandatory 14 day detention

5.2 Shift change over

Table 5: Key steps and AO roles and responsibilities during shift change over

Step	AO roles and responsibilities	Mandatory obligation	Section (PHWA)
Introduction	1. Introduce yourself to: • hotel/duty manager • head of security • DHHS Team Leader • DJPR site manager (if on site) • medical staff.		
Handover	2. Obtain a handover from the previous AO (verbal and high-level information) to: • understand detainee issues, early releases, exemptions (including status) and permissions • ascertain location of records and template forms • any hotel operational issues (e.g. physical exercise space unavailable, changes to operational policies like food delivery) • ensure COVID-19 Compliance Application has been updated • if exits from detention expected, ensure AO team and release team aware of plans and location of documentation.		

5.3 Hotel check-in

The purpose of hotel check-in is to:

- enable hotel staff to provide people being detained with a room number and key
- reiterate obligations for those being detained.

Table 5. Key steps and AO roles and responsibilities – hotel check-in

Step	AO roles and responsibilities	Mandatory obligation	Section (PHWA)
Check-in	1. Ensure person to be detained provides Direction and Detention Notice to hotel staff; hotel staff to write on the notice: i. room number ii. the date that the person will be detained until (14 days after arrival at place of detention). 2. AO to initial the room number on the notice, record in the Compliance App and take a photo of the page with the room number before returning to the detainee.	**Yes**	
Check and reiterate Direction and detention notice	3. AO answers compliance-related questions and deals with compliance issues, including reiterating aspects relating to the notice.		Sections 166, and 203(1)
Liaise with medical and welfare staff	4. Liaise with nurses to identify persons that might require permissions for temporary leave (e.g. for medical treatments).		

5.4 Monitoring compliance

The AO will provide oversight and ensure compliance with the direction and detention notice

Table 6. Key steps and AO roles and responsibilities – monitoring compliance

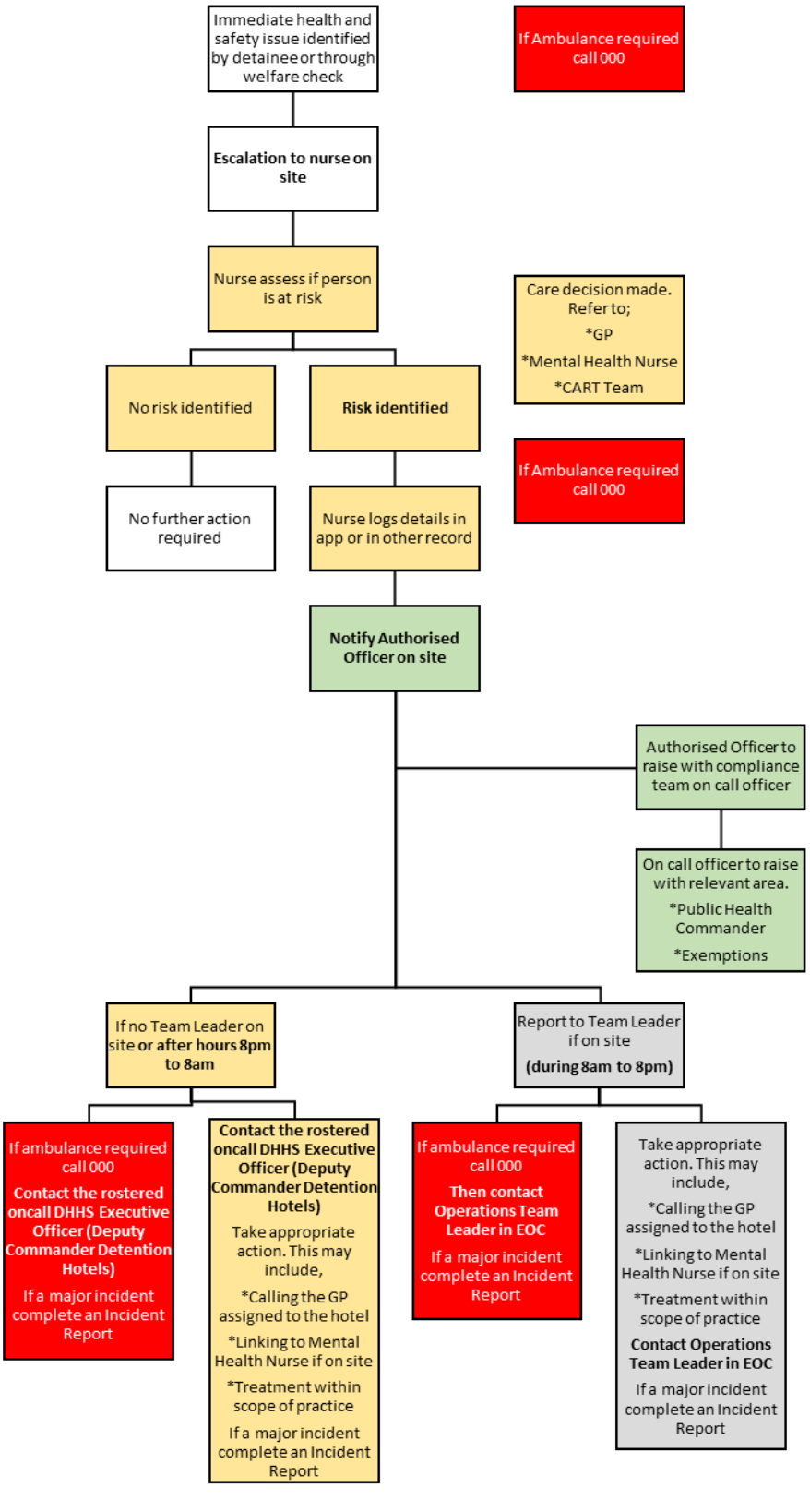
Step	AO roles and responsibilities	Mandatory obligation	Section (PHWA)
Liaise with security	1. Check that security undertake floor walks to encourage compliance and deter non-compliance.		
Oversee compliance	2. Oversee and provide advice on compliance-related issues such as: • a person refusing to comply and a person demanding to be removed from detention • reminding a person the reason for the detention, their obligations under the detention and direction notice and the penalties if they do not comply • responding to requests from security to address compliance issues • answering questions from hotel staff, security and police as to what persons may be permitted or not permitted to do • seeking assistance from security or Victoria police to support compliance efforts • facilitating any reasonable requests for communication. **For translation, call Victorian Interpretation and translation service on** REDACTE **PIN code is** REDA		202, 203(1)
Permissions	3. See Section 0 (Permissions). 4. Raise requests for permission to leave with the Senior AO if there is not an authorised area for the detainee to exercise the permission or there is complexity in applying the transition (e.g. requires leaving the hotel site). All requests by detainees to leave the hotel site must be escalated to Deputy Command AO operations if not already approved. 5. Administer permission to leave and monitor compliance.		203(1)
Exemptions	6. See Section 6 (Exemptions). 7. Raise any exemption requests with Senior AO in the first instance. The Senior AO may make an exemption request through the Compliance App [or may request the AO to do so] for consideration. Criteria for consideration is: i) detainee may be unsafe in the hotel environment		200(2),200(4) and 203(1)

	ii) cannot accommodate detainees needs in the hotel 8. Issue Direction and Detention Notices for detention in alternate locations if ECC Commander approves an exemption request. In this case, a case manager from the Exemptions Team will contact the AO with details. **Before issuing notice, explain reasons for detention and warn that refusal to comply is an offence.**		
Records	9. Notes of any communication or engagement with the detainee should be made in the contact log section of the Compliance app 10. Record all permissions in the permissions section of the COVID Compliance App. 11. Take photos of all amended or reissued direction notices issued while at the hotel using the Compliance App.		
Other issues	12. Inform nurse, medical practitioner, welfare staff or DHHS concierge staff of other matters you become aware of. 13. If an emergency occurs with a detainee, follows the emergency procedure and alert the Team Leader and the Senior AO. 14. The Senior AO is to ensure the Deputy Commander AO operations and the ECC Commander is alerted to all emergencies. Where a matter may lead to an exemption being required, they should also alert the Exemptions team		

5.5 Emergency health and welfare incidents

Where there is an immediate health and welfare issue identified at the hotel, the following process is to be followed.

Figure 2. Emergency Workflow



5.6 Clarity about role of AO

AOs should be aware that their role and scope is related to administration of, and compliance with, the direction and detention notice under the PHWA. Activities outside the scope of the role of the AO include:

- transport. This is the responsibility of the DHHS Team Leader on-site. If a DHHS Team Leader is not on-site, please refer to the Emergency Operations Command at DHHSOpSoteriaEOC@dhhs.vic.gov.au and title the email "Referral to organise transport"
- physically moving COVID-19 patients. Please see procedure under 'Occupational Health and safety"
- retrieving luggage
- food quality
- inspecting care packs, removing items from care packs such as perishables and alcohol and ordering food such as Uber eats. This includes providing any advice in relation to these inspections
- arranging accommodation for any detainee leaving the hotels
- monitoring or ordering PPE or other supplies.

If an AO becomes aware of these or other non-compliance related issues in a hotel, they should refer them to the DHHS Team Leader on-site for follow up. For medical and welfare issues, the AO should inform on-site medical and nursing staff in accordance with section 5.5 above.

5.7 Daily review and reporting by the AO Review Team

The daily review is a mandatory obligation to determine whether continued detention of a person is reasonably necessary to eliminate or reduce a serious risk to health. There are mandatory obligations for the AO to inform the Chief Health Officer (CHO) and the CHO to inform the Minister. This is the responsibility of the Deputy Command AO Operations who will be aided by the AO operations support team in fulfilling this task.

Table 7. Key steps and AO Review Team roles and responsibilities – daily review

Step	AO Review Team roles and responsibilities	Mandatory obligation	Section (PHWA)
Daily review	1. AO operations support Team will – at least once every 24 hours – review whether the continued detention of the person is reasonably necessary to protect public health.	Yes	S 200(6)
Review checks	2. Undertake an electronic review of detainment arrangements by viewing the COVID-19 Compliance Application. This includes: • reviewing the date and time of the previous review (to ensure it occurs at least once every 24 hours) • reviewing the number of detainees present at the hotel • reviewing the duration each detainee has been in detention for, to ensure that the 14-day detention period is adhered to • noting individuals who have been tested and cleared of COVID-19 by Public Health Command while in detention.		

	• Noting any exemptions issued or concerns raised with any detainee 3. Determine whether continued detention of each detainee is reasonably necessary to eliminate or reduce a serious risk to health. 4. Consider the human rights being impacted – refer to 'Charter of Human Rights' obligations in Appendix 16 5. Consider any other issues that have arisen.		
Review considerations	6. Consider that the person is a returned overseas traveller who is subject to a notice and that they are obliged to comply with detainment. 7. Consider that detainment is based on expert medical advice that overseas travellers are of an increased risk of COVID-19 and form most COVID-19 cases in Victoria. 8. Consider any other relevant compliance and welfare issues, such as: • person's health and wellbeing • any breaches of self-isolation requirement • issues raised during welfare checks (risk of self-harm, mental health issues) • actions taken to address issues • a person having been tested and cleared of COVID-19 while in detention • any other material risks to the person.		
Possible release from detention	9. Review could identify that detention may no longer be required. These matters will be provided to the Deputy Command Policy and Exemptions for further consideration.		
Prepare brief (Minister)	10. Complete template brief from CHO to Minister to advise of notice received about detention and review. The brief will serve as a written notice that: • a person has been made subject to detention • following a review, whether continued detention is reasonably necessary to eliminate or reduce the serious risk to public health. 11. The notice to the CHO must include: • the name of the person being detained • statement as to the reason why the person is being, or continues to be, subject to detention.	Yes	Sections 200(7) and (8) Section 200(9)

	12. Deputy Command AO operations to review and approve the Review and Brief 13. Report to be sent to Public Health Command, cc to ECC Commander and Deputy Command Policy and Exemptions.		

5.8 Departure – release from mandatory detention

The purpose is to ensure and confirm the person being detained:

i. has completed their period of detention under the Direction and Detention notice
ii. is released in a timely and orderly manner.

5.8.1 Pre-check out

In the days leading up to release the AO Operations support team will work with DJPR, the EOC and Public Health Command to identify the detainees to be released, the exit times for the detainees and whether any detainees are required to be issued a non-general end of detention notice as a result of any COVID-19 testing completed during the quarantine period. The release notices are to be prepared in accordance with the policy in Appendix 9

The Operations Support team will print out release notices for all detainees as well as an exist sheet and will arrange for these to be delivered to the relevant hotels.

Prior to release of a person being detained, DHHS (with the help of hotel security) will provide each person being detained with either:

1. An End of Detention Notice, Appendix 10**;**
2. An End of Detention Notice (confirmed case not cleared infection), Appendix 11
3. An End of Detention Notice (close contact), Appendix 12
4. An End of Detention Notice (symptoms of respiratory illness), Appendix 13
5. An End of Detention Notice (continued detention) Appendix 14

These notices provide information about the discharge process and the obligations of the detainees.

Continued detention will only be applied where a detainee who normally reside interstate is symptomatic and a close case or confirmed and refuses to remain in Victoria. The decision to continue to detain an individual will be made by the EC Commander in consultation with legal and the PH Commander

5.8.2 Health check

Health checks will be undertaken by medical staff on the second last day prior to the 14-day period ending to make an assessment of whether each person being detained is well, symptomatic or positive.

Everyone will be offered a voluntary temperature and symptom check by a nurse around 24 hours before release.

If people being detained have a temperature or other symptoms of coronavirus before leaving or at the health check, this will not affect the completion of their detention. They will not be detained for longer than the 14-day detention period, even if they have symptoms consistent with coronavirus. However, if they do have symptoms at the health check, when they are released, they will need to seek medical care and will be required to self-isolate (as is required as of all members of the community).

- If people have been diagnosed with COVID-19 during their quarantine, they will be subject to the Isolation (Diagnosis) directions and can only be released from these on receipt of a formal clearance letter from the Public Health Commander. These letters are sent to COVIDquarantine@dhhs.vic.gov.au for supply to the detainee. Once this letter has been received, the detainee should be released from detention even if this is before the end of the mandatory quarantine period with the appropriate form.
- If a confirmed case does not receive clearance before the end of the mandatory quarantine period, the public health operations team may permit them to travel home with appropriate PPE and transport precautions if they are Victorian residents. If they are residents of other states a further detention order may be issued in consultation with the public health and legal teams.

5.8.3 Day of release

Security will provide detainees approximately 1 hour notice of their exit time. Security will then bring detainees down at their scheduled exit time.

5.8.4 Check-out process overview (compliance check-out)

The release process will consist of an organised check-out procedure (the compliance check-out). This means people being detained will be released in stages throughout a set time period on the day of release.

COVID-19 cases and suspects require a separate check-out time. Extra infection control measures such as PPE will need to be implemented.

Security will bring travelling parties down to reception in stages to complete the check-out process. People being detained will also need to settle any monies owing to the hotel for additional meals and drinks if they have not already done so. Physical distancing must be maintained throughout this process.

Table 8. Key steps, roles and responsibilities at check-out (AO role unless specified)

Step	Roles and responsibilities	Mandatory obligation	Section (PHWA)
Notification of COVID-19 cases of close contacts	1. ECC Operations Support Team, to inform AO of cases and close contacts confirmed COVID-19 case, suspects, COVID-19 cleared or close contacts. Public health will have contacted each detainee in these categories to discuss arrangements post detention. 2. AO to note and to inform security that COVID-19 cases and suspects will need separate check-out time and implement extra precautionary measures.		
Check-out	3. Request to see identification (passport) and the End of Detention notice from each person 4. Cross check the person's identification details and room number with information on exit sheet 5. Sign the End of Detention notice, take photo through the **COVID-19 Compliance Application** which will automatically note the detainee as released. 6. Provide End of Detention notice back to the person. 7. Confirm the period of detention and explain detention period has ceased. 8. Confirm self-isolation requirements for all confirmed COVID cases. 9. Detainee to sign discharge exit sheet as evidence they have received a notice and have been discharged.		
Record	10. All exit sheets are to be returned to the Operational Support team as soon as possible		

Where a person has been COVID-19 cleared, their detention release must be accompanied with a COVID-19 Clearance letter provided by Public Health Command. This will be included in the release pack prepared by the AO Operations Support team.

6 Exemption requests

6.1 Key points

- AOs must be aware of how requests for exemption from detention are escalated.
- DHHS case manager from Exemptions Team will liaise with Senior AO regarding approved exemption request.

6.2 Exemption requests – overview

In limited circumstances, approval may be sought to undertake detention in another location, transit to another state/country or early release. **Generally, exemptions are not granted.**

Requests for exemption from mandatory hotel detention may be considered before a person commences detention or while in detention. **The Enforcement and Compliance Commander** is responsible for approving and granting approvals to alter the way in which mandatory quarantine applies in accordance with Appendix 23*Guidance Note — Exceptions to the General Quarantine Policy.*

While each exemption request must be considered on its own merits, the following circumstances have been identified as open for consideration of early release or change of detention location. These include:

- Unaccompanied minors in transit to another state
- Unaccompanied minors where a parent or guardian does not agree to come into the hotel
- Foreign diplomats coming into the country – The diplomatic status that Australian citizens have in other countries does not apply in Australia, so Australians with diplomatic status must undertake mandatory detention for 14 days in a designated hotel
- ADF staff travelling for essential work
- People with a terminal illness
- People whose health and welfare cannot be accommodated in a hotel environment (e.g. mental health or requirements for in-facility health treatment)
- People who are transiting directly to another country (and who do not need to travel domestically first)
- Air crew including medevac crew
- Maritime workers who have come off a boat and will be leaving by boat
- Maritime workers who have come off a plane and will be leaving by boat within the quarantine period.

Supporting evidence, such as report from a medical practitioner, may need to be provided before an exemption request is considered.

Any approval must consider the public health risk and ensure the individual is not showing symptoms of COVID consider if the person may be released into an environment where a highly vulnerable person may be a close contact.

6.3 Exemption requests – general approach

Exemptions for medical, welfare and compassionate grounds will be considered in exceptional and case-by-case circumstances where:

- the needs of the individual are unlikely to be able to be met within the hotel
- the public health risks are outweighed by the risks of continuing to detail the individual in hotel detention.

For an individual seeking exemption prior to entering the hotels, there must be supporting evidence from a suitable expert or treating practitioner regarding the illness, welfare or compassionate concerns. It also must be clear that the needs of the individual cannot be met in hotel detention.

For an individual seeking exemption while already within a hotel, welfare staff, nurses or the Complex Assessment and Response Team (CART) should assess the individual. This assessment along with any recommendation from a treating practitioner will inform consideration of an exemption.

Table 9 outlines the key steps for processes requests for exemptions based on medical, welfare and compassionate grounds.

Table 9. Exemptions case management process

Step	Roles and responsibilities	Mandatory obligation	Section (PHWA)
Request and triage	1. Exemption Team receives a request for exemption through CRM system[5] 2. If request come through another channel, triage officer must enter information into the CRM 3. The triage officer should review the available information as assess if the case should be considered based on • If the detainee would be unsafe in the hotel environment or • Their needs can't be accommodated in the hotel • permissions are sufficient. 4. If the triage officer believes the case should be considered they will allocate a case manager. The case manager should contact the requestor to advise them their request is being considered. 5. Recommendations to not consider the case will need to be approved by the Exemptions manager.		

[5] An onsite nurse or welfare staff can recommend the exemption for a person via covidquarantine email and outline why they believe an exemption should be considered. Unless impracticable the person on whose behalf the request has been made should be consulted

	6. If the manager agrees the request should not be considered the triage officer should advise the requestor within 12 hours in writing. 7. If the Manager is of the view the case should be considered, they will allocate to a case manager.		
Case management (Assessment and decisions)	8. Case manager will need to consider the nature of the request to determine whether it should be approved. The case manager should first and foremost consider the public health risk and how the need of the detainee may be met within the hotel environment through permissions, health and welfare support a carer joining the individual or providing addition supplies. The case manager should have regard to the • Current policy • Precedent • Medical information provided • Position of other jurisdictions if interstate travel is required 9. In some cases further validation of a detainees condition and needs will be required. This may be achieved by: • Discussions with the treating practitioner or health team • Assessments by the CART team • Consultation with Mental Health Branch 10. Complex cases should be discussed early at the daily complex case meeting with the EC Commander. 11. Should a case be considered for detention in an alternative location, the case manager should identify if there is a suitable alternative location that would enable the detainee to meet the required conditions. In particular the location should not house any vulnerable individuals or a large number of people. 12. A recommendation should be reviewed by the manager and then submitted to the EC Commander for approval. 13. In particularly complex cases the EC Commander may seek further approval from the Public Health Commander.		

	14. Once approve the case manager will be required to complete the required documentation to action the decision.		
Case closure (Exemptions team)	15. Depending on the nature of the request, the exemptions case manager may need to alert the following of the outcome: • inform requestor • inform the Senior AO at airport or hotel, Deputy Command AO operations, OpSoteria EOC, hotel Team Leader and CART team if required • Airport operations at Northandwest.eoc@dhhs.vic.gov.au • inform Victoria Police arrange for compliance oversight • contact other jurisdictions (if transiting through Victoria) • upload release or exemption letter in COVID-19 Compliance Application.		
AO to issue Notice of Direction and Detention	16. Following confirmation with the Hotel Team Leader of any arrangements, the AO will: • Issue the required documentation • Provide any information required associated with the documentation • Take a photo of the signed documentation under the release section of the compliance app.	Yes	200(2) and (4) 203(1)

6.4 Unaccompanied minors

Unaccompanied minors will be considered on a case-by-case basis. If an unaccompanied minor is detained in a hotel without a parent or guardian, a specific process must apply.

In general, there is a presumption that there are no exemptions granted to mandatory detention. The issues associated with mandatory detention of unaccompanied minors include:

1. where this occurs, and
2. with what adult supervision.

The State can issue a detention order to a person under 18 years who is unaccompanied outside the home (a person in the care of the state) if certain conditions are met. However, this is not preferred because of the welfare obligations imposed.

There is guidance for AOs on how to comply with the Charter of Human Rights in relation to unaccompanied minors at Appendix 8.

Table 10 outlines four options and corresponding policy principles.

Table 10. Options for unaccompanied minors and policy principles

Options	Guiding principles
Detention at hotel with parent of guardian	Parents or guardians are strongly encouraged to join the unaccompanied minor in detention. In this case, an exemption is not granted. The carer is provided with a copy of the letter found in Appendix 4 in order to detain them.
Detention in another state or territory	For minors who reside interstate, parents or guardians are strongly encouraged to join the unaccompanied minor in detention. However, if a parent or guardian cannot join the minor, an exemption can be granted to allow an unaccompanied minor to transit interstate.
Detention at an alternate location with a parent or guardian	Parents or guardians are strongly encouraged to join the unaccompanied minor in detention. However, if parent or guardian cannot join the minor, an exemption can be granted to allow the unaccompanied minor to undertake detention at an alternate location with parent or guardian.
Detention in hotel with DHHS welfare support (overnight stay for international transit)	Parent or guardians are encouraged to book flights without overnight layover in Victoria. If not possible, unaccompanied minor are permitted one overnight stay before transitioning to an international flight.

6.4.1 Escalation of issues

Should an AO become aware of any concern about a child, the AO must:

- contact the department's welfare teams immediately. Child Protection contact details for each Division are available from: https://services.dhhs.vic.gov.au/child-protection-contacts. West Division Intake covers the City of Melbourne LGA: 1300 664 977.
- if it is after hours, contact the after-hours child protection team on 13 12 78 if the AO thinks a child may be harmed, and Victoria Police on 000 if the immediate safety of a child is at risk.

6.5 International transit

6.5.1 Immediate transits within 8 hours

Individuals who are on a connecting international flight that leaves within 8 hours of arrival are not to be detained. The AO should check they are not displaying any symptoms of COVID and have a ticket for an onward flight within 8 hours. The AO should record the traveller as being in transit in the Compliance app and direct them to the appropriate waiting areas airside. Transit passengers should not go landside at the airport. They do not require any documentation.

6.5.2 Transits longer than 8 hours

If travellers are on the ground for more than 8 hours they will be detained.

Prior to release the AO will be required to check that the detainee is not showing symptoms of COVID and confirm they have a ticket for an international flight. This should be recorded in the Compliance App along with a copy of the release notice (Appendix 18).

Following release, the detainee must be escorted to the airport by Airport operations to ensure they minimise any potential contamination.

Travellers not be allowed to travel domestically to catch an onward international flight.

6.6 Compassionate interstate travel

Interstate travel is not permitted except in exceptional health and compassionate circumstances. These are generally limited to:

- Receiving specific health treatment in another state that cannot be provided in Victoria
- Visiting a terminal family member
- Attending a funeral of a close family member

In each of these circumstanced the receiving jurisdiction must approve the transit and the detainee will be subject to any quarantine arrangements required by the receiving jurisdiction.

The letter in Appendix 19 is used.

6.7 Foreign diplomats

Foreign diplomats are exempt from mandatory 14-day detention. Australian diplomats must undertake mandatory detention upon arriving in Victoria from an international location.

Foreign diplomats (and any family members) should travel immediately to their place of residence via private or rental vehicle and self-isolate for 14 days. The exemptions team will prepare a letter for the foreign diplomat and their family confirming they are not required to completed 14-day mandatory detention (Appendix 20).

Where a foreign diplomat needs to defer travelling to their usual place of residence, the diplomat (and any family members) should stay in a designated quarantine hotel. They should be transported to and from the airport via organised transport, or via a private or rental vehicle and are issued a letter regarding staying in a quarantine hotel (Appendix 21)

6.8 Maritime Crew

The DHHS *Border health measures policy summary* of 18 May 2020 summarises a broad range of circumstances and corresponding risk-based policies regarding travellers and crew arriving at airports and seaports. A summary of the circumstances and policies relating to maritime crew is Appendix 17**.**

As a guiding principle, maritime crew arriving into Victoria from overseas on aircraft or maritime vessel are subject to a Direction and Detention Notice and must be detained in a designated hotel for a 14-day period (unless an exemption applies).

- Where a vessel is leaving the country, crew may leave the hotel to board the vessel no earlier than 48 hours before the vessel is due to leave to enable handovers.
- Where a vessel is remaining is staying in Australian waters its crew must do 14 days quarantine
- Where disembarking crew a leaving the country, they may leave the vessel and travel immediately to the airport to depart. They may shelter on land for 24 hours before a flight. If they are required to be on land for longer, they must go to a quarantine hotel until they are ready to leave the country.

- Disembarking crew that live in Australia must go into hotel quarantine unless they did 14 days quarantine prior to boarding the vessel and no other international crew joined the vessel.
- Crew may leave a vessel to seek medical treatment.

7 Permissions

7.1 Key points

- AOs can make decisions in consultation with their Senior AO or Deputy Commander AO Operations for simple requests.
- AO must complete a permission for temporary leave form and enter details in COVID-19 Compliance Application.

There are four circumstances under the Direction and Detention Notice in which permission to leave the room may be granted:

- for the purpose of attending a medical facility to receive medical care
- where it is reasonably necessary for physical or mental health
- on compassionate grounds
- emergency situations.

AOs should refer to the 'Permission for Temporary Leave from Detention' guide at Appendix 6**.**

7.2 AO to make decisions on certain permission requests on case-by-case basis

An AO in consultation with their Senior AO or Deputy Commander AO operations can make certain straightforward decisions about the following scenarios on a case-by-case basis:

- attendance at a funeral
- medical treatment
- seeing family members who have a terminal illness, (noting that there are directions on visiting care facilities and hospitals which must be complied with).
- smoke breaks where people are suffering extreme anxiety and where it is safe to do so from a public health/infection control perspective.
- exercise breaks where it is safe to do so.

Not all leave requests can accommodated and may be site and resource dependent. Any arrangement for leave would need to meet public health, human rights requirements and balance the needs of the person.

It is expected that those with medical needs, seeking to attend a funeral or with family members who are about to pass away are granted leave. The AO should confirm appropriate details before issuing permission to leave (refer to Table 11 for further details).

If medical care is deemed urgent by an on-site nurse or medical practitioner, the AO should prioritise and approve leave immediately. The emergency escalation process should be followed (see section 5.5). The Hospital information sheet should be provided to the driver of the vehicle to hand to the medical facility.

AOs are not responsible for transport arrangements. This is the responsibility of the DHHS Team Leader on-site. If a DHHS Team Leader is not on-site, please refer to the Operation Soteria Emergency Operations Centre at DHHSOpSoteriaEOC@dhhs.vic.gov.au and title the email "Referral to organise transport".

Table 11. Key steps, roles and responsibilities for temporary leave

Step	Roles and responsibilities	Mandatory obligation	Section (PHWA)
Assess site for suitability	1. Senior AO to assess site for suitability of exercise and fresh air breaks. 2. AO to consider safety and security and obtain agreement from Security and DHHS Team Leader on suitable site 3. Site Map to be put on the Team Sharepoint site and attached as an attachment to this protocol following Deputy Command AO Operations approval.		
Request for temporary leave	4. Person may seek permission directly from the AO and explain the grounds for temporary leave		
AO assessment and decision	5. AO to make decision and consider: • those that require exercise or fresh air break or those who may be at risk without these breaks (this is the most important consideration for fresh air and exercise breaks) • willingness and availability of security to oversee and facilitate exercise or other fresh air breaks (the number of security officers will determine how many people can undertake temporary leave, as well as the ability to ensure small groups by room are distanced accordingly • site layout, safety and capability to ensure persons are in a cordoned off area • maintaining infection control, such as ensuring persons do not touch door handles or lift buttons • adherence to exercise and smoking procedures. 6. In considering a request for a person to visit a terminally ill family member in hospital, the AO will need to first check whether the medical facility will accept the person, noting the Hospital Visitors Direction.		
Issue permission for temporary leave	7. AOs to: • instruct security on the dates and times permitted for leave • provide procedural guidance to security and the person in detention, such as exercising in a cordoned off area not accessed by members of the public		s.203(1)

	• request the medical facility or hospital inform the AO prior to return (for medical temporary leave) • prepare a Permission for Temporary Leave from Detention form (see Appendix 5), and issue to the detainee and explain the leave obligations. For example: - a person attending a funeral must not attend the wake, must practice physical distancing and return immediately within stipulated timeframes - an exercise break is for a certain time and the person must return to their room following exercise or fresh air break. • warn the person that failure to comply with these directions is an offence • ensure the person checks back into the hotel at specified time • seek feedback on implementation of temporary leave and note any issued raised.		
Permissions for hospital treatment	8. AO should facilitate any permissions required for medical treatment. Where possible and end time should be recorded on the notice and app. Where an end time is not clear, the permission should note the detainee can only return on medical release. 9. A permission for medical treatment should not extend beyond 24 hours. Should a detainee be required to be admitted to the facility, a change of location detention notice should be issue following approval by the Deputy Command AO Operations. If the detainee returns to the hotel a new detention notice should be issued for the remainder of the 14 days. The AO should actively monitor that a detainee has returned within the 24 hour period. 10. When issuing a permission, the AO should also provide the hospital information sheet with contact details for Hotel team leader and Deputy Command AO operations. 11. If a medical facility wishes to release the detainee to a location outside of the hotel, the Deputy Command AO operations must obtain approval from EC Command.		
Compliance	12. If the AO is of the view the detainee may not comply with conditions of the permission, an escort must be arranged to travel with the individual. This is a particular consideration where a person may be visiting a home		

	environment where other non-palliative people will be present. Highly vulnerable people cannot be in the same immediate environment as the detainee 13. Permission cannot be granted for more than 2 hours on the basis that physical distancing is observed. If physical distancing is not likely to be observed and there is likely to be close contact, the detainee must be limited to 15 minutes. 14. If the detainee does not comply with the permission conditions, further permissions may not be granted.		
Record	15. If AO approves leave be granted, the AO must enter details in COVID-19 Compliance Application.		

7.3 Emergency situations

Table 20: Key steps, roles and responsibilities for emergency leave

Step	Roles and responsibilities	Mandatory obligation	Section (PHWA)
Determine risk	1. AOs and Victoria Police officers may need to determine the severity of any emergency (such as a building fire, flood, natural disaster etc) and the health risk they pose to persons in detention.		
Evacuation	2. Assist with immediate evacuation to common assembly point 3. Contact Victoria police, emergency services and Deputy Commander AO operations to support 4. Promote infection prevention and control and physical distancing principles if possible 5. Account for all persons being detained at the assembly point by way of the register of persons in detention/COVID-19 compliance application		

7.4 Procedure for a person in detention / resident to leave their room for exercise or smoking

A person must be compliant and must not have symptoms before they could be allowed to have supervised exercise or a smoking break. Only well residents from the same room should be able to go out to exercise at the same time.

7.5 Guidance for safe movement associated with permissions

7.5.1 Guidance for person in detention

The steps that must be taken by the person in detention are:

- Confirm to the person who will escort them that they are well.
- Confirm to the person who will escort them that they have washed their hands immediately prior to leaving the room.
- Don a single-use facemask (surgical mask), to be supplied by the security escort prior to leaving the room.
- Perform hand hygiene with alcohol-based hand sanitiser as they leave, this will require hand sanitiser to be in the corridor in multiple locations.
- Be reminded to – and then not touch any surfaces or people within the hotel on the way out, and then not actually do it.
- Return immediately to their hotel room following the break.

7.5.2 Guidance for security escort

Security escort should:

- Don a single-use facemask (surgical mask) if a distance of >1.5 metres cannot be maintained when escorting the person;
- Perform hand hygiene with an alcohol-based hand sanitiser or wash hands in soapy water before each break;
- Remind the person they are escorting to not touch any surfaces or people within the hotel on the way out or when coming back in
- Be the person who touches all surfaces if required such as the lift button or door handles (where possible using security passes and elbows rather than hands);
- Wherever possible, maintain a distance (at least 1.5 metres) from the person;
- Perform hand hygiene with an alcohol-based hand sanitiser or wash hands in soapy water at the end of each break and when they go home
- Ensure exercise is only undertaken in a cordoned off area with no public access or interaction.

7.5.3 Infection control considerations

Points to remember when using a single-use facemask (surgical mask):

- Always perform hand hygiene before donning the mask.
- Mould the metal clip over the bridge of the nose and ensure the bottom of the mask fits snuggly under the chin.
- Avoid touching or adjusting the mask once it has been donned.
- Unless damp or soiled, masks may be worn for the duration of a shift for up to four hours.
- Masks must be removed and disposed of for breaks and then replaced if needed.
- Masks must never be partially removed (for example, top tie undone and left dangling around the neck) and then re-worn.
- Perform hand hygiene immediately before and after removal of the mask.

There is no requirement to wear gloves and this is not recommended, as many people forget to take them off and then contaminate surfaces. Hand hygiene is one of the most effective ways to prevent the spread of infection and gloves should not be seen as a substitute for hand hygiene. If gloves are worn, remove the gloves immediately after the person is back in their room and then wash your hands.

In addition:

Family groups may be taken out in a group provided it is only 2 adults and less than 5 in total.
They can be taken to an outside area with sunlight, for up to 15 minutes outside of the hotel.
Smokers can take up to 2 breaks per day if staffing permits.
Rostering to be initiated by the departmental staff/AO present.

8 Compliance

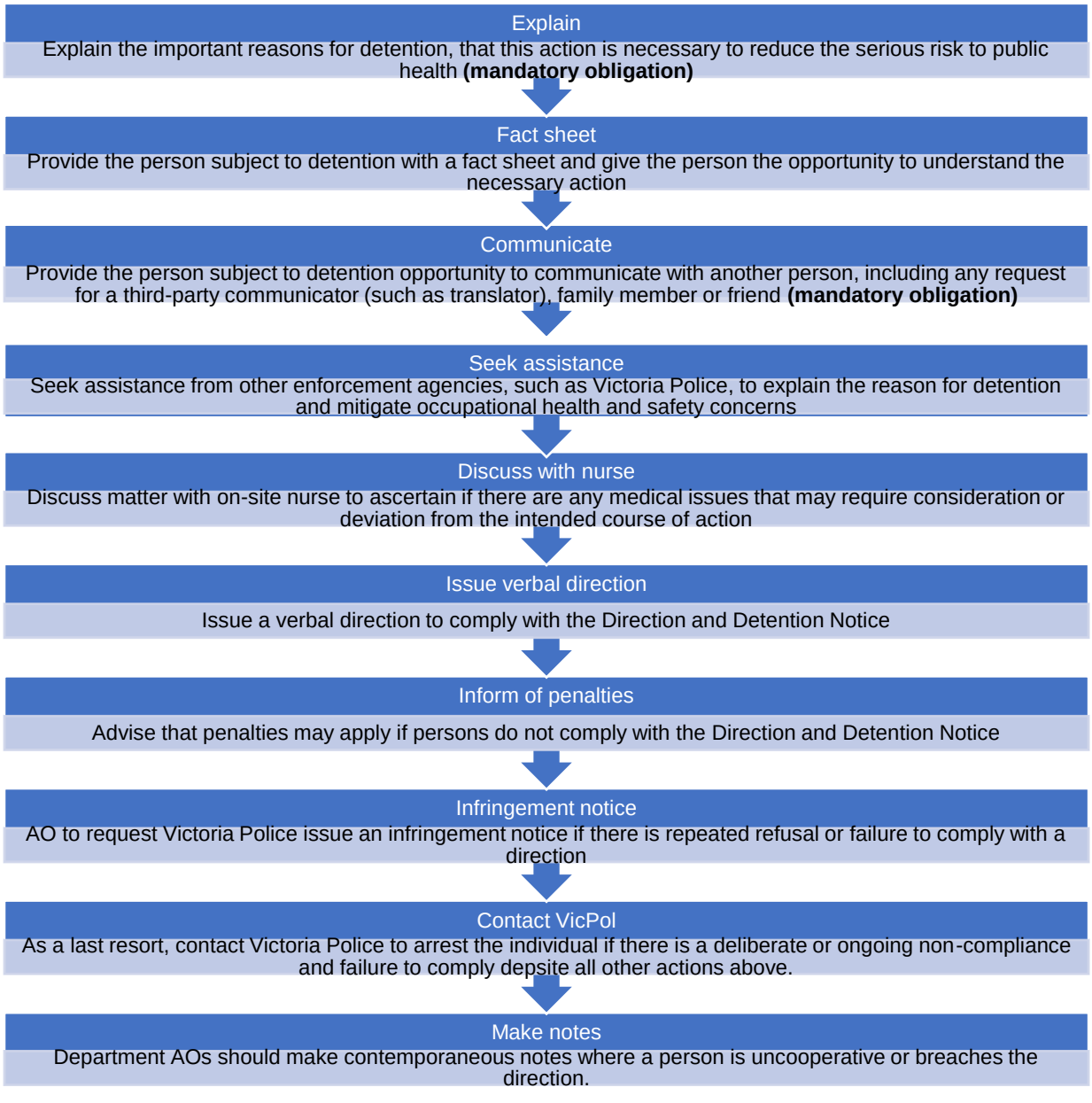
8.1 Key points

- AOs to apply a graduated approach to compliance.
- Police and security can assist in compliance and enforcement activities

8.2 Options to facilitate compliance

AOs should make every effort to inform the person of their obligations, facilitate communication if requested and explain the important rationale for the direction. Non-compliance could take the form of a person refusing to comply with the direction at the airport or hotel.

The following graduated approach should guide AOs:



8.3 Unauthorised departure from accommodation

Table 12. Key steps, roles and responsibilities for managing unauthorised departure from accommodation

Step	Roles and responsibilities	Mandatory obligation	Section (PHWA)
Notify and search	1. AO to notify Senior AO, on-site security and hotel management and request search.		
Contact Victoria police and Deputy Commander	2. AO to seek police assistance and notify the Deputy Commander AO Operations if the person is not found.		
Identification and compliance	3. If the person is located, AO to: • seek security or Victoria Police assistance if it is determined the person poses a risk of trying to leave • provide an opportunity for the person to explain the reason why they left their room • assess the nature and extent of the breach, for example: - a walk to obtain fresh air - a deliberate intention to leave the hotel - mental health issues - escaping emotional or physical violence. • consider issuing an official warning or infringement through Victoria Police • reassess security arrangements.		s.203(1)

8.4 Infringements

There are four infringement offences applicable to detention arrangements. These are:

Table 13. List of infringements

Section (PHWA)	Description	Amount
s.183	Hinder or obstruct an authorised officer exercising a power without reasonable excuse (5 penalty units).	5 penalty units (PU)
s.188(2)	Refuse or fail to comply with a direction by CHO to provide information made under s.188(10 penalty units for a natural person and 30 penalty units for a body corporate without a reasonable excuse).	10 PU natural person, 30 PU body corporate
s.193(1)	Refuse or fail to comply with a direction given to, or a requirement made or, a person in the exercise of a public health risk powers (10 penalty units for natural person and 60 penalty units for body corporate).	10 PU natural person, 60 PU body corporate

s.203(1)	Refuse or fail to comply with a direction given to, or a requirement made or, a person in the exercise of a power under an authorisation given under s.199 (10 penalty units for natural person and 60 penalty units for body corporate).	10 PU natural person, 60 PU body corporate

9 Occupational health and safety (OHS) for Authorised Officers

The purpose of this section is to provide an occupational health and safety procedure for AOs when attending off site locations during the current State of Emergency.

9.1 Key points

- OHS is a shared responsibility of both the employer and the employee. AOs must raise hazards, concerns and incidents with the Senior AO or the Deputy Commander AO operations.
- AOs must take steps to protect themselves from transmission of COVID-19 and adhere to physical distancing protocols wherever possible

9.2 Health Emergency

Coronaviruses are a large family of viruses that cause respiratory infections. These can range from the common cold to more serious diseases. COVID-19 is the disease caused by a new coronavirus. It was first reported in December 2019 in Wuhan City in China.

Symptoms of COVID-19 can range from mild illness to pneumonia. Some people will recover easily, and others may get very sick very quickly which in some cases can cause death.

9.3 OHS

OHS is a shared responsibility of both the employer and the employee. Officers must raise hazards, concerns and incidents with the rostered AO Team Leader.

One of the foremost issues associated with site attendance is the ‘uncontrolled environment’ that exists. AOs can be exposed to infectious diseases (such as COVID-19), confrontational and/or aggressive members of the public who may be drug affected, mentally ill or intellectually impaired. The very nature of this work is likely to be perceived as invasive and can provoke a defensive response.

Risks can be minimised by maintaining routine safe work practices and proper planning. Prior to any site visit, risks and hazards should be identified and assessed.

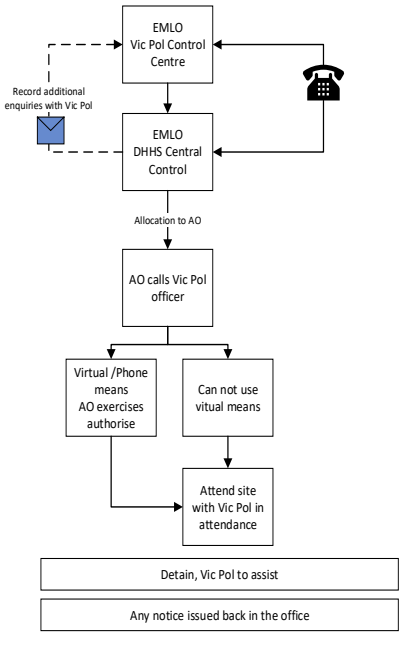
Officers and managers both have a shared responsibility for occupational health and safety. All employees have a responsibility to report and discuss hazards or perceived hazards, by bringing this to the managers attention.

9.4 Fatigue

AOs will be rostered on a rotating basis, with the aim of mitigating the risk of fatigue. Fatigue may impede decision making capability and when driving a motor vehicle to a location. When fatigue is identified please make this known to your Senior AO or Deputy Commander AO operations.

To mitigate the risk of fatigue, AOs should be aware of any fatigue they may have. A good tool to use to help officers identify their level of fatigue is to use the following calculator:
http://www.vgate.net.au/fatigue.php

AOs are required to hold a valid motor vehicle licence and are required to adhere to the requirements of the department’s driving policy. Information about this policy can be found on the DHHS intranet site.



9.5 Risk assessment before attendance -Personal Protection

Officers must only take a direction to attend a site with the approval of the Central DHHS Emergency Management Liaison Officer and a Senior AO or the Deputy Commander AO operations or DHHS management.

In the first instance, officers are required to use technology (i.e: mobile phone, Facetime, Skype) to exercise their authority. This aims to protect officers from attending an uncontrolled environment, where the risk of harm is increased.

Before attending a site, whether an airport or a hotel, the officer should make themselves familiar with the recommendations produced by the Australian Government and the Department of Health and Human Services, in the protection against COVID-19.

Interventions are known as 'transmission reduction, or 'physical distancing' measures. Officers can take the following personal measures to reduce their risk of exposure to COVID-19. Officers with pre-existing medical conditions that put them more at risk of COVID-19, should discuss this with their medical practitioner and manager.

9.6 Personal measures to reduce risk the risk of exposure to COVID

9.6.1 General

AOs must take steps to protect themselves from transmission of COVID-19 and adhere to physical distancing protocols wherever possible. For example,:

- Stay healthy with good nutrition, regular exercise, sensible drinking, sleep well, and if you are a smoker, quit.
- Wash your hands often with soap and water for at least 20 seconds, especially after you have been in a public place, or after blowing your nose, coughing, sneezing, or using the toilet. If soap and water are not readily available, use a hand sanitiser that contains at least 60 per cent alcohol.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Cover your nose and mouth with a tissue when you cough or sneeze. If you don't have a tissue, cough or sneeze into your upper sleeve or elbow.
- Stop shaking hands, hugging or kissing as a greeting.
- Ensure a **distance of 1.5 metres** is kept between yourself and others.
- Get vaccinated for flu (influenza) as soon as available. This could help reduce the risk of further problems. *Note: the department covers expenses for vaccines, speak to your Senior AO for more details.*
- Clean and disinfect high touch surfaces regularly, for example: telephones, keyboards, door handles, light switches and, bench tops.

When an officer is called to attend the airport or a hotel to exercise powers in relation to the Direction and Detention notice they should take a **risk-based approach** and assess the most suitable way to reduce harm to themselves. Before attending, the officer must obtain information such as:

- Is the person being detained a suspected or confirmed case of COVID-19?
- Has the person being detained been recently in close contact with a confirmed case of COVID-19?
- Has the person being detained recently returned from overseas within the last 14 days?

Officers are required to use their discretion and take into account their own personal safety. The Department of Health and Human Services has provided the following PPE:

- Single-use surgical mask
- Gloves
- Hand Sanitiser.

9.6.2 AOs going onto floors of hotel

AOs going onto hotel floors with persons subject to detention must wear a surgical mask. There will be surgical masks for AO's at the hotels.

AO's should not enter the room in which a person is being detained. Communication should be from the corridor or outside the room.

9.6.3 Relocating a confirmed case of COVID-19

All COVID-19 confirmed cases will be transferred to a COVID-19 hotel. The AO should amend the detention notice with the new location details prior to the detainee leaving the premises. Gloves and mask should be work when amending the notice and advising the detainee of the amendment.

Companions of the confirmed COVID-19 case may wish to remain with the confirmed COVID-19 detainee and transfer to the COVID-19 hotel. Their detention notice will also need to be amended.

Transfer of the detainee is the responsibility of the EOC.

The room or location change must be recorded in the compliance app by the AO.

9.7 Measures and guides to enhance occupational health and safety

Table 14. Using Personal Protective Equipment

PPE/measure	Guide
Single-use face mask (surgical mask)	When there is suspected or confirmed case of COVID-19, or a person subject to detention has been recently exposed to COVID-19 and a distance of at least 1.5 metres cannot be maintained.
Gloves	If contact with the person or blood or body fluids is anticipated.
Hand hygiene / Hand Sanitizer Soap and water	Always
Physical distancing of at least 1.5 meters	Always

Table 15. Known risks and hazards

Hazard	Risk	Mitigate
COVID-19 infection	Serious illness / death	Follow personal protective measures
Fatigue	Impaired decisions / driving to site	In the first instance use virtual technology to perform duties Use fatigue calculator http://www.vgate.net.au/fatigue.php
Physical Injury	Low / Medium	Only attend a site with Victoria Police or with security.
Other infectious agents		Follow personal protective measures

9.7.1 COVID-19 testing for Authorised Officers

Should an AO need to be tested for COVID-19, the AO should ask that their test to be marked urgent given the critical front-line response work.

Appendix 1. Direction and Detention notice

DIRECTION AND DETENTION NOTICE

Public Health and Wellbeing Act 2008 (Vic)
Section 200

1 Reason for this Notice

(1) You have arrived in Victoria from overseas, on or after midnight on 11 May 2020.

(2) A state of emergency exists in Victoria under section 198 of the *Public Health and Wellbeing Act 2008* (Vic) (the **Act**), because of the serious risk to public health posed by COVID-19.

(3) In particular, there is a serious risk to public health as a result of people travelling to Victoria from overseas. People who have been overseas are at the highest risk of infection and are one of the biggest contributors to the spread of COVID-19 throughout Victoria.

(4) You will be detained at the hotel specified in clause 2 below, in the room specified in clause 2 below, for a period of 14 days, because, having regard to the medical advice, that detention is reasonably necessary for the purpose of eliminating or reducing a serious risk to public health, in accordance with section 200(1)(a) of the Act.

(5) You must comply with the directions in clause 3 below because they are reasonably necessary to protect public health, in accordance with section 200(1)(d) of the Act.

(6) The Chief Health Officer will be notified that you have been detained. The Chief Health Officer must advise the Minister for Health of your detention.

Note: These steps are required by sections 200(7) and (9) of the Act.

2 Place and time of detention

(1) You will be detained at:

Hotel: _____ *(to be completed at place of arrival)*

Room No: _____ *(to be completed on arrival at hotel)*

(2) You will be detained until: _____ on ____of _____2020

(to be completed at place of arrival)

3 Directions — transport to hotel

(1) You must **proceed immediately to the vehicle** that has been provided to take you to the hotel, in accordance with any instructions given to you.

(2) Once you arrive at the hotel, **you must proceed immediately to the room** you have been allocated above in accordance with any instructions given to you.

4 Conditions of your detention

(1) **You must not leave the room in any circumstances**, unless:

Direction and Detention Notice 1 of 2

(a) you have been granted permission to do so:

(i) for the purposes of attending a medical facility to receive medical care; or

(ii) where it is reasonably necessary for your physical or mental health; or

(iii) on compassionate grounds; or

(b) there is an emergency situation.

(2) **You must not permit any other person to enter your room**, unless the person is authorised to be there for a specific purpose (for example, providing food or for medical reasons).

(3) Except for authorised people, the only other people allowed in your room are people who are being detained in the same room as you.

(4) You are permitted to communicate with people who are not staying with you in your room, either by phone or other electronic means.

Note: An authorised officer must facilitate any reasonable request for communication made by you, in accordance with section 200(5) of the Act.

(5) If you are under 18 years of age your parent or guardian is permitted to stay with you, but only if they agree to submit to the same conditions of detention for the period that you are detained.

5 Review of your detention

Your detention will be reviewed at least once every 24 hours for the period that you are in detention, in order to determine whether your detention continues to be reasonably necessary to eliminate or reduce a serious risk to public health.

Note: This review is required by section 200(6) of the Act.

6 Offence and penalty

(1) It is an offence under section 203 of the Act if you refuse or fail to comply with the directions and requirements set out in this Notice, unless you have a reasonable excuse for refusing or failing to comply.

(2) The current penalty for an individual is $19,826.40.

REDACTED

Name of Authorised Officer: Dr. Annaliese van Diemen

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

Appendix 2. Script for plane/arrival

Required script before issuing a direction and detention notice

My Name is XXXX, I work for the Department of Health and Human Services Victoria and I am an Authorised Officer under the Public Health and Wellbeing Act. I am also authorised for the purposes of the emergency and public health risk powers in Victoria's current State of Emergency.

Please be advised that a State of Emergency has been declared in Victoria because of the serious risk to public health posed by COVID-19 virus.

Because you have arrived in Victoria from overseas, when you disembark off this plane you will be issued with a direction and detention notice, which requires you to quarantine for a 14-day period at the hotel nominated on the notice.

People who have been overseas are at the highest-risk risk of infection with COVID-19 and are one of the biggest contributors to the spread of COVID-19 in Victoria. Therefore, you will be detained in a hotel for 14 days because that is reasonably necessary to reduce or eliminate the serious risk to public health posed by COVID-19.

Please be advised that refusal or failure to comply without reasonable excuse is an offence. There are penalties for not complying with the notice.

Once you have been issued with the notice, please keep it with you at all times.

We greatly appreciate your co-operation and assistance in these challenging times. Thank you again.

Appendix 3. Detention notice for unaccompanied minors

DIRECTION AND DETENTION NOTICE

SOLO CHILDREN

Public Health and Wellbeing Act 2008 (Vic)

Section 200

1 Reason for this Notice

(1) You have arrivedin Victoria from overseas, on or after midnight on 28 March 202(or on or after 13 April 2020 or 11 May 2020.

(2) A state of emergency has been declared under section 198 of the *Public Health and Wellbeing Act 2008* (Vic) (the **Act**), because of the serious risk to public health posed by COVID-19.

(3) In particular, there is a serious risk to public health as a result of people travelling to Victoria from overseas. People who have been overseas areat the highest risk of infection and are one of the biggest contributors to the spread of COVID -19 throughout Victoria.

(4) You will be detained at the hotel specified in clause 2 below,in the room specified in clause 2 below, for a period of 14 days, because that is reasonably necessary for the purpose of eliminating or reducing a serious risk to public health , in accordance with section 200(1)(a) of the Act.

(5) Having regard to the medical advice, 14 day s is the period reasonably required to ensure that you have not contracted COVID -19 as a result of your overseas travel.

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

(7) The Chief Health Officer will be notified that you have been detained. The Chief Health Officer must advise the Minister for Health of your detention.

Note: These steps are required by sections 200(7) and (9) of the Act.

2 Place and time of detention

(1) You will be detained at:

Hotel: _____ *(to be completed at place of arrival)*

Room No: _____ *(to be completed on arrival at hotel)*

(2) You will be detained until: _____ on ____of _____2020.

3 Directions — transport to hotel

(1) You must **proceed immediately to the vehicle** that has been provided to take you to the hotel, in accordance with any instructions given to you.

(2) Once you arrive at the hotel, **you must proceed immediately to the room** you have been allocated above in accordance with any instructions given to you.

4 Conditions of your detention

(1) **You must not leave the room in any circumstances**, unless:

(a) you have been granted permission to do so:

(i) for the purposes of attending a medical facility to receive medical care; or

(ii) where it is reasonably necessary for your physical or mental health; or

(iii) on compassionate grounds; or

(b) there is an emergency situation.

(2) **You must not permit any other person to enter your room**, unless the person is authorised to be there for a specific purpose (for example, providing food or for medical reasons).

(3) Except for authorised people, the only other people allowed in your room are people who are being detained in the same room as you.

(4) You are permitted to communicate with people who are not staying with you in your room, either by phone or other electronic means.

Note: An authorised officer must facilitate any reasonable request for communication made by you, in accordance with section 200(5) of the Act.

(5) If you are under 18 years of age your parent or guardian is permitted to stay with you, but only if they agree to submit to the same conditions of detention for the period that you are detained.

5 Review of your detention

Your detention will be reviewed at least once every 24 hours for the period that you are in detention, in order to determine whether your detention continues to be reasonably necessary to eliminate or reduce a serious risk to public health.

Note: This review is required by section 200(6) of the Act.

6 Special conditions because you are a solo child

Because your parent or guardian is not with you in detention the following additional protections apply to you:

(a) We will check on your welfare throughout the day and overnight.

(b) We will ensure you get adequate food, either from your parents or elsewhere.

(c) We will make sure you can communicate with your parents regularly.

(d) We will try to facilitate remote education where it is being provided by your school.

(e) We will communicate with your parents once a day.

7 Offence and penalty

(1) It is an offence under section 203 of the Act if you refuse or fail to comply with the directions and requirements set out in this Notice, unless you have a reasonable excuse for refusing or failing to comply.

(2) The current penalty for an individual is $19,826.40.

_____

Name of Authorised Officer: _____

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

Appendix 4. Letter for carer to join detention

Dear [**insert name**]

In accordance with section 198 of the *Public Health and Wellbeing Act 2008* (**Act**), a state of emergency has been declared in Victoria as a result of the serious risk to public health posed by COVID-19.

In order to mitigate this public health risk, the Victorian government has introduced a quarantine period for people arriving in Victoria from overseas.

I note that [**insert name of persons in hotel detention that are being joined by the kinship carer**] have been issued with a direction and detention notice on [**insert**] under section 200(1)(a) of the Act.

You have agreed to be detained in quarantine with the above persons who have arrived from overseas in [**insert hotel name**], to provide kinship care and support.

In these circumstances, you will be subject to quarantined in accordance with the attached direction and detention notice issued under section 200(1)(a) of the Act, which sets out the terms and conditions of your period of quarantine.

Yours sincerely

Authorised Officer

[**insert date**]

Appendix 5. Permission for temporary leave

PERMISSION FOR TEMPORARY LEAVE FROM DETENTION

Public Health and Wellbeing Act 2008 (Vic)

Section 200

An Authorised Officer has granted you permission to leave your room based on one of the grounds set out below. This is temporary. You will be supervised when you leave your room. You must ensure you comply with all the conditions in this permission and any directions an Authorised Officer gives you. You must return to your room at the time specified to finish your detention. Speak to your supervising Authorised Officer if you require more information.

1 Temporary leave

(1) You have arrived in Victoria from overseas, on or after midnight on 28 March 2020 or on or after 13 April 2020 or 11 May 2020 and have been placed in detention, pursuant to a Direction and Detention Notice that you were provided on your arrival in Victoria (**Notice**).

(2) This Permission for Temporary Leave From Detention (**Permission**) is made under paragraph 4(1) of the Notice.

2 Reason/s for, and terms of, permission granting temporary leave

(1) Permission for temporary leave has been granted to: _____ _____ [insert name] for the following reason/s [tick applicable]:

(a) for the purpose of attending a medical facility to receive medical care:

☐ **Name of facility:** _____

Time of admission/appointment:_____

Reason for medical appointment:_____

(b) where it is reasonably necessary for physical or mental health:

☐ **Reason leave is necessary:**_____

Proposed activity/solution:_____

(c) on compassionate grounds:

☐ **Detail grounds:**_____

(2) The temporary leave starts on _____

and ends on _____ [insert date and time].

_____ **Signature of Authorised Officer**

Name of Authorised Officer: _____

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

3 Conditions

(1) You must be supervised **at all times**/may be supervised *[delete as appropriate]* while you are out of your room. You are not permitted to leave your hotel room, even for the purpose contained in this Permission, unless you are accompanied by an Authorised Officer.

(2) While you are outside your room you must practice social distancing, and as far as possible, maintain a distance of 1.5 metres from all other people, including the Authorised Officer escorting you.

(3) When you are outside your room you must refrain from touching communal surfaces, as far as possible, such as door knobs, handrails, lift buttons etc.

(4) When you are outside your room you must, **at all times**, wear appropriate protective equipment to prevent the spread of COVID-19, if directed by the Authorised Officer escorting you.

(5) When you are outside your room you must, **at all times**, comply with any direction given to you by the Authorised Officer escorting you.

(6) At the end of your temporary leave, you will be escorted back to your room by the Authorised Officer escorting you. You must return to your room and remain there to complete the requirements under the Notice.

(7) Once you return to the hotel, **you must proceed immediately to the room** you have been allocated above in accordance with any instructions given to you.

(8) You must comply with any other conditions or directions the Authorised Officer considers appropriate.
(Insert additional conditions, if any, at Annexure 1)

4 Specific Details

(1) Temporary leave is only permitted in limited circumstances, to the extent provided for in this Permission, and is subject to the strict **conditions** outlined at paragraph 3. You must comply with these conditions **at all times** while you are on temporary leave. These conditions are reasonably necessary to protect public health, in accordance with section 200(1)(d) of the *Public Health and Wellbeing Act 2008* (Vic).

(2) Permission is only granted to the extent necessary to achieve the **purpose** of, and for the **period of time** noted at paragraph 2 of this Permission.

(3) Nothing in this Permission, invalidates, revokes or varies the circumstances, or period, of your detention, as contained in the Notice. The Notice continues to be in force during the period for which you are granted permission for temporary leave from detention. The Notice continues to be in force until it expires.

5 Offence and penalty

(1) It is an offence under section 203 of the Act if you refuse or fail to comply with the conditions set out in this Permission, unless you have a reasonable excuse for refusing or failing to comply.

(2) The current penalty for an individual is $19,826.40.

Annexure 1: Additional conditions *[if applicable]*

Appendix 6. Guidance Note: Permission for Temporary Leave from Detention

How do you issue a Permission for Temporary Leave from Detention?

It is recommended that Authorised Officers take the following steps when issuing a Permission for Temporary Leave from Detention:

- **Before you provide the Permission for Temporary Leave from Detention**

- carefully consider the request for permission and consider the grounds available under paragraph 4(1) of the Direction and Detention Notice – which include:
  - for the purposes of attending a medical facility to receive medical care; or
  - where it is reasonably necessary for the person's physical or mental health; or
  - on compassionate grounds.
- complete all sections of the Permission, including clearly documenting the reasons for the Permission, date and time when the temporary leave is granted from and to, and whether the person will be supervised by the authorised officer during the temporary leave
- ensure the reference number is completed.

- **When you are provide the Permission for Temporary Leave from Detention**

- you must warn the person that refusal or failure to comply without reasonable excuse, is an offence;
- explain the reason why it is necessary to provide the Permission and the conditions which apply to the temporary leave (including that the person is still subject to completing the remainder of the detention once the temporary leave expires, and the Permission is necessary to protect public health);
- provide the Permission to the person, provide them with time to read the Permission and take a photo of the Permission for the department's records.

NB If it is not practicable to explain the reason why it is necessary to give the Permission, please do so as soon as practicable after Permission has been exercised.

- **What are the requirements when you are granting a permission to a person under the age of 18?**

The same requirements set out above apply when issuing a Permission to an unaccompanied minor. However, the supervising Authorised Officer must have Working With Children Check, have regard to the special conditions in the Direction and Detention Notice as well as the person's status as a child.

- **What other directions can you give?**

Section 200(1)(d) of the PHWA sets out an emergency power that allows an authorised officer to give any other direction that the authorised officer considers is reasonably necessary to protect public health.

What are your obligations when you require compliance with a direction?

Exercising this power imposes several obligations on departmental authorised officers including that an authorised officer must, before exercising any emergency powers, warn the person that refusal or failure to comply without reasonable excuse, is an offence.

Appendix 7. Guidance: Exemptions under Commonwealth law

Please note that Victoria may vary from this guidance

Exemptions to the 14 day mandatory quarantine period for international travellers

The Australian Health Protection Principal Committee (AHPPC) recognise that there should be some exemptions from quarantine requirements for specific industry groups, provided they adhere to specified risk mitigations measures. These specific exemptions are recommended because of the industry infection prevention requirements, training these groups have undergone, and the vital role of these industries in Australia.

While these are national recommendations, mandatory quarantine is enforced under state and territory public health legislation. Individual states and territories may choose to implement additional requirements at the point of arrival.

Some jurisdictions may also have additional quarantine requirements upon entry to the state or territory. Depending on the jurisdiction, this could mean that an international traveller is required to go into mandatory quarantine at the first point of arrival into Australia, and further quarantine upon entry to another jurisdiction.

The following groups are recommended to be exempt from the 14 day mandatory quarantine requirements when entering Australia. While these groups are exempt from mandatory quarantine, **all** arrivals into Australia **must** continue to practise social distancing, cough etiquette and hand hygiene. Other requirements, such as self-isolation, may still apply and are outlined below.

Aviation crew

International flight crew (Australian residents/citizens)

- Are not required to undertake 14 days of mandatory quarantine on arrival.
- Are not required to complete the Isolation Declaration Card.
- Are not required to self-isolate.

International flight crew (foreign nationals)

- Are not required to undertake 14 days of mandatory quarantine on arrival.
- Are not required to complete the Isolation Declaration Card.
- Must self-isolate in their hotel on arrival until their next flight.
- Must use privately organised transport to transfer to and from hotels between flights.
- May fly domestically to their next point of departure from Australia if required.

Domestic flight crew

- Exempt from self-isolation requirements *except when a state or territory specifically prohibits entry.*

Maritime crew (excluding cruise ships)

- Are not required to undertake 14 days of mandatory quarantine on arrival into Australia. They are therefore not required to complete the Isolation Declaration Card.
- Must proceed directly to the vessel on arrival.

Exemptions to the 14 day mandatory quarantine period, version 2 (06/04/2020)
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- If access to the vessel is not immediate, crew must self-isolate at their accommodation during any lay-over period.
- May travel domestically and/or take a domestic flight to meet their vessel at the next point of departure if required.
- At the completion of their shifts, they are not required to go into mandatory 14 days quarantine, but must undertake 14 days self-isolation.
- Time at sea counts towards the 14 days of self-isolation if no illness has been reported on-board. Therefore crew signing off commercial vessels that have spent greater than 14 days at sea, with no know illness on-board, do not need to self-isolate on arrival.

Unaccompanied minors

Unaccompanied minors will be allowed to travel domestically after entering Australia to self-quarantine with a parent or guardian at their home.

Transit passengers

- International transit passengers arriving into Australia are able to depart on another international flight if the following conditions are met:
  - If the individual has up to 8 hours until the departing international flight, they must remain at the airport and be permitted to onward travel, maintaining social distancing and hand hygiene.
  - If 8-72 hours before the departing flight, they must go to mandatory quarantine at the state designated facility until the time of the departing flight.
- No domestic onward travel is allowed, even if this is to meet a departing international flight. These people should go into mandatory quarantine at the state designated facility at the first point of arrival.

Diplomats

- Australia has legal obligations under the Vienna Convention to ensure diplomats freedom of movement and travel, and protection from detention. Diplomats are not required to undertake 14 days of mandatory quarantine on arrival into Australia. They are therefore not required to complete the Isolation Declaration Card.
- Diplomats should self-isolate at their mission or in their usual place of residence on arrival for 14 days.
- Diplomats must continue to practise social distancing, cough etiquette and hand hygiene.

Compassionate or medical grounds

Applications on medical or compassionate grounds should be submitted to the relevant state or territory who will consider requests on a case-by-case basis.

Contact details for state or territory public health agencies are available at www.health.gov.au/state-territory-contacts.

Where can I get more information?

For the latest advice, information and resources, go to www.health.gov.au.

Call the National Coronavirus Helpline on 1800 020 080. This line operates 24 hours a day, seven days a week. If you require translating or interpreting services, call 131 450.

Appendix 8. Guidance note: unaccompanied minors

Introduction

You are an officer authorised by the Chief Health Officer under section 199(2)(a) of the *Public Health and Wellbeing Act 2008* (Vic) to exercise certain powers under that Act. You also have duties under the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**Charter**).

These Guidelines have been prepared to assist you to carry out your functions in relation to Victorian unaccompanied minors who have arrived in Victoria and are subject to detention notices, requiring them to self-quarantine in a designated hotel room for 14 days in order to limit the spread of Novel Coronavirus 2019 (**2019-nCoV**) where no parent, guardian or other carer (**parent**) has elected to join them in quarantine (a **Solo Child Detention Notice**).

As part of your functions, you will be required to make decisions as to whether a person who is subject to a Solo Child Detention Notice should be granted permission to leave their room:

- for the purposes of attending a medical facility to receive medical care; or
- where it is reasonably necessary for their physical or mental health; or
- on compassionate grounds.

Authorised Officers are also required to review the circumstances of each detained person at least once every 24 hours, in order to determine whether their detention continues to be reasonably necessary to eliminate or reduce a serious risk to public health.

Your obligations under the Charter of Human Rights and Responsibilities Act 2006

You are a public officer under the Charter. This means that, in providing services and performing functions in relation to persons subject to a Detention Notice you must, at all times:

- act compatibly with human rights; and
- give 'proper consideration' to the human rights of any person(s) affected by your decisions.

How to give 'proper consideration' to human rights

'Proper consideration' requires you to:

- **first**, understand in general terms which human rights will be affected by your decisions (these rights are set out below under 'relevant human rights');
- **second**, seriously turn your mind to the possible impact of your decisions on the relevant individual's human rights, and the implications for that person;
- **third**, identify the countervailing interests (e.g. the important public objectives such as preventing the further spread of 2019-nCoV, which may weigh against a person's full enjoyment of their human rights for a period of time); and
- **fourth**, balance the competing private and public interests to assess whether restricting a person's human rights (e.g. denying a person's request to leave their room) is justified in the circumstances.

Relevant human rights

The following human rights protected by the Charter are likely to be relevant to your functions when conducting daily wellbeing visits and when assessing what is reasonably necessary for the physical and mental health of children who are subject to Solo Child Detention Notices:

- The right of children to such protection as is in their best interests (s 17(2)). As the Solo Child Detention Notices detain children in circumstances where no parent has elected to join them in quarantine, greater protection must be provided to these children in light of the vulnerability that this creates. Where possible the following additional protection should be provided:
- You should undertake two hourly welfare checks while the child is awake and once overnight. You should ask the child to contact you when they wake each morning and let you know when they go to sleep so that this can be done.
- You should ask the child if they have any concerns that they would like to raise with you at least once per day.
- You should contact the child's parents once per day to identify whether the parent is having contact with the child and whether the parent or child have any concerns.
- You should ensure that where the child does not already have the necessary equipment with them to do so (and their parent is not able to provide the necessary equipment) the child is provided with the use of equipment by the department to facilitate telephone and video calls with their parents. A child must not be detained without an adequate means of regularly communicating with their parents.
- You should ensure that where the child does not already have the necessary equipment with them to do so (and their parent is not able to provide the necessary equipment) the child is provided with the use of equipment by the department to participate in remote education if that is occurring at the school they are attending. Within the confines of the quarantine you should obtain reasonable assistance for the child in setting up that computer equipment for use in remote education.
- You should allow the child's parents to bring them lawful and safe items for recreation, study, amusement, sleep or exercise for their use during their detention. This should be allowed to occur at any time within business hours, and as many times as desired, during the detention.
- The rights to liberty (s 21) and freedom of movement (s 12), and the right to humane treatment when deprived of liberty (s 22). As the Solo Child Detention Notices deprive children of liberty and restrict their movement, it is important that measures are put in place to ensure that the accommodation and conditions in which children are detained meet certain minimum standards (such as enabling parents to provide detained children with food, necessary medical care, and other necessities of living). It is also important that children are not detained for longer than is reasonably necessary.
- Freedom of religion (s 14) and cultural rights (s 19). Solo Child Detention Notices may temporarily affect the ability of people who are detained to exercise their religious or cultural rights or perform cultural duties; however, they do not prevent detained persons form holding a religious belief, nor do they restrict engaging in their cultural or religious practices in other ways (for example, through private prayer, online tools or engaging in religious or cultural practices with other persons with whom they are co-isolated). Requests by children for additional items or means to exercise their religious or cultural practices will need to be considered and accommodated if reasonably practicable in all the circumstances.
- The rights to recognition and equality before the law, and to enjoy human rights without discrimination (s 8). These rights will be relevant where the conditions of detention have a disproportionate impact on detained children who have a protected attribute (such as race or disability). Special measures may need to be taken in order to address the particular needs and vulnerabilities of, for example Aboriginal persons, or persons with a disability (including physical and mental conditions or disorders).
- The rights to **privacy, family and home** (s 13), **freedom of peaceful assembly** and **association** (s 16) and the **protection of families** (s 17). Solo Child Detention Notices are likely to temporarily restrict the rights of persons to develop and maintain social relations, to freely assemble and associate, and will prohibit physical family unification for those with family members in Victoria. Children's rights may be particularly affected, to the extent that a Solo Child Detention Notice results in the interference with a child's care and the broader family environment. It is important, therefore, to ensure children subject to Solo Child Detention Notices are not restricted from non-physical forms of

communication with relatives and friends (such as by telephone or video call). Requests for additional items or services to facilitate such communication (e.g. internet access) will need to be considered and accommodated if reasonably practicable in all the circumstances.

Whether, following 'proper consideration', your decisions are compatible with each these human rights, will depend on whether they are reasonable and proportionate in all the circumstances (including whether you assessed any reasonably available alternatives).

General welfare considerations

All persons who are deprived of liberty must be treated with humanity and respect, and decisions made in respect of their welfare must take account of their circumstances and the particular impact that being detained will have on them. Mandatory isolation may, for some people, cause greater hardship than for others – when performing welfare visits you will need to be alert to whether that is the case for any particular person.

In particular, anxieties over the outbreak of 2019-nCoV in conjunction with being isolated may result in the emergence or exacerbation of mental health conditions amongst persons who are subject to Detention Notices.

If you have any concerns about the mental health of a detained person, you should immediately request an assessment of mental health be conducted and ensure appropriate support is facilitated. Hotel rooms are not normally used or designed for detention, so you should be aware that a person who is detained in a hotel room could have greater opportunity to harm themselves than would be the case in a normal place of detention.

Additional welfare considerations for children

Children differ from adults in their physical and psychological development, and in their emotional and educational needs. For these reasons, children who are subject to Solo Child Detention Notices may require different treatment or special measures.

In performing functions and making decisions with respect to a detained person who is a child, the best interests of the child should be a primary consideration. Children should be given the opportunity to conduct some form of physical exercise through daily indoor and outdoor recreational activities. They should also be provided with the ability to engage in age-appropriate activities tailored to their needs.

Each child's needs must be assessed on a case-by-case basis. Requests for items or services to meet the needs of individual children will need to be considered and accommodated if reasonably practicable in all the circumstances.

Where available, primary school age children should be allocated rooms that have an outside area where it is safe for active physical play to occur (not a balcony) and consideration should be given to allowing small children access to any larger outdoor areas that are available within the hotel, where possible within relevant transmission guidelines. Although each child’s needs must be assessed daily and individually, it can be assumed that it will have a negative effect on a child’s mental health to be kept in the same room or rooms for two weeks without access to an adequate outdoor area in which to play.

Balancing competing interests

However, the best interests of children and the rights of anyone who is subject to a Solo Child Detention Notice will need to be balanced against other demonstrably justifiable ends; for example, lawful, reasonable and proportionate measures taken to reduce the further spread of 2019-nCoV.

It is your role to undertake this balance in your welfare checks, based on the information and advice that you have from the department and on the information provided to you by the children that you are assessing.

Appendix 9. Policy guiding release notices

Table 2. Management based on outcomes of Day 11 routine testing

		Staying in Victoria on exit	Leaving Victoria on exit (interstate or international)
Negative result	Asymptomatic	• **Subject to the Stay at Home Directions** • Issue End of Detention Notice (standard) • Allow to exit detention	• **Subject to the Stay at Home Directions until they leave Victoria** • Issue End of Detention Notice (standard) • Allow to exit detention
	Symptomatic	• **Subject to the Stay at Home Directions** • Issue End of Detention Notice (standard) • Allow to exit detention • Advise to stay at home until symptoms have resolved for 72 hours	• **Subject to the Stay at Home Directions until they leave Victoria** • Allow to exit detention • Issue End of Detention Notice (standard) • Allow to travel interstate • Advise to stay at home until symptoms have resolved for 72 hours
Positive result	All cases	• **Subject to the Diagnosed Persons and Close Contacts Direction** • Issue End of Detention Notice (confirmed case) • If the person has more than 24 hours left in mandatory quarantine before they are due to exit, they should be transferred to the COVID hotel (Rydges) for the remainder of the quarantine period. • If the person is due to exit to home within 24 hours of receiving the positive test result, the decision to transfer to the COVID hotel (Rydges) should be made on a case-by-case basis, and exiting from their current hotel to home on Day 14 may be the more appropriate arrangement. • When the 14-day mandatory quarantine period is complete: – Victorians who are still infectious (who have not yet met the department's criteria for release from isolation of a	• **Subject to the Diagnosed Persons and Close Contacts Direction** • Issue End of Detention Notice (confirmed case) • **Must not travel interstate** • When the 14-day mandatory quarantine period is complete: – Individuals from interstate who are still infectious (who have not yet met the department's criteria for release from isolation of a confirmed case) are permitted to isolate at an identified residence in Victoria, if they can do so safely and appropriately – Individuals from interstate who cannot safely isolate at an alternative residence in Victoria may continue to isolate at the COVID hotel (Rydges) until they meet the

		confirmed case) are permitted to isolate at home, if they can do so safely and appropriately – Victorians who cannot safely isolate at home may continue to isolate at the COVID hotel (Rydges) until they meet the department's criteria for release from isolation of a confirmed case • Transport of positive cases (to home or to the COVID hotel) should be by Non-Emergency Patient Transport (NEPT) • Positive cases should wear PPE while in transit	department's criteria for release from isolation of a confirmed case • Transport of positive cases (to the COVID hotel or to other appropriate accommodation in Victoria) should be by NEPT • Positive cases should wear PPE while in transit • If there are concerns that the person will not safely isolate in Victoria, a further Direction and Detention Notice should be considered, in consultation with the Public Health Commander and DHHS Legal
	Asymptomatic	• If a person is currently asymptomatic and has no history of symptoms in the past 14 days, then the test date will be taken as a proxy for a symptom onset date (day 0) and they will be required to isolate for 10 days from this date.	• If a person is currently asymptomatic and has no history of symptoms in the past 14 days, then the test date will be taken as a proxy for a symptom onset date (day 0) and they will be required to isolate for 10 days from this date.
	Symptomatic	• If a person is symptomatic, the isolation period will be determined as per the department's criteria for release from isolation of a confirmed case • Release from isolation will be actively considered when ALL the following criteria are met: – the person has been afebrile for the previous 72 hours, **AND** – at least **ten days** have elapsed after the onset of the acute illness, **AND** – there has been a noted improvement in symptoms, **AND** – a risk assessment has been conducted by the department and deemed no further criteria are needed	• If a person is symptomatic, the isolation period will be determined as per the department's criteria for release from isolation of a confirmed case • Release from isolation will be actively considered when ALL the following criteria are met: – the person has been afebrile for the previous 72 hours, **AND** – at least **ten days** have elapsed after the onset of the acute illness, **AND** – there has been a noted improvement in symptoms, **AND** – a risk assessment has been conducted by the department and deemed no further criteria are needed
Results pending	Asymptomatic	• **Subject to the Stay at Home Directions** • Issue End of Detention Notice (standard) • Allow to exit detention • All persons exiting mandatory quarantine who have COVID-19 test results pending should be advised to isolate until the test result is known	• **Subject to the Stay at Home Directions until they leave Victoria** • Issue End of Detention Notice (standard) • Allow to exit detention

		• DHHS should ensure the test result, positive or negative, is provided to the person	• All persons exiting mandatory quarantine who have COVID-19 test results pending should be advised to isolate until the test result is known • DHHS should ensure the test result, positive or negative, is provided to the person and, if positive, to the relevant state/territory public health department
	Symptomatic	• **Subject to the Stay at Home Directions** • Issue End of Detention Notice (respiratory symptoms) • Allow to exit detention • Victorians who can safely isolate at home must do so until the test result is known • Transport by NEPT, should wear PPE while in transit • Victorians who cannot safely isolate at home or other appropriate accommodation may continue to isolate at the quarantine hotel until the test result is known • DHHS should ensure the test result, positive or negative, is provided to the person	• **Subject to the Stay at Home Directions until they leave Victoria** • Issue End of Detention Notice (respiratory symptoms) • **Must not** travel interstate, must stay in Victoria until test result is known • If there is concern that they will not follow this advice, a further Direction and Detention Notice may be issued in consultation with the Public Health Commander and DHHS Legal • DHHS will accommodate in quarantine hotel until test result is known, if they have no other appropriate/safe accommodation to isolate in Victoria • If required, transport by NEPT and wear PPE while in transit • DHHS should ensure the test result, positive or negative, is provided to the person and, if positive, to the relevant state/territory public health department
Newly symptomatic after Day 11 test		• Where a person develops symptoms after the Day 11 testing, and the Day 11 test result is negative, repeat testing should be undertaken • Management should be as per the relevant category described above	• Where a person develops symptoms after the Day 11 testing, and the Day 11 test result is negative, repeat testing should be undertaken • Management should be as per the relevant category described above
Not tested (declined testing or other reason)	Asymptomatic	• **Subject to the Stay at Home Directions** • Issue End of Detention Notice (standard) • Allow to exit detention	• **Subject to the Stay at Home Directions until they leave Victoria** • Issue End of Detention Notice (standard) • Allow to exit detention

	Symptomatic	• **Subject to the Stay at Home Directions** • Issue End of Detention Notice (respiratory symptoms) • Allow to exit detention • Strongly advise to be tested • Document that they are symptomatic, and that they have been offered and refused testing • If requiring transport, they should go by NEPT and should wear PPE while in transit	• **Subject to the Stay at Home Directions until they leave Victoria** • Issue End of Detention Notice (respiratory symptoms) • Strongly advise to be tested • Document that they are symptomatic, and that they have been offered and refused testing • Each instance must be discussed with the Deputy Public Health Commander for a risk assessment, a further Direction and Detention Notice may be considered, in consultation with the Public Health Commander and DHHS Legal • DHHS will accommodate in quarantine hotel until test is agreed and result known, if they have no other appropriate/safe accommodation to isolate in in Victoria • If required, transport by NEPT and wear PPE while in transit
Close contact (not tested)	All close contacts	• **Subject to the Diagnosed Persons and Close Contacts Direction** • Issue End of Detention Notice (standard) • Close contacts of confirmed cases must isolate for 14 days since last contact with the confirmed case during their infectious period • All close contacts of confirmed cases should be encouraged to separate from the confirmed case so that their new quarantine period can commence • Close contacts from Victoria are permitted to isolate at home, if they can do so safely and appropriately • DHHS will accommodate in hotel if they have no other appropriate/safe accommodation to isolate in in Victoria • If required, transport by NEPT and wear PPE while in transit	• **Subject to the Diagnosed Persons and Close Contacts Direction** • Issue End of Detention Notice (standard) • Close contacts of confirmed cases must isolate for 14 days since last contact with the confirmed case during their infectious period • All close contacts of confirmed cases should be encouraged to separate from the confirmed case so that their new quarantine period can commence • **Must not travel interstate** • If there is a concern that they will not follow this advice (i.e. if refusing to isolate in Victoria and planning to travel interstate), a new Direction and Detention Notice should be considered, in consultation with the Public Health Commander and DHHS Legal • DHHS will accommodate in hotel if they have no other appropriate/safe accommodation to isolate in in Victoria

			• If required, transport by NEPT and wear PPE while in transit

Appendix 10. End of Detention Notice

END OF DETENTION NOTICE

Public Health and Wellbeing Act 2008 (Vic)

Section 200

Subject to the conditions below, this Notice is evidence that this detainee has completed their period of detention under a *Direction and Detention Notice* issued to reduce or eliminate the serious public health risk posed by COVID-19.

1 Detention Notice

(1) You have arrivedin Victoria from overseas, on or after midnight on 28 March 2020 and have been placed in detention, pursuant to a Direction and Detention Notice that you were provided on your arrival in Victoria (**Notice**).

2 Details of Detention Notice

(1) **Name of Detainee:** **<<FIRST NAME>> <<LAST NAME>>**

(2) **Date of Direction and Detention Notice:** <<DETENTION START DATE>>

(3) **Place of Detention:** <<HOTEL>> <<ROOM>>

3 End of Detention Notice

(1) In accordance with section 200(6) of the *Public Health and Wellbeing Act 2008* (Vic) (**Act**), I have reviewed your continued detention.

(2) On review of the Notice, I have made the following findings:

(a) you will have served the required detention period by <<DETENTION END DATE>>; and

(b) you have not started exhibiting any symptoms of COVID-19.

(3) In consideration of the above circumstances, I have decided that your continued detention is not reasonably necessary to eliminate or reduce a se rious risk to public health.

(4) I advise that your detention pursuant to section 200(1)(a) of the Act and the Notice will end on <<**DETENTION END DATE**>> at _____ after you have been discharged by an Authorised Officer and have commenced transportation to your ordinary residence.

(5) **You must not leave your hotel room until you have been collected by Security** at which time you are permitted to travel to the hotel lobby to meet an Authorised Officer who will **sight your identification** and discharge you from detention. **On your exit date Security will give you approximately an hour notice of when they will collect you, which will be prior to midnight.**

(6) Although you will no longer to be detained pursuant to the Notice, you are required to comply with all directions currently in force in Victoria. This includes the Stay at Home Directions (No 6) (**Direction**), as amended or replaced from time to time. Pursuant to the Direction, if you live in Victoria you are required to

travel directly to the premises where you ordinarily reside, and remain there unless you are leaving for one of the reasons listed in the Direction.

(7) If you are a resident of another state arrangements will be made for you to return home. While you remain in the State of Victoria, you are required to comply with all Directions in operation in Victoria. Once you have returned home, you are required to comply with the Directions and/or Orders in place in your home jurisdiction, including any directions that may require you to isolate for a further 14 day period.

(8) In the event that you start to experience symptoms of COVID-19, it is important that you self-isolate and, if necessary, contact your General Practitioner or local Public Health Unit.

4 End of Detention Instructions

(1) Your detention **does not end** until the time stated in paragraph 3(4) of this notice which will be filled in by an authorised officer when you are discharged from detention. Until that time you must continue to abide by the requirements of your detention, as contained in the Notice.

(2) When leaving detention you **must** adhere to the following safeguards:

(a) if provided to you, you **must** wear personal protective equipment;

(b) you **must** refrain, as far as possible, from touching communal surfaces, such as handrails, elevator buttons and door handles;

(c) you **must** where possible, practise physical distancing, maintaining a distance of 1.5 metres from other people; and

(d) upon leaving your hotel room, you **must** go straight to the foyer for discharge and then immediately after travel to your transportation and travel directly to your ordinary residence.

These steps are to ensure your protection, and reduce the risk of you becoming infected with COVID-19 by any persons detained in the hotel, or in the community, who may have COVID-19.

(3) Until your detention has concluded, you must follow instructions from Authorised Officer/s and any other conditions set out.

5 Offence and penalty

(1) It is an offence under section 203 of the Act if you refuse or fail to comply with the directions set out in this notice, unless you have a reasonable excuse for refusing or failing to comply.

(2) The current penalty for an individual is $19,826.40.

_____ **Signature of Authorised Officer**

Name of Authorised Officer: _____

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

Appendix 11. End of Detention Notice - confirmed case

PLEASE BRING THIS NOTICE AND YOUR IDENTIFICATION WITH YOU. BOTH ITEMS ARE NEEDED TO EXIT THE HOTEL

END OF DETENTION NOTICE - Confirmed COVID-19 case

Public Health and Wellbeing Act 2008 (Vic)

Section 200

The detainee has returned a positive test for COVID-19. Subject to the conditions below, this Notice is evidence that this detainee has completed their period of detention under a *Direction and Detention Notice* issued to reduce or eliminate the serious public health risk posed by COVID-19 and is transitioning to a suitable premises to self-isolate pursuant to the Diagnosed Persons and Close Contacts Directions

1 Detention Notice

(1) You have arrivedin Victoria from overseas, on or after midnight on 28 March 2020 and have been placed in detention, pursuant to a Direction and Detention Notice that you were provided on your arrival in Victoria (**Notice**).

2 Details of Detention Notice

(1) **Name of Detainee:** _____

(2) **Date of Direction and Detention Notice:** _____

(3) **Place of Detention:** _____ Room

(4) **Medical Facility:**_____
(if medical care is required)

(5) **COVID-19 Status (Confirmed)**: _____ [date of test]

3 End of Detention Notice

(1) In accordance with section 200(6) of the *Public Health and Wellbeing Act 2008* (Vic) (**Act**), I have reviewed your continued detention.

(2) On review of the Notice, I note that you have been diagnosed with COVID-19.

(3) In consideration of the above, I do not believe that continued detention is reasonably necessary to eliminate or reduce a serious risk to public health because:

(a) You have been confirmed to have COVID -19 and will be required to self -isolate in accordance with the Diagnosed Persons and Close Contacts Directions, as amended from time to time, in a premises that is suitable for you to reside in, or travel directly to a hospital for medical treatment , until such time as you are notified that you no longer need to self -isolate and a clearance from self-isolation is given; and

(b) You are/are not [*delete as applicable*] ordinarily a resident of Victoria, and have chosen to self-isolate at the following premises:

your ordinary residence ☐ another premises that is suitable for you to reside in for the purpose of self-isolation ☐

Address of premises for self-isolation: _____

(4) I advise that your detention pursuant to section 200(1)(a) of the Act and the Notice will end on _____ at _____ after you have been discharged by an Authorised Officer and have commenced transportation to the premises detailed in 3(3)(b).

(5) Although you are no longer to be detained pursuant to the Notice, you are required to comply with all directions pursuant to the *Public Health and Wellbeing Act 2008* currently in force in Victoria. Compliance with these directions is required to eliminate or reduce a serious risk to public health posed by COVID-19. It is essential that you self-isolate in accordance with the Diagnosed Persons and Close Contacts Directions, as amended or replaced from time to time,, until such time as you are notified that you no longer need to self-isolate and a clearance from self-isolation is given.

(6) The Notice is ended subject to the directions listed below under paragraph 4. Non-compliance with these conditions is an offence.

4 Conditions

(1) **You must not leave your hotel room until you have been collected by Security** at which time you are permitted to travel to the hotel lobby to meet an Authorised Officer who will **sight your identification** and discharge you from detention. **On your exit day Security will give you approximately an hour notice of when they will collect you, which will be prior to midnight.**

(2) Your detention **does not end** until the time stated in paragraph 3(4) of this notice which will be filled in by an authorised officer when you are discharged from detention. Until that time you must continue to abide by the requirements of your detention, as contained in the Notice.

(3) You will transit from the hotel where you have been detained to the premises detailed in 3(3)(b) to self-isolate pursuant to the Diagnosed Persons and Close Contacts Directions, as amended or replaced from time to time. You may be supervised during transit.

(4) While you are transiting to the premises detailed in 3(3)(b), you must refrain, as far as possible, from touching communal surfaces, such as handrails, elevator buttons and door handles.

(5) When you are transiting to the premises detailed in 3(3)(b), you must, **at all times**, wear appropriate protective equipment to prevent the spread of COVID-19, as directed by the Authorised Officer.

(6) You must practise physical distancing, and as far as possible, maintain a distance of 1.5 metres from all other people, including any persons escorting you.

(7) When you are transiting to the premises detailed in 3(3)(b), you must, **at all times**, comply with any direction given to you by any Authorised Officer escorting you.

5 Offence and penalty

(1) It is an offence under section 203 of the Act if you refuse or fail to comply with the directions and requirements set out in this notice and/or the Isolation (Diagnosis) Direction unless you have a reasonable excuse for refusing or failing to comply.

(2) The current penalty for an individual is $19,826.40.

_____ **Signature of Authorised Officer**

Name of Authorised Officer: _____
As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

PLEASE BRING THIS NOTICE AND YOUR IDENTIFICATION WITH YOU.
BOTH ITEMS ARE NEEDED TO EXIT THE HOTEL

Appendix 12. End of detention notice – Close contact

PLEASE BRING THIS NOTICE AND YOUR IDENTIFICATION WITH YOU. BOTH ITEMS ARE NEEDED TO EXIT THE HOTEL

END OF DETENTION NOTICE – CLOSE CONTACTS

Public Health and Wellbeing Act 2008 (Vic)

Section 200

The detainee is a close contact of a COVID-19 diagnosed person. Subject to the conditions below, this Notice is evidence that this detainee has completed their period of detention under a *Direction and Detention Notice* issued to reduce or eliminate the serious public health risk posed by COVID-19 and is transitioning to the premises at which they ordinarily reside to self-quarantine pursuant to the Diagnosed Persons and Close Contacts Directions

1 Detention Notice

(1) You have arrivedin Victoria from overseas, on or after midnight on 28 March 2020 and have been placed in detention, pursuant to a Direction and Detention Notice that you were provided on your arrival in Victoria (**Notice**).

2 Details of Detention Notice

(1) **Name of Detainee:** _____

(2) **Date of Direction and Detention Notice:** _____

(3) **Place of Detention:** _____ Room

3 End of Detention Notice

(1) In accordance with section 200(6) of the *Public Health and Wellbeing Act 2008* (Vic) (**Act**), I have reviewed your continued detention.

(2) On review of the Notice, Inote that you are a close contact of a persondiagnosed with COVID-19.

(3) In consideration of the above, I do not believe that continued detention is reasonably necessary to eliminate or reduce a serious risk to public health because you have been confirmed to be a close contact of a person diagnosed with COVID-19 and will be required to self -quarantine at the premises at which you ordinarily reside, in accordance with the Diagnosed Persons and Close Contacts Directions, as amended or replaced from time to time.

(4) I advise that your detention pursuant to section 200(1)(a) of theAct and the Notice will end on _____ at _____ after you have been discharged by an Authorised Officer and have commenced transportation to the premises at which you ordinarily reside, in accordance with the Diagnosed Persons and Close Contacts Directions , as amended or replaced from time to time, for the purpose of self-quarantine.

Although you are no longer to be detained pursuant to the Notice, you are required to comply with all directions pursuant to the Act currently in force in Victoria. Compliance with these directions is required to eliminate or reduce a

serious risk to public health posed by COVID-19. It is essential that you self-quarantine in accordance with the Diagnosed Persons and Close Contacts Directions, as amended or replaced from time to time.

(6) The Notice is ended subject to the directions listed below under paragraph 4. Non-compliance with these conditions is an offence.

4 Conditions

(1) **You must not leave your hotel room until you have been collected by Security** at which time you are permitted to travel to the hotel lobby to meet an Authorised Officer who will **sight your identification** and discharge you from detention. **On your exit day Security will give you approximately an hour notice of when they will collect you, which will be prior to midnight.**

(2) Your detention **does not end** until the time stated in paragraph 3(4) of this notice which will be filled in by an authorised officer when you are discharged from detention. Until that time you must continue to abide by the requirements of your detention, as contained in the Notice.

(3) You will transit from the hotel where you have been detained to the premises at which you ordinarily reside to self-quarantine pursuant to the Diagnosed Persons and Close Contacts Directions, as amended or replaced from time to time. You may be supervised during transit.

(4) While you are transiting to the premises at which you ordinarily reside to self-quarantine, you must refrain, as far as possible, from touching communal surfaces, such as handrails, elevator buttons and door handles.

(5) When you are transiting to the premises at which you ordinarily reside to self-quarantine, you must, **at all times**, wear appropriate protective equipment to prevent the spread of COVID-19, as directed by the Authorised Officer.

(6) You must practise physical distancing, and as far as possible, maintain a distance of 1.5 metres from all other people, including any persons escorting you.

(7) When you are transiting to the premises at which you ordinarily reside to self-quarantine, you must, **at all times**, comply with any direction given to you by any Authorised Officer escorting you.

5 Offence and penalty

(1) It is an offence under section 203 of the Act if you refuse or fail to comply with the directions and requirements set out in this notice and/or the Isolation (Diagnosis) Direction unless you have a reasonable excuse for refusing or failing to comply.

(2) The current penalty for an individual is $19,826.40.

_____ **Signature of Authorised Officer**

Name of Authorised Officer: _____

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

Appendix 13. End of detention notice – Symptoms of respiratory illness

PLEASE BRING THIS NOTICE AND YOUR IDENTIFICATION WITH YOU. BOTH ITEMS ARE NEEDED TO EXIT THE HOTEL

END OF DETENTION NOTICE – Symptoms of respiratory illness (transition to suitable premises)

Public Health and Wellbeing Act 2008 (Vic)

Section 200

The detainee has demonstrated symptoms of respiratory illness. Subject to the conditions below, this Notice is evidence that the detainee has completed their period of detention under a *Direction and Detention Notice* issued to reduce or eliminate the serious public health risk posed by COVID-19.

1 Detention Notice

(1) You have arrivedin Victoria from overseas, on or after midnight on 28 March 2020 and have been placed in detention, pursuant to a Direction and Detention Notice that you were provided on your arrival in Victoria (**Notice**).

2 Details of End of Detention Notice

(1) **Name of Detainee:** _____

(2) **Date of Direction and Detention Notice:** _____

(3) **Place of Detention:** _____ Room

(4) **Medical Facility:**_____
(if medical care is required)

(5) **Respiratory illness symptoms** [tick applicable]:

coughing	☐	sort throat	☐
fever or temperature in excess of 37.5 degrees	☐	body aches	☐
congestion, in either the nasal sinuses or lungs	☐	fatigue	☐
runny nose	☐		

3 End of Detention Notice

(1) In accordance with section 200(6) of the *Public Health and Wellbeing Act 2008* (Vic) (**Act**), I have reviewed your continued detention.

(2) On review of the Notice, I note that you have exhibited the symptoms of respiratory illness.

(3) In consideration of the above, I do not believe that continued detention is reasonably necessary to eliminate or reduce a serious risk to public health because:

(a) You are showing symptoms of respiratory illness and will be required to self-isolate in accordance with the Stay at Home Direction currently in force in Victoria and will need to travel directly to your ordinary residence or a premises that is suitable for you to temporarily reside in Victoria once you leave detention, and remain there unless you are permitted to leave for a reason specified in the Stay at Home Direction;

(b) You have:

☐ been tested for 2019-nCoV and it is estimated that you will receive the results of that test by _____ [*insert time*];

☐ not been tested for 2019-nCoV and are aware that you need to take precautions including #detail any specific precautions# for 72 hours after the time you cease showing symptoms of respiratory illness.

(c) You are ordinarily a resident in Victoria or you have indicated that although you ordinarily reside outside of Victoria, you have a suitable premises within Victoria to temporarily reside and intend to remain there until you have received your test results OR for 27 hours after the time you cease showing symptoms of respiratory illness *[delete as applicable]*.

(4) I advise that your detention pursuant to section 200(1)(a) of the Act and the Notice will end on _____ at _____ after you have been discharged by an Authorised Officer and have commenced transportation to your ordinary residence or a suitable premises within Victoria to temporarily reside until you have received your test results OR for 27 hours after the time you cease showing symptoms of respiratory illness *[delete as applicable]*.

(5) Compliance with all directions made pursuant to the Act currently in force in Victoria is required to reduce or eliminate the serious risk to public health posed by COVID-19. It is essential that you return to your ordinary residence or a premises that is suitable for you to reside temporarily in Victoria and remain there unless you are permitted to leave for a reason specified in the Stay at Home Direction. Please monitor your symptoms and seek appropriate medical care if required.

(6) The Notice is ended subject to the directions below under paragraph 4. Non-compliance with these directions is an offence.

4 Conditions

(1) You will transit from the hotel where you have been detained to your ordinary residence or a premises that is suitable for you to temporarily reside in Victoria. You **must not leave your hotel room until you have been collected by Security** at which time you are permitted to travel to the hotel lobby to meet an Authorised Officer who will sight your identification and discharge you from detention. **Security will give you approximately an hour notice of when they will collect you, which will be prior to midnight on your exit date.**

(2) Your detention **does not end** until the time stated in paragraph 3(4) of this notice which will be filled in by an authorised officer when you are discharged from

detention. Until that time you must continue to abide by the requirements of your detention, as contained in the Notice.

(3) While you are transiting to your ordinary residence, or a premises that is suitable for you to temporarily reside in, you must refrain as far as possible, from touching communal surfaces, such as handrails, elevator buttons and door handles.

(4) When you are transiting to your ordinary residence or a premises that is suitable for you to temporarily reside in, you must, **at all times**, wear appropriate personal protective equipment to prevent the spread of COVID-19, if directed by an Authorised Officer.

(5) You must practise physical distancing, and as far as possible, maintain a distance of 1.5 metres from all other people, including any persons escorting you.

(6) When you are transiting to your ordinary residence or a premises that is suitable for you to temporarily reside in, you must, **at all times**, comply with any direction given to you by an Authorised Officer escorting you.

(7) You must remain at your ordinary residence or a premises that is suitable for you to temporarily reside in until you receive your 2019-nCoV test results OR for 72 hours after the time you cease showing symptoms of respiratory illness *[delete as applicable]*.

5 Offence and penalty

(1) It is an offence under section 203 of the Act if you refuse or fail to comply with the directions and requirements set out in this notice unless you have a reasonable excuse for refusing or failing to comply.

(2) The current penalty for an individual is $19,826.40.

_____ **Signature of Authorised Officer**

Name of Authorised Officer: _____
As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

Appendix 14. End of detention notice: continued detention

DIRECTION AND CONTINUATION OF DETENTION NOTICE

Public Health and Wellbeing Act 2008 (Vic)

Section 200

1 Detention Notice

(1) You have arrived in Victoria from overseas, on or after midnight on28 March 2020 and have been placed in detention, pursuant to a Direction and Detention Notice (**Notice**) that you were provided on your arrival in Victoria .

(2) A state of emergency exists in Victoria under section 198 of the *Public Health and Wellbeing Act 2008* (Vic) (**Act**), because of the serious risk to public health posed by COVID-19.

(3) In particular, there is a serious risk to public health as a result of people travelling to Victoria from overseas. People who have been overseas are at the highest risk of infection and ar e one of the biggest contributors to the spread of COVID -19 throughout Victoria.

(4) Pursuant to the Notice, y ou have been detained at the hotel and in the room specified in clause 1(5) below, for a period of 14 days, because, having regard to the medical adv ice, that detention is reasonably necessary for the purpose of eliminating or reducing a serious risk to public health , in accordance with section 200(1)(a) of the Act.

(5) **Place and time of current detention**

You have been detained at:

Hotel: _____

Room No: _____

(6) You were to be detained until: _____ on ____of _____2020

(7) An Authorised Officer has decided to continue your detention and issue this Direction and Continuation of Detention Notice. This decision has been made following the mandatory review of your Notice because:
(tick as applicable)

(a) you have developed respiratory symptoms and are awaiting the results of a test for COVID-19 ☐

(b) you have returned a positive test for COVID-19 and have not been medically cleared to leave detention ☐

(8) You must comply with the directions in clause 2 and 3 below because they are reasonably necessary to protect public health, in accordance with section 200(1)(d) of the Act.

(9) The Chief He alth Officer will be notified that you have been detained. The Chief Health Officer must advise the Minister for Health of your detention.

Note: These steps are required by sections 200(7) and (9) of the Act.

2 Place and time of continued detention

(1) You will be detained at:

Hotel: _____ *(to be completed at place of arrival)*

Room No: _____ *(to be completed on arrival at hotel)*

(2) You will be detained until: _____ on ____of _____2020

3 Conditions of your detention

(1) **You must not leave the room in any circumstances**, unless:

(a) you have been granted permission to do so:

(i) for the purposes of attending a medical facility to receive medical care; or

(ii) where it is reasonably necessary for your physical or mental health; or

(iii) on compassionate grounds; or

(b) there is an emergency situation.

(2) **You must not permit any other person to enter your room**, unless the person is authorised to be there for a specific purpose (for example, providing food or for medical reasons).

(3) Except for authorised people, the only other people allowed in your room are people who are being detained in the same room as you.

(4) You are permitted to communicate with people who are not staying with you in your room, either by phone or other electronic means.

Note: An authorised officer must facilitate any reasonable request for communication made by you, in accordance with section 200(5) of the Act.

(5) If you are under 18 years of age your parent or guardian is permitted to stay with you, but only if they agree to submit to the same conditions of detention for the period that you are detained.

4 Review of your detention

Your detention will be reviewed at least once every 24 hours for the period that you are in detention, in order to determine whether your detention continues to be reasonably necessary to eliminate or reduce a serious risk to public health.

Note: This review is required by section 200(6) of the Act.

5 Offence and penalty

(1) It is an offence under section 203 of the Act if you refuse or fail to comply with the directions and requirements set out in this Notice, unless you have a reasonable excuse for refusing or failing to comply.

(2) The current penalty for an individual is $19,826.40.

_____

Name of Authorised Officer: _____

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

Appendix 15. End of detention guidance note

How to conclude a person's detainment under a *Direction and Detainment Notice* if they have served the required period of detainment, become a confirmed case of COVID-19 or have symptoms of respiratory illness

What do you have to do before you issue an End of Detention Notice?

- if the person has served 14 days of detention you must decide how to administer the completion of that person's detention arrangements:
  - selecting a time for the person to attend a foyer after the 14 day period has concluded - it is recommended that this occur in small groups of people who are practicing appropriate social distancing and with sufficient time between groups to avoid crowds. This will ensure Authorised Officers can safely discharge each detainee
  - collecting a person from their hotel room after the 14 day period has concluded – this approach should be carefully administered to ensure Authorised Officers can safely discharge each person
- if a person's detainment is concluding because they have a confirmed case of COVID-19 or symptoms of respiratory illness they must be discharged when it is safe to do so – e.g. when other detained people are in their rooms, under full supervision etc.
- complete all sections of the Notice, including clearly documenting the reasons for the end of detention and the details recorded on the Direction and Detention Notice
- update all the registers and relevant records about the person's detainment arrangements
- ensure the reference number is completed.

When should you issue an End of Detention Notice?

It is preferable that an End of Detention Notice be issued the day before a person's detainment is set to conclude – this will give the person adequate time to prepare (e.g. to pack their belongings) and ensure the orderly discharge of large groups of people.

A notice may be provided earlier but it creates a risk that a person may develop COVID-19 symptoms before the day the detainment period must end.

What do you have to do when you issue an End of Detention Notice?

When you issue an End of Detention Notice you must:

- explain the reason why detention has ceased and is no longer necessary to eliminate or reduce a serious risk to public health
- advise that person of the arrangements being made for their discharge from detention (e.g. at an allocated time at the foyer; when they are escorted from their room etc)
- notify they person that although they are no longer subject to detention when they are discharged and leave the premises of their detention, they are still subject to the directions which are in force in Victoria, including
  - if they are ordinarily resident in Victoria, they are required to return immediately to their ordinary residence, where they must remain, in accordance with the Stay at Home Directions (No 2)
  - if they have a confirmed case of COVID-19, they must isolate at home in accordance with the Isolation (Diagnosis) Direction

Appendix 16. : Charter of Human Rights obligations

Key points

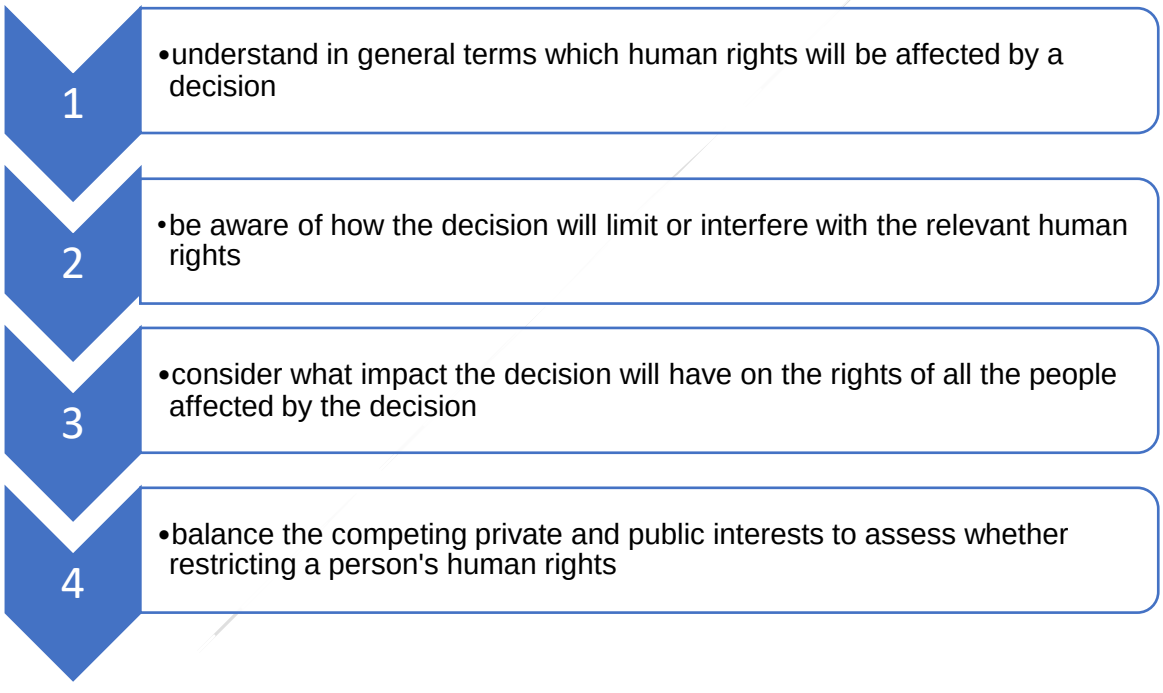
- AO must act compatibly with human rights.
- AO must give 'proper consideration' to the human rights of any person(s) affected by an AO's decision.

Department AO obligations under the Charter of Human Rights and Responsibilities Act 2006

Department AOs are public officials under the Charter of Human Rights. This means that, in providing services and performing functions in relation to persons subject to the Direction and Detention Notice, department AOs must, at all times: act compatibly with human rights; and

give 'proper consideration' to the human rights of any person(s) affected by a department AO's decisions.

Figure 3. How to give 'proper consideration' to human rights



The relevant Charter Human Rights that departmental AOs need to be aware of that may be affected by a decision:

Charter Right	Obligation
Right to life	**This includes a duty to take appropriate steps to protect the right to life and steps to ensure that the person in detention is in a safe environment and has access to services that protect their right to life**
Right to protection from torture and cruel, inhuman or degrading treatment	**This includes protecting persons in detentions from humiliation and not subjecting persons in detention to medical treatments without their consent**
Right to freedom of movement	**while detention limits this right, it is done to minimise the serious risk to public health as a result of people travelling to Victoria from overseas**
Right to privacy and reputation	**this includes protecting the personal information of persons in detention and storing it securely**
Right to protection of families and children	**this includes taking steps to protect families and children and providing supports services to parents, children and those with a disability**
Property Rights	**this includes ensuring the property of a person in detention is protected**
Right to liberty and security of person	**this includes only be detained in accordance with the PHWA and ensuring steps are taken to ensure physical safety of people, such as threats from violence**
Rights to humane treatment when deprived of liberty	**this includes treating persons in detention humanely.**

Appendix 17. Border health measures policy summary, 18 May 2020

General principal

To protect Victoria from imported human biosecurity risks associated with coronavirus (COVID-19), pre-existing and enhanced border health measures are in place at Victoria's international air and seaports.

Entry to Victoria

From 11.59pm AEDT 28 March 2020, all travellers arriving from overseas at Victorian airports or disembarking at maritime ports are subject to a Direction and Detention Notice (No 3), which mandates compulsory quarantine at designated hotels for the quarantine period of 14 days from the day of arrival (unless they are provided an exemption to this direction). The mandatory quarantine period must be undertaken in the port of arrival.

All travellers arriving at airports and seaports who are subject to mandatory quarantine will undergo health screening on arrival by DHHS nursing staff, working with Biosecurity Officers and Authorised Officers, at the port of entry (NOTE: individual arrangements may be put in place at seaports depending on the circumstances).

Policy summary

Arrival	Airport	Seaport
Passengers	All passengers arriving into Victoria from overseas on aircraft are subject to the Direction and Detention Notice (No 3) and must quarantine in mandatory detention hotels for a period of 14 days from arrival (unless an exemption has been granted). **International transit passengers** arriving into Australia **are** able to depart on another international flight if the following conditions are met: • If the individual has up to 8 hours until the departing international flight, they must remain at the airport and be permitted to onward travel, maintaining physical distancing and hand hygiene. • If more than 8-72 hours (with rare exceptions on 72 hours if connecting international flight is difficult to arrange) before	All passengers arriving into Victoria from overseas on maritime vessels (whether recreational or commercial) are subject to the Direction and Detention Notice (No 3) and must quarantine in mandatory detention hotels for a period of 14 days from arrival (unless an exemption has been granted).

	the departing flight, they must go into mandatory quarantine until the time of the departing flight. Domestic onward travel is allowed in order to meet a departing international flight if the receiving jurisdiction (Australian state or territory) has been consulted and is willing to accept the passenger to transit to their international flight.	
Crew	Air crew are not subject to the Direction-Detention Notice but must self-isolate for 14 days on arrival into Victoria. **9.7.1.1 International air crew who live in Victoria** • Are not required to go into mandatory hotel quarantine. • Must self-isolate at their place of residence (or hotel) between flights, or for 14 days, whichever is shorter. • Are not required to complete the Isolation Declaration Card. **9.7.1.2 International air crew who do not live in Victoria** • Are not required to go into mandatory hotel quarantine. • Will be allowed to leave on their scheduled flight. They must self-isolate in their hotel on arrival until their next flight, or for 14 days, whichever is shorter. • Must use privately-organised transport to transfer to and from hotels between flights following appropriate physical distancing measures. • May fly domestically to their next point of departure from Australia if required. • Are not required to complete the Isolation Declaration Card. **9.7.1.3 Domestic air crew** • Are exempt from self-isolation requirements in Victoria.	Maritime crew arriving into Victoria from overseas on aircraft or maritime vessel are subject to the Direction-Detention Notice (No 3) and must quarantine in mandatory detention hotels for a period of 14 days from arrival (unless an exemption applies). **Maritime crew arriving into Victoria from overseas on an international flight planning to board a maritime vessel** • **If maritime crew are transiting interstate**, they will be subject to the Direction-Detention Notice (No 3) and must go into mandatory hotel quarantine for 14 days from arrival before being allowed to travel interstate (unless granted a specific exemption) • **If maritime crew are joining a maritime vessel in Victoria**, they will be subject to the Direction-Detention Notice (No 3) and must go into mandatory quarantine for 14 days from arrival UNLESS: – They are granted a specific exemption, OR – They are boarding a maritime vessel at a Victorian port directly from the flight, and the time between boarding the vessel and the vessel departing the Victorian port for an international port is NO MORE THAN 48 hours. – The crew member must use privately organised transport and follow appropriate physical distancing measures while transiting from the airport to the maritime vessel.

		Maritime crew arriving into Victoria on vessels from international waters **Maritime crew who live in Victoria** • Where a vessel has arrived at a Victorian port from international waters, maritime crew disembarking from this vessel must go into mandatory hotel quarantine for 14 days prior to returning to their Victorian residence (if they reside in Victoria). **Maritime crew who are transiting interstate** • Where a vessel has arrived at a Victorian port from international waters, maritime crew disembarking from this vessel must go into mandatory hotel quarantine for 14 days prior to onward travel interstate. **Maritime crew who are leaving Victoria on an international flight** • Maritime crew will be allowed to transit from their ship to an international flight: if the flight is leaving the same day and they travel directly to the airport using privately organised transport following appropriate physical distancing measures. Otherwise, the crew member must self-isolate in their hotel for up to 24 hours then travel directly to the airport to take their flight. • If there is more than 24 hours until the flight, they must stay in mandatory hotel quarantine until the flight, or for 14 days, whichever is shorter. **Maritime crew arriving on an international vessel ("the old vessel") and planning to leave Victoria on another vessel that is departing for an international port ("the new vessel")** Maritime crew **are not** subject to mandatory hotel detention in the following situations:

		• If they are boarding a new vessel directly after disembarking the old vessel, AND the time between boarding the vessel and the vessel departing the Victorian port for an international port is NO MORE THAN 48 hours. – The crew member must use privately organised transport (if needed) and follow appropriate physical distancing measures while transiting between the vessels. • If the time from disembarking the old vessel and joining the new vessel is no more than 24 hours AND the time between boarding the new vessel and the vessel departing the Victorian port for an international port is NO MORE THAN 48 hours. – In this case the crew member must self-isolate in their accommodation (organised by their shipping company) for the layover period and travel directly to the accommodation and then to the port to join the new vessel. – The crew member must use privately organised transport and follow appropriate physical distancing measures while transiting to and from the vessels and their accommodation. • **If the above situations do not apply**, the crew member must go into mandatory hotel quarantine until the time the new vessel leaves, or for 14 days, whichever is shorter, as long as the crew member travels directly from the quarantine hotel to the vessel on the day it departs Victoria. **Where a vessel left an Australian port, travelled into international waters, and then arrives back into a Victorian port** The crew **do not** need to enter mandatory hotel quarantine or go into self-isolation on disembarkation if: • All maritime crew aboard (who travelled from overseas to join the vessel in Australia) completed 14 days of mandatory hotel quarantine in Australia prior to joining the vessel AND

		• No further crew have joined the vessel during its voyage AND • The vessel did not dock at a foreign port during its voyage AND • There is no reported illness that could potentially indicate COVID-19 infection on board the vessel. **Maritime crew arriving into Victoria on vessels that have only been in Australian waters** Maritime crew disembarking from these vessels **do not** need to enter mandatory hotel quarantine or self-isolation on arrival into a Victorian port if: • The vessel has not left Australian waters AND • The vessel has only taken on maritime crew who have done 14 days mandatory hotel quarantine on arrival into Australia prior to boarding the vessel (and are able to verify this with documentation) AND • There is no reported illness that could potentially indicate COVID-19 infection on board the vessel. **Note** that crew who then travel interstate may be subject to separate, state-based quarantine or self-isolation requirements on arrival.
		9.7.1.4 Crew requiring medical attention (for non-COVID-19 or other listed human disease-related illness) who would not be otherwise disembarking in Victoria A crew member may be granted approval to disembark a maritime vessel at a Victorian port WITHOUT having to go into mandatory hotel quarantine if: • They are coming off the vessel for the sole purpose of seeking medical review for a non COVID-19 related medical complaint and have also been given clearance by ABF and DAWE to do so AND

		• The crew member wears a surgical mask, and travels directly to the medical facility in private transport, maintaining physical distancing between the crew member and the driver AND • The crew member or operator of the vessel notifies the driver of the transport AND medical facility prior to their arrival that the crew member is coming off an international maritime vessel and has not completed 14 days mandatory hotel quarantine AND • If deemed well enough to not need hospital admission or stay on shore for further testing etc, AND • Following medical review, the crew member travels directly back to the vessel in the same manner as they travelled to the hospital.
		Cruise ships • All international cruise vessels have been banned from sailing into or out of Australian ports from 15 March 2020. • From 11.59pm AEDT 28 March 2020, **all cruise vessel passengers and crew** arriving from overseas at maritime ports are subject to mandatory hotel quarantine for a period of 14 days. The 14-day self-isolation period commences on disembarkation from the cruise vessel in Victoria. • Onward domestic or international travel is only allowed once the 14-day quarantine period is completed. Separate quarantine requirements may also apply at the next destination.
		Yachts and recreational vessels All passengers and crew arriving into Victoria from overseas on yachts and pleasure craft are subject to the Direction and Detention Notice (No 3) and must quarantine in mandatory detention hotels for a period of 14 days from arrival (unless an exemption has been granted).

Departure	Airport	Seaport
All travellers	From 27 March 2020, all travellers departing the designated Victorian international airports for Pacific Island countries and Timor-Leste (as per the Biosecurity (Exit Requirements) Determination 2020) will undergo health screening at the airport prior to departure. See **Appendix 4**.	
Vessel access at port	**Airport**	**Seaport**
		Shore-based professionals • Non-crew members (such as pilots, stevedores, Vessels Agents, surveyors, fumigators, shipper/receiver representative) can come on board the vessel to carry out essential vessel functions, provided necessary precautions have been put in place on the vessel. • Crew on board must use PPE in public spaces on the vessel while non-crew members are on-board or whilst interacting with non-crew members. It is the requirement of the employer or vessel to provide adequate PPE for their workers. • Where possible, shore-based professionals should stay 1.5 metres or more away from crew and interactions with persons on board the vessel should be limited to essential crew. • Shore-based professionals should: – Wash their hands frequently while on board the vessel with soap and water, or use alcohol-based hand rub. – Wear appropriate PPE (surgical masks) while on board a vessel. – Avoid touching their mouth, eyes, and nose with unwashed or gloved hands. • If a shore-based professional becomes aware of any ill person on board, they should contact their local port authority and public health authority, and ask the vessel master to report the illness via MARS

		• The ill crew member or passenger should isolate on the vessel in a single cabin until further direction is given by a biosecurity officer or human biosecurity officer. • **If the above measures, namely hand hygiene, strict physical distancing and use of PPE, are not adhered to by shore-based professionals boarding a vessel**, they will be required to self- isolate for 14 days from the time of disembarkation from the vessel. • Shore-based staff who **do not** board the vessel but may interact with crew from the vessel (e.g. stevedores) should maintain appropriate physical distancing measures but PPE is not currently advised.
		International crew performing shore based activities • All crew must remain on-board while the vessel is berthed in Victoria, with the exception of conducting brief essential docking, security and maintenance tasks. • Only the minimum necessary number of staff should be used to perform these tasks and interactions with shore-based professionals must be kept to a minimum. Where interaction is required, a distance of 1.5 metres should be kept between crew and shore-based professionals. • Crew who are leaving the vessel to conduct essential shore-based activities must wear PPE.

Appendix 18. Early release for International transit

e000-xxx

Name of person
Address
Address
VICTORIA

Dear name

Notification of international arrivals exemption from mandatory hotel detention in Victoria

I am aware that you have just returned to Victoria from overseas.

A state of emergency exists in Victoria under section 198 of the *Public Health and Wellbeing Act 2008* (Vic) because of the serious risk to public health posed by Covid-19. In particular, there is a serious risk to public health as a result of people travelling to Victoria from overseas. People who have been overseas are at the highest risk of infection and are one of the biggest contributors to the spread of Covid-19 throughout Victoria. Because of this, international arrivals are issued with a direction and detention notice that requires them to quarantine in a specified hotel.

I note that you were issued with a direction and detention notice on [date] under section 200(1)(a) of the Act and are currently complying with that detention notice.

I have been advised that you are travelling from [international location] to [destination Country], and that you are in transit in Victoria for a period of [insert timeframe > 8 hours].

In these circumstances, I have decided to bring your detention to an end in order to allow you to continue your return journey overseas. You will not be subject to the usual 14 day quarantine requirements because you intend to leave Victoria within that 14 day period. On the basis that you will immediately proceed to your destination outside of Victoria once you leave detention, I do not consider your continued detention is necessary to eliminate or reduce a serious risk to public health in Victoria.

If you need to discuss the conditions of this direction, please contact [name of contact].

Yours sincerely

Name of person authorised under s 199
Title

/ / 2020

Appendix 19. Early release for interstate transit

e000-xxx

Name of person
Address
Address
VICTORIA

Dear name

Notification of international arrivals exemption from mandatory hotel detention in Victoria

I am aware that you have just returned to Victoria from overseas.

A state of emergency exists in Victoria under section 198 of the *Public Health and Wellbeing Act 2008* (Vic) because of the serious risk to public health posed by Covid-19. In particular, there is a serious risk to public health as a result of people travelling to Victoria from overseas. People who have been overseas are at the highest risk of infection and are one of the biggest contributors to the spread of Covid-19 throughout Victoria. Because of this, international arrivals are issued with a direction and detention notice that requires them to quarantine in a specified hotel.

I note that you were issued with a direction and detention notice on [date] under section 200(1)(a) of the Act and are currently complying with that detention notice.

I have been advised that you are travelling from [international location] to [destination State/Territory], and that you are in transit in Victoria for a period of [insert timeframe].

There is a general policy in place in Victoria that people returning from overseas will be issued with detention notices requiring them to be isolated in a designated hotel room for a period of 14 days from their arrival. This policy generally applies to those in transit to an interstate residence, because of the risks of transmitting the virus within Australia while transiting.

I am advised that the [insert name of destination State/Territory] government has approved you travelling to [insert] from Victoria without firstly having completed the usual quarantine period required upon arrival in Victoria.

After considering your circumstances, I have decided that they warrant an exception being made to the above policy to allow you to continue your onward journey interstate. These circumstances are:

- Outline the reasons why an exception is being made:
    - *UNACCOMPANIED MINORS (brief summary of justification)*
    - *MEDICAL AND COMPASSIONATE GROUNDS (brief summary of justification)*

In these circumstances, I have decided to bring your detention to an end in order to allow you to continue your return journey home. You will not be subject to the usual 14 day quarantine requirements because you intend to leave Victoria within that 14 day period. On the basis that you will immediately proceed to your destination outside of Victoria once you leave detention, I do not consider your continued detention is necessary to eliminate or reduce a serious risk to public health in Victoria.

If you need to discuss the conditions of this direction, please contact [name of contact].

Yours sincerely

Name of person authorised under s 199
Title

/ / 2020

Appendix 20. Exemption letter for foreign diplomats and their families

First name, last name
Address line 1
Address line 2

Dear [name]

Notification of diplomat exemption from mandatory hotel detention in Victoria

A state of emergency exists in Victoria under section 198 of the *Public Health and Wellbeing Act 2008* (Vic) because of the serious risk to public health posed by Covid-19. In particular, there is a serious risk to public health as a result of people travelling to Victoria from overseas. People who have been overseas are at the highest risk of infection and are one of the biggest contributors to the spread of Covid-19 throughout Victoria. Because of this, there is a mandatory 14 day quarantine period for international arrivals requiring detention in a hotel.

You have been confirmed as having diplomatic status under the Vienna Convention.

Australia has legal obligations under the Vienna Convention to ensure diplomats and their family's freedom of movement and travel, and protection from detention. Diplomats are therefore not required to undertake 14 days of mandatory quarantine on arrival into Australia. They are also not required to complete the Isolation Declaration Card.

I confirm that, as a diplomat flying to Australia, you are not subject to a direction to go into immediate compulsory quarantine in Victoria, or in your Australian state of residence, and are free to travel there once you arrive in Victoria. In keeping with Australian Government policy, you should self-isolate at your mission or in your usual place of residence on arrival for 14 days.

I understand that arrangements have been put in place for you to travel to your place of residence. These travel arrangements should be via private or rental vehicle to your destination, including interstate travel, to minimise the risk of disease transmission.

It is essential that you practise social distancing, cough etiquette and hand hygiene, bearing in mind the important public health reasons for the mandatory quarantine policy. Although that policy does not apply to you because of your diplomatic status, I am sure you will appreciate the responsibility you bear to manage the potential risk that you and/or a family member may be infected.

If you need to discuss the conditions of this direction, please contact [name of contact].

Yours sincerely

Name of person authorised under s 199
Title

/ / 2020

Appendix 21. Letter for diplomat staying at hotel

Ref Diplomat

[insert addressee details]

Notification of diplomat exemption from mandatory hotel detention in Victoria

You have been confirmed as having diplomatic status under the Vienna Convention.

Australia has legal obligations under the Vienna Convention to ensure diplomats and their family's freedom of movement and travel, and protection from detention. Diplomats are not required to undertake 14 days of mandatory quarantine on arrival into Australia. They are therefore not required to complete the Isolation Declaration Card.

I confirm that, as a diplomat flying to Australia, you are not subject to a direction to go into immediate compulsory quarantine in Victoria. In keeping with Australian Government policy, you should self-isolate at your mission or in your usual place of residence on arrival for 14 days.

I understand that you will be staying at [insert name] hotel for [insert number days]. During the period you are staying at the hotel, **you should not leave the room in any circumstances**, unless:

(1) you [have advised an authorised officer and] are doing so:

  (i) for the purposes of attending a medical facility to receive medical care; or

  (ii) where it is reasonably necessary for your physical or mental health; or

  (iii) on compassionate grounds; or

  (iv) because there is an emergency situation.

(2) **You should not permit any other person to enter your room**, unless the person is authorised to be there for a specific purpose (for example, providing food or for medical reasons).

(3) Except for authorised people, the only other people that you should allow in your room are people who are staying (because they are your family members or are also a diplomat) in the same room as you.

(4) You can communicate with people who are not staying with you in your room, either by phone or other electronic means.

I understand that, after your stay at the hotel has concluded, arrangements have been put in place for you to travel to your place of residence. These travel arrangements should be via private or rental vehicle to your destination, including interstate travel, to minimise the risk of disease transmission.

You must continue to practise social distancing, cough etiquette and hand hygiene.

Yours sincerely

XXXXX
Enforcement and Compliance Commander

/ / 2020

Appendix 22. Exemption letter for key workers and covid cleared

e000-xxx

TO BE USED FOR:

- *KEY WORKERS*
- *SURVIVORS*

Name of person
Address
Address
VICTORIA

Dear name

Notification of international arrivals exemption from mandatory hotel detention in Victoria

I am aware that you have just returned to Victoria from overseas.

A state of emergency exists in Victoria under section 198 of the *Public Health and Wellbeing Act 2008* (Vic) because of the serious risk to public health posed by COVID-19. In particular, there is a serious risk to public health as a result of people travelling to Victoria from overseas. People who have been overseas are at the highest risk of infection and are one of the biggest contributors to the spread of Covid-19 throughout Victoria. Because of this, there is a mandatory 14 day quarantine period for international arrivals.

After considering your circumstances, I have concluded that you fall within one of the categories of people who the above policy does not apply to because:

- you are travelling to Victoria to engage in urgent and essential work to support the Covid-19 health response in Australia and appropriate arrangements are in place for your accommodation while you reside here.
- you have previously been diagnosed with Covid-19, and you have since received medical clearance indicating that you are now fully recovered.

Yours sincerely

Name of person authorised under s 199
Title

/ / 2020

Appendix 23. Guidelines for considering exemptions

Summary

You are an officer authorised by the Chief Health Officer under section 199(2)(a) of the *Public Health and Wellbeing Act 2008* (Vic) (**PHW Act**) to exercise certain powers under that Act. You also have duties under the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**Charter**).

This guidance note has been prepared to assist the Enforcement and Compliance Commander to determine whether individual persons arriving in Victoria from overseas should be exempted from being subject to detention notices requiring them to self-quarantine in a designated hotel room for 14 days in order to limit the spread of Novel Coronavirus 2019 (**2019-nCoV**). Such persons are ordinarily subject to detention notices because they are at increased risk of infection from 2019-nCoV and may inadvertently transmit it to others upon their return (and because earlier requirements to self-isolate at home were not uniformly complied with or easily enforceable).

If you decide that an exception applies, the relevant person will either be:

1. exempted from any kind of quarantine in Victoria; or
2. required to self-isolate at home or in another facility — either in Victoria, in which case they would either be subject to similar conditions as in the Self-Isolation (Diagnosis) Directions, or their home jurisdiction.

The exact outcome will depend on the person's circumstances. People in certain categories will be subject to an automatic exemption from the 14 day quarantine requirement. These categories are:

1. people in short-term international transit (up to 8 hours and not overnight);
2. people in long-term international transit (who are still required to quarantine, but are allowed to leave quarantine before the expiration of the usual 14 day period in order to undertake their onward journey overseas);
3. previous confirmed cases of 2019-nCoV who now have medical clearance and no longer require quarantine;
4. diplomats (who instead are requested to self-isolate at their mission or residence on arrival for 14 days); and
5. key workers (including aviation and medevac crew, except those on cruise ships)
6. Maritime crew in certain circumstances

How to deal with other categories of people will involve an exercise of your discretion, including by engaging in the process of proper consideration of relevant human rights under the Charter (discussed below). The question to be determined in relation to persons in these categories is whether they should be allowed to self-isolate for 14 days at another location as an alternative to hotel detention. These categories are:

1. unaccompanied minors whose legal guardians are unable to reside with them at the hotel; and
2. people who raise compassionate or medical grounds.

Decisions about people falling into these categories need to be made on a case-by-case basis, applying the considerations set out in this guidance note. Although decisions need to be made in light of the individual circumstances of each person, care must be taken to ensure consistency, transparency and a commitment to the mandatory quarantine policy unless alternative self-isolation is preferable and you consider it can provide sufficient protection to the community.

Your obligations under the Charter (when exercising discretion)

You are a public officer under the Charter. This means that you **must give 'proper consideration' to relevant human rights when exercising your discretion** (that is, to grant an exception to an unaccompanied minor or to a person on medical or compassionate grounds). This includes the human rights of *any person* affected by the decision, including the person who would otherwise be subject to the detention notice, the person(s) who they may self-isolate with if they were to self-isolate at home, and members of the community.

'Proper consideration' requires you to:

- **first**, understand in general terms which human rights will be affected by your decision (***see the description of relevant rights at the end of this note***);
- **second**, seriously turn your mind to the possible impact of your decision on the relevant individual's human rights, and the implications for that person (*some of the possible impacts of your decision are discussed in this note; however, much will depend on the particular facts of the request*);
- **third**, identify the countervailing interests (*for example, the important public objectives such as preventing the further spread of 2019-nCoV, which may weigh against a person's full enjoyment of their human rights for a period of time*); and
- **fourth**, balance the competing private and public interests to assess whether restricting a person's human rights is justified in the circumstances (***see relevant factors in s 7(2) of the Charter below***).

The Charter provides that a human right may only be subject to 'reasonable limits as can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom' (s 7(2)). In considering whether a limit is reasonable and demonstrably justified, **all relevant factors** must be taken into account, including, but not limited to, five factors listed in s 7(2) of the Charter:

- the nature of the right;
- the importance of the purpose of the limitation;
- the nature and extent of the limitation;
- the relationship between the limitation and the purpose; and
- any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve.

You are **not required to give proper consideration to human rights when applying automatic exemptions**, because that is a decision that has already been made.

Automatic exceptions

There are certain categories of exception that **must** be automatically granted if certain criteria are met.

- For most categories of automatic exception — if granted, the person will **not** be subject to a detention notice or required to self-isolate at an alternative location. They will receive a letter from you confirming that the mandatory detention requirement does not apply to them (except for diplomats and their families, who will instead be issued a letter from **DHHS** by a DHHS Authorised officer at the airport).
- For one category of automatic exception (long-term international transit passengers) — the person **will** be subject to a detention notice for the period that they are in transit but, if granted, they will receive a letter from you allowing them to leave hotel detention to take their onward journey. However, short-term international transit passengers will not receive a detention notice and will be automatically exempt from the mandatory detention requirement.

These decisions are likely to have a positive effect on the Charter rights of the people most immediately affected (namely, their rights to **liberty** (s 21) and **freedom of movement** (s 12)).

However, it is acknowledged that these decisions may have an adverse effect on the rights of people in the Victorian community.

- It could limit the rights to **life** (s 9) and **health** (protected by art 12 of the International Covenant on Economic, Social and Cultural Rights, to which Australia is a signatory) of other people in the

community, particularly those most susceptible to adverse health effects of the virus (namely, the elderly and those with certain pre-existing medical conditions).
- Consequently, it could also limit the rights to **privacy and family** (s 13) and the **protection of family and children** (s 17) by threatening to introduce a potential source of the virus into the community, which could subsequently interfere with the development and maintenance of social and familial connections, the best interests of children, and the broader family environment.

Any limitation of rights is considered reasonable and justified in light of the importance of each exception (as discussed below), as well as the relatively small risk of any particular person inadvertently spreading the virus in the community.

International transit passengers

Description of category

This category is intended to cover people who are travelling from one country to another and are in transit in Australia as part of their journey. For example, a passenger travelling from the UK to a Pacific Island, whose connecting flight is through Victoria. Those people do not intend to spend time in Victoria, other than for the purposes of transit.

The length of transit will range from short-term (up to 8 hours and not overnight) to long-term (8–72 hours or overnight).

- *Short-term international transit passengers* will **not** receive a detention notice and will not be escalated to you for review. You are not required to consider their case or issue them with a letter confirming their exemption from mandatory detention. They will be permitted to depart on another international flight, without being subject to the mandatory hotel quarantine requirement for 14 days or for the period of transit. This is because it is assumed, as a matter of practicality, that they will remain at the airport for their period of transit, which is a confined area in which those in attendance are aware that international travellers are likely to be present and social distancing and cleaning practices are likely to be strictly adhered to. This adequately manages the risk that they pose.
- *Long-term international transit passengers* **will** receive a detention notice requiring them to quarantine at an airport hotel (or nearby hotel) until their onward flight. Their cases will be escalated to you for review and, if exempted, they will receive a letter from you confirming that their period of detention has been cut short to enable them to continue their journey overseas. Although they are required to reside at a hotel for the period of transit, they are exempted from the requirement to quarantine in Victoria for the full 14 days. The justification for this exception is that it would be overly impractical and unreasonable to compel international transit passengers, who would otherwise only be in Victoria for a very short period of time, to quarantine for 14 days and thereby miss their onward journey. Detention for the duration of the transit period adequately manages the risk posed by long-term transit passengers while they are here.

The exception for short-term and long-term international transit passengers recognises that the risk they pose to public health will be borne primarily by the receiving jurisdiction. Consequently, upon arrival at their final overseas destination, international passengers will be subject to the quarantine arrangements of that jurisdiction. The brief period of time in which international transit passengers are in Victoria, in either the airport or a hotel, does not warrant mandatory quarantine for the full 14 day period.

It is noted that this policy is consistent with the Commonwealth guide to exemptions to the 14 day mandatory quarantine period (**Commonwealth guide**), which provides that short-term transit passengers (up to 8 hours) are exempt from detention if they remain in the airport and long-term transit passengers (8–72 hours) will be subject to mandatory detention in a hotel for the period of transit.

Checklist of factors

To confirm that an exception under this category applies, you must be reasonably satisfied that a person is a **long-term international transit passenger**.

Relevant factors to consider in coming to your decision include (but are not limited to):

- the passenger's travel documents (namely, passport and onward travel ticket), the country they are travelling to, the country they have travelled from;

- the length of time they will be in transit for;
- the public health risk profile of the passenger, including:
    - whether they have been tested for 2019-nCoV and, if so, whether the results were negative; and
    - whether they are exhibiting any clinical symptoms or signs of 2019-nCoV.

Outcome

If you are reasonably satisfied that a person is a **long-term international transit passenger**, you must provide them with a letter confirming that their detention will be brought to an end to enable them to continue their journey overseas (see ***template letter for long-term international transit passengers***).

Previous confirmed cases with medical clearance who no longer require quarantine

Description of category

This category is intended to provide an exception for persons arriving in Victoria from overseas who are 'survivors' of 2019-nCoV. That is, those persons who have previously been infected with 2019-nCoV, have been medically cleared and now no longer require quarantine.

The Chief Health Officer considers that recovered survivors who have been medically cleared do not pose a sufficient health risk to warrant mandatory detention or self-isolation for 14 days. Therefore, survivors of 2019-nCoV who can demonstrate proof of medical clearance will be exempt from mandatory detention or self-isolation for 14 days.

Checklist of factors

To confirm that an exception under this category applies, you must be reasonably satisfied that the passenger has **previously been infected with 2019-nCoV, made a full recovery and since been medically cleared**.

Relevant factors to consider in coming to your decision include (but are not limited to):

- medical documentation demonstrating that the passenger was infected with 2019-nCov and has since tested negative and been medically cleared (for example, a letter or test results from a medical practitioner);
- confirmation from public health command that the clearance satisfies Victorian requirements

Outcome

If you are reasonably satisfied that a person has **previously been infected with 2019-nCoV, made a full recovery and since been medically cleared**, you must provide them with a letter confirming that the mandatory hotel detention requirement is waived (see ***template letter for keys workers and survivors of 2019-nCoV***).

Diplomats

Description of category

This category captures people who are covered by diplomatic immunity under the Vienna Convention. Australia has legal obligations under the Vienna Convention to ensure diplomats' and their families' freedom of movement and travel, and protection from detention. Diplomats are therefore not required to undertake 14 days of mandatory quarantine on arrival into Australia. They are also not required to complete the Isolation Declaration Card.

Upon arrival in Victoria, the diplomat and their family will be issued a letter from DHHS by an Authorised Officer at the airport. This letter will notify them of their exemption status and provide relevant information, including that diplomats and family members should self-isolate at their mission or usual place of residence for 14 days and that they should continue to practice social distancing, cough etiquette and hand hygiene.

Travel arrangements for diplomats and their families is the responsibility of the Department of Foreign Affairs and Trade (**DFAT**). It is the expectation that upon disembarking in Victoria, diplomats and their families should travel by private or rental vehicle to their destination, including interstate travel, to minimise the risk of disease transmission. If diplomats require overnight accommodation prior to road travel, then accommodation should be at a government nominated quarantine hotel.

A record of the letter must be made in the Compliance Application.

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Exceptions that require your discretion

Unaccompanied minors whose guardians are unable to reside with them at the hotel

Description of category

This category is intended to capture unaccompanied children who were travelling alone or with another child or children from overseas. This exception is only available if the parent or legal guardian of the child demonstrates that they are unable to reside with their child at the designated hotel. This may be due to a number of reasons, including other caring responsibilities that the parent or guardian may have at home or because the child ordinarily resides in another State or Territory and is transiting through Victoria on their way to their home jurisdiction.

The exception recognises the unique vulnerability of children and the unduly harsh and unreasonable impact that mandatory hotel detention without a parent or guardian could have on the child and their family, particularly if the child is detained in a different jurisdiction to where the family reside. Imposition of the mandatory detention period could adversely affect the development and care of the child, as well as their broader family environment. It may result in an unreasonable and disproportionate limitation of several human rights under the Charter, including the rights of children and families to protection, the right to equality, and freedom from inhumane treatment in detention (see below).

If the exception is granted, the child in question will be permitted to self-isolate at an alternative location, such as their home (either in Victoria or their home State or Territory) for 14 days. If they self-isolate in Victoria, they will be subject to similar conditions as in the Isolation (Diagnosed Persons and Close Contacts) Directions for the period of self-isolation. Unless there are sufficient reasons not to require it, the entire household, including parents or guardians, must also self-isolate for the purposes of mitigating the risk of spreading 2019-nCoV. If they self-isolate in another State or Territory, they will be subject to the conditions imposed in that respective jurisdiction.

Checklist of factors

To grant an exception under this category, you must be reasonably satisfied that the passenger is an **unaccompanied minor whose parent or legal guardian is unable to reside with them** at the hotel.

Relevant factors to consider in coming to your decision include (but are not limited to):

- the age and needs of the child (including whether they are in transit in Victoria on their way to another State or Territory);
- the reason that the parent or legal guardian is unable to reside with them at the hotel (including whether they have other caring responsibilities at home or ordinarily reside in a different State or Territory);
- the availability of another adult to reside with them at the hotel, for example, another family member who may assume temporary care of them for the period of detention;
- the public health risk profile of the child, including:
    - whether they have been tested for 2019-nCoV and, if so, whether the results were negative; and
    - whether they are exhibiting any clinical symptoms or signs of 2019-nCoV.

Relevant human rights

The following human rights protected by the Charter are likely to be relevant to your functions in deciding whether to grant an exception to an unaccompanied minor whose parent or legal guardian cannot reside with them in the hotel.

- The **protection of children** (s 17). Children are entitled to such protection that is in their best interests and is needed by them by reason of being a child. Detaining an unaccompanied minor in a hotel room for 14 days will almost certainly not be in their best interests, particularly if the child is an interstate transit passenger and detained in a different jurisdiction to where their family reside. Given the special vulnerability of children, they may require different treatment or special measures as detention in a hotel without a parent or guardian is likely to have a disproportionately adverse impact on their physical and psychological development and emotional and educational needs. It will interfere with the child's care and the broader family environment, potentially significantly and detrimentally.

    - In deciding whether to permit a minor to self-isolate at home with their family (either in Victoria or their home jurisdiction) instead of alone at a hotel, the best interests of the child should be a primary consideration, including their developmental, emotional and educational needs. However, in appropriate circumstances, these interests can be balanced against other demonstrably justifiable ends; for example, lawful, reasonable and proportionate measures taken to reduce the further spread of 2019-nCoV. They may also depend on other factors, such as the age and dependence of the child (for example, in some circumstances it may be reasonable for an unaccompanied 17 year old to be detained in a hotel room for 14 days, but it is impossible to envisage any situation where this would be reasonable for an unaccompanied 7 year old).
- The right to **humane treatment when deprived of liberty** (s 22). As detention notices deprive persons of liberty, it is important that measures are put in place to ensure that the accommodation and conditions in which persons are detained meet certain minimum standards (such as enabling detained persons to obtain food, necessary medical care, and other necessities of living). However, even with those measures and balanced against the imperative need to protect public health, the detention of a child without a parent or guardian may nonetheless constitute inhumane treatment, having regard to factors such as the child's age and needs.
- The rights to **privacy, family and home** (s 13) and the **protection of families** (s 17). The detention of an unaccompanied minor, without the care of a parent or guardian, for 14 days, may constitute an arbitrary interference with privacy, family or home and/or a limitation of the right to the protection of families if it is not reasonable and appropriately justified. The enforcement of detention notices on unaccompanied children is likely to temporarily restrict the rights of persons (children and their family members) to develop and maintain social and familial relations, to live at home, and to be unified with other family members (particularly if the child is an interstate transit passenger and detained in a different jurisdiction to where their family reside). The reasonableness of any limitation on rights will depend on factors such as the importance of the purpose of protecting public health, the extent of the limitation of rights caused by detention, and the availability of less restrictive alternatives which also achieve the same purpose, for example, self-isolation of the child with their family at home (either in Victoria or their home State or Territory).
- The rights to **equality** and **freedom from discrimination** (s 8). These rights will be relevant due to the effect that detention may have on a parent or legal guardian who has other caring responsibilities, for example, if they have children or other dependants at home who require their care. An exception may need to be made in order to address the particular needs and vulnerabilities of those people, for example, by allowing the child to self-isolate at home with their family as an alternative to mandatory detention, which would mean that their parent or guardian is able to fulfil all of their carer responsibilities instead of having to prioritise one over another.
- The right to **life** (s 9). While allowing a child to quarantine at home with their family rather than by themselves at a designated hotel will prevent a potential breach of their rights, including their rights to protection under s 17(2) and humane treatment under s 22, it may limit the right to life of those family members and others in the community. However, depending on the circumstances of the child and their family, this may be considered less of a risk due to the engagement of the family and their understanding of the special treatment being afforded to their child, which would mean that they are unlikely to breach the terms of the quarantine. Families are also warned that detention may be required if self-isolation at home is not complied with, which will be a highly motivating factor for compliance.

Outcome

If you are reasonably satisfied that a person is an **unaccompanied minor whose parent or legal guardian is unable to reside with them**, you must provide them and their parents or guardians with a letter confirming that they must self-isolate at home or an alternative location for 14 days and setting out the conditions of self-isolation (see ***template letter for home isolation***).

Compassionate or medical grounds

Description of category

This category of exception is intended to apply to cases that warrant departing from the general policy of mandatory hotel detention for compassionate or medical reasons.

The particular compassionate or medical grounds of the person in question must be sufficient to justify why they should be allowed to self-isolate at home (or an alternative location) instead of being detained in a hotel. You must give proper consideration to whether detention may result in an unreasonable and disproportionate limitation of their human rights under the Charter, including the right to equality and freedom from inhumane treatment in detention (see below).

To be granted an exemption under this category, the person must demonstrate why detention in a hotel for 14 days would be unduly harsh, unreasonable or, in the case of some medical cases, disproportionately risky. For comparison, consideration should be had to the severity of other restrictions currently in place to limit social contact and movement in Victoria, including limiting the number of people who can attend funerals and restricting visitors to aged care facilities and hospitals. Given the Deputy Chief Health Officer has considered it necessary to impose these restrictions, which impose significant emotional and psychological hardship on affected Victorians, this exception category should reflect the seriousness of this public health threat and the fact that hardship is being endured by many people under the current restrictions.

If an exception is granted on compassionate or medical grounds, the person in question will be required to self-isolate at an alternative location, such as their home (either in Victoria or their home State or Territory) for 14 days. In very limited circumstances, the self-isolation requirement may be waived for the purposes of allowing a person to receive medical treatment or to attend the end-of-life of a family member. If the person self-isolates in Victoria, they will be subject to the same conditions as in the Isolation (Diagnosed Persons and Close Contacts) Directions. Unless there are sufficient reasons not to require it, the entire household must self-isolate for the purposes of mitigating the risk of spreading 2019-nCoV. If they self-isolate in another State or Territory, they will be subject to the conditions imposed in that respective jurisdiction.

The requests to you must be supported by a letter from a medical practitioner confirming that detention would be inappropriate or unreasonable for the person given their circumstances, unless the reason is obvious in which case a letter from an authorised officer would suffice.

If it is reasonably possible to amend the conditions of hotel detention to accommodate the person's particular compassionate or medical circumstances, whilst maintaining their right to be treated with humanity and respect, then this is preferable to granting an exemption. For example, if the person has a particular disability or medical condition that would render hotel detention by themselves to be unduly harsh, a better option may be to allow their nominated carer to quarantine with them for the detention period. This would manage the person's medical circumstances and also mitigate the risk of a 2019-nCoV outbreak.

Checklist of factors

To grant an exception under this category, you must be reasonably satisfied that the person has **compassionate or medical circumstances** that would make their detention unduly harsh, unreasonable or risky.

Relevant factors to consider in coming to your decision include (but are not limited to):

- the precise nature of their compassionate or medical circumstances, including, if relevant, whether they are transiting through Victoria on their way to their home jurisdiction;
- any proof of their circumstances, for example, a letter from a medical practitioner;
- the effect that detention would have on the person (or other people, if relevant), in light of their particular circumstances;
- whether their compassionate or medical circumstances can be appropriately managed in hotel detention;
- whether self-isolation at an alternative location (either in Victoria or the person's home jurisdiction) would be likely to mitigate or appropriately manage the risk posed by detention;
- the public health risk profile of the person, including:
    - whether they have been tested for 2019-nCoV and, if so, whether the results were

negative; and
    - whether they are exhibiting any clinical symptoms or signs of 2019-nCoV.

Relevant human rights

The following human rights protected by the Charter are likely to be relevant to your functions in deciding whether to grant an exception to a person on compassionate or medical grounds.

- The rights to **equality** and **freedom from discrimination** (s 8). Given that disability is a protected attribute and includes physical and mental disability, equality rights are particularly relevant for a person whose medical condition may mean that detention is disproportionately harsh or arbitrary. It may also be relevant for a person with a different protected attribute, such as age, race or parental or carer status, if that attribute means that detention would be unfairly disadvantageous for them. The exact impact of detention on the person will depend on the nature of their medical condition or compassionate circumstances, and the extent to which their condition or circumstances can be appropriately managed in detention.
    - The reasonableness of the measures will depend on whether they are proportionate to the purpose of protecting public health and whether there are less restrictive alternatives reasonable available to achieve that same purpose. Particularly in circumstances where there is medical or other proof to demonstrate the disproportionate impact of detention in a hotel room for 14 days, these rights may support a decision to allow the person to self-isolate at home (either in Victoria or their home jurisdiction) with appropriate conditions to mitigate any public health risks. Further, special measures that address the particular needs and vulnerabilities of persons with a disability or other protected attribute (such as self-isolation at home) will not be considered discriminatory against others who do not have that attribute, and may be required to ensure substantive equality.
- The right to **humane treatment when deprived of liberty** (s 22). The Charter requires that people be treated humanely when they are deprived of liberty, including in hotel detention. This may require that a person in detention be provided with adequate assistance, support and care as may be needed by them by reason of their medical condition, special vulnerability or other attribute. This assistance would have to be provided by DHHS and its authorised officers, unless a carer can reside with the person in the hotel for the period of detention. Depending on the particular circumstances, it may not be possible for either DHHS or a carer to provide the requisite assistance, care and support to the person in detention. This may be due to a range of reasons, including resourcing constraints, other caring responsibilities of the carer, the carer residing in another State or Territory, or the physical limitations of the hotel room. Given that it may not be humane to require a person to be detained in a hotel room for 14 days where they cannot receive the assistance, care and support they require, it may be preferable to make an exception for them to self-isolate at an alternative location (either in Victoria or their home jurisdiction) and to impose alternative conditions to ameliorate any public health risks.

- The rights to **privacy, family and home** (s 13) and the **protection of families** (s 17). The detention of a person with a disability, medical condition or other compassionate reason may constitute an arbitrary interference with privacy, family or home and/or a limitation of the right to the protection of families if it is not reasonable and appropriately justified. Much will turn on the particular circumstances of the person; however, it may be that detention will unduly affect their right to develop and maintain social and familial relations and to be unified with other family members, particularly if they depend on the care of a family member due to a disability or medical condition. The reasonableness of any limitation on rights will depend on factors such as the importance of the purpose of protecting public health, the extent of the limitation of rights caused by detention, and the availability of less restrictive alternatives which also achieve the same purpose, for example, self-isolation at home.
- The right to **life** (s 9). Although allowing a person with particular medical or compassionate circumstances to self-isolate at home rather than at a designated hotel will prevent a potential breach of their rights, including their rights to equality under s 8 and humane treatment under s 22, it may limit the right to life of other people they reside with and people in the community. However, depending on the circumstances of the person and their living situation, this may be considered less of a risk if they live alone or have the support and engagement of members of their household, which would mean that they are unlikely to breach the terms of their self-isolation. Families are also warned that detention may be required if self-isolation at home is not complied with, which will be a highly motivating factor for compliance.

Outcome

If you are reasonably satisfied that a person has sufficient **compassionate or medical grounds**, you must provide them with a letter confirming that they must self-isolate at home or an alternative location for 14 days and setting out the conditions of self-isolation (see ***template letter for home isolation***).

Attachment — Description of relevant human rights

Humane treatment when deprived of liberty

Section 22(1) of the Charter requires that all persons deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person. The right to humane treatment while deprived of liberty recognises the vulnerability of all persons deprived of their liberty and acknowledges that people who are detained should not be subject to hardship or restraint other than the hardship or restraint that is made necessary by the deprivation of liberty itself.

Rights to privacy, family and home

Section 13(a) of the Charter provides, relevantly, that a person has the right not to have their privacy, family or home 'unlawfully' or 'arbitrarily' interfered with. An interference will be lawful if it is permitted by a law which is precise and appropriately circumscribed, and will be arbitrary only if it is unjust or unreasonable, in the sense of being disproportionate to the legitimate aim sought. The right to 'privacy' has a very wide scope, and includes the protection of the individual's personal and social sphere, such as their right to establish and develop meaningful social relations. The 'family' aspect of s 13(a) is related to s 17(1) of the Charter (see below), but contains a negative obligation that only prohibits unlawful or arbitrary interferences with family. The 'home' aspect of s 13(a) refers to a person's place of residence, and may cover actions that prevent a person from continuing to live in their home.

Protection of families and children

Section 17(1) of the Charter recognises that families are the fundamental group unit of society, and entitles families to protection by the society and the State. The term 'family' is construed widely and includes ties between near relatives, with other indicia of familial relationships including cohabitation, economic ties, and a regular and intense relationship. Cultural traditions may be relevant when considering whether a group of persons constitute a 'family' in a given case.

Section 17(2) of the Charter provides that every child has the right, without discrimination, to such protection as is in their 'best interests' and is needed by them by reason of being a child. It recognises the special vulnerability of children, defined in the Charter as persons under 18 years of age. 'Best interests' is considered to be a complex concept which must be determined on a case-by-case basis. However, the following elements may be taken into account when assessing the child's best interests: the child's views; the child's identity; preservation of the family environment and maintaining relationships; care, protection and safety of the child; situation of vulnerability; the child's right to health; and the child's right to education.

Right to equality

Section 8(3) of the Charter relevantly provides that every person is entitled to equal protection of the law without discrimination and has the right to equal and effective protection against discrimination. 'Discrimination' under the Charter is defined by reference to the definition in the *Equal Opportunity Act 2010* on the basis of a 'protected attribute', which includes age, race, disability (including physical and mental disability, whether permanent and temporary), and parental or carer status.

Indirect discrimination occurs where there is a requirement, condition or practice imposed that is the same for everyone but disadvantages a person, or is likely to disadvantage a person, because they have one or more of the protected attributes, and the requirement, condition or practice is not reasonable. Direct discrimination occurs where a person treats a person with a protected attribute unfavourably because of that attribute. Section 8(4) of the Charter provides that measures taken for the purpose of assisting persons disadvantaged because of discrimination do not constitute discrimination.

Australian Government
Department of Health

Coronavirus disease (COVID-19)

Exemptions to the 14 day mandatory quarantine period for international travellers

The Australian Health Protection Principal Committee (AHPPC) recognises that there should be some exemptions from quarantine requirements for specific industry groups, provided they adhere to specified risk mitigations measures. These specific exemptions are recommended because of the industry infection prevention requirements, training these groups have undergone, and the vital role of these industries in Australia.

While these are national recommendations, mandatory quarantine is enforced under state and territory public health legislation. Individual states and territories may choose to implement additional requirements at the point of arrival.

Some jurisdictions may also have additional quarantine requirements upon entry to the state or territory. Depending on the jurisdiction, this could mean that an international traveller is required to go into mandatory quarantine at the first point of arrival into Australia, and further quarantine upon entry to another jurisdiction.

The following groups are recommended to be exempt from the 14 day mandatory quarantine requirements when entering Australia. While these groups are exempt from mandatory quarantine, **all** arrivals into Australia **must** continue to practise social distancing, cough etiquette and hand hygiene. Other requirements, such as self-isolation, may still apply and are outlined below.

Aviation crew

Aviation crew must not join an aircraft or travel domestically if they are experiencing any signs of illness and should seek medical assistance.

<u>International flight crew (Australian residents/citizens)</u>

- Are not required to undertake 14 days of mandatory quarantine on arrival.
- Are not required to complete the Isolation Declaration Card.
- Must self-isolate at their place of residence (or hotel) until their next international flight, or for 14 days, whichever is shorter.
    - Essential flight-related duties from a regulatory or safety perspective may be undertaken during this time (eg flight simulation training, safety and security training).

<u>International flight crew (foreign nationals)</u>

- Are not required to undertake 14 days of mandatory quarantine on arrival.
- Are not required to complete the Isolation Declaration Card.
- Must self-isolate in their hotel on arrival until their next flight.
- Must use privately organised transport to transfer to and from hotels between flights.
- May fly domestically to their next point of departure from Australia if required.

Domestic flight crew

- Are subject to the normal self-isolation requirements of the relevant state or territory.

Medevac and air ambulance crew

- Are subject to the same requirements as international flight crew.
- May request exemptions to return to duties beyond the essential flight-related duties already exempt.
    - A request for exemption must be made to the relevant state or territory.
    - Exemption requests will be considered on a case-by-case basis.

Maritime crew (excluding cruise ships)

For the purposes of this factsheet, maritime crew are defined as anyone required to be part of a crew operating or providing services to support the operation of a commercial vessel (excluding cruise vessels) or a government vessel in Australian waters. This includes support staff such as livestock handlers and veterinarians.

Maritime crew must not join a vessel or travel domestically if experiencing any signs of illness and should seek medical assistance.

International maritime crew travelling to Australia (via aircraft) to join a vessel

- Are not required to undertake 14 days of mandatory quarantine on arrival.
- Are not required to complete the Isolation Declaration Card.
- May be subject to additional screening by biosecurity.
- Must proceed directly to the vessel on arrival or self-isolate at their accommodation.
- May travel domestically and/or take a domestic flight to meet their vessel at the next point of departure if required, but must self-isolate at their accommodation for any layover time.

International maritime crew travelling to Australia (by sea)

- Must complete their 14-day self-isolation period following the departure from their last international port of call.
- Time at sea counts towards the 14-day self-isolation period if no illness has been reported on-board. Crew signing off commercial vessels that have spent greater than 14 days at sea, with no known illness on-board, do not need to self-isolate on arrival.
- All crew signing off a vessel at an Australian port are permitted to transit and depart Australia via air or proceed to join another vessel in Australia. If this is within the 14-day period, crew must travel directly to the flight or vessel and must isolate in accommodation for any layover time.
- Australian crew can return to their normal place of residence in Australia. If this is within the 14-day period, crew must complete the remainder of their 14-day self-isolation period in their residence.

Unaccompanied minors

Unaccompanied minors will be allowed to travel domestically after entering Australia to self-quarantine with a parent or guardian at their home.

Transit passengers

- International transit passengers arriving into Australia are able to depart on another international flight if the following conditions are met:
    - If the individual has up to 8 hours until the departing international flight, they must remain at the airport and be permitted to onward travel, maintaining social distancing and hand hygiene.
    - If 8-72 hours before the departing flight, they must go to mandatory quarantine at the state designated facility until the time of the departing flight.
- No domestic onward travel is allowed, even if this is to meet a departing international flight. These people should go into mandatory quarantine at the state designated facility at the first point of arrival.

Diplomats

- Australia has legal obligations under the Vienna Convention to ensure diplomats freedom of movement and travel, and protection from detention. Diplomats are not required to undertake 14 days of mandatory quarantine on arrival into Australia. They are therefore not required to complete the Isolation Declaration Card.
- Diplomats should self-isolate at their mission or in their usual place of residence on arrival for 14 days.
- Diplomats must continue to practise social distancing, cough etiquette and hand hygiene.

Compassionate or medical grounds

Applications on medical or compassionate grounds should be submitted to the relevant state or territory who will consider requests on a case-by-case basis.

Contact details for state or territory public health agencies are available at www.health.gov.au/state-territory-contacts.

Where can I get more information?

For the latest advice, information and resources, go to www.health.gov.au.

Call the National Coronavirus Helpline on 1800 020 080. This line operates 24 hours a day, seven days a week. If you require translating or interpreting services, call 131 450.

FW: Operations Plan - Operation Soteria v2.0 draft

From: "SCC-Vic (State Controller Health)" <sccvic.sctrl.health@scc.vic.gov.au>

To: "Meena Naidu (DHHS)" [redacted], "Pam Williams (DHHS)" [redacted], "StateEmergencyManagementCentre SEMC (DHHS)" <semc@health.vic.gov.au>, [redacted], splo@police.vic.gov.au, [redacted], "Sandy Austin (DHHS)" [redacted], "SCC-Vic (State Controller Health)" <sccvic.sctrl.health@scc.vic.gov.au>

Cc: "Finn Romanes (DHHS)" [redacted], "Annaliese Van Diemen (DHHS)" [redacted]

Date: Fri, 10 Apr 2020 13:32:07 +1000

Attachments: Operations Plan - Operation Soteria - 10 April 2020 v2.0 - draft.docx (438.2 kB)

Dear all

Please find attached draft Operations Plan – Operation Soteria v2.0 for your feedback and input. It is important to include links to key policies, plans or protocols for the functions of the operational leads, and I welcome your consideration of appropriate references to these documents in the relevant sections of the plan, and updating of contacts in appendix 4. The quarantine accommodation exit plan and Appendix 5 risks and incidents escalation process for quarantine hotels will be forwarded once finalised and approved, expected today.

I acknowledge the rapidly evolving nature of this operation, and the collective and collegiate multi-agency team needed to achieve an effective outcome. I'll take this opportunity to flag that the next version will need a section on data and reporting from all operational leads, to be drafted in the coming days. We look forward to continuing to work with you, and appreciate all of your efforts to date.

Please return your feedback to sccvic.sctrl.health@scc.vic.gov.au by **end of day Saturday 11 April**. Please let Scott, Jason (incoming State Controller – Health Saturday-Tuesday) or me know if you have any queries.

Many thanks
Andrea Spiteri

State Controller - Health

From: SCC-Vic (State Controller Health)
Sent: Friday, 10 April 2020 1:16 PM
To: Finn Romanes (DHHS) [redacted] Annaliese Van Diemen (DHHS) [redacted] 'SEMC' <semc@dhhs.vic.gov.au>
Subject: Operations Plan - Operation Soteria v2.0 draft

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I intend to distribute v2.0 of the operations plan to the Operation Soteria operational leads today

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REDACTED

From: Finn Romanes (DHHS) REDACTED
Sent: Thursday, 9 April 2020 4:54 PM
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Subject: Request - Governance and Planning for Mandatory Quarantine Programme (aka Operation Soteria)
Importance: High

Dear State Controller and REDACTED

There has been a range of good work by colleagues across DELWP, DHHS, EMV and elsewhere to bring into effect – at short notice – a mandatory quarantine (detention) programme in relation to COVID-19 since midnight Saturday 29 March, including that a number of people have been placed into mandatory quarantine.

There appears to be a lack of a unified plan for this program, and there is considerable concern that the lead roles have not had an opportunity to be satisfied there is a policy and set of processes to manage the healthcare and welfare of detainees, for whom this program is accountable.

There are now a considerable complexity and considerable risk that unless governance and plans issues are addressed there will be a risk to the health and safety of detainees.

Governance
The Chief Health Officer and Deputy Chief Health Officer are formally requesting an urgent review governance of the mandatory quarantine (detention) programme, also known as Operation Soteria, to be conducted this afternoon, with **new and clear arrangements to be established by 8pm this evening**. These arrangements should provide for:

- A clear lead, who could remain the REDACTED
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The plan will require endorsement by the Deputy Chief Health Officer (Public Health Commander) before provision to any overall lead officer.
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We are very grateful for all the hard work of the team, and appreciate your help in advance for establishing these necessary steps in the governance and oversight of this program.,

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Dr Finn Romanes
Deputy Public Health Commander - Planning
Novel Coronavirus Public Health Emergency
REDACTED
Department of Health and Human Services
State Government of Victoria

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Regards

Finn
Dr Finn Romanes
Deputy Public Health Commander - Planning
Novel Coronavirus Public Health Emergency
REDACTED
Department of Health and Human Services
State Government of Victoria

RE: Welfare for hotel quarantine

From: Angie Bone (DHHS) REDACTED
To: Annaliese Van Diemen (DHHS) REDACTED Pam Williams (DHHS) REDACTED Helen Mason (DHHS) REDACTED Euan Wallace (DHHS) REDACTED REDACTED REDACTED REDACTED Andrea Spiteri (DHHS) REDACTED Finn Romanes (DHHS) REDACTED Jason Helps (DHHS) REDACTED
Cc: Anthony J Kolmus (DHHS) REDACTED
Date: Thu, 16 Apr 2020 08:42:20 +1000

Thanks Annaliese – relevant and intersects with the compliance role as well

As discussed yesterday there is an urgent need for consistent policies around:

1. 1. What can be brought into the hotel (food, cigarettes, alcohol) and searching of bags (noting that we have no authority to do this under the emergency powers (and questions have been asked), but a knife was identified and confiscated)
2. 2. Transport – to and from hotels (not just the PH elements but also who organises)
3. 3. PPE for staff at hotels – on Sunday I was expected to wear one mask and one set of gloves at all times by the hotel staff while releasing detainees after 14 days – not appropriate, and potential increased risk, but in the end easier to go along with it
4. 4. Case management and co-traveller management in hotels including exits and especially when interstate residents (eg in terms of accommodation)
5. 5. Data collection and management

Many of these policies will need agreement with DJPR who have contracted services (eg hotel and security) who wish to apply their own policies.

There has been a significant policy gap in these areas so it is wonderful news that this will be filled. Happy to support from the regulatory perspective.

Angie

Dr Angie Bone MBChB MSc MRCP FFPH FAFPHM
Deputy Chief Health Officer (environment)
Health Protection Branch
Regulation, Health Protection and Emergency Management Division
Department of Health & Human Services
50 Lonsdale Street, Melbourne, Victoria 3000
REDACTED

From: Annaliese Van Diemen (DHHS) REDACTED
Sent: Wednesday, 15 April 2020 11:46 PM
To: Pam Williams (DHHS) REDACTED Helen Mason (DHHS) REDACTED Euan Wallace (DHHS) REDACTED REDACTED REDACTED REDACTED Andrea Spiteri (DHHS) REDACTED Finn Romanes (DHHS) REDACTED Angie Bone (DHHS) REDACTED Jason Helps (DHHS) REDACTED

Subject: RE: Welfare for hotel quarantine

Thanks Pam and for the conversation we had earlier,

As per a few discussions today, we are now much closer to the point of greater clarity in roles and responsibilities across this.

Apologies if this was already clear to everyone else and I am finally joining the party, this is as much for my own clarity as the rest of you.

I think now is a good time to make the clear distinction, as made by Andrea yesterday regarding this (particularly for health and welfare)

- * The policy and protocols around health and welfare will be the responsibility of Public Health IMT – this is being supported by some resource offered by Euan around clinical care pathways etc
- * The implementation of these policies and protocols, including logistics, rostering etc will sit with the EOC

There will be points where these two intersect and that is where we need to ensure we have enough meetings and reviews in place to determine where there are policy issues and where there are operational issues and what is needed from whom to clear these up. But I think a lot of clarity should fall out from this going forward.

For example, below there is a policy question about who calls which passengers and how often, and how this intersects with other care and referral pathways. This should be resolved (ideally tomorrow and with input from the original designers of the policy) in terms of what the policy is, before it is passed onto Pams team to implement via the EOC. Given this we will need to have a discussion with REDAC, tomorrow about which aspects of the current welfare cell are the operations parts and should go to the EOC, and which have been driving policy and should sit with the PHIMT.

Happy to discuss further at our catch up tomorrow or earlier if required.

Cheers

Annaliese

Dr Annaliese van Diemen MBBS BMedSc MPH FRACGP FAFPHM
Public Health Commander- COVID-19 Department Incident Management Team
Deputy Chief Health Officer (Communicable Disease)
Regulation, Health Protection & Emergency Management
Department of Health & Human Services | 14 / 50 Lonsdale St
REDACTED
health.vic.gov.au/public-health

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

From: Pam Williams (DHHS) REDACTED
Sent: Wednesday, 15 April 2020 6:19 PM
To: Helen Mason (DHHS) REDACTED Euan Wallace (DHHS) REDACTED REDACTED ; Annaliese Van Diemen (DHHS)

REDACTED
REDACTED Andrea Spiteri (DHHS) REDACTED
Subject: RE: Welfare for hotel quarantine

The discussion today was very helpful.
I think a way forward may be to consider:

- * Nurses to undertake the first welfare check call on Day 1 or 2 of entry. This call follows a comprehensive script that is designed to assist in determining the health and welfare risk of the guest and to provide information that will determine any immediate needs. The nurse will then be able to triage the guests, such that some will thereafter be regarded as high needs and others as lower needs.
  - * High needs people will be managed by the nurses who will do a daily welfare check and support their health needs. The welfare check information will go into the BTIM system and any clinical data will be held in another way (there was not clarity about how that was being held now – although we seem to have received at the EOC a large amount of paperwork from the exited hotels).
  - * Low needs people will receive a daily welfare check from the welfare cell.

- * The welfare cell will be arranged by hotel and those doing the calls for a particular hotel will have a daily briefing with the nurses to check that no-one has been escalated to high needs and is no longer to be called by the welfare check cell.

This approach is similar to the original intention and needs to be supported by the IT system and hardware. If nurses cannot access the BTIM system directly, their input from the first call will need to be prioritised for data entry.
There will probably need to be more nurses to achieve this, but the welfare cell will be able to focus on getting through the low risk calls so they should be able to address the backlog, or at least make sure that they are keeping up better with the new demand. There may need to be some calls made about how those already in the hotels are managed, with a focus on nurses getting that first call and triaging done for everyone.

I am rostered off for the next few days, but I have discussed this approach with Merrin Bamert (who helped design the original approach) and we believe it will give us what is required from a compliance, human rights, health and wellbeing perspective.

Pam Williams
COVID19 Accommodation Commander
Department of Health and Human Services
REDACTED
www.dhhs.vic.gov.au

From: Helen Mason (DHHS)REDACTED
Sent: Wednesday, 15 April 2020 3:53 PM
To: Euan Wallace (DHHS)REDACTED
REDACTED
Annaliese Van Diemen (DHHS)REDACTED
REDACTED Andrea Spiteri (DHHS)
REDACTED Pam Williams (DHHS)REDACTED
Subject: Welfare for hotel quarantine

Hi

Thanks for the helpful conversations I have had with a number of you today.

I thought I'd try and summarise my understanding of the situation before our telco:

Current Situation

1: Welfare checks through REDACT team: these are intended to happen on day 3 and day 9. Line of escalation to department team leaders. REDAC is proposing that the focus of these be on what happens once the person is released from quarantine. Ie do they have some place to go, a job, etc REDACT has a team of 30 but needs a team of 50. So an urgent need for 20 people to join

this team. Skill set hasn't been specified. Could be nurse, social worker, other. Have a data base which others will have access to over time but hasn't happened yet.

2. Presence at hotels: nurses (contracted by Public Health), GPs (contracted by EM), Mental health staff (not sure where they fit in), as well as AOs. Virtual concierge run by DJPR (no presence on site). Health staff at hotels are responding to adhoc requests. At smaller hotels the nurses are doing daily welfare calls. This isn't happening at larger hotels due to lack of capacity. No point of escalation. No overall governance. Urgent need for nurses to join this team to enable daily checks to happen for everyone.

3. AOs are on site: role is to ensure comply with directions. Needed 24/7. Working alone, not involved in welfare checks. Line of escalation is to department team leaders.

4. DJPR playing role in securing accommodation, security, food, etc. Plus "concierge role" sits with DJPR remotely. Allocate people to hotels. Arrange some of logistics of exit strategy (eg travel)

5. VicPol also involved.

Problems we need to address:

1. 1. Immediate staffing needs for REDACTE welfare team and for nurses doing daily welfare checks.
2. 2. Escalation process for nurses, docs and mental health staff at hotels.
3. 3. Governance of process
4. 4. Shared information across welfare and onsite team.
5. 5. Decisions on which option to progress.

Way forward

Three options:

1. 1. Shore up the arrangements which are currently in place
2. 2. Partial change to the model, for example with escalation of nursing/GP/MH concern into a health service
3. 3. Change the model to health services doing a full in reach.

If we go with Option 3 which there appears to be interest in, then the 3 health services best placed would be: the Alfred, Royal Melbourne and St Vincent's. All 3 RE are aware we may be seeking their support and are willing to help.

Ways to think about the needs of those quarantined:

1. 1. Basics of life – food/cot/clothes, etc.
2. 2. Health/mental health needs
3. 3. What support they need after they are released.

I hope that's helpful.

Speak soon.

Helen

Helen Mason
Executive Director of Commissioning
Health and Wellbeing Division
Department of Health and Human Services
50 Lonsdale Street, Melbourne Victoria 3000
REDACTED
w. www.dhhs.vic.gov.au

COVID-19 – Interim Healthcare and Welfare Mandatory Quarantine Plan

11 April 2020

Contents

Purpose

This plan is intended to:

- Describe the roles and responsibilities of all parties involved in the mandatory quarantine process
- Outline the healthcare and welfare protocols in place
- Outline the legal requirements
- Describe the policy and procedures of DHHS authorised officers (AOs)

Authorising environment

Emergency Management Commissioner and State Controller

State Controller (Class 2) is appointed to coordinate the overall response, working within the emergency management arrangements.

Chief Health Officer and Deputy Chief Health Officer

Under a state of emergency declared by the Victorian Government, the Chief Health Officer and Deputy Chief Health Officer have exercised powers to make a range of Directions that reflect physical distancing controls in Victoria.

Governance of mandatory quarantine policy within the DIMT

A Mandatory Quarantine Cell will be chaired by the Deputy Public Health Commander – Physical Distancing and Planning, on behalf of the Deputy Chief Health Officer (Public Health Commander). There will be a Mandatory Quarantine operations lead (an executive lead for compliance), and a policy and strategy lead.

Direction

The direction and detention notice issued by the Deputy Chief Health Officer states that people travelling to Victoria from overseas, on or after midnight on 28 March 2020 will be detained at a hotel for a period of 14 days.

The direction and detention notice is available on the department's website: https://www.dhhs.vic.gov.au/sites/default/files/documents/202003/detention-notice-signed-2020-03-28.pdf

Cabinet

Advice was provided by the AHPPC to National Cabinet on 25 March 2020. On the 27 March 2020 National Cabinet, agreed to take action to further restrict reduce the spread of coronavirus in Australia, by introducing mandatory quarantine for all returning travellers coming from overseas.

Victoria Police

Victoria Police will provide assistance with compliance with directions.

Compliance and enforcement for mandatory quarantine

Purpose of this section

The purpose of this compliance protocol is to set out the compliance approach in relation to Deputy Chief Health Officer (D/CHO) directions under *Public Health and Wellbeing Act 2008* (PHWA).

Scope of compliance and enforcement

The scope of enforcement and compliance activity will include persons under quarantine for returning from overseas.

Strategy for compliance and enforcement

The outcomes being sought are to reduce the transmission COVID-19 through mandatory quarantine for 14 days of those returning from overseas. The focus of activity will be on implementation of a mandatory detention program for new arrivals from overseas.

Data management to support compliance and enforcement

Authorised officers are responsible for uploading information to the business system which will then inform an upload to PHESS so that all persons in mandatory detention are recorded in PHESS for compliance and monitoring and surveillance purposes. This upload will occur under the accountability of the Director of Health Regulation and Reform.

Plan for people returning from overseas to Victoria

Background to the mandatory quarantine (detention) intervention

A mandatory quarantine (detention) approach was introduced by creation of a policy that a detention order would be used for all people arriving from overseas into Victoria from midnight on Saturday 28 March 2020. An example detention order is available at https://www.dhhs.vic.gov.au/state-emergency

The objectives of the plan for people returning from overseas to Victoria are:

- To identify any instance of illness in returned travellers in order to detect any instance of infection;
- To ensure effective isolation of cases should illness occur in a returned traveller;
- To provide for the healthcare and welfare needs of returned travellers who are well or shown to be COVID-19 negative but are required to remain in quarantine for the required 14 days;
- To implement the direction of the Deputy Chief Health Officer through meeting:
  - A requirement to detain anyone arriving from overseas for a period of 14 days at a hotel in specific room for a specified period unless an individual determination is made that no detention is required;
  - A requirement to record provision of a detention notice showing that the order was served and to manage access to information on who is in detention using a secure database;
  - A requirement to undertake checks every 24 hours by an authorised officer during the period of detention;
  - A requirement to fairly and reasonably assess any request for permission to leave the hotel room / detention.

Governance and oversight of the mandatory quarantine (detention) intervention

Lead roles

The Chief Health Officer and Deputy Chief Health Officer have instituted a policy, in keeping with a conclusion from National Cabinet, that leads to issuance of detention orders for people returned from overseas.

The following lead roles are involved in the oversight of the mandatory detention intervention:

- Oversight report to EMC - REDACTED
- State compliance and public health stream – Deputy Chief Health Officer (Annaliese van Diemen)

  - Deputy Chief Health Officer – overall lead and authorising environment for the mandatory detention scheme, decision to issue a detention notice or not;
  - Deputy Public Health Commander Planning – delegate of DCHO for these arrangements including initial advice to DCHO/PHC on requests where a decision is needed whether to grant leave (permission) or not detain, and for public health advice regarding the detention regime;
  - Director Health Regulation and Reform – is the Compliance Lead, for compliance and enforcement activity including authorised officer workforce – including the issuing and modification of detention orders (for example including moving a person from one room to another);
- Health and welfare stream – State Health Coordinator (Euan Wallace)
  - Deputy State Health Coordinator – lead for healthcare provision to persons in detention;
  - Director Health Protection and Emergency Management – lead for welfare and implementation of healthcare provision to persons in detention;
- Logistics including accommodation and transport stream – Executive DHHS Lead for Accommodation (Pam Williams)
  - Department of Health and Human Services Commander – lead for logistics for provision of mandatory detention involving transport and accommodation.
  - DJPR lead.

Information management for people in mandatory detention

A business system is being developed by BTIM to assist with the management of the healthcare and welfare for people included in this intervention. That system articulates with the PHESS database through a common link key. Critical information about people in mandatory detention will be uploaded to PHESS at two points in the day as a download from the business system to be used.

To be determined: the master source of who has exited the airport in mandatory detention.

To be completed: the build of the business system to support welfare and health needs of people in mandatory detention.

The Enforcement and Compliance section will ensure identities and basic compliance information of all persons in detention are entered onto PHESS through the twice daily upload process from the completed business system.

As a parallel system, Isolation Declaration Card (IDCs) are collected at the airport and batched and sent to an Australia Post call centre. The data is entered into a spreadsheet and sent to DHHS for cross entry into PHESS. This process takes approximately 24 hours. This can then be reconciled with any passenger list or persons in detention list.

Enforcement and Compliance Command for Mandatory Quarantine

Deliverables of the enforcement and compliance function

The Director of Health Regulation and Compliance role is responsible for:

- Overall public health control of the detention of people in mandatory quarantine;
- Oversight and control of authorised officers administering detention;
- Administration of decisions to detain and decision to grant leave from detention.

Authorised officer* and Chief Health Officer obligations

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

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

Any AO that is unsure as to whether they been authorised under s.199 should contact administrative staff in the DHHS Health Protection Branch prior to enforcing compliance with the Direction and Detention Notice.

Exercising this power imposes several obligations on DHHS authorised officers including:

- producing their identity card for inspection prior to exercising a power under the PHWA
- before the person is subject to detention, explaining the reason why it is necessary to detain the person
- if it is not practicable to explain the reason why it is necessary to detain the person, doing so as soon as practicable
- before exercising any emergency powers, warning the person that refusal or failure to comply without reasonable excuse, is an offence
- facilitating any reasonable request for communication made by a person subject to detention
- reviewing, every 24 hours, whether continued detention of the person is reasonably necessary to eliminate or reduce a serious risk to health
- giving written notice to the Chief Health Officer (CHO) that a person:
  - has been made subject to detention
  - following a review, whether continued detention is reasonably necessary to eliminate or reduce the serious risk to public health.

The notice to the CHO must include:

- the name of the person being detained
- statement as to the reason why the person is being, or continues to be, subject to detention.

Following receipt of a notice, the CHO must inform the Minister as soon as reasonably practicable.

** DHHS Authorised Officer under the PHWA that has been authorised for the purposes of the emergency order.*

Required authorised officer actions at the airport

The lead for this situation is the Compliance Lead through a lead Authorised Officer.

DHHS Authorised Officers*:

- declare they are an Authorised Officer and show AO card [s.166] **(mandatory AO obligation)**
- must provide a copy of the Direction and Detention Notice to each passenger (notification to parent/guardian may need to be conducted over the phone and interpretation services may be required) and:
  - explain the reasons for detention [s. 200(2)] **(mandatory AO obligation)**
  - warn the person that refusal or failure to comply with a reasonable excuse is an offence and that penalties may apply [s. 200(4)] **(mandatory AO obligation)**
- ensure the Direction and Detention Notice:
  - contains the hotel name at which the person will be detained
  - states the name/s of the person being detained
- record issue and receipt of the notice through a scanned photograph and enter into business system
- if necessary, facilitate a translator to explain the reasons for detention

- facilitate any reasonable request for communication, such as a phone call or email [s. 200(5)] **(mandatory AO obligation)**
- provide a fact sheet about detention (what the detainee can and can't do, who to contact for further information)
- record any actions taken in writing, including the above mandatory obligations, use of translator and any associated issues.
- use the list of arriving passengers to check off the provision of information to each arrival. This will help ensure all arrivals have been provided the information in the Direction and Detention Notice.
- check the vehicle transporting detainees is safe (in accordance with the review of transport arrangements procedure)

If it is not practicable to explain the reason for detention prior to subjecting the person to detention, the AO must do so as soon as practicable. This may be at the hotel, however every effort should be made to provide the reason at the airport [s. 200(3)] **(mandatory AO obligation)**.

*DHHS Authorised Officer under the PHWA that has been authorised for the purposes of the emergency order.

Authorised Officer review of transport arrangements

AO should consider the following:

- All persons must have been issued a direction and detention notice to board transport
- Is there adequate physical distance between driver and detainees?
- If not wait for another suitable vehicle to be arranged by the hotel.
- Has the vehicle been sanitised prior to anyone boarding? If not, then vehicle must be cleaned in accordance with DHHS advice (business sector tab).
- Ensure the driver has adequate PPE
- Are the persons subject to detention wearing face masks? (Refer to Airport and transit process)
- Are there pens/welfare check survey forms available for each detainee to complete on route or at the hotel?

People who are unwell at the airport

The lead for this situation is the Human Biosecurity Officer on behalf of the Deputy Chief Health Officer (Communicable Diseases).

Any person who is unwell at the airport will be assessed by a DHHS staff member (nurse) and biosecurity officer at the airport. After discussion with the Human Biosecurity Officer, if it is determined that the person meets the criteria as a suspected case, the following actions should take place:

- The Human Biosecurity Officer should organise an ambulance transfer to the Royal Melbourne Hospital or Royal Children's Hospital for testing and assessment;
- The authorised officer from DHHS at the airport should log the person as requiring mandatory quarantine at a specified hotel and then should follow-up with the hospital to update on whether the person has been found to be negative, so a transfer by (patient transfer/ambulance/ maxi taxi etc.) can be organised to return to the hotel;
- If the person is unwell and requires admission, they should be admitted and the Compliance Lead informed;
- If the person is well enough to be discharged, they should return to the hotel through an arrangement by the authorised officer, (comments as above) and be placed in a COVID-19 floor if positive, or in a general part of the hotel if tested negative for COVID-19.

Transfer of uncooperative person to be detained to secure accommodation (refer to Authorised Officer review of transport arrangements procedure)

- It is recommended that a separate mode of transport is provided to a person who is to be detained who is uncooperative to a hotel or other location for the 14-day isolation.
- Ensure appropriate safety measures are taken including child locks of doors and safety briefing for drivers etc.

Requirement for review each day

- DHHS AO must – at least once every 24 hours – review whether the continued detention of the person is reasonably necessary to protect public health [s. 200(6)] **(mandatory AO obligation).**
- DHHS AO will undertake an electronic review of detainment arrangements by viewing a Business system. This includes reviewing:
  - the date and time of the previous review (to ensure it occurs at least once every 24 hours)
  - number of detainees present at the hotel
  - duration each detainee has been in detention for, to ensure that the 14-day detention period is adhered to
  - being cleared of COVID-19 results while in detention, which may be rationale for discontinuing detention
  - determining whether continued detention of each detainee is reasonably necessary to eliminate or reduce a serious risk to health
  - any other issues that have arisen.

To inform decision-making, a DHHS AO must:

- consider that the person is a returned overseas traveller who is subject to a notice and that they are obliged to comply with detainment
- consider that detainment is based on expert medical advice that overseas travellers are of an increased risk of COVID-19 and form most COVID-19 cases in Victoria
- note the date of entry in Australia and when the notice was given
- consider any other relevant compliance and welfare issues the AO[1] becomes aware of, such as:
  - person's health and wellbeing
  - any breaches of self-isolation requirement
  - issues raised during welfare checks (risk of self-harm, mental health issues)
  - actions taken to address issues
  - being cleared of COVID-19 results while in detention
  - any other material risks to the person
- record the outcomes of their review (high level notes) for each detained person (for each 24-hour period) in the agreed business system database. This spreadsheet allows ongoing assessment of each detainee and consideration of their entire detention history. This will be linked to and uploaded to PHESS.

To ascertain any medical, health or welfare issues, AO will need to liaise with on-site nurses and welfare staff (are there other people on-site an AO can liaise with to obtain this information).

Additional roles of the AO

- AOs should check that security are doing some floor walks on the floors to ascertain longer-term needs and possible breaches.

- AO going onto the floors with persons subject to detention must wear gloves and masks. There should be P2 masks for AO's at the hotels (in addition to the surgical masks).
- AO should provide a handover to the incoming AO to get an update of any problems or special arrangements. For example, some people are permitted to attend cancer therapy at Peter Mac etc.
- AO responsible for uploading information to the business system which will then inform an upload to PHESS so that all persons in mandatory detention are recorded in PHESS for compliance and monitoring and surveillance purposes.

Charter of Human Rights considerations in decision-making process

AO should consider the Charter of Humans Rights when exercising emergency powers and reviewing a person's detention every 24 hours, namely:

- **Right to life** – This includes a duty to take appropriate steps to protect the right to life and steps to ensure that the person in detention is in a safe environment and has access to services that protect their right to life
- **Right to protection from torture and cruel, inhuman or degrading treatment –** This includes protecting detainees from humiliation and not subjecting detainees to medical treatments without their consent
- **Right to freedom of movement –** While detention limits this right, it is done to minimise the serious risk to public health as a result of people travelling to Victoria from overseas
- **Right to privacy and reputation** – This includes protecting the personal information of detainees and storing it securely
- **Right to protection of families and children –** This includes taking steps to protect facility and children and providing supports services to parents, children and those with a disability
- **Property rights –** This includes ensuring a detainee's property is protected
- **Right to liberty and security of person –** this includes only be detained in accordance with the PHWA and ensuring steps are taken to ensure physical safety of people, such as threats from violence
- **Rights to humane treatment when deprived of liberty** - This includes treating detainees with humanity

Mandatory reporting (mandatory AO obligation)

A DHHS AO must give written notice to the Chief Health Officer as soon as is reasonably practicable that:

- a person has been made subject to detention
- following a review, whether continued detention is reasonably necessary to eliminate or reduce the serious risk to public health.

The notice to the CHO must include:

- the name of the person being detained
- statement as to the reason why the person is being, or continues to be, subject to detention.

To streamline, the reporting process will involve a daily briefing to the CHO of new persons subject to detention and a database of persons subject to detention. The database will specify whether detention is being continued and the basis for this decision.

The CHO is required to advise the Minister for Health of any notice [s. 200(9)].

Possible release from detention based on review

The daily review by the lead AO could identify that detention may no longer be required (with the approval of the Compliance Lead and Public Health Commander.

In the first instance the AO should contact the specialist area if needed (i.e. Mental Health)

Based on specialist advise, there will be a recommendation to the Compliance Lead and Public Health Commander/CHO.

Grant of leave from detention

Grant of leave from the place of detention

This is a different legal test to that which applies after the notice is issued. It relates solely to the granting of leave (permission) and requires a different process and set of considerations.

The detention notice provides for a 24-hour review (which is required by legislation) to assess whether ongoing detention is needed, and, in addition, a person may be permitted to leave their hotel room on certain grounds, including compassionate grounds.

Any arrangements for approved leave would need to meet public health (and human rights) requirements. It will be important that the authorised officer balances the needs of the person and public health risk. For example, if the person needs immediate medical care, public health risks need to be managed appropriately, but the expectation is that the leave would automatically be granted. This would be more nuanced and complex when the request is made on compassionate grounds where there is a question about how public health risks might be managed. However, again, human rights need to be considered closely.

Potential mechanisms for grant of leave from detention

Noting that there are broadly two mechanisms available to the authorised officer on behalf of the Compliance Lead / Public Health Commander to release a person from mandatory detention:

- The daily review by the authorised officer could find that detention is no longer required (with agreement of the Compliance Lead), or
- There could be permission given by the authorised officer (with agreement of the Compliance Lead) that a person has permission to leave the room in which they are detained.

The Public Health Commander could determine that detention should be served in an alternative location to a hotel, by writing a detention order to that effect.

Potential reasons for permission to grant leave from detention

There is a policy direction from the Deputy Chief Health Officer that permission to leave mandatory detention should be exceptional and always based on an individual review of circumstances.

In the following circumstances there could be consideration of permission grant after an application to the Deputy Chief Health Officer however this will require permission:

- A person who has a medical treatment in a hospital;
- A person who has recovered from confirmed COVID-19 infection and is released from isolation;
- An unaccompanied minor (in some circumstances – see below);
- Instances where a person has a reasonably necessary requirement for physical or mental health or compassionate grounds to leave the room, as per the detention notice.

Note that the last category is highly subjective. This means it is the expectation of the authorising environment that exemption applications on those grounds are made on exceptional circumstances.

Process for considering requests for permission to leave or not have detention applied

It is critical that any procedure allows for authorised officers to be nimble and able to respond to differing and dynamic circumstances impacting people who are detained, so that the detention does not become

arbitrary. The process outlined here reflects their ability to make critical decisions impacting people in a timely manner.

Matters discussed with Legal Services on this matter should copy in REDACTED and Ed Byrden.

Considerations

Any arrangements for approved leave would need to meet public health (and human rights) requirements. It will be important that the authorised officer balances the needs of the person and public health risk. For example, if the person needs immediate medical care, public health risks need to be managed appropriately, but the expectation is that the leave would automatically be granted. This would be more nuanced and complex when the request is made on compassionate grounds where there is a question about how public health risks might be managed. However, again, human rights need to be considered closely.

Requests in relation to the mandatory quarantine (detention) orders or permission to leave (for people in detention) should be rapidly reviewed by staff in the call centre function, and should always be funnelled through the COVID Directions inbox. That will allow that inbox to be a complete repository of all categories of requests for permission, exceptional circumstances requests and advice / exemption requests.

There should then be a presumption that these requests are forwarded immediately (within two hours) to COVID-19.vicpol@dhhs.vic.gov.au for review by an Authorised Officer working directly to the Director lead for compliance and enforcement, as these are a high priority category of request.

Temporary leave from the place of detention (Detention notice)

There are four circumstances in which permission may be granted:

1. **For the purpose of attending a medical facility to receive medical care**

- D/CHO or Public Health Commander will consider circumstances determine if permission is granted. See *Policy on permissions and application of mandatory detention*. AO must be informed so they are aware.
- In particular circumstances, an on-site nurse may need to determine if medical care is required and how urgent that care may be. DHHS AO officers and on-site nurse may wish to discuss the person's medical needs with their manager, on-site nurse and the Director, Regulation and Compliance officer to assist in determining urgency and whether temporary leave is needed.
- Where possible, on-site nurses should attempt to provide the needed medical supplies.

2. **Where it is reasonably necessary for physical or mental health; or**

See policy on permissions and application of mandatory detention

- D/CHO or Public Health Commander will consider circumstances to determine if permission is granted. See *Policy on permissions and application of mandatory detention.*AO must be informed so they are aware.
- If approval is granted:
  - the AO must be notified
  - persons subject to detention are not permitted to enter any other building that is not their (self-isolating) premises
  - persons subject to detention should always be accompanied by an on-site nurse, DHHS authorised officer, security staff or a Victoria Police officer, and social distancing principles should be adhered to
- a register of persons subject to detention should be utilised to determine which detainees are temporarily outside their premises at any one time.

3. **On compassionate grounds;**

- D/CHO or Public Health Commander will consider circumstances to determine if permission is granted. *See Policy on permissions and application of mandatory detention*
- The AO must be notified if a detainee has been granted permission to temporarily leave their room and under what circumstances.

4. **Emergency situations must also be considered.**

- DHHS authorised officers and Victoria Police officers may need to determine the severity of any emergency (such as a building fire, flood, natural disaster etc) and the health risk they pose to detainees
- if deemed that numerous detainees need to leave the premises due to an emergency, a common assembly point external to the premises should be utilised; detainees should be accompanied at all times by a DHHS authorised officer or a Victoria Police officer, and infection control and social distancing principles should be adhered to
- the accompanying DHHS authorised officer or a Victoria Police officer should ensure that all relevant detainees are present at the assembly point by way of a register of detainees.

The process for a person not yet in detention is:

- Members of the public who wish to ask for detention not to be applied, or permission to be granted to leave, have the option of submitting a request in writing to the COVID Directions inbox;
- Authorised officers should also use the COVID Directions inbox to submit requests for detention not to be applied or permission to be assessed so that the COVID Directions inbox is a complete funnel for handling these requests;
- All requests for permission that are considered are logged on the secure MS Teams site established by Legal Services in a manner that can be audited and reviewed by any party in this compliance chain;
- The Director of Health Protection and Emergency Management (lead for COVID-19 Directions) who oversees the inbox and team managing this process assesses the merits of the individual proposal – including through delegates - and applies judgment as to whether the application should proceed to the next step. There is a policy view – outlined in this Plan – that exceptional circumstances are generally required for the Authorised Officer to NOT issue a notice of detention for an overseas arrival;
- If a request is determined to require to proceed, it should then be sent to COVID-19.vicpol@dhhs.vic.gov.au for review by the AO reporting directly to the Direct E+C;
- The Compliance Lead will seek legal advice and a discussion with the Deputy Public Health Commander urgently if required;
- The outcome will be recorded in writing and communicated back to the COVID Directions team and requestor in writing.

Policy on unaccompanied minors

Instances where an unaccompanied minor is captured by a detention order must be managed on a case by case basis.

In general, there is a presumption that there are no exemptions granted to mandatory quarantine. The issues in relation to mandatory quarantine of unaccompanied minors include: where this occurs, and with what adult supervision.

Preliminary legal advice is that the State could issue a detention order to a person under 18 years who is unaccompanied outside the home (a person in the care of the state) if certain conditions are met. These must include:

- AO has to check in regularly;
- Person can easily contact parent / guardian;
- Has adequate food;
- Remote education is facilitated.

A draft detention notice is being put together by Legal Services should this be required.

When an unaccompanied minor normally resides outside Victoria

It is proposed that where there is no clear alternative, an unaccompanied minor who normally resides outside of Victoria may be facilitated to undertake detention in their normal home state of residence, with appropriate risk management of any possible exposures to others on a domestic flight out of Victoria to that state. The department will need to be satisfied that the receiving state will take the person under 18 years and manage public health risks.

When an unaccompanied minor is normally resident in Victoria

It is proposed that an adult (who is not themselves a returned overseas traveller) who supervises a minor should join that minor at a place of detention. If that occurs, the adult should then remain with that person in quarantine although there is no legislative power to issue a direction to that adult to detain the adult.

If an unaccompanied minor who normally resides in Victoria is unable to be joined by a parent / guardian (for example because that parent / guardian has other caring duties and cannot thus join the minor in detention) then on a case by case basis, an assessment will be undertaken to identify whether detention is to be served in the home.

Whilst it may be acceptable for older children (16 – 18 year old) to be in quarantine without their parent(s) or guardian, it's likely to be unacceptable for younger children (12 or 13 years old or younger) and in that situation it's more appropriate to defer an alternative arrangement (i.e. parents join them in quarantine or quarantine at home).

If a child is quarantined at home with their parents, a detention notice should still be provided to the child and parents outlining the same requirements for children as if they were in quarantine in a hotel, together with the guidance about advice to close contacts in quarantine. Legal services will adapt notices for that purpose.

Authorised officers monitoring unaccompanied minors have current Working With Children Checks and understand their reporting requirements under the Reportable Conduct Scheme.

When a minor is detained at their home

If it is determined to be appropriate to detain a child at home after a risk assessment, the arrangement will involve:

- Issuing a detention order naming the specific home and / or parts of the home, and
- The detention order will be accompanied by advice on minimising risk of transmission to others in the home where the minor is detained (equivalent to advice to close contacts in quarantine); and
- An Authorised Officer will undertake a process to undertake a review each day in the manner required by the Act.

When an unaccompanied minor is detained in a hotel

If an unaccompanied minor is detained in a hotel without parents, a specific notice and process is below.

- A Detention Notice – Solo Children, is found at Appendix 1.
- A guideline for authorised officers in this respect is found at Appendix 2.

This is a more intensive process for the authorised officers, which is commensurate with the additional risk of quarantining a child because the child is subject to the care of the Chief Health Officer and department.

Working with Children Checks and Child Safe Standards

DHHS will work with Department of Justice and Community Safety to facilitate Working With Children Checks for Authorised Officers.

Escalation of issues

Should an AO become aware of any concern about a child, the AO must:

- contact the department's welfare teams immediately. Child Protection contact details for each Division: https://services.dhhs.vic.gov.au/child-protection-contacts. West Division Intake covers the City of Melbourne LGA: REDACTED
- contact after hours child protection team on REDAC if an AO thinks a child may be harmed and Victoria Police on 000 if the immediate safety of a child is at risk.

Release from mandatory quarantine (detention) after 14 days

The fourteen-day period is calculated from the day following arrival of the person in Australia and ends at midnight fourteen days later.

DHHS Authorised Officer prior to release should:

- review the case file and ensure the 14 day detention has been met.
- liaise with on-site nurse to check the detainee meets the following – i.e. no symptoms of COVID-19 infection.
- any physical checks of the room (damage, missing items, left items etc).

Supporting detainee to reach their preferred destination:

- DHHS organise for the detainee to be transported to their destination by completing a cab charge, Uber or appropriate mode of transport.
- Release from isolation criteria are as per current DHHS Victoria guidelines (based on the SoNG).

DHHS AO to update the business systems database with details of release.

Options to facilitate compliance

DHHS authorised officers should make every effort to inform the person of their obligations, facilitate communication if requested and explain the important rationale for the direction. The following graduated approach should guide an DHHS authorised officer:

- explain the important reasons for detention, that is this action is necessary to reduce the serious risk to public health **(mandatory obligation)**
- provide the person subject to detention with a fact sheet and give opportunity to understand the necessary action
- provide the person subject to detention opportunity to communicate with another person, including any request for a third-party communicator (such as translator), family member or friend (**mandatory obligation)**
- seek assistance from other enforcement agencies, such as Victoria Police, to explain the reason for detention and mitigate occupational health and safety concerns
- discuss matter with on-site nurse to ascertain if there are any medical issues that may require consideration or deviation from the intended course of action
- issue a verbal direction to comply with the Direction and Detention Notice

- advise that penalties may apply if persons do not comply with the Direction and Detention Notice
- recommend that Victoria Police issue an infringement notice if there is repeated refusal or failure to comply with a direction
- recommend Victoria Police physically detain the non-compliant individual for transfer to another site.

DHHS Authorised Officers should make contemporaneous notes where a person is uncooperative or breaches the direction.

Transfer of uncooperative detainee to secure accommodation (refer to Authorised Officer review of transport arrangements procedure)

It is recommended that a separate mode of transport is provided to uncooperative detainees to hotel or other for 14-day isolation.

Ensure appropriate safety measures are taken including child locks of doors and safety briefing for drivers etc.

Unauthorised departure from accommodation

If there is reason to believe a person subject to detention is not complying with the direction and detention notice, the DHHS authorised officer should:

- notify on-site security and hotel management
- organise a search of the facility
- consider seeking police assistance
- notify the Director, Regulatory Reform if the person subject to detention is not found

If the person is located, DHHS authorised officer should:

- seek security or Victoria Police assistance if it is determined the person poses a risk of trying to leave
- provide an opportunity for the person to explain the reason why they left their room
- assess the nature and extent of the breach, for example:
  - a walk to obtain fresh air
  - a deliberate intention to leave the hotel
  - mental health issues
  - escaping emotional or physical violence
- assess possible breaches of infection control within the hotel and recommend cleaning
- consider issuing an official warning or infringement through Victoria Police
- reassess security arrangements
- report the matter to the Director, Regulation Reform.

DHHS Authorised Officers should make contemporaneous notes where a person is uncooperative or breaches a direction.

Occupational health and safety for Authorised Officers

See **Appendix 3** for Occupational health and Safety measures.

Logistics for Mandatory Quarantine

Deliverables of the logistics function

The Director of the Office of the Secretary in DJPR role is responsible for:

- contract management with accommodation providers;
- transport arrangements from the airport;

- material needs including food and drink.

Airport and transit process

The lead for this situation is the DHHS Authorised Officer.

Passengers pass through immigration, customs and enhanced health checks before being transferred to their hotel.

- Every passenger is temperature checked by a registered nurse (RN) contracted by DHHS.
- Every passenger is handed a copy of the direction and a detention notice by a DHHS Authorised Officer (AO) authorised under the emergency provisions of the *Public Health and Wellbeing Act 2008*.
- Every passenger is provided an information sheet by DHHS.
- Passengers are met by VicPol/Border Force and escorted to organised buses for transport to the hotel.
- Every passenger is given a single-use facemask to wear while in transit to their hotel room.
- Every passenger is given a welfare survey to fill out on the bus or at the hotel.

Health and Welfare for Mandatory Quarantine

This section of the plan outlines the arrangements in place to provide welfare and medical, nursing and mental healthcare to individuals detained in mandatory quarantine.

Deliverables of the health and welfare function

The Deputy State Health Coordinator role is responsible for:

- provision of healthcare to detainees;
- provision of welfare to detainees through the Director Health Protection and Emergency Management;
- ensuring the safety and wellbeing of detainees and staff;
- ensuring a safe detention environment at all times.

Welfare in mandatory quarantine

Potential threats to health and wellbeing of people in mandatory detention

Potential risks associated with detention of returned travellers for compulsory 14-day quarantine can broadly be divided in physical or mental health risks.

Physical risks	Mental health risks
Transmission/development of COVID-19	Family violence
Transmission of other infectious diseases	Depression
Other medical problems	Anxiety
Diet – poor/imbalanced diet, food allergies/intolerances, over-consumption	Social isolation/loneliness
Lack of exercise	Claustrophobia
Lack of fresh air	Drug and alcohol withdrawal
Smoking – nicotine withdrawal, risk of smoking within rooms/fire hazard	Self-harm
Injury	

Tiers of risk for persons in mandatory detention

- Residents will be triaged into three tiers of risk. The type of welfare check will depend on the tier the passenger falls into.
- For phone calls (tier 1 and tier 2), translators must be available as needed. Language requirements should be recorded on arrival at the hotel and provisions made as required.
- Automated text messages are sent to all passengers in tier 3 via Whispir.
- Residents may be moved between risk tiers throughout their quarantine period as need dictates. The following table is an initial framework for triaging the type and frequency of welfare check required.

Risk Tier	Risk factors	Welfare check type
Tier 1	Residents with suspected or confirmed COVID-19 Families with children < 18 years	Daily phone call

	Passengers aged > 65 years Aboriginal and Torres Strait Islander peoples Residents with underlying comorbidities (e.g. respiratory or cardiac conditions) Residents with a history of mental illness	
Tier 2	Those who indicate they require a phone call but do not have any other risk factors. Residents who are by themselves.	Phone call every second day
Tier 3	Low risk – everyone else.	Daily text message (via Whispir)

Arrival at hotel – check in

At hotel check-in:

- Detainee provides Direction and Detention Notice to hotel staff; hotel staff to write on the notice:
  - room number
  - the date that the person will be detained until (14 days after arrival at place of detention).
- Detainee provides completed Direction and Detention Notice to authorised officer to confirm that the following details on the notice are correct:
  - the hotel name;
  - hotel room number and arrival date, time and room on notice;
  - the date that the person will be detained until (14 days after arrival at place of detention).
- AO must take a photo of the person's Direction and Detention Notice and enters this into database.
- Following any medical and welfare check of the person, AO to liaise with nurses to identify detainees with medical or special needs. The AO must refer this information to the nurse or doctor if needed.
- AO to note detainees with medical or special needs, such as prescription and medical appointments, significant medical history or mental health history, or history of anaphylaxis (this list is not extensive).

Persons will be sent to their allocated room and informed that a person will contact them in the afternoon or next day (if non-urgent).

Welfare and health service provision

Welfare checks are being undertaken on residents. The welfare checking process includes phoning a subset of residents each day and conducting long and short surveys. Referrals to the nurse, social supports, the concierge and the department's Authorised Officers are taking place as a result. An on-call Complex Care Team is also in place to support residents with more complex needs.

- Residents will have a welfare check (as specified below) each day.
- DHHS welfare officers conducting welfare checks phone and email covid-19.vicpol@dhhs.vic.gov.au and authorised officer individually to alert authorised officers of medical and welfare issues.
- Residents will be provided with a resident satisfaction survey to complete each week. Any concerns raised on the survey will be escalated and managed as appropriate.
- Residents can seek review by the nurse 24 hours a day if required.
- 24 hour on-call medical support will be available to detainees at all sites. This will initially be provided by a Field Emergency Medical Officer (FEMO), and subsequently through a locum general practice service.

- Medical care is organised by Deputy State Health Coordinator. Deliverables include:
  - Primary care assessments: 24 hour access to general practitioners;
  - Prescription provision;
  - 24 hour access to nursing assessment;
  - Access to mental health services as needed.
- It is advisable that where possible, individuals who are in detention are linked to receive telehealth care from their normal general practice provider.

Conduct of a welfare check

A welfare check will allow passengers to be assessed for medical and social issues, and concerns flagged and responded to. These issues include but are not limited to health, mental health, safety and family violence concerns. A welfare check will be conducted by a DHHS officer which is included as a script at **Appendix 4.** Welfare checks are made from the DHHS welfare call centre.

Safety / mental health

If there are concerns about the safety or mental health of passengers, the process is as follows:

- The nurse will review via phone or in person if required with appropriate PPE.
- If escalation is required, the nurse will contact the Anxiety Recovery Centre Victoria for psychosocial support.
- If there is deemed to be an acute risk to the detainee, Mental Health triage at RMH/the Alfred can be contacted.
- If the person is acutely unwell, at serious risk, at risk of self-harm or expressing suicidal ideations, or if the nurse/doctor requests this, urgent ambulance should be arranged by calling 000 to take the person to the emergency department.
- If mental health concerns, at least once daily welfare check phone calls should be implemented thereafter if not already implemented.

Family violence (FV)

If there are concerns about family violence / the safety of women and children, the process is as follows:

- Case worker is called to review via phone initially or in person if required (with appropriate PPE).
- A separate room may need to be organised to facilitate the review away from the other family members.
- If deemed necessary, separate rooms should be organised to separate the family members.
- Case worker to review again as required.

Alcohol and other drugs

If there are concerns about alcohol or other substance abuse or withdrawal:

- Request nurse or medical review.
- Provide numbers for support services (listed below).
- Preference for provision of standard drinks to a limit rather than prescribing diazepam for alcohol withdrawal.
- Prescriptions – Schedule 8 prescriptions for drug-dependent patients can only be provided after discussion with the DHHS Medicines and Poisons Branch.
- If there are concerns about mental state/mental illness, escalate for urgent medical review.

Diet

- Ensure a well-balanced diet with options provided for those with specific dietary requirements.

- Ensure access to essentials within the room (e.g. snacks, tea and coffee) to limit the amount of interactions/contact required with staff.
- Ensure access to additional food if required.
- Ensure that food allergies are recorded and communicated to the catering providers.

Exercise and fresh air

- If the room has a balcony, ensure the residents can access it for fresh air.
- Advise residents to open windows/balconies where possible for fresh air and ventilation.
- If it is possible for residents to go outside to take some exercise for organised/supervised short periods of time, this should be facilitated where possible. Residents should ensure physical distancing is practised during this period. Only well residents from the same room should be able to go out to exercise at the same time.
- Residents should be provided with resources for exercise routines and yoga/meditation that they can perform safely within their rooms.

Procedure for a detainee / resident to leave their room for exercise or smoking

A person must be compliant and must not have symptoms before they could be allowed to have supervised exercise or a smoking break.

The steps that must be taken by the detainee are:

- Confirm they are well;
- Confirm they have washed their hands immediately prior to leaving the room;
- Don a single-use facemask (surgical mask);
- Perform hand hygiene with alcohol-based handrub as they leave;
- Be reminded to – and then not touch any surfaces internal to the hotel on the way out;

The procedure for the security escort is:

- Don a mask;
- Undertake hand hygiene with an alcohol-based handrub or wash hands in soapy water;
- Be the person who touches all surfaces if required such as the lift button, handles;
- Maintain a distance (1.5 metres) from the person;

There is no requirement to wear gloves and this is not recommended, as many people forget to take them off and then contaminate surfaces. If gloves are worn, remove the gloves immediately after the person is back in their room and then wash your hands.

Social and communications

- All residents should have access to **free** wifi/internet where at all possible.
- All residents should have access to entertainment such as television and streaming services (e.g. Netflix).
- All residents should have access to communications so that they can keep in regular contact with family and friends throughout the quarantine period.
- Toys and equipment should be provided for small children if possible.

Care packages for people in detention

A public health risk assessment has been conducted that indicates that care packages, such as food or toys, can be delivered for provision to people in detention. The care package should be provided to the hotel reception or other party for conveyance to the person in detention and should not be directly handed to the person in quarantine by the person gifting the care package. Ensuring the package passes

to the person in detention without misdirection or tampering is essential. There is no public health reason for an inspection of any care package.

Smoking policy for people in detention

As part of the emergency response to COVID-19, individuals have been confined within hotels while under quarantine. The movement of these people has been restricted to hotel rooms, without access to outdoor spaces, where they can smoke.

Current laws

Under the *Tobacco Act 1987* (Tobacco Act), smoking is prohibited in an ”enclosed workplace”, however, Section 5A (2) (g), provides an exemption for the personal sleeping or living areas of a premises providing accommodation to members of the public for a fee. This means that, while a hotel is considered an enclosed workplace, the hotel could allow the occupants of the rooms to smoke if they choose.

In many cases, hotels have implemented their own smoke-free policies in rooms as the smoke is likely to enter the centralised air conditioning systems resulting in occupants of other rooms and staff being exposed to the smoke. Smoke also remains on the surfaces of the room and permeates soft furnishings meaning that it remains in the room and exposes staff cleaning the room to the remaining residual smoke. The Department of Health and Human Services supports and encourages hotels to designate their rooms smoke-free.

If smokers were to be permitted to leave their rooms for supervised cigarette breaks, they would need to be taken to an area that does not constitute an enclosed workplace. This might be a balcony, roof top or other outdoor area. This area should preferably be away from open windows, doors and air conditioning intake points.

COVID-19 and smoking

The World Health Organization (WHO) has advised that any kind of tobacco smoking is harmful to the bodily systems, including the cardiovascular and respiratory systems, and puts smokers at greater risk in the context of COVID-19. Information from China, where COVID-19 originated, showed that people with cardiovascular and respiratory conditions, including those caused by smoking, were at higher risk of developing severe COVID-19 symptoms and death.

The Victorian Chief Health Officer has recommended that quitting smoking reduces the health risks associated with COVID-19.

Other examples of restricting access to smoking

There are some precedents of people being confined to facilities where they are unable smoke. This includes mental health facilities, prisons and, if people are unable to leave, hospitals. In these circumstances, individuals are supported to manage cravings using pharmacotherapies such as nicotine replacement therapies.

Victoria's Charter of Human Rights and Responsibilities

Removing the ability to smoke would be compatible with the *Charter of Human Rights and Responsibilities Act 2006 (the Charter)*, as it would be for the purposes of protecting the right to life. Section 9 of the Charter states that “Every person has the right to life and to not have their life taken. The right to life includes a duty on government to take appropriate steps to protect the right to life.”

Options

Option 1: Provide support for smokers to quit or manage cravings (Recommended)

The preferred option, for both the benefit of the individual and broader community would be to support smokers to quit or manage withdrawal while confined to their hotel room. This would mean that smokers be supported to manage cravings while they are unable to smoke but would not be forced to quit.

This could be easily managed through the provision of approved nicotine replacement therapies (NRT), with meal deliveries, accompanied by counselling through the Quitline. Quit Victoria has recommended a box of patches and an intermittent form of NRT such as a spray. These items are available for purchase without a prescription from a range of retailers including pharmacies and some big supermarkets.

Other pharmacotherapies, like zyban or champix, would require a prescription from a GP and are designed to help people completely quit as opposed to a short-term measure for people who are forced to stop smoking abruptly. These medications can take a while to take effect and, with champix, the advice is to continue smoking until it starts to impact on your cravings which means that it would not be an appropriate option for the circumstances.

Addiction to cigarettes includes both nicotine dependence and a behavioural and emotional dependence, which is why counselling plus pharmacotherapy is required. Someone who is heavily addicted will crave a cigarette every 45-60 minutes.

Telephone counselling is available via the Quitline - 13 78 48

Even if someone doesn't want to quit, Quitline can help them reduce the number of cigarettes they smoke.

People can also contact their regular general practitioner via telehealth.

Option 2: Relax no smoking restrictions for the hotel rooms

While it would be legally possible to enable people in quarantine to smoke in their rooms, this option is not recommended. This would have an adverse impact on hotels and their staff and goodwill in the circumstances. It would also increase the health risks of individuals potentially already at risk of COVID-19.When sharing a room with children, smoking should not be allowed.

Option 3: Accompany individuals to leave the room to smoke

While it would be possible to create a smoking area for people wishing to smoke, such as in an outdoor drinking area attached to a bar or restaurant facility, this option is not recommended. Allowing people to leave their hotel rooms to smoke undermines the quarantine restrictions being put in place. The individuals would need to be accompanied by security guards and might need to travel floors via lifts to access an outdoor area or leave the building.

Even if we assume, that the hotel is not currently operating for other customers, movement in the hotel creates an increased risk for staff and a need for greater vigilance in cleaning and maintaining distance.

<u>Current policy for smokers in mandatory quarantine</u>

The following actions should occur –

- Nicotine Replacement Therapy should be promoted strongly for smokers;
- Smoking restrictions should remain in relation to the room;
- Only where absolutely necessary, and in exceptional circumstances, a person in mandatory quarantine could be granted permission to leave their room under specific circumstances, where public health risk is managed:
  - The Authorised Officer is aware and grants permission;
  - They are accompanied by security, who are provided PPE to wear;
  - They are instructed to – and follow the instruction – not to touch surfaces en-route to the smoking area and coming back;
  - They return immediately to their hotel room.

Other health and wellbeing issues

- All residents should be given the contact information for support services such as Lifeline and Beyond Blue at the beginning of their quarantine period (the information sheet they are provided with at the airport should also have these contact numbers).
- Residents should have access to fresh bedlinen and towels as required.
- Care packages may be permitted for delivery to residents (via hotel reception).
- Residents can be provided with up to three standard drinks per day if there is a risk of alcohol withdrawal (this is in preference to prescribing benzodiazepines for withdrawal).
- Other residents can also request alcoholic drinks as part of their food and drink provisions.
- Smoking breaks or NRT should be offered to all smokers if feasible.
- Residents may request help with cleaning and room hygiene if needed.
- Provision of resources to facilitate education and online learning for children

All reasonable requests should be facilitated where possible, to ensure that persons in detention are as comfortable as possible during their mandatory quarantine period.

Medical care in mandatory quarantine

Coordination of medical care

Due to the large number of detainees, the high risk environment and length of time in detention, and the potentially complex needs of detainees, a **Medical Lead** should be appointed to oversee the medical care of all detainees, as provided by the doctors and nurses contracted. The Medical Lead should have a healthcare background and have experience managing complex programmes such as this. They will oversee the staffing of the various sites, reassess medical workforce needs, provide advice to staff, and ensure the minimum standards of care are being met.

They should identify any risks or issues and refer these to the Compliance Lead to urgently address. They should be a senior point of contact for the Compliance Lead, the State Emergency Controller / DHHS Commander, and the Public Health Commander and Deputy Public Health Commander for Physical Distancing.

Standards of care

The health and welfare of persons in detention is the highest priority and the main purpose of this plan. Mandatory detention for 14 days is not without health and mental health risks and requires a high standard of medical care to be provided to persons in detention at all times to mitigate this risk.

Medical records

Each detainee must have a medical record accessible to all health care providers who require access to it and who are providing care. This record must state the person's significant medical history, current medications, allergies and any other significant components of the medical history. Each time health care is requested **and** provided it must be documented in this record. This record is confidential and should only be accessed by persons coordinating and providing care for the person. If the Authorised Officers require information, they can take this from the welfare survey the detainee completes when they first enter detention.

Accurate and comprehensive medical record keeping is essential for the health and safety of all detainees and will ensure continuity of care for healthcare providers in subsequent shifts. These records should be stored securely and should not be accessed by anyone not providing medical care. If medical

notes are recorded on paper, these should be stored securely and uploaded on to the information management system as soon as is practicable.

Physical examination standards

When a detainee requires medical assessment, they are entitled to receive the highest standard of medical care including physical examination if indicated. It is not appropriate to defer or delay physical examination (if it is indicated), because the person is in mandatory quarantine. All requests for, and findings from physical examinations should be documented in the medical record, as described above. If a healthcare provider refuses to see a patient that the have been requested to see, the reason should be record in the notes.

Sufficient and appropriate PPE should be provided. If this is not available, it should be flagged immediately to the team leader/site manager to arrange for urgent stock to be delivered from another site. If appropriate PPE is worn and used correctly, there should be no additional risk to the health care provider, or the patient (detainee).

Phone consults or telemedicine should not be used as a substitute for direct clinical review if it is clinically indicated. If healthcare providers are concerned for their own safety, the case should be escalated to the Medical Lead. Security may be able to assist if necessary.

Triage and waiting times

On-site medical care is provided by nursing staff and general practitioners. Requests for medical care must be actioned within a determined time frame, in keeping with the acuity of the issue and the availability of services. Where staffing allows the doctor may see patients before the nurse, particularly if the request is deemed urgent. Where appropriate, non-urgent issues

- For emergency medical care see below.
- For physical medical issues requiring urgent medical review but not 000, the detainee must be reviewed within 30 minutes by the hotel nurse (by contacting the hotel nurse direct line) who should review the patient in person and alert the on-call doctor to arrange urgent review if required. The GP should attend as soon as possible and within 2 hours.
- For matters requiring medical review (require assessment and management) that is not classified as urgent or emergency, the detainee must be reviewed by a nurse (within 4 hours) first then the on-call doctor must be contacted to arrange review depending on the acuity of the issue but within an 8 hour period.
- For urgent mental health issues, the patient should be reviewed by the nurse or doctor-on-call within 1 hour. Where a detainee may pose a risk of harm to themselves or others, a full risk assessment must be conducted by the doctor-on-call and escalation as per current policy – see safety and mental health section.
- For all other issues, review by the on-call doctor should be arranged within 24 hours.
- For new prescriptions of regular medications, these should be arranged within a 24-hour turnaround period.
- For urgent prescriptions required same day, these should be arranged within 8 hours.

Acuity of issue	**Time frame for response**
Minor health issue, non-urgent	Phone review as soon as practicable Nurse assessment within 8 hours GP review (if required) within 24 hours
Non-urgent issue requiring review and management	Nurse review within 4 hours GP review (if required) within 12 hours

Urgent request by detainee or mental health concerns	Nurse / mental health nurse review as soon as practicable (within 30 minutes) GP review within 2 hours
Emergency: serious health concern / life-threatening issue	Call 000 ASAP

Access to essential medications

All detainees should have timely access to the medication they require, be it prescription or over the counter (OTC) medications.

Audit of medical care

Medical care provided by doctors and nurses contracted by DHHS will be audited regularly. The audit process may consist of, but is not limited to, the following:

- Assessing waiting times for delivery of care
- Record-keeping and review of medical records
- Detainee medical care satisfaction surveys
- Number of repeat requests for medical care/escalation
- Number of risks reported
- Feedback from authorised officers and other organisations involved/staff.

Personal protective equipment

As above, PPE stocks should be checked regularly by the team leader/ manager, and urgently requested if needed. Regular stocktake should be undertaken to pre-empt additional orders. A supply of P2/N95 masks and gowns should be maintained, in addition to single-use face masks and gowns.

Healthcare providers and workforce

In addition to the above, doctors and nurses must report any risks or concerns to the Medical Lead, for individual patients/detainees or from the general environment. Doctors and nurses should report to the Medical Lead if they feel additional workforce are required for their site.

Test results

It is the responsibility of the doctor who orders the test (COVID-19 or otherwise) to follow up on the result and notify the patient in a timely manner. If they cannot/ if they will not be available to do so, they must handover this task to the next doctor and record this in the medical record or test log book. A list of all detainees who have had COVID-19 swabs should be sent to the department each day. This will also serve as a safety net for the department to notify the patient if the treating doctor hasn't already.

Clean rooms

Though not directly medical care, all detainees have the right to a safe and comfortable room and environment. Detainees may not be able to upkeep their rooms for various reasons, which may affect their physical and mental health. If cleaning cannot be regularly provided, all efforts should be made to assist the detainee with cleaning their room. In rare instances the detainee may need to be moved out of the room, and staff don full PPE to provide a rapid cleaning of the room. This should only occur in rare instances where the detainee is not capable of doing so themselves.

Models of care

The following care models will be continually assessed, audited and scaled up accordingly.

Emergency Health Care

In a medical emergency, an ambulance should be called on 000. This call may be made by anyone - a resident, nurse, GP or other staff member on site. **There is no requirement for residents to access or notify on-site staff prior to calling 000 in an emergency.** Ambulances attending the hotels should be given free access to the patient for whom the ambulance has been called. In the event the transport of a patient is necessary, refer to "Transports to hospital" below.

Nursing

Agency nurses suppled from "Your Nursing Agency" (YNA) are in place at each hotel on a 24/7 basis. The required nursing complement is continually reviewed according to the caseload and case types being reported at each hotel.

The current nursing complement at each hotel is:

- One Emergency Department (ED) trained registered nurse available 24/7
- Two general registered nurses available from 7.00am to 9.30pm
- One general registered nurse available from 9.00pm to 7.30am

In addition, mental health registered or enrolled nurses are being engaged at hotels where a growing mental health caseload is being identified. Currently, this is in place at Crowne Plaza, Crown Metropol and Crown Promenade with a view to rolling out to all quarantine sites.

A department-supplied mobile phone is provided to the nurses at each site. Residents can access the nurse either directly by phone, or via the hotel concierge.

The complement of nurses can be increased or decreased according to demand, by contacting the Public Health Logistics unit (publichealth.logistics@dhhs.vic.gov.au).

Primary care

General Practitioners (GPs) supplied by Medi7 and Doctor Doctor are providing 24/7 medical support to residents. GPs are currently being engaged at a ratio of one GP per two quarantine sites, with twice-weekly teleconferences between the Deputy State Health Coordinator and the directors of Medi7 and Doctor Doctor to review workload and vary this ratio if necessary.

GPs attend in person from 8.00am to 6.00pm daily and revert to telehealth arrangements at night.

GPs are currently available at the following locations:

- Crown Promenade – 2 GPs
- Park Royal, Tullamarine – 1 GP
- Rydges on Swanston – 1 GP
- A further GP will be on-site at Crown Promenade from Saturday 11 April to provide support to the extra hotels opening in the vicinity, and another on Monday 13 April.

GPs are contactable via the nurses at each location. After hours, the nurse may contact the on-call GP on REDACTED from 6.00pm each night). The on-call GP can provide telehealth services as required or attend the relevant hotel.

Over long weekends and public holidays, a fleet of 8-10 deputising GPs is accessible to the on-site GPs should further assistance be required.

Mental Health

Mental health services are available through the following sources:

- Nurse on site for initial assessment
- Doctor on-call for non-urgent or urgent review
- NorthWestern Mental Health triage service
- Call 000, urgent ambulance to emergency department
- Calling lifeline or beyond blue
- Detainees can also be assisted to contact their usual mental health providers (psychologists, counsellors, psychiatrists or other) via telehealth

Nurses and doctors can review persons with mental health concerns upon request by the detainee or other sources (e.g. if concern flagged by the welfare check, the authorised officer, security, other residents etc.). Mental state examinations can be carried out on site by general practitioners and an initial assessment made.

Melbourne Health's NorthWestern Mental Health triage service has been engaged from 28 March to provide specialist mental health support through direct or secondary consultation for persons in quarantine. Nurses and residents can contact **1300 TRIAGE** (**1300 874 243**) for specialist mental health support.

If there is concern about a mental health emergency in a detainee (i.e. acute suicidal ideation, thoughts of self-harm, or psychosis), and there is a delay in contacting the psychiatric triage team (**1300 TRIAGE**), the detainee should be reviewed by the doctor on-call as a matter of urgency and have a risk assessment completed. The doctor on call should then assess the detainee to determine if transfer to hospital via ambulance is required for urgent psychiatric assessment or if psychiatric advice can be obtained over the phone. If the detainee is deemed as needing urgent psychiatric review and is not willing to be transferred for assessment, the doctor on call will need to decide if enacting the mental health act is appropriate.

As per other medical emergencies, the AO, reception or other parties do not need to be contacted before 000 is called.

Refer to the "Nursing" section above for further information on mental health nursing presence in the hotels.

Detainees can also contact Beyond Blue (**1300 22 4636**) and Lifeline (**13 11 14**) whilst in detention but must also be reviewed by the on-call doctor and a risk assessment performed. The department's Mental Health and Drugs Branch is exploring further proactive mental health resources with Beyond Blue.

Who can alert the welfare team to mental health concerns of a detainee?

A detainee, authorised officer, nurse or doctor, security, Vic Police, family members, or anyone else who has a concern about the mental health or wellbeing of a detainee can raise this concern to the welfare team. All concerns should be escalated as necessary and documented/recorded in the welfare system.

Chain of escalation for mental health issues

Situation	Responded to by	Escalated to	Reported to
Non-urgent mental health concern	Nurse or GP Regular healthcare provider by telemedicine	Mental health nurse Psych triage	Medical lead
Repeated mental health concerns / acute mental health concern	Mental health nurse or GP, urgent review Psych triage urgent review Daily physical welfare review thereafter	Ongoing mental health nurse management	Welfare lead Medical lead Compliance lead
Risk of self-harm / serious mental health concerns	Immediately phone 000 → Emergency Department Call GP/nurse to attend urgently	Emergency rnpatient tertiary care	Welfare lead Medical lead Compliance lead DPHC / PHC

Escalation to leads

Escalation to leads (Compliance, Medical, Welfare, DPHC, PHC, CHO) should be triggered in the following scenarios:

•

Pharmacy arrangements

The following pharmacies have been engaged to support the healthcare of detainees:

- Core Pharmacy Tullamarine, servicing Park Royal and Holiday Inn at Melbourne Airport
- Southgate Pharmacy, servicing Crown Metropol, Crown Promenade and Crowne Plaza
- Core Pharmacy Brunswick, servicing the remainder of sites and any new sites that come online into the future

These pharmacies will accept prescriptions emailed by the resident's usual GP or made by the on-site GP and have delivery arrangements in place to the relevant hotel.

These pharmacies have a billing arrangement in place with the department.

Southgate Pharmacy will be operating over the long weekend. The Core Pharmacies will be available in the event of urgent scripts being required, and Southgate Pharmacy can be used for urgent scripts from any hotel.

Should the existing complement of pharmacies prove incapable of meeting demand, extra pharmacies will be sought through engagement with the Pharmacy Guild.

Core Pharmacy Tullamarine: contact REDACTED 195 Melrose Dr Tullamarine. Email REDACTED

Southgate Pharmacy: contact REDACTED 3 Southgate Ave Southbank. Email REDACTED

Core Pharmacy Brunswick: contact REDACTED 69 Sydney Rd Brunswick. Email REDACTED

Pathology arrangements

Each site has a twice-daily pathology courier pickup, transporting swabs taken from that site to VIDRL.

Currently, the delivery of swabs to each hotel and the arrangement of couriers is being undertaken by RE REDACTED

The marking requirements for each swab in order to ensure appropriate delivery of results and prioritisation of testing are as follows:

- The pathology request slip must be clearly marked as a hotel quarantine swab – this could be included in the clinical details section or at the top of the form (e.g. “Swab for a person in mandatory quarantine in hotel Crown Metropol, room 1234”)
- There must be three identifiers on every swab and pathology request (name, DOB, address)
- The address must be listed as the hotel where the person is being quarantined, not their usual home address
- A phone number must be provided for every patient being swabbed
- The name and phone number of the testing clinician **and** the responsible Authorised Officer for the hotel should be included

A daily record of all detainees who have had swabs done and their details should be forwarded to publichealth.operations@dhhs.vic.gov.au each day.

Transport to hospital

Refer to “Process for transferring quarantined passengers to hospital”, April 2020.

In summary:

- Unplanned transfers occur via a phone call to Ambulance Victoria via 000 from the nurse or doctor. The nurse or doctor then notifies an Authorised Officer of the transport, who provides an information sheet to stay with the patient throughout the journey. The patient is then treated and transported by AV or Non-Emergency Patient Transport (NEPT) to hospital.
- Planned transfers occur via clinical staff at each hotel notifying the Authorised Officer of the transport and arranging transport via the most appropriate transport provider (e.g. AV, NEPT, Clinic Transport Service etc). The transport then occurs to the relevant location.

For all emergencies call 000 immediately.

Specific health issues

Severe allergies / anaphylaxis

Where detainees have severe allergies and a history of anaphylaxis, this must be recorded and flagged in the welfare survey completed on the way to or at the hotel. All detainees who require medications including antihistamines, corticosteroids and epipens should have an adequate supply of these. If they require an additional prescription for these this should be facilitated by the healthcare providers at the hotel and the nominated pharmacy as a matter of urgency. If a person reports that they are having an anaphylactic reaction, 000 should be called immediately. This does not need to be escalated to an AO (or any other member of staff, medical or non-medical) first – the urgent ambulance should be called immediately by whoever is first aware of the situation. The health of the detainee and the provision of

urgent healthcare is the priority in this medical emergency. The authorised officer can be informed as soon as is practicable thereafter.

Note: detainees may call 000 themselves in the event of an emergency, they do not need to do this via an AO, a nurse or reception in an emergency.

Food allergies

Detainees should report all allergies in their initial health and welfare survey, and indicate if they are severe, have a history of anaphylaxis, or have been prescribed Epipens. This must be filled out by every detainee. If no allergies are reported, they should record “no known allergies”. Detainees dietary requirements should be carefully recorded and communicated to the catering providers. It is the responsibility of the welfare team to ensure that food safety arrangements are in place and that this information is communicated to the catering staff.

Please refer to food safety plan.

Detection and management of COVID-19

Actions to detect and test for COVID-19 amongst people in mandatory quarantine

The following are the actions to enact this:

- Detainees will be asked daily (via phone or text) if they have symptoms consistent with COVID-19. These include but are not limited to fever, cough, shortness of breath and fatigue.
- The nurse onsite will be notified. The nurse will call the detainee (patient) and assess them over the phone. If face to face assessment is required, the nurse will assess them in the room with appropriate PPE.
- Security staff in PPE (masks and gloves) will accompany all nurses visiting hotel rooms. They will wait outside unless requested to enter by the nurses (full PPE is required to enter rooms).
- The nurse will assess the patient for symptoms of coronavirus. If deemed necessary, they will take swabs to test for COVID-19.
- If the patient is well enough, they can remain in quarantine at the hotel to await the test results. If they are sharing a room with another resident, they should be moved to a separate room if feasible and according to availability of rooms. If separation is not possible, they should practise physical distancing as far as is possible.
- If the test is positive and the patient is well, they can remain in quarantine at the hotel but should be moved to a separate section/floor of the hotel which is designated for confirmed cases. If they are sharing with other people, then arrangements such as a separate room or provision of PPE may be required, depending on the circumstances (for example it may not be feasible or appropriate to separate young children from parents).

Testing for COVID-19 in detainees

The following requirements relate to how testing is conducted by nursing (or medical) staff:

- That the pathology request slip be clearly marked that this is a hotel quarantine swab – this could go in the clinical details section or at the top of the form (as long as it’s included somewhere) –
  e.g. swab for a person in mandatory quarantine in hotel xx, room xx.
- That there be 3 identifiers on every swab and pathology request (name, DOB, address).
- That the address be listed as the hotel where the person is being quarantined (not their usual home address, as this will result in notification to a different health department).
- That a phone number is provided for every patient being swabbed.

- That the name and phone number of the testing clinician **and** the responsible AO for the hotel be included.

Record of testing

Within each hotel there should be a spreadsheet, case list or other record of all detainees who have had COVID-19 testing carried out. This should record the following details as a minimum dataset for each swab taken:

- Testing doctor (and time)
- Name of detainee tested
- Date of birth
- Usual address
- Contact number
- Email address
- Hotel address and room number
- Date of arrival
- Date of expected release from detention

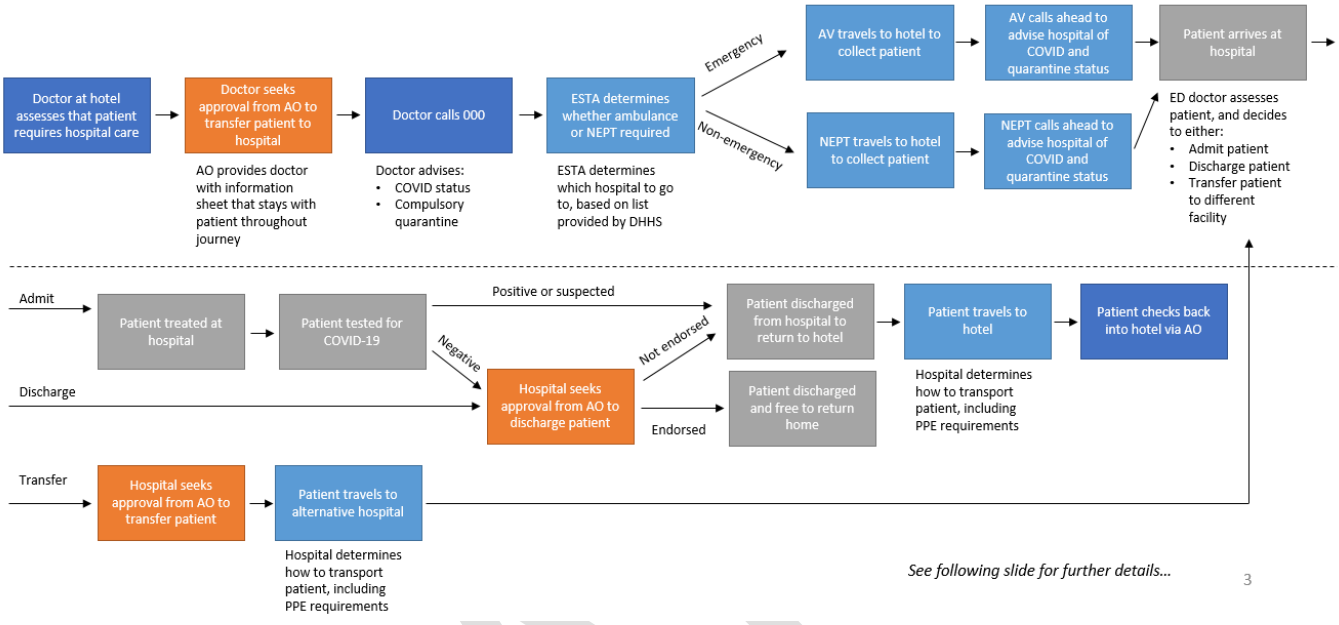
All COVID-19 swabs taken should be documented in this spreadsheet, even if the person has already had swabs taken while in quarantine. This spreadsheet should be sent to the COVID-19 operations team daily by emailing publichealth.operations@dhhs.vic.gov.au. This is so the Operations team are aware of the pending test results and can look out for them, and so that if details are missing from the swab/pathology slip, the specimen details can be cross-checked with this information, so the test is not lost.

Hospital transfer plan

- Passengers requiring hospital assessment/treatment for suspected or confirmed COVID-19 or other conditions, should be transferred to either the Royal Melbourne Hospital (RMH) or The Alfred Hospital, depending on proximity (**note children should be transferred to the Royal Children's Hospital**).
- If the hospital transfer is non-urgent, the nurse, doctor or AO may assist in arranging the transfer.
- If the hospital transfer is urgent, call 000 to request ambulance and inform them that the passenger is a suspected (or confirmed) case of COVID-19.
- Contact the Admitting Officer at RCH/RMH/the Alfred and inform the hospital of patient and details.
- Staff should don full PPE (droplet and contact precautions) and the passenger must wear a single-use surgical mask if tolerated.
- All relevant staff including AO must be notified prior to the transfer (but this should not delay the provision of urgent medical assistance or the request for an ambulance if needed).
- AO must view appropriate authorisation.
- The passenger should be transferred on a trolley or bed from ambulance into the designated COVID-19 ambulance reception area.
- The patient should be managed under routine droplet and contact transmission-based precautions in a negative pressure room if available. The patient should wear a single-use surgical mask if leaving the isolation room. Further PPE considerations should be determined by the treating doctors.
- Ambulance services will list the hotels as an area of concern in case of independent calls and will ask on site staff to assess need for attendance in the case of low acuity calls.
- All residents who are: in high risk groups, unwell, breathless or hypoxic (O2 sats <95%) should be considered for hospital transfer.

A flowchart for a process to transfer passengers to hospital in an unplanned manner is below.

Process to transfer passengers to hospital (unplanned)



LEGEND

- Patient at hotel
- Patient in transit
- Patient at hospital
- AO decision

HOSPITALS IN SCOPE

People subject to a direction and detention order will be housed in hotels in the Melbourne CBD. As such, it will only be practicable to transfer patients to hospitals in the inner-Melbourne area.

The following hospitals are in scope for unplanned presentations:

- Royal Women's Hospital
- Royal Children's Hospital
- Royal Melbourne Hospital
- The Alfred
- St Vincent's Hospital

INFORMATION SHEET

When the AO approves the patient to be transferred to hospital, the AO provides the hotel doctor with an information sheet that must stay with the patient throughout their journey.

The information sheet contains information to support AV/NEPT and the hospital to ensure the patient's compliance with the direction and detention notice, including:

- Key notice requirements (e.g. period of enforced quarantine)
- Room arrangements (e.g. single room only)
- Visitor requirements
- Security requirements
- Instructions for seeking AO endorsement to transfer or discharge the patient

Actions for confirmed cases of COVID-19 in people in mandatory detention

The following actions should be taken:

- Residents with confirmed COVID-19 should be accommodated / cohorted in a separate section/floor of the hotel, away from the non-COVID-19 infected passengers → the **RED ZONE.**
- A designated COVID-19 hotel may also be available at times during this response.

Personal protective equipment (PPE)

Staff who engage with monitoring or assisting persons in mandatory detention in person:

1. Apply standard infection prevention and control precautions at all times:
    a. maintain 1.5 metre distance

   b. wash your hands or use anti-bacterial agents frequently
   c. avoid touching your face.
2. Every situation requires a risk assessment that considers the context and client and actions required.
3. If you are not able to maintain a 1.5 metre distance and the person has symptoms (for example coughing) or is known to be a COVID-19 case use:
   a. fluid-resistant surgical mask (replace when moist or wet)
   b. eye protection
   c. disposable gloves.
4. If you need to be in a confined space (<1.5 metre) with a known COVID-19 case for more than 15 minutes, wear a single use facemask, eye protection and gloves.

Cleaning of rooms

Housekeeping services will not be provided routinely to residents. Fresh linen, towels and additional amenities can be left outside of rooms for residents to then collect. Biohazard bags can be left for residents to place dirty linen in and to leave outside their rooms for collection. Terminal cleaning is required on vacation of each room. Rooms that have been vacated will not be repurposed during the quarantine period.

Managing confirmed cases of COVID-19 entering mandatory quarantine

Persons may be diagnosed with COVID-19 while in mandatory quarantine. These cases will be managed as per the above procedures. They can be released from mandatory quarantine when they meet the current DHHS criteria for release from home isolation, with permission from the Compliance lead.

Confirmed cases of COVID-19 entering mandatory quarantine may arise in two different scenarios. A person may be:

1. Diagnosed before they arrive in Victoria from overseas, but they are still infectious / requiring isolation when they are detained (current infectious cases)
2. Diagnosed and meeting the criteria for release from isolation before they arrive in Victoria from overseas (recovered cases)

Current infectious cases

- In the situation that an arriving passenger is a current infectious case of COVID-19, they will still be handed the detention notice and will be placed in mandatory quarantine.
- They will be given a single use face mask to wear and will be kept separate from the other passengers where possible.
- At the hotel, they will be asked to provide confirmation of their diagnosis. If there is any doubt surrounding the certainty of the diagnosis of COVID-19, they may be tested again.
- These cases will be considered for release from detention once they meet the department's release from isolation criteria.

Recovered cases

- In the situation that a passenger states that they are a confirmed case of COVID-19 and have recovered from the infection, they will still be handed the detention notice and placed in mandatory quarantine.
- The onus on them is to provide the evidence that they have a confirmed case of COVID-19 and the required amount of time has passed such that they are no longer considered infectious.

- If they meet the criteria for release from isolation (see below) and provide the necessary evidence, they can be considered for release from detention.
- They will still be handed the detention notice until this can be verified and the request has been approved.

Note – there are no automatic exemptions for persons who are recovered cases. These requests need to be assessed on a case-by-case situation. The process for requesting non-ordering of detention in these cases is as per 'the process for a person not yet in detention outlined above.'

Release from isolation of confirmed cases in mandatory quarantine

Criteria for release from isolation

Confirmed cases of COVID-19 will be considered for release from mandatory quarantine, once they meet the department's criteria for release from isolation of a confirmed case:

- the person has been afebrile for the previous 72 hours, and
- at least **ten days** have elapsed after the onset of the acute illness, and
- there has been a noted improvement in symptoms, and
- a risk assessment has been conducted by the department and deemed no further criteria are needed

Clearance testing is not required for release from isolation, either in the home or in mandatory quarantine.

Process for release from isolation

As per the DHHS guidelines for health services and general practitioners, the department will determine when a confirmed case no longer requires to be isolated in hospital or in their own home, in consultation with the treating clinician.

- In this case, the treating clinician is considered the medical practitioner looking after the cases in that hotel.
- Every confirmed case that is diagnosed in Victoria is notified to the department, and assigned a case and contact officer (CCO), regardless of whether they are diagnosed in detention or outside of detention. Every confirmed case receives daily contact from the case and contact team.
- The CCO will advise when it is appropriate for consideration for release from isolation, and will issue a clearance certificate (via email) to the case when they meet the criteria for release from isolation.

Nurses looking after confirmed cases in detention should temperature check and review symptoms of confirmed cases daily. The date of acute illness onset should be clearly documented in their records.

If a confirmed case is due for release from mandatory quarantine, but does not meet the department's criteria for release from isolation, they will not be detained longer than the 14-day quarantine period. They will be released from detention at the agreed time, but will be required to self-isolate at home or at other accommodation until they meet the required criteria. In this case they will be subject to the self-isolation direction. They will be given a single-use face mask to wear when checking-out from the hotel and in transit to their next destination. They will be provided with a 'confirmed case' information sheet.

Authorised Officer Protocols

Authorised officer* and Chief Health Officer obligations

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

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

Any AO that is unsure as to whether they been authorised under s.199 should contact administrative staff in the department's Health Protection Branch prior to enforcing compliance with the Direction and Detention Notice.

Exercising this power imposes several obligations on departmental AOs including:

- producing their identity card for inspection prior to exercising a power under the PHWA
- before the person is subject to detention, explaining the reason why it is necessary to detain the person
- if it is not practicable to explain the reason why it is necessary to detain the person, doing so as soon as practicable
- before exercising any emergency powers, warning the person that refusal or failure to comply without reasonable excuse, is an offence
- facilitating any reasonable request for communication made by a person subject to detention
- reviewing, every 24 hours, whether continued detention of the person is reasonably necessary to eliminate or reduce a serious risk to health
- giving written notice to the Chief Health Officer (CHO) that a person:
  - has been made subject to detention
  - following a review, whether continued detention is reasonably necessary to eliminate or reduce the serious risk to public health.

The notice to the CHO must include:

- the name of the person being detained
- statement as to the reason why the person is being, or continues to be, subject to detention.

Following receipt of a notice, the CHO must inform the Minister as soon as reasonably practicable.

** A departmental Authorised Officer under the PHWA that has been authorised for the purposes of the emergency order*

Use of a Business System – Quarantine and Welfare System COVID-19 Compliance Application

The Quarantine and Welfare System is comprised of two applications:

- COVID-19 Compliance Application - This application supports Authorised Officers to maintain Detainee and Detention Order records
- COVID-19 Welfare Application (not part of Authorised Officer responsibilities).

A **User Guide** is available to guide Authorised Officers.
Support email for users: **ComplianceandWelfareApplicationSupport@dhhs.vic.gov.au**
Support will be active between 8am and 8pm. You can email support for access issues, technical issues, application use questions. A **phone number** will also be provided shortly

Authorised officers and powers

Authorisation under section 200 for the purposes of the emergency order

Only departmental AOs under the PHWA that have been authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the PHW can exercise emergency powers under section 200. The powers extend only to the extent of the emergency powers under section 200 and as set out in the PHWA.

Powers and obligations under the Public Health and Wellbeing Act 2008

The general powers are outlined under Part 9 of the PHWA (Authorised Officers). The following is an overview of powers and obligations. It does not reference all powers and obligations.

AOs are encouraged to read Part 9 and seek advice if they are unsure in the administration of their powers.

Authorised officer obligations:

Produce your identity card - s166

Before exercising powers provided to you under the PHWA:
At any time during the exercise of powers, if you are asked to show your ID card
As part of good practice, you should produce your identity card when introducing yourself to occupiers or members of the public when attending complaints or compliance inspections.

Inform people of their rights- s167

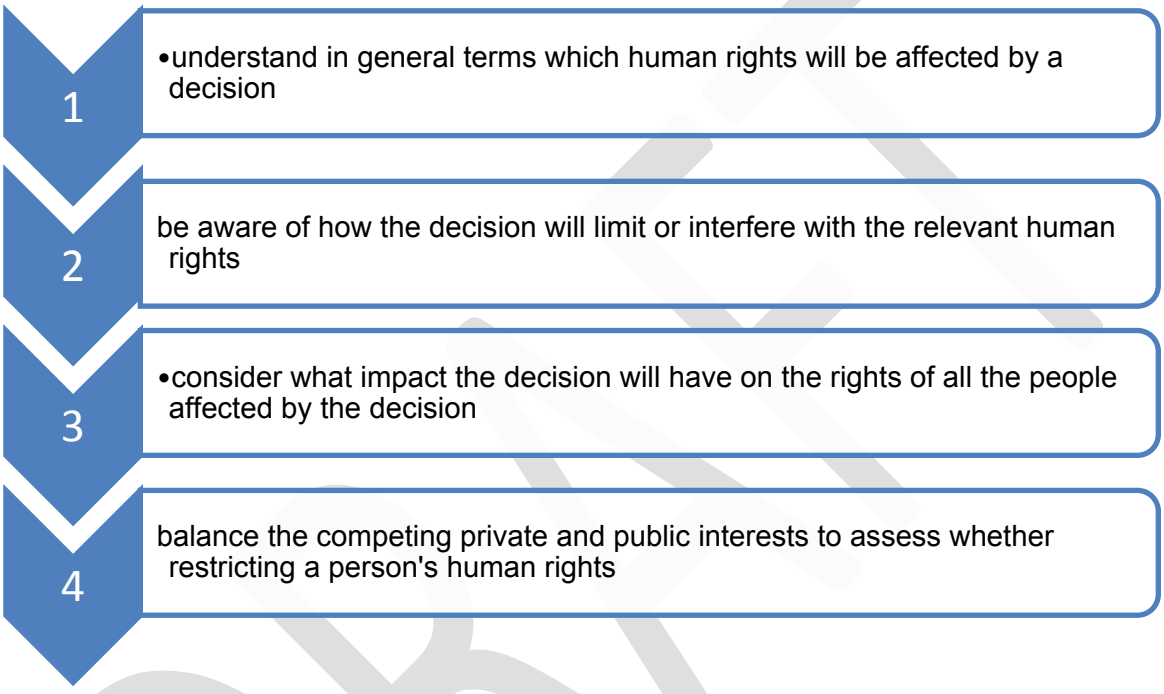
You may request a person to provide information if you believe it is necessary to investigate whether there is a risk to public health or to manage or control a risk to public health.
But you must first advise the person that they may refuse to provide the information requested.

Charter of Human Rights obligations

Department AO obligations under the *Charter of Human Rights and Responsibilities Act 2006*

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

How to give 'proper consideration' to human rights



The relevant Charter Human Rights that departmental AOs need to be aware of that may be affected by a decision:

- **Right to life** – This includes a duty to take appropriate steps to protect the right to life and steps to ensure that the person in detention is in a safe environment and has access to services that protect their right to life
- **Right to protection from torture and cruel, inhuman or degrading treatment –** This includes protecting persons in detentions from humiliation and not subjecting persons in detention to medical treatments without their consent
- **Right to freedom of movement –** while detention limits this right, it is done to minimise the serious risk to public health as a result of people travelling to Victoria from overseas
- **Right to privacy and reputation** – this includes protecting the personal information of persons in detention and storing it securely
- **Right to protection of families and children –** this includes taking steps to protect families and children and providing supports services to parents, children and those with a disability
- **Property rights –** this includes ensuring the property of a person in detention is protected
- **Right to liberty and security of person –** this includes only be detained in accordance with the PHWA and ensuring steps are taken to ensure physical safety of people, such as threats from violence
- **Rights to humane treatment when deprived of liberty** – this includes treating persons in detention humanely.

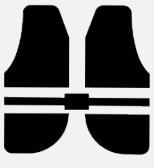
Airport

Key responsibilities

The following outlines required procedures at the airport for departmental Authorised officers.

Authorised Officers*:

Responsibility		Mandatory obligation	Section (PHWA)
	• must declare they are an Authorised Officer and show AO card	Yes	Section 166
	• must provide a copy of the Direction and Detention Notice to each passenger (notification to parent/guardian may need to be conducted over the phone and interpretation services may be required) and: – explain the reasons for detention – warn the person that refusal or failure to comply with a reasonable excuse is an offence and that penalties may apply	Yes. If it is not practicable to explain the reason for detention prior to subjecting the person to detention, the AO must do so as soon as practicable. This may be at the hotel, however every effort should be made to provide the reason at the airport [s. 200(3)] **(mandatory AO obligation)**.	Section 200(2) and 200(4)
	• ensure the Direction and Detention Notice: – states the name/s of the person being detained – states the name of AO – contains signature of person being detained – contains signature of AO – contains the hotel name at which the person will be detained – contains date the person will be detained till.		
	• record issue and receipt of the notice through a scanned photograph and enter into business system[1] • request person subject to		

Responsibility		Mandatory obligation	Section (PHWA)
	detention present to AO at hotel		
	• facilitate any reasonable request for communication, such as a phone call or email and including if necessary, organising a translator to explain the reasons for detention (need to provide VITS number)	Yes	Section 200(5)
	• provide a fact sheet about detention (what a person in detention can and can't do, who to contact for further information)		
	• record any actions taken in writing, including the above mandatory obligations, use of translator and any associated issues.		
	• use the list of arriving passengers to check off the provision of information to each arrival. This will help ensure all arrivals have been provided the information in the Direction and Detention Notice.		
	• check the vehicle transporting a person in detention is safe (in accordance with the review of transport arrangements procedure).		

** DHHS Authorised Officer under the PHWA that has been authorised for the purposes of the emergency order*

The Business system referred to here is the Quarantine and Welfare System COVID-19 Compliance Application

Additional roles

Authorised Officer review of transport arrangements to hotel

AO should consider the following:

- All persons must have been issued a direction and detention notice to board transport.
- Adequate physical distance between driver and persons being detained should be ensured.
- If not wait for another suitable vehicle to be arranged by the hotel.
- Has the vehicle been sanitised prior to anyone boarding? If not then the vehicle must be cleaned in accordance with departmental advice (business sector tab).
- Ensure the driver has adequate personal protective equipment (if required).
- Are the persons subject to detention wearing face masks? (Refer to Airport and transit process)
- Are there pens/welfare check survey forms available for each person to be detained to complete enroute or at the hotel?

Other airport issues

People who are unwell at the airport

The Compliance lead for this situation is the Human Biosecurity Officer on behalf of the Deputy Chief Health Officer (Communicable Disease).

Any person who is unwell at the airport will be assessed by a departmental staff member and biosecurity officer at the airport. After discussion with the human biosecurity officer, if it is determined that the person meets the criteria as a suspected case, the following actions should take place:

- The human biosecurity officer should organise an ambulance transfer to the Royal Melbourne Hospital or Royal Children's Hospital for testing and assessment
- The department AO at the airport should log the person as requiring mandatory quarantine at a specified hotel and then should follow-up with the hospital to update on whether the person has been found to be negative, so a transfer by (patient transfer/ambulance/ maxi taxi etc) can be organised to return to the hotel
- If the person is unwell and requires admission, they should be admitted and the Compliance Lead informed
- If the person is well enough to be discharged they should return to the hotel through an arrangement by the authorised officer, (refer to points above) and be placed in a COVID-19 floor if positive, or in a general part of the hotel if tested negative for COVID-19.

Transfer of uncooperative person to be detained to secure accommodation (refer to Authorised Officer review of transport arrangements procedure)

It is recommended that a separate mode of transport is provided to a person who is to be detained who is uncooperative to a hotel or other location for the 14-day isolation.

Ensure appropriate safety measures are taken including child locks of doors and safety briefing for drivers etc.

Arrival at hotel – check in

Key responsibilities

At hotel check-in:

- Person to be detained provides Direction and Detention Notice to hotel staff; hotel staff to write on the notice:
  - room number
  - the date that the person will be detained until (14 days after arrival at place of detention).
- Person to be detained provides completed Direction and Detention Notice to AO to confirm that the following details on the notice are correct:
  - the hotel name;
  - hotel room number and arrival date, time and room on notice;
  - the date that the person will be detained until (14 days after arrival at place of detention).
- AO must take a photo of the person's Direction and Detention Notice and enters this into database.
- Following any medical and welfare check of the person, AO to liaise with nurses to identify persons being detained with medical or special needs.
- AO to note persons being detained with medical or special needs, such as prescription and medical appointments.
- AO to note any allergies of detainees, including history of anaphylaxis or if no allergies are known

Persons being detained will be sent to their allocated room and informed that a person will contact them in the afternoon or next AO to make themselves known to the security supervisor onsite.

Additional roles of the AO

- AOs should check that security are doing some floor walks on the floors to ascertain longer-term needs and possible breaches
- AO should provide a handover to the incoming AO to get an update of any problems or special arrangements. For example, some people are permitted to attend cancer therapy at Peter Mac etc. This information should be also uploaded on the database/spreadsheet? Or is this covered below?
- AO responsible for uploading information to the business system which will then inform an upload to PHESS so that all persons in mandatory detention are recorded in PHESS for compliance and monitoring and surveillance purposes.

Regular review of detention

Requirement for review each day

- The AO must – at least once every 24 hours – review whether the continued detention of the person is reasonably necessary to protect public health [s. 200(6)] **(mandatory AO obligation).**
- The AO will undertake an electronic review of detainment arrangements by viewing a Business system. This includes reviewing:
  - the date and time of the previous review (to ensure it occurs at least once every 24 hours)
  - number of detainees present at the hotel
  - duration each detainee has been in detention for, to ensure that the 14-day detention period is adhered to
  - being cleared of COVID-19 results while in detention, which may be rationale for discontinuing detention
  - determining whether continued detention of each detainee is reasonably necessary to eliminate or reduce a serious risk to health
  - consideration of the human rights being impacted – refer to 'Charter of Human Rights' obligations
  - any other issues that have arisen.

Decision making

To inform decision-making, an AO must:

- consider that the person is a returned overseas traveller who is subject to a notice and that they are obliged to comply with detainment
- consider that detainment is based on expert medical advice that overseas travellers are of an increased risk of COVID-19 and form most COVID-19 cases in Victoria
- note the date of entry in Australia and when the notice was given
- consider any other relevant compliance and welfare issues the AO becomes aware of, such as:
  - person's health and wellbeing
  - any breaches of self-isolation requirement
  - issues raised during welfare checks (risk of self-harm, mental health issues)
  - actions taken to address issues
  - being cleared of COVID-19 results while in detention
  - any other material risks to the person
- record the outcomes of their review (high level notes) for each detained person (for each 24-hour period) in the agreed business system database. This spreadsheet allows ongoing assessment of each detainee and consideration of their entire detention history. This will be linked to and uploaded to PHESS.

To ascertain any medical, health or welfare issues, AO will need to liaise with on-site nurses and welfare staff (are there other people on-site an AO can liaise with to obtain this information).

Mandatory reporting (mandatory AO obligation)

A departmental AO must give written notice to the Chief Health Officer as soon as is reasonably practicable that:

- a person has been made subject to detention
- following a review, whether continued detention is reasonably necessary to eliminate or reduce the serious risk to public health.

The notice to the CHO must include:

- the name of the person being detained
- statement as to the reason why the person is being, or continues to be, subject to detention.

To streamline, the reporting process will involve a daily briefing to the CHO of new persons subject to detention and a database of persons subject to detention. The database will specify whether detention is being continued and the basis for this decision.

The CHO is required to advise the Minister for Health of any notice [s. 200(9)].

Grant of leave or release from detention

Mechanisms for grant of leave from detention

There are broadly two mechanisms available to the AO on behalf of the Compliance Lead / Public Health Commander to grant leave or release a person from mandatory detention:

- The daily review by the AO could find that detention is no longer required (with agreement of the Compliance Lead), or
- There could be permission given by the AO (with agreement of the Compliance Lead) that a person has permission to leave the room in which they are detained for various reasons outlined below.

Process for considering requests for permission to leave or not have detention applied

It is critical that any procedure allows for authorised officers to be nimble and able to respond to differing and dynamic circumstances impacting people who are detained, so that the detention does not become arbitrary. The process outlined here reflects the ability of an AO to make critical decisions impacting people in a timely manner.

Matters discussed with Legal Services on this matter should copy in REDACTED REDACTED and Ed Byrden REDACTED

Considerations

Any arrangements for approved leave would need to meet public health (and human rights) requirements. It will be important that the AO balances the needs of the person and public health risk.

For example, if the person needs immediate medical care, public health risks need to be managed appropriately, but the expectation is that the leave would automatically be granted. This would be more nuanced and complex when the request is made on compassionate grounds where there is a question about how public health risks might be managed. However, again, human rights under the Charter need to be considered closely.

Temporary leave from the place of detention (Detention notice)

There are four circumstances in which permission may be granted:

1. For the purpose of attending a medical facility to receive medical care

AO should refer to the '*Permission for Temporary Leave from Detention'* guide at **Appendix 5.**

- AO will consider circumstances to determine if permission is granted.
- An on-site nurse may need to determine if medical care is required and how urgent that care may be. Departmental AOs and on-site nurse may wish to discuss the person's medical needs with their manager, on-site nurse and the Director, Health and Human Services Regulation and Reform (Lead

Executive – COVID-19 Compliance) to assist in determining urgency and whether temporary leave is needed
- Where possible, on-site nurses should attempt to provide the needed medical supplies.
- If AO recommends leave be granted, they should seek approval from the Director, Health and Human Services Regulation and Reform (Lead Executive – COVID-19 Compliance).
- AO to be informed of decision
- If approval is granted, AO should complete a Permission for Temporary Leave from detention form / and enter into business system, **Appendix 6**
- AO should complete a register for Permission Granted / enter into business system,
- AOs should follow the Hospital Transfer Plan below.

2. Where it is reasonably necessary for physical or mental health

AO should refer to the *'Permission for Temporary Leave from Detention'* guide at **Appendix 5.**

- AO will consider circumstances to determine if permission is granted.
- AO should request DHHS Welfare team perform a welfare check to assist decision-making.
- If AO recommends leave be granted, they should seek approval from the Director, Health and Human Services Regulation and Reform (Lead Executive – COVID-19 Compliance).
- If approval is granted, AO should complete a Permission for Temporary Leave from detention form and enter into business system, **Appendix 6**
- AO should complete a register for Permission Granted / enter in business system,
- If approval is granted:
  - the on-site AO must be notified
  - persons subject to detention are not permitted to enter any other building that is not their (self-isolating) premises
  - persons subject to detention should always be accompanied by an on-site nurse, the department's authorised officer, security staff or a Victoria Police officer, and social distancing principles should be adhered to
- a register of persons subject to detention should be utilised to determine which persons are temporarily outside their premises at any one time.

3. On compassionate grounds:

AO should refer to the *'Permission for Temporary Leave from Detention'* guide at **Appendix 5.**

- AO will consider circumstances to determine if permission is granted.
- AO may request DHHS Welfare team perform a welfare check to assist decision-making.
- If AO recommends leave be granted, they should seek approval from the Director, Health and Human Services Regulation and Reform (Lead Executive – COVID-19 Compliance).
- If approval is granted, AO should complete a Permission for Temporary Leave from detention form/new system, **Appendix 6**
- AO should complete a register for Permission Granted / enter into business system

4. Emergency situations

- Department AOs and Victoria Police officers may need to determine the severity of any emergency (such as a building fire, flood, natural disaster etc) and the health risk they pose to persons in detention.
- If deemed that numerous persons in detention need to leave the premises due to an emergency, a common assembly point external to the premises should be utilised; persons in detention should be

accompanied at all times by a department authorised officer or a Victoria Police officer, and infection control and social distancing principles should be adhered to

- The accompanying departmental AO or a Victoria Police officer should ensure that all relevant persons in detention are present at the assembly point by way of a register of persons in detention.

Procedure for a person in detention / resident to leave their room for exercise or smoking

A person must be compliant and must not have symptoms before they could be allowed to have supervised exercise or a smoking break. Details must be recorded on new system.

The steps that must be taken by the person in detention are:

- Confirm to the person who will escort them that they are well,
- Confirm to the person who will escort them that they have washed their hands immediately prior to leaving the room,
- Don a single-use facemask (surgical mask), to be supplied by the security escort prior to leaving the room,
- Perform hand hygiene with alcohol-based handrub as they leave, this will require hand rub to be in the corridor in multiple locations,
- Be reminded to – and then not touch any surfaces or people within the hotel on the way out, and then not actually do it.

The procedure for the security escort is:

- Don a single-use facemask (surgical mask);
- Perform hand hygiene with an alcohol-based handrub or wash hands in soapy water;
- Be reminded to – and then not touch any surfaces or people within the hotel on the way out, and then not actually do it
- Be the person who touches all surfaces if required such as the lift button or door handles (where possible using security passes and elbows rather than hands;
- Maintain a distance (1.5 metres) from the person;
- Perform hand hygiene with an alcohol-based handrub or wash hands in soapy water as the end of each break.

There is no requirement to wear gloves and this is not recommended, as many people forget to take them off and then contaminate surfaces. If gloves are worn, remove the gloves immediately after the person is back in their room and then wash your hands.

In addition:

- Family groups may be taken out in a group provided it is only 2 adults and less than 5 in total.
- They can be taken to an outside area with sunlight, for up to 15 minutes outside of the hotel.
- Smokers can take up to 2 breaks per day if staffing permits.
- Rostering to be initiated by the departmental staff/AO present.

Hospital transfer plan

The following is a general overview of the transfer of a patient to hospital involving nurses, doctors, AOs, Ambulance Victoria (AV) and hospitals. The bold highlight AO interactions.

1. Nurse/doctor assess that patient requires hospital care
2. **There is also a one pager to explain to AO how to grant permission at Appendix 5 Permission to temporarily leave. Leave should be recorded on the business system or register.**
3. **All relevant staff including AO must be notified prior to the transfer.**
4. Patient is transferred to the appropriate hospital. Patients requiring hospital assessment/treatment for suspected or confirmed COVID-19 or other conditions, should be transferred to either the Royal Melbourne Hospital (RMH) or The Alfred Hospital, depending on proximity **(note children should be transferred to the Royal Children's Hospital).**
5. If the hospital transfer is urgent call 000 to request ambulance and inform them that the passenger is a suspected (or confirmed) case of COVID-19.
6. Contact the Admitting Officer at RCH/RMH/the Alfred, inform the hospital of patient and details.
7. Staff should don full PPE and the passenger must wear a single-use surgical mask if tolerated.
8. The passenger should be transferred on a trolley or bed from ambulance into the designated COVID-19 ambulance reception area.
9. The patient should be managed under routine droplet and contact transmission-based precautions in a negative pressure room if available. The patient should wear a single-use surgical mask if leaving the isolation room.
10. Ambulance services will list the hotels as an area of concern in case of independent calls and will ask on site staff to assess need for attendance in the case of low acuity calls.
11. All residents who are: in high risk groups, unwell, breathless or hypoxic (O2 sats <95%) should be considered for hospital transfer.
12. Assessment and diagnosis made as per medical care and plan made for either admission to same hospital or more appropriate medical care or for discharge. (receiving hospital ED)
13. Prior to any movement of the patient out of the ED a new plan or detention approval must be sought for either return or admission to different location in consultation with compliance team (receiving hospital and compliance team).
14. **Hospitals will need to contact the AO at hotels (a mobile will need to be sourced that stays at each hotel across shifts) then the AO Team lead will advise Lead Executive Compliance to obtain any necessary approvals)**

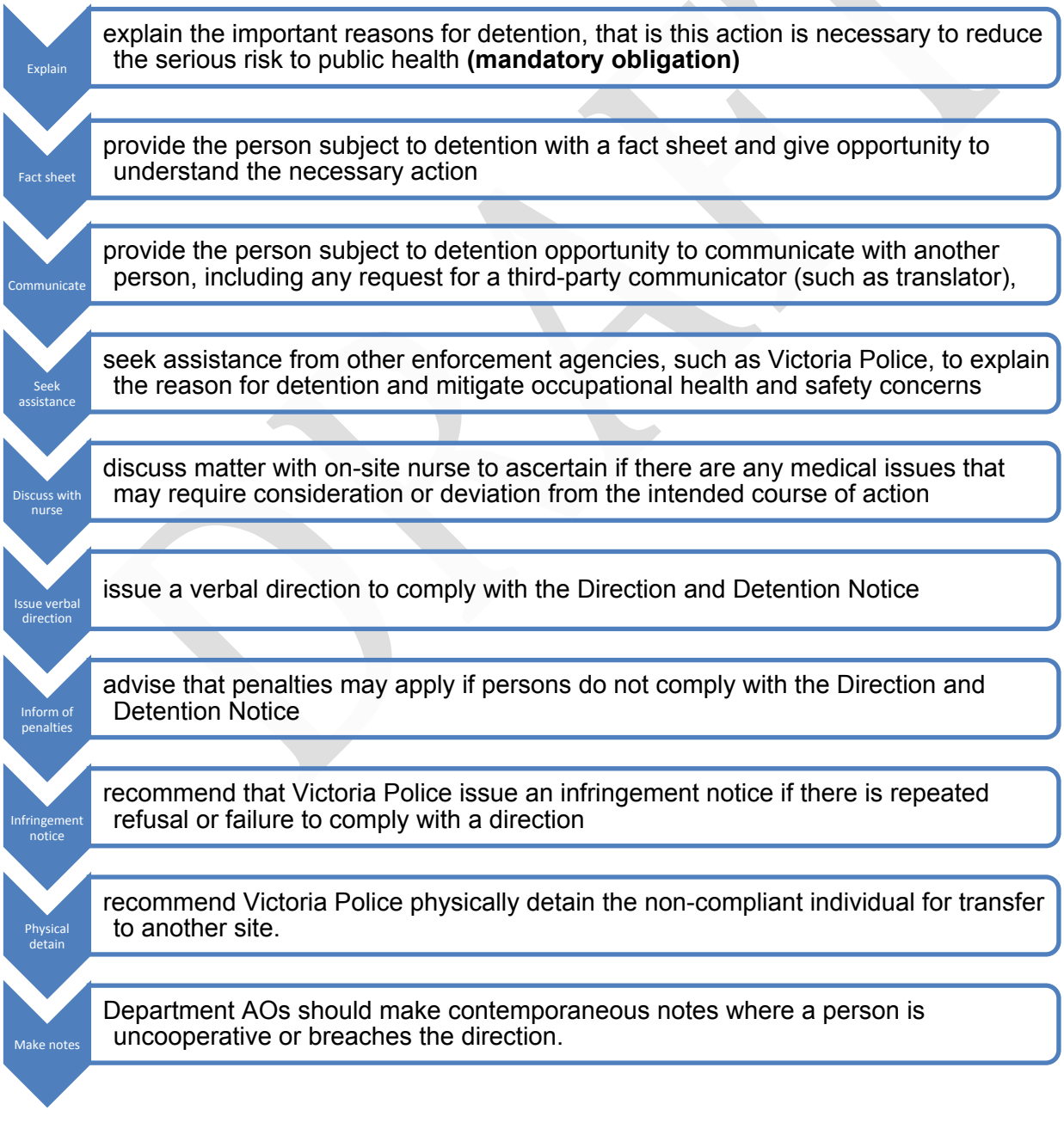
The flow diagrams below outline the processes, including interactions with AO for the transfer and return of a patient.

Compliance

The role of an AO in compliance is only to exercise the powers under section 199 of the PHWA, Any arrests, including moving people into detainment or physical contact with a person must be managed by Victoria Police.

Options to facilitate compliance

Department AOs should make every effort to inform the person of their obligations, facilitate communication if requested and explain the important rationale for the direction. The following graduated approach should guide AOs:



Unauthorised departure from accommodation

If there is reason to believe a person subject to detention is not complying with the direction and detention notice, the AO should:

- notify on-site security and hotel management
- organise a search of the facility
- consider seeking police assistance
- notify the Director, Regulatory Reform if the person subject to detention is not found

If the person is located, the AO should:

- seek security or Victoria Police assistance if it is determined the person poses a risk of trying to leave
- provide an opportunity for the person to explain the reason why they left their room
- assess the nature and extent of the breach, for example:
  - a walk to obtain fresh air
  - a deliberate intention to leave the hotel
  - mental health issues
  - escaping emotional or physical violence
- assess possible breaches of infection control within the hotel and recommend cleaning
- consider issuing an official warning or infringement through Victoria Police
- reassess security arrangements
- report the matter to the Director, Regulation Reform.

Departmental AOs should make contemporaneous notes where a person is uncooperative or breaches a direction.

Infringements

On 28 March 2020, the Public Health and Wellbeing Regulations 2019 were amended to create four new infringement offences. These are:

Table 1 List of infringements

Section (PHWA)	Description	Amount
s.183	Hinder or obstruct an authorised officer exercising a power without reasonable excuse (5 penalty units).	5 penalty units PU
s.188(2)	Refuse or fail to comply with a direction by CHO to provide information made under s.188(10 without a reasonable excuse.	10 PU natural person, 30 PU body corporate
s.193(1)	Refuse or fail to comply with a direction given to, or a requirement made or, a person in the exercise of a public health risk powers (10 penalty units for natural person and 60 penalty units for body corporate).	10 PU natural person, 30 PU body corporate
s.203(1)	Refuse or fail to comply with a direction given to, or a requirement made or, a person in the exercise of a public health risk powers (10 penalty units for natural person and 60 penalty units for body corporate).	10 PU natural person, 30 PU body corporate

DRAFT for review - This process is under development.

Departure – release from mandatory detention

Background

Prior to release of a person being detained, they will be provided with an end of detention letter (End of Detention Notice) or End of Detention Notice (confirmed case or respiratory illness symptoms) that confirms release details and specifies requirements to follow other relevant directions post release, dependant of the outcome of their final health check. Detention is 14 days from the date of arrival and ends at 12am on the last day. No-one will be kept past their end of detention.

Responsibilities

Departmental staff/Department of Jobs, Precincts and Regions to notify the person in detention that:

- they will be due for release from detention in 48 hours
- a health check to determine their status is recommended
- provide information for people exiting quarantine on transport and other logistical matters.

Health check

- In accordance with section 200(6) of the PHWA, the daily health check will be used to review the persons continued detention. In order to assess whether the person has fulfilled their 14-day quarantine period as required under the direction and detention notice.
- The health checks on the second last day prior to the 14-day period ending must be used to make an assessment of whether the person is well, symptomatic or positive.
- Everyone will be offered a voluntary temperature and symptom check by a nurse around 24 hours before release.
- If people being detained have a temperature or other symptoms of coronavirus before leaving or at the health check, this will not affect the completion of their detention. They will not be detained for longer than the 14-day quarantine period, even if they have symptoms consistent with coronavirus. However, if they do have symptoms at the health check, when they are released, they will need to seek medical care and self-isolate as appropriate, as do all members of the community.

Checkout process

- The release process will consist of an organised check out procedure (the compliance check out). This will mean people being detained will be released in stages throughout a set time period on the day of release. Travelling parties will be brought down to reception in stages to complete the check out process. People being detained will also need to settle any monies owing to the hotel for additional meals and drinks if they have not already done so. Physical distancing must be maintained throughout this process.
- Prior to the departure of people being detained, they will be given a compliance form with their documented end date and time of detention. The DHHS authorised officer will confirm the period of detention with people being detained and will ask them to sign the compliance form. They need to be signed out by a DHHS authorised officer before you they can leave.
- Transportation will be organised for you.

Reporting and evaluation on mandatory quarantine

A report will be prepared to summarise the activity of the program, and provided to the Deputy Chief Health Officer on a regular basis in confidence.

Appendix 1 – Direction and detention notice – Solo Children

DIRECTION AND DETENTION NOTICE

SOLO CHILDREN

Public Health and Wellbeing Act 2008 (Vic)

Section 200

1. Reason for this Notice

(2) You have arrived in Victoria from overseas, on or after midnight on 28 March 2020.

(3) A state of emergency has been declared under section 198 of the *Public Health and Wellbeing Act 2008* (Vic) (the **Act**), because of the serious risk to public health posed by COVID-19.

(4) In particular, there is a serious risk to public health as a result of people travelling to Victoria from overseas. People who have been overseas are at the highest risk of infection and are one of the biggest contributors to the spread of COVID-19 throughout Victoria.

(5) You will be detained at the hotel specified in clause 2 below, in the room specified in clause 2 below, for a period of 14 days, because that is reasonably necessary for the purpose of eliminating or reducing a serious risk to public health, in accordance with section 200(1)(a) of the Act.

(6) Having regard to the medical advice, 14 days is the period reasonably required to ensure that you have not contracted COVID-19 as a result of your overseas travel.

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

(8) The Chief Health Officer will be notified that you have been detained. The Chief Health Officer must advise the Minister for Health of your detention.

Note: These steps are required by sections 200(7) and (9) of the Act.

2. Place and time of detention

(9) You will be detained at:

Hotel: _____ *(to be completed at place of arrival)*

Room No: _____ *(to be completed on arrival at hotel)*

(10) You will be detained until: _____ on ____of _____2020.

3. Directions — transport to hotel

(11) You must **proceed immediately to the vehicle** that has been provided to take you to the hotel, in accordance with any instructions given to you.

(12) Once you arrive at the hotel, **you must proceed immediately to the room** you have been allocated above in accordance with any instructions given to you.

1. Conditions of your detention

(13) **You must not leave the room in any circumstances**, unless:

(c) you have been granted permission to do so:

(i) for the purposes of attending a medical facility to receive medical care; or

(ii) where it is reasonably necessary for your physical or mental health; or

(iii) on compassionate grounds; or

(d) there is an emergency situation.

(14) **You must not permit any other person to enter your room**, unless the person is authorised to be there for a specific purpose (for example, providing food or for medical reasons).

(15) Except for authorised people, the only other people allowed in your room are people who are being detained in the same room as you.

(16) You are permitted to communicate with people who are not staying with you in your room, either by phone or other electronic means.

Note: An authorised officer must facilitate any reasonable request for communication made by you, in accordance with section 200(5) of the Act.

(17) If you are under 18 years of age your parent or guardian is permitted to stay with you, but only if they agree to submit to the same conditions of detention for the period that you are detained.

2. Review of your detention

Your detention will be reviewed at least once every 24 hours for the period that you are in detention, in order to determine whether your detention continues to be reasonably necessary to eliminate or reduce a serious risk to public health.

Note: This review is required by section 200(6) of the Act.

3. Special conditions because you are a solo child

Because your parent or guardian is not with you in detention the following additional protections apply to you:

(a) We will check on your welfare throughout the day and overnight.

(b) We will ensure you get adequate food, either from your parents or elsewhere.

(c) We will make sure you can communicate with your parents regularly.

(d) We will try to facilitate remote education where it is being provided by your school.

(e) We will communicate with your parents once a day.

4. Offence and penalty

(19) It is an offence under section 203 of the Act if you refuse or fail to comply with the directions and requirements set out in this Notice, unless you have a reasonable excuse for refusing or failing to comply.

(20) The current penalty for an individual is $19,826.40.

_____

Name of Authorised Officer: _____

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

Appendix 2 – Guidelines for Authorised Officers (Unaccompanied Minors)

Guidelines for Authorised Officers - Ensuring physical and mental welfare of international arrivals in individual detention (unaccompanied minors)

Introduction

You are an officer authorised by the Chief Health Officer under section 199(2)(a) of the *Public Health and Wellbeing Act 2008* (Vic) to exercise certain powers under that Act. You also have duties under the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**Charter**).

These Guidelines have been prepared to assist you to carry out your functions in relation to Victorian unaccompanied minors who have arrived in Victoria and are subject to detention notices, requiring them to self-quarantine in a designated hotel room for 14 days in order to limit the spread of Novel Coronavirus 2019 (**2019-nCoV**) where no parent, guardian or other carer (**parent**) has elected to join them in quarantine (a **Solo Child Detention Notice**).

As part of your functions, you will be required to make decisions as to whether a person who is subject to a Solo Child Detention Notice should be granted permission to leave their room:

- for the purposes of attending a medical facility to receive medical care; or
- where it is reasonably necessary for their physical or mental health; or
- on compassionate grounds.

Authorised Officers are also required to review the circumstances of each detained person at least once every 24 hours, in order to determine whether their detention continues to be reasonably necessary to eliminate or reduce a serious risk to public health.

Your obligations under the *Charter of Human Rights and Responsibilities Act 2006*

You are a public officer under the Charter. This means that, in providing services and performing functions in relation to persons subject to a Detention Notice you must, at all times:

- act compatibly with human rights; and
- give 'proper consideration' to the human rights of any person(s) affected by your decisions.

How to give 'proper consideration' to human rights

'Proper consideration' requires you to:

- **first**, understand in general terms which human rights will be affected by your decisions (these rights are set out below under 'relevant human rights');
- **second**, seriously turn your mind to the possible impact of your decisions on the relevant individual's human rights, and the implications for that person;
- **third**, identify the countervailing interests (e.g. the important public objectives such as preventing the further spread of 2019-nCoV, which may weigh against a person's full enjoyment of their human rights for a period of time); and
- **fourth**, balance the competing private and public interests to assess whether restricting a person's human rights (e.g. denying a person's request to leave their room) is justified in the circumstances.

Relevant human rights
The following human rights protected by the Charter are likely to be relevant to your functions when conducting daily wellbeing visits and when assessing what is reasonably necessary for the physical and mental health of children who are subject to Solo Child Detention Notices:

- The right of **children** to such protection as is in their best interests (s 17(2)). As the Solo Child Detention Notices detain children in circumstances where no parent has elected to join them in quarantine, greater protection must be provided to these children in light of the vulnerability that this creates. Where possible the following additional protection should be provided:
    - You should undertake two hourly welfare checks while the child is awake and once overnight. You should ask the child to contact you when they wake each morning and let you know when they go to sleep so that this can be done.
    - You should ask the child if they have any concerns that they would like to raise with you at least once per day.
    - You should contact the child's parents once per day to identify whether the parent is having contact with the child and whether the parent or child have any concerns.
    - You should ensure that where the child does not already have the necessary equipment with them to do so (and their parent is not able to provide the necessary equipment) the child is provided with the use of equipment by the department to facilitate telephone and video calls with their parents. A child must not be detained without an adequate means of regularly communicating with their parents.
    - You should ensure that where the child does not already have the necessary equipment with them to do so (and their parent is not able to provide the necessary equipment) the child is provided with the use of equipment by the department to participate in remote education if that is occurring at the school they are attending. Within the confines of the quarantine you should obtain reasonable assistance for the child in setting up that computer equipment for use in remote education.
    - You should allow the child's parents to bring them lawful and safe items for recreation, study, amusement, sleep or exercise for their use during their detention. This should be allowed to occur at any time within business hours, and as many times as desired, during the detention.
- The rights to **liberty** (s 21) and **freedom of movement** (s 12), and the right to **humane treatment when deprived of liberty** (s 22). As the Solo Child Detention Notices deprive

children of liberty and restrict their movement, it is important that measures are put in place to ensure that the accommodation and conditions in which children are detained meet certain minimum standards (such as enabling parents to provide detained children with food, necessary medical care, and other necessities of living). It is also important that children are not detained for longer than is reasonably necessary.

- **Freedom of religion** (s 14) and **cultural rights** (s 19). Solo Child Detention Notices may temporarily affect the ability of people who are detained to exercise their religious or cultural rights or perform cultural duties; however, they do not prevent detained persons form holding a religious belief, nor do they restrict engaging in their cultural or religious practices in other ways (for example, through private prayer, online tools or engaging in religious or cultural practices with other persons with whom they are co-isolated). Requests by children for additional items or means to exercise their religious or cultural practices will need to be considered and accommodated if reasonably practicable in all the circumstances.
- The rights to **recognition and equality before the law**, and to **enjoy human rights without discrimination** (s 8). These rights will be relevant where the conditions of detention have a disproportionate impact on detained children who have a protected attribute (such as race or disability). Special measures may need to be taken in order to address the particular needs and vulnerabilities of, for example Aboriginal persons, or persons with a disability (including physical and mental conditions or disorders).
- The rights to **privacy, family and home** (s 13), **freedom of peaceful assembly** and **association** (s 16) and the **protection of families** (s 17). Solo Child Detention Notices are likely to temporarily restrict the rights of persons to develop and maintain social relations, to freely assemble and associate, and will prohibit physical family unification for those with family members in Victoria. Children's rights may be particularly affected, to the extent that a Solo Child Detention Notice results in the interference with a child's care and the broader family environment. It is important, therefore, to ensure children subject to Solo Child Detention Notices are not restricted from non-physical forms of communication with relatives and friends (such as by telephone or video call). Requests for additional items or services to facilitate such communication (e.g. internet access) will need to be considered and accommodated if reasonably practicable in all the circumstances.

Whether, following 'proper consideration', your decisions are compatible with each these human rights, will depend on whether they are reasonable and proportionate in all the circumstances (including whether you assessed any reasonably available alternatives).

General welfare considerations

All persons who are deprived of liberty must be treated with humanity and respect, and decisions made in respect of their welfare must take account of their circumstances and the particular impact that being detained will have on them. Mandatory isolation may, for some people, cause greater hardship than for others – when performing welfare visits you will need to be alert to whether that is the case for any particular person.

In particular, anxieties over the outbreak of 2019-nCoV in conjunction with being isolated may result in the emergence or exacerbation of mental health conditions amongst persons who are subject to Detention Notices. If you have any concerns about the mental health of a detained person, you should immediately request an assessment of mental health be conducted and ensure appropriate support is facilitated. Hotel rooms are not normally used or designed for detention, so you should be aware that a

person who is detained in a hotel room could have greater opportunity to harm themselves than would be the case in a normal place of detention.

Additional welfare considerations for children

Children differ from adults in their physical and psychological development, and in their emotional and educational needs. For these reasons, children who are subject to Solo Child Detention Notices may require different treatment or special measures.

In performing functions and making decisions with respect to a detained person who is a child, the best interests of the child should be a primary consideration. Children should be given the opportunity to conduct some form of physical exercise through daily indoor and outdoor recreational activities. They should also be provided with the ability to engage in age-appropriate activities tailored to their needs. Each child's needs must be assessed on a case-by-case basis. Requests for items or services to meet the needs of individual children will need to be considered and accommodated if reasonably practicable in all the circumstances. Where available, primary school age children should be allocated rooms that have an outside area where it is safe for active physical play to occur (not a balcony) and consideration should be given to allowing small children access to any larger outdoor areas that are available within the hotel, where possible within relevant transmission guidelines. Although each child's needs must be assessed daily and individually, it can be assumed that it will have a negative effect on a child's mental health to be kept in the same room or rooms for two weeks without access to an adequate outdoor area in which to play.

Balancing competing interests

However, the best interests of children and the rights of anyone who is subject to a Solo Child Detention Notice will need to be balanced against other demonstrably justifiable ends; for example, lawful, reasonable and proportionate measures taken to reduce the further spread of 2019-nCoV. It is your role to undertake this balance in your welfare checks, based on the information and advice that you have from the department and on the information provided to you by the children that you are assessing.

Appendix 3- Occupational health and safety for Authorised Officers

Purpose

The purpose of this section is to provide an occupational health and safety procedure for department AOs when attending off site locations during the current State of Emergency.

Health Emergency

Coronaviruses are a large family of viruses that cause respiratory infections. These can range from the common cold to more serious diseases. COVID-19 is the disease caused by a new coronavirus. It was first reported in December 2019 in Wuhan City in China.

Symptoms of COVID-19 can range from mild illness to pneumonia. Some people will recover easily, and others may get very sick very quickly which in some cases can cause death.

Compliance Activity

On 16 March 2020 a State of Emergency was declared in Victoria to combat COVID-19 and to provide the Chief Health Officer with the powers he needs to eliminate or reduce a serious risk to the public.

Under a State of Emergency, Authorised Officers, at the direction of the Chief Health Officer, can act to eliminate or reduce a serious risk to public health by detaining people, restricting movement, preventing entry to premises, or providing any other direction an officer considers reasonable to protect public health.

Using a roster-based system, AOs will be placed on call to exercise authorised powers pursuant to section 199 of the PHWA. **AOs compliance role is only to exercise the powers under section 199 of the Act, any arrests, including moving people into detainment or physical contact a person must be managed by Victoria Police**.

OHS

Occupational Health and Safety is a shared responsibility of both the employer and the employee. Officers must raise hazards, concerns, incidents with: REDACTED

One of the foremost issues associated with site attendance is the 'uncontrolled environment' that exists. AOs can be exposed to infectious diseases (such as COVID-19), confrontational and/or aggressive members of the public who may be drug affected, mentally ill or intellectually impaired. The very nature of this work is likely to be perceived as invasive and can provoke a defensive response.

Risks can be minimised by maintaining routine safe work practices and proper planning. Prior to any site visit, risks and hazards should be identified and assessed.

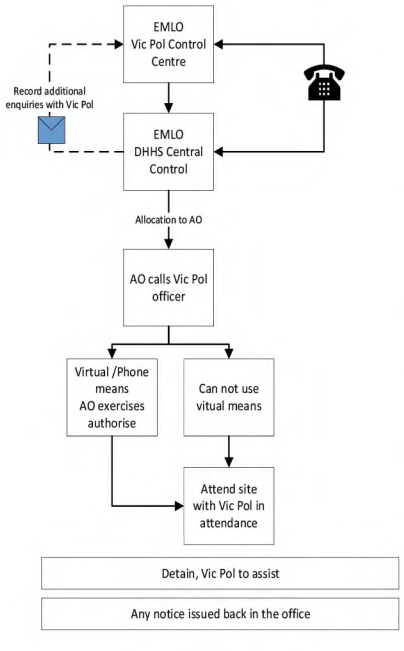
Officers and managers both have a shared responsibility for occupational health and safety. All employees have a responsibility to report and discuss hazards or perceived hazards, by bringing this to the managers attention.

Fatigue

AOs will be rostered on a rotating basis, with the aim of mitigating the risk of fatigue. Fatigue may impede decision making capability and when driving a motor vehicle to a location. When fatigue is identified please make this known to your manager.

To mitigate the risk of fatigue, AOs should be aware of any fatigue they may have. A good tool to use to help officers identify their level of fatigue is to use the following calculator: http://www.vgate.net.au/fatigue.php

AOs are required to hold a valid motor vehicle licence and are required to adhere to the requirements of the department's driving policy. Information about this policy can be found on the DHHS intranet site.



Risk assessment before attendance | Personal Protection

Officers must only take a direction to attend a site with the approval of the Central DHHS emergency Management Liaison Officer or DHHS duty manager. An officer must only attend a location where there is the confirmed attendance of the Victoria Police.

In the first instance, officers are required to use technology (i.e: mobile phone, Facetime, Skype) to exercise their authority. This aims to protect officers from attending an uncontrolled environment, where the risk of harm is increased.

Before attending a site, whether an airport or a hotel, the officer should make themselves familiar with the recommendations produced by the Australian Government and the Department of Health and Human Services, in the protection against COVID-19.

Interventions are known as 'transmission reduction, or 'physical distancing' measures. Officers can take the following personal measure to reduce their risk

of exposure to COVID-19. Officers with pre-existing medical conditions that put them more at risk of COVID-19, should discuss this with their medical practitioner and manager.

Personal measures to reduce risk the risk of exposure to COVID-19 include:

- Stay healthy with good nutrition, regular exercise, sensible drinking, sleeping well, and if you are a smoker, quitting.
- Wash your hands often with soap and water for at least 20 seconds, especially after you have been in a public place, or after blowing your nose, coughing, sneezing, or using the toilet. If soap and water are not readily available, use a hand sanitiser that contains at least 60 per cent alcohol.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Cover your nose and mouth with a tissue when you cough or sneeze. If you don't have a tissue, cough or sneeze into your upper sleeve or elbow.
- Stop shaking hands, hugging or kissing as a greeting.
- Ensure a **distance of 1.5 metres** is kept between yourself and others.
- Get vaccinated for flu (influenza) as soon as available. This could help reduce the risk of further problems. *Note: the department covers expenses for vaccines, speak to your manager for more details.*
- Clean and disinfect high touch surfaces regularly, for example: telephones, keyboards, door handles, light switches and, bench tops.

When an officer is called to attend the airport or a hotel to exercise powers in relation to the Direction and Detention notice they should take a **risk-based approach** and assess the most suitable way to reduce harm to themselves. Before attending, the officer must obtain information such as:

- Is the person being detained a positive case of COVID-19?
- Has the person being detained been recently in close contact with a positive case of COVID-19?
- Has the person being detained recently returned from overseas within the last 14 days?

Officers are required to use their discretion and take into account their own personal safety. The Department of Health and Human Services has provided the following PPE:

- Face mask (N95 or equivalent)
- Gloves
- Hand Sanitizer

- The following is only a guide for AOs to consider. AOs going onto hotel the floors with persons subject to detention must wear gloves and masks. There should be P2 masks for AO's at the hotels (in addition to the surgical masks).

PPE	Guide
Face mask	When there is known case of COVID-19, or an a person subject to detenti has been recently exposed to COVID-19
Gloves	Always
Hand Sanitizer / Soap	Always
Social Distancing of at least 1.5 meters	Always

Known risks and hazards

Hazard	Risk	Mitigate
COVID-19 infection	Serious illness / death	Follow personal protective measures

Fatigue	Impaired decisions / driving to site	In the first instance use virtual technology to perform duties Use fatigue calculator http://www.vgate.net.au/fatigue.php
Physical Injury	Low / Medium	Only attend a site with Victoria Police
Other infectious agents		Follow personal protective measures

Appendix 4 – Welfare Survey

Survey questions – daily check-in

Date:	
Time:	
Call taker name:	
Passenger location:	Hotel: Room number:
location (room number):	
Confirm passenger name:	
Passenger DOB:	
Contact number:	Mobile: Room:
Interpreter required:	Yes/no Language:

Script

Good morning / afternoon, I'm XXX. Can I confirm who I'm speaking with?

I am working with the Department of Health and Human Services to support people in quarantine following their arrival in Australia, and I'm giving you a call to check on your welfare. We know that this may be a stressful time for you, and our aim is to make sure that you are as comfortable as you can be during this quarantine period.

I am a Victorian Public Servant and any information that you provide to me is subject to privacy legislation.

We will be checking in with you and the people you have been travelling with every 24 hours to make sure that you are ok and to find out if you have any health, safety or wellbeing concerns that we can address.

There are 23 questions in total, and it should take only a few minutes to go through these with you. When you answer, we would like to know about you as well as any other occupants in your room.

If you have needs that require additional support, we will connect you with another team who can provide this support.

Introductory questions

1. Are you still in Room XXX at the hotel? Circle YES / NO

2. Are you a lone occupant in your hotel room? Yes/No if No:
   a. Who are your fellow occupants, including your partner or spouse, children or fellow travellers?

Name	Relationship	Age (children/dependents)

3. Have you or your fellow occupants had to leave your room for any reason? If so, what was the reason? YES /N0

Health questions

4. Have you had contact with a medical staff nurse whilst in quarantine? If yes, can you please provide details and is it being monitored?

5. Have you or your fellow occupants had any signs or symptoms of COVID-19, including fever, cough, shortness of breath, chills, body aches, sore throat, headache, runny nose, muscle pain or diarrhoea)?

6. Do you or anyone you are with have any medical conditions that require immediate support? (ie smokers requiring nicotine patches)

7. Do you, or anyone in your group (including children) have any immediate health or safety concerns?

8. Do you have any chronic health issues that require management?

9. Do you or anyone you are with have enough prescribed medication to last until the end of the quarantine period?

10. Are you keeping up regular handwashing?

11. What sort of things help you to live well every day? For example, do you exercise every day, do you eat at the same time every day?

Safety questions

12. How is everything going with your family or the people you are sharing a room with?

13. Is there anything that is making you feel unsafe?

14. Are there any concerns that you anticipate in relation to your own or other occupant's safety that might become an issue in the coming days?

If the person answers yes to either question 10 or the one above, you could say:

- You have identified safety concerns -would you like me to establish a safe word if you require additional support regarding your safety?

If yes…

- The word I am providing is <xxx> (different word for each individual). You can use that word in a conversation with me and I will know that you need immediate support/distance from other occupants in the room or may be feeling a high level of distress.

Where family violence, abuse or acute mental health is identified as an issue refer to specific guidance / escalate for specialist support.

Wellbeing questions

15. How are you and any children or other people that you are with coping at the moment?

16. Do you have any immediate concerns for any children / dependents who are with you?

17. Do you have any additional support needs that are not currently being met, including any access or mobility support requirements?

18. Have you been able to make and maintain contact with your family and friends?

19. What kind of things have you been doing to occupy yourself while you're in isolation, e.g. yoga, reading books, playing games, playing with toys?

20. Have you been able to plan for any care responsibilities that you have in Australia? Can these arrangements be maintained until the end of the quarantine period?

Final

21. What has the hotel's responsiveness been like? Have you had any trouble getting food, having laundry done, room servicing etc.?

22. Do you have any other needs that we may be able to help you with?

23. Do you have any other concerns?

End of survey

Thank you for your time today. We will contact you again tomorrow.

Office use only

5. Referral details

Nurse	
Authorised officer	
Complex Client Specialist	
Other	

6. NOTES:

7. **Enter on spreadsheet**

- Any referrals or issues
- Short or long survey for the next call contact (short may be by text message so they will need a mobile phone number)
- Safe word documented
- Make note of mobile number or if they don't have one.

Appendix 5 - Permission for temporary leave from detention

PERMISSION FOR TEMPORARY LEAVE FROM DETENTION

Public Health and Wellbeing Act 2008 (Vic)

Section 200

An Authorised Officer has granted you permission to leave your room based on one of the grounds set out below. This is temporary. You will be supervised when you leave your room. You must ensure you comply with all the conditions in this permission and any directions an Authorised Officer gives you. You must return to your room at the time specified to finish your detention. Speak to your supervising Authorised Officer if you require more information.

Temporary leave

(21) You have arrived in Victoria from overseas, on or after midnight on 28 March 2020 and have been placed in detention, pursuant to a Direction and Detention Notice that you were provided on your arrival in Victoria (**Notice**).

(22) This Permission for Temporary Leave From Detention (**Permission**) is made under paragraph 4(1) of the Notice.

Reason/s for, and terms of, permission granting temporary leave

(23) Permission for temporary leave has been granted to: _____ _____ [insert name] for the following reason/s [tick applicable]:

(f) for the purpose of attending a medical facility to receive medical care:

☐ **Name of facility:** _____

Time of admission/appointment:_____

Reason for medical appointment:_____

☐ (g) where it is reasonably necessary for physical or mental health:

Reason leave is necessary:_____

Proposed activity/solution:_____

☐ (h) on compassionate grounds:

Detail grounds:_____

(24) The temporary leave starts on _____

and ends on _____ [insert date and time].

_____ **Signature of Authorised Officer**

Name of Authorised Officer: _____

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

Conditions

(25) You must be supervised **at all times**/may be supervised *[delete as appropriate]* while you are out of your room. You are not permitted to leave your hotel room, even for the purpose contained in this Permission, unless you are accompanied by an Authorised Officer.

(26) While you are outside your room you must practice social distancing, and as far as possible, maintain a distance of 1.5 metres from all other people, including the Authorised Officer escorting you.

(27) When you are outside your room you must refrain from touching communal surfaces, as far as possible, such as door knobs, handrails, lift buttons etc.

(28) When you are outside your room you must, **at all times**, wear appropriate protective equipment to prevent the spread of COVID-19, if directed by the Authorised Officer escorting you.

(29) When you are outside your room you must, **at all times**, comply with any direction given to you by the Authorised Officer escorting you.

(30) At the end of your temporary leave, you will be escorted back to your room by the Authorised Officer escorting you. You must return to your room and remain there to complete the requirements under the Notice.

(31) Once you return to the hotel, **you must proceed immediately to the room** you have been allocated above in accordance with any instructions given to you.

(32) You must comply with any other conditions or directions the Authorised Officer considers appropriate.

(Insert additional conditions, if any, at Annexure 1)

Specific details

(33) Temporary leave is only permitted in limited circumstances, to the extent provided for in this Permission, and is subject to the strict **conditions** outlined at paragraph 3. You must comply with these conditions **at all times** while you are on temporary leave. These conditions are reasonably necessary to protect public health, in accordance with section 200(1)(d) of the *Public Health and Wellbeing Act 2008* (Vic).

(34) Permission is only granted to the extent necessary to achieve the **purpose** of, and for the **period of time** noted at paragraph 2 of this Permission.

(35) Nothing in this Permission, invalidates, revokes or varies the circumstances, or period, of your detention, as contained in the Notice. The Notice continues to be in force during the

period for which you are granted permission for temporary leave from detention. The Notice continues to be in force until it expires.

Offences and penalties

(36) It is an offence under section 203 of the Act if you refuse or fail to comply with the conditions set out in this Permission, unless you have a reasonable excuse for refusing or failing to comply.

(37) The current penalty for an individual is $19,826.40.

Appendix 6 - Guidance Note: Permission for Temporary Leave from Detention

How do you issue a Permission for Temporary Leave from Detention?

It is recommended that Authorised Officers take the following steps when issuing a Permission for Temporary Leave from Detention:

Before you provide the Permission for Temporary Leave from Detention

- carefully consider the request for permission and consider the grounds available under paragraph 4(1) of the Direction and Detention Notice – which include:
  - for the purposes of attending a medical facility to receive medical care; or
  - where it is reasonably necessary for your physical or mental health; or
  - on compassionate grounds.
- complete all sections of the Permission, including clearly documenting the reasons for the Permission, date and time when the temporary leave is granted from and to, and whether the person will be supervised by the authorised officer during the temporary leave
- ensure the reference number is completed.

When you are provide the Permission for Temporary Leave from Detention

- you must warn the person that refusal or failure to comply without reasonable excuse, is an offence;
- explain the reason why it is necessary to provide the Permission and the conditions which apply to the temporary leave (including that the person is still subject to completing the remainder of the detention once the temporary leave expires, and the Permission is necessary to protect public health);
- provide a copy of the Permission to the person, provide them with time to read the Permission and keep the completed original for the department's records.

NB If it is not practicable to explain the reason why it is necessary to give the Permission, please do so as soon as practicable after Permission has been exercised.

What are the requirements when you are granting a permission to a person under the age of 18?

The same requirements set out above apply when issuing a Permission to an unaccompanied minor. However, the supervising Authorised Officer must have Working With Children Check, have regard to the special conditions in the Direction and Detention Notice as well as the person's status as a child.

What other directions can you give?

Section 200(1)(d) of the PHWA sets out an emergency power that allows an authorised officer to give any other direction that the authorised officer considers is reasonably necessary to protect public health.

What are your obligations when you require compliance with a direction?

Exercising this power imposes several obligations on departmental authorised officers including that an authorised officer must, before exercising any emergency powers, warn the person that refusal or failure to comply without reasonable excuse, is an offence.

Appendix 7 – Hotel Isolation Medical Screening Form

DHHS Hotel Isolation Medical Screening Form	
Registration Number:	
Full Name:	Male ☐ Female ☐ Other ☐
Address:	Indigenous ☐ Torres Strait Islander ☐
Phone Number:	Nationality:
Date of Birth:	Place of Birth:
Phone #:	Primary language:
Please provide the information requested below, as it may be needed in case of an emergency. This information does not modify the information on the emergency card.	
Allergies:	
Past Medical History: Alerts: Alcohol & Other Drugs Y/N Disability Y/N Significant Mental Health Diagnosis Y/N	
Medications:	
Regular Medical Clinic/Pharmacy:	
General Practitioner:	
Next of Kin	Contact Number:

Covid-19 Assessment Form

Name	DOB	Room	Date of Admission	mobile	

Ask patient and tick below if symptom present

Day	Date	Fever	Cough	SOB	Sore Throat	Fatigue	Needs further review (nurse assessment)	Reason (if needs further assessment)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								

Appendix 8 - Factsheet for use by healthcare workers in the event a detainee develops symptoms of COVID-19 whilst in mandatory hotel quarantine

In an emergency

In a medical emergency, an ambulance should be called on 000. This may take place from a resident (detainee), nurse, GP or other staff member on site. **There is no requirement for residents (detainees) to access or notify on-site staff prior to calling 000 in an emergency.** Ambulances attending the hotels should be given free access to the patient that called them. The 000 operator should be notified that the **patient is suspected COVID-19 and in compulsory hotel quarantine**

Nursing presence in hotels

Agency nurses suppled from "Your Nursing Agency" (YNA) are in place at each hotel on a 24/7 basis. The required nursing complement is continually reviewed according to the caseload and case types being reported at each hotel.

The current nursing complement at each hotel is:

- One Emergency Department (ED) trained registered nurse available 24/7
- Two general registered nurses available from 7.00am to 9.30pm
- One general registered nurse available from 9.00pm to 7.30am

In addition, mental health registered or enrolled nurses are being engaged at hotels where a growing mental health caseload is being identified. Currently, this is in place at Crowne Plaza, Crown Metropol and Crown Promenade with a view to rolling out to all quarantine sites.

A department-supplied mobile phone is provided to the nurses at each site. Residents can access the nurse either directly by phone, or via the hotel concierge.

The complement of nurses can be increased or decreased according to demand, by contacting the Public Health Logistics unit (publichealth.logistics@dhhs.vic.gov.au).

Medical presence in hotels

General Practitioners (GPs) supplied by Medi7 and Doctor Doctor are providing 24/7 medical support to residents.

GPs are currently being engaged at a ratio of one GP per two quarantine sites, with twice-weekly teleconferences between the Deputy State Health Coordinator and the directors of Medi7 and Doctor Doctor to review workload and vary this ratio if necessary.

GPs attend in person from 8.00am to 6.00pm daily and revert to telehealth arrangements at night.

GPs are currently available at the following locations:

- Crown Promenade – 2 GPs
- Park Royal, Tullamarine – 1 GP
- Rydges on Swanston – 1 GP
- A further GP will be on-site at Crown Promenade from Saturday 11 April to provide support to the extra hotels opening in the vicinity, and another on Monday 13 April.

GPs are contactable via the nurses at each location. After hours, the nurse may contact the on-call GP on REDACTED (from 6.00pm each night). The on-call GP can provide telehealth services as required or attend the relevant hotel.

Over long weekends and public holidays, a fleet of 8-10 deputising GPs is accessible to the on-site GPs should further assistance be required.

Appendix 9 - COVID-19 testing procedure for healthcare workers in hotels

1. Patient reports **possible COVID-19 symptoms** to hotel nurse either directly or via hotel concierge OR symptoms are identified during daily phone or text message checks by DHHS (as per Finn's guide- unclear if this is the same as welfare checks). (Symptoms include but are not limited to: fever, cough, sore throat, shortness of breath, fatigue).
2. Nurse on site to call the patient (detainee) and assess them **over the phone**
3. If face to face assessment is required, the nurse on site should assess the patient with appropriate PPE. **Droplet and contact PPE** is required for the nurse to enter the patient's room.
4. Security staff with appropriate PPE to accompany all nursing staff who are required to assess a patient in their hotel room. Security staff to wait outside unless requested to enter the room by nursing staff.
5. The nurse should then assess the patient for symptoms of COVID-19 to ensure they meet **current criteria for testing** (insert link to current case definition) and perform a nasopharyngeal swab (refer to swab guide/ one pager?)
6. Details of the detainee who has been swabbed must then be entered into a 'COVID-19 testing record form' (insert link) to be forwarded to DHHS at the end of each day.
7. The following details must be marked on **ALL** swabs taken from detainees:
    - Three identifiers: name, date of birth and address of detainee (address must be the hotel address of the detainee NOT their usual home address)
    - The swab must be clearly marked as a 'hotel quarantine swab' either in the clinical details section or on the top of the form e.g. "Swab for a person in mandatory quarantine in hotel Crown Metropol, room 1234".
    - The name and phone number of the **referring doctor** AND the **authorised officer** for the hotel **must** be listed on the pathology request form for each swab taken

    Each site has a twice-daily pathology courier pickup, transporting swabs taken from that site to VIDRL.

    Currently, the delivery of swabs to each hotel and the arrangement of couriers is being undertaken by REDACTED
8. If the patient is assessed as having only mild symptoms, they can **remain in their hotel room** in quarantine until the results of swabs are known.
9. If the detainee is deemed as needing medical assessment by a doctor, the nurse on site should contact the **doctor on call/ on site** for review.
10. If the detainee is deemed by the doctor on site to need assessment in hospital, the **AO must approve transfer of the detainee to hospital**. See "Process for transferring quarantined passengers to hospital".
11. The doctor who has assessed the patient must call 000 to arrange transfer to hospital and notify the 000 operator that the **patient is suspected COVID-19 and in compulsory hotel quarantine**.
12. The AO must provide the hotel doctor with a **form that must stay with the patient at all times** to assist AV/patient transport and hospital staff. This form details the period of enforced quarantine, instructions for how to accommodate the patient (single room only), visitor requirements, security requirements and how to seek AO endorsement for discharge or transfer the patient from hospital.
13. If the detainee being tested is well enough to await their results in their room but are sharing a room with another resident, they should be moved to a **separate room** if feasible and according to availability of rooms. If separation is not possible, they should practise **physical distancing** as far as is possible.
14. If the test is **positive** and the patient is well, they can remain in quarantine at the hotel but should be moved to a separate section/floor of the hotel which is designated for confirmed cases. If they are sharing with other people, then arrangements such as a separate room or provision of PPE may be required,

depending on the circumstances (for example it may not be feasible or appropriate to separate young children from parents).

15. For confirmed cases, they will be contacted daily by the department of health and advised when they can come out of mandatory quarantine.
16. It is the responsibility of the **referring doctor** to follow up the results of any swabs taken from detainees.
17. Hotels have also been asked to complete a daily tally of swabs conducted with details of detainees so these can be traced by the department (insert link to test record form).
18. **The referring doctor must notify the department of confirmed cases as soon as practicable by calling 1300 651 160, 24 hours a day.**
19. If the swab is negative, the patient must remain in hotel quarantine until they have completed their 14 day quarantine period and been assessed as having no symptoms of COVID-19 before release from detention.
20. For specific criteria for release from mandatory quarantine, see “release from mandatory quarantine criteria” section in main document.
21. Detainees with potential symptoms of COVID-19 who initially test negative, will be considered for repeat testing should they have **persistent symptoms** or **deteriorate** whilst in mandatory quarantine.

Appendix 10- COVID 19 Return Travelers Testing at VIDRL

VIDRL CONTACTS

- VIDRL Specimen Reception
- Operations Manager, Anna Ayres
- VIDRL registrar - Brian Chong

REDACTED

REQUEST FORMS

- VIDRL will be providing a pre-printed pathology request slips and specimen bags- please use these and not the agency forms
- Please ensure you include **Patient name, DOB, typical residential address** and **mobile phone** number (so DHHS can contact patients if needed)

The details of the Hotel have been added to the sender field (this is how we will identify where the reports are being sent from)**SWABS**

- Nasopharyngeal **and** throat swab for COVID-19 PCR. This can be on whatever swab you routinely use for respiratory viral testing i.e. dry/flocked/with VTM.
- Please ensure name and DOB are on the swab collected from each patient
- Place swab and pathology slip into specimen bag.
- Please bag all samples into provided zip lock bag when sending swabs to VIDRL
- We have also provided a foam Esky for the safe transportation of samples and to comply with the NPAAC guidelines for triple packaging (we will try to send Eskies back to you)

RESULTS

- **ALL** Return Travelers COVID testing results from **ALL** hotels will be faxed to the following fax number REDACTED **(Pan Pacific Hotel)**
- **Positive results will be notified to DHHS and to thethe Clinician/Nurse stationed at each Hotel**

Hotels	Nurses Phone	Hotels	Nurses Phone
▪ **Crowne Metropol**	REDACTED	▪ **Four points Hotel**	REDACTED
▪ **Plaza**		▪ **Park Royal (Airport) Hotel**	
▪ **Crowne Promenade**		▪ **Holiday Inn (Airport Hotel)**	
▪ **Pan Pacific**		▪ **Travel Lodge**	Pending notification
▪ **Mercure**		▪ **Ridges/Novatel**	Pending notification

PLEASE NOTE: DO NOT ADVISE PATIENTS TO CONTACT VIDRL DIRECTLY FOR RESULTS

Saved in TRIM For Information / Holding pattern - Draft Healthcare and Welfare Plan for Operation Soteria

From: "Finn Romanes (DHHS)" <REDACTED

To: "Annaliese Van Diemen (DHHS)" <REDACTED

Cc: REDACTED REDACTED REDACTED , "Claire Harris (DHHS)" REDACTED "Andrea Spiteri (DHHS)" >, "Jason Helps (DHHS)" "Meena Naidu (DHHS)" , "Brett Sutton (DHHS)"

Date: Fri, 17 Apr 2020 21:21:18 +1000

Attachments: Protocol for AO - Direction and Detention notice.DOCX (1.16 MB); Draft Mandatory Quarantine Health and Welfare Plan - 17 April 2020.docx (344.06 kB); Protocol for AO - Direction and Detention notice.tr5 (274 bytes); Draft Mandatory Quarantine Health and Welfare Plan - 17 April 2020.tr5 (292 bytes)

Hi Annaliese and Andrea and Jason

The team has drafted and we have worked over a draft Healthcare and Welfare Plan for Mandatory Quarantine.

Tomorrow, I understand REDA and Claire will come in and do some more work to locate and flesh out the appendices, but the body of the document is now in good shape, re-ordered and policy positions refreshed and duplications within the document removed.

Once they have finished, and have cross-checked against the Protocol for AOs plan (also attached for reference), then both are ready for a check-over by Meena, the Case and Contact Management Sector and then for State Health Coordinator.

They could then be reviewed by all the parties in the EOC that will use them or need them, and be ready for your endorsement and Andrea/Jason/REDACTED endorsement.

But as holding policy, they contain what the DPHC-Planning cell thinks is the current position on everything to do with healthcare and welfare, including recent policy calls on exit arrangements for COVID-19 positives etc, in case required in the next 24 hours.

Thanks for the chance to work on this, and hope the product we provide you all tomorrow afternoon / evening meets your needs, and safeguards the wellbeing of the people in detention.

Many kind regards

Finn

Dr Finn Romanes
Deputy Public Health Commander - Planning
Novel Coronavirus Public Health Emergency
REDACTED
REDACTED

Department of Health and Human Services
State Government of Victoria

COVID-19 Policy and procedures – Mandatory Quarantine (Direction and Detention Notice) V1

Authorised Officers under the *Public Health and Wellbeing Act 2008*

15 April 2020 Version 1

Working draft not for wider distribution

For URGENT operational advice contact

On call (as per the roster) DHHS Team leader

VICTORIA State Government | Health and Human Services

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For URGENT operational advice contact

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COVID-19 Policy and Procedure – Mandatory Quarantine (Direction and Detention Notice)

Authorised Officers under the *Public Health and Wellbeing Act 2008*

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

Available at insert web site or web page name and make this the live link <web page address>

Contents

Purpose

This purpose of this document is to:

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

Processes may be subject to change

It is acknowledged that the covid-19 response is a rapidly evolving situation and matters are subject to fluidity and change. This is particularly the case for the direction and detention notice and the use of hotels to facilitate this direction.

To this end, this document will not cover every situation and will be subject to change. For example, the process for collecting data and signed direction and detention notices may change.

This document aims to describe key responsibilities and provide a decision-making framework for AOs. AOs are encouraged to speak to compliance leads for further advice and guidance.

Direction and detention notices

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

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

More information can be obtained from:

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

AO Operational contacts

For URGENT operational advice contact the on call (as per the roster) DHHS Compliance management.

DHHS Compliance lead	Title	Contact details
Anthony Kolmus REDACTED	Human Services Regulator Health and Human Services Regulation and Reform Regulation, Health Protection and Emergency Management Department of Health and Human Services	p REDACTED e. REDACTED
REDACTED	State-wide Manager - Regulatory Compliance & Enforcement Human Services Regulator | Health & Human Services Regulation & Reform Branch Regulation, Health Protection & Emergency Management Division Department of Health & Human Services	REDACTED
REDACTED	Manager Environmental Health Regulation & Compliance Environmental Health Regulation & Compliance Unit Health Protection Branch Regulation, Health Protection & Emergency Management Division Department of Health and Human Services	REDACTED REDACTED

At a glance: Roles and responsibilities

The role of an AO is primarily focussed on compliance and meeting obligations under the PHWA.

AOs should be aware that their role and scope is related to administration of, and compliance with, the direction and detention notice under the *Public Health and Wellbeing Act 2008*.

Table 1 is a high-level description of the responsibilities of each role not a specific list of functions.

Table 1 Roles and responsibilities of staff at hotels

Role	Responsibility	Authority
Authorised Officers under the *Public Health and Wellbeing Act 2008* at airport and hotels	Primary responsible for: • administration of, and ensuring compliance with, the Direction and Detention Notices (27 March 2020 and 13 April 2020) • meeting obligations under the PHWA (noting it is expected that the Compliance Lead conducts the review of those subject to detention). AOs are encouraged to keep records (written or electronic) of compliance and other issues they become aware of.	*Public Health and Wellbeing Act 2008* s199 Direction and Detention Notices (No 1 and No 2)
Hotel site lead	• Supports the health and well-being of staff, • Liaises with airport command and staff from other departments and agencies represented at the hotel • Provides situational awareness and intelligence to inform transport providers, state-level emergency management arrangements and airport operations • Provides a point of reference to all site-staff to help resolve operations, logistics or site-related issues and / or escalations required • Ensures appropriate records management processes are in place.	
Medical staff	• Provide 24 hour on-call medical support subject to demand • Provide welfare to detainees through a daily welfare check — welfare officers email covid-19.vicpol@dhhs.vic.gov.au and phone the site AO individually to alert AO of medical and welfare issues • Provide a satisfaction survey for residents to complete each week.	Contracted by DHHS.

Department and hotel staff	• Capture client personal needs, e.g. dietary, medication, allergies, personal hygiene needs • Deliver hyper-care (concierge) services onsite • Manage contracts with accommodation providers • Manage transport arrangements from the airport • Manage material needs including food and drink.	

AOs should be cognisant that persons subject to detention will be tired and stressed. AO may need to use conflict negotiation and mediation skills to help persons settle into the new environment.

Background

Key points

- The detention policy is given effect through the direction and detention notices.
- AOs should be clear on their authorisation before commencing enforcement activities.

Background to the mandatory quarantine (detention) intervention

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

The objectives of the plan for people returning from overseas to Victoria are:

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

Enforcement and Compliance Command for Mandatory Quarantine

Deliverables of the enforcement and compliance function

The Physical Distancing Compliance Lead under the Covid-19 Public Health Incident Management Team [1] is responsible for:

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

Authorised officer* and Chief Health Officer obligations

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

[1] Director, Health and Human Services Regulation and Reform (Lead Executive – COVID-19 Compliance)[1]

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

Note: Any AO that is unsure as to whether you have been authorised under s. 199 should contact administrative staff in the department's Health Protection Branch prior to enforcing compliance with the Direction and Detention Notices.

Mandatory requirements for AOs

- AOs have mandatory obligations that must be followed before carrying out functions.
- AO must show ID card before carrying out actions/exercising powers
- AO must explain to the person the reason why it is necessary to detain them – if not practicable, it must be done as soon as practicable
- AO must warn the person that refusal or failure to comply without reasonable excuse, is an offence before carrying out actions/exercising powers
- AO must facilitate a reasonable request for communication
- Lead AO must review every 24 hours, whether continued detention of the person is reasonably necessary to eliminate or reduce a serious risk to health
- AO must give written notice to the CHO that detention has been made and if it is reasonably necessary to continue detention to eliminate or reduce the serious risk to public health.

The notice to the CHO must include:

- the name of the person being detained
- statement as to the reason why the person is being, or continues to be, subject to detention.

Following receipt of a notice, the CHO must inform the Minister as soon as reasonably practicable.

** A departmental Authorised Officer under the PHWA that has been authorised for the purposes of the emergency order*

Use of a Business System –Quarantine and Welfare System COVID-19 Compliance Application

The Quarantine and Welfare System is comprised of two applications:

- COVID-19 Compliance Application - This application supports Authorised Officers to maintain Detainee and Detention Order records
- COVID-19 Welfare Application (not part of Authorised Officer responsibilities).

A **User Guide** is available to guide Authorised Officers.
Support email for users: ComplianceandWelfareApplicationSupport@dhhs.vic.gov.au
Support will be active between 8am and 8pm. You can email support for access issues, technical issues, application use questions. A **phone number** will also be provided shortly.

Authorised officers and powers

Key points

- AOs must only act within their legal authority.
- AOs must follow mandatory requirements before carrying out powers.

Authorisation under section 200 for the purposes of the emergency order

Only departmental AOs under the PHWA that have been authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the PHW can exercise emergency powers under section 200. The powers extend only to the extent of the emergency powers under section 200 and as set out in the PHWA.

AOs are encouraged to read Part 9 and seek advice from Compliance Lead if they are unsure in the administration of their powers

Powers and obligations under the Public Health and Wellbeing Act 2008

The general powers are outlined under Part 9 of the PHWA (Authorised Officers). The following is an overview of powers and obligations. It does not reference all powers and obligations.

Authorised officer obligations:

Produce your identity card - s166

Before exercising powers provided to you under the PHWA:
At any time during the exercise of powers, if you are asked to show your ID card
As part of good practice, you should produce your identity card when introducing yourself to occupiers or members of the public when attending complaints or compliance inspections.

Inform people of their rights and obligations

You may request a person to provide information if you believe it is necessary to investigate whether there is a risk to public health or to manage or control a risk to public health.
Before exercising any emergency powers, you must, unless it is not practicable to do so, warn the person that a refusal or failure to comply without a reasonable excuse, is an offence.

Charter of Human Rights obligations

Key points

- AO must act compatibly with human rights.
- AO must give 'proper consideration' to the human rights of any person(s) affected by an AO's decision.

Department AO obligations under the *Charter of Human Rights and Responsibilities Act 2006*

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

How to give 'proper consideration' to human rights

1. understand in general terms which human rights will be affected by a decision
2. be aware of how the decision will limit or interfere with the relevant human rights
3. consider what impact the decision will have on the rights of all the people affected by the decision
4. balance the competing private and public interests to assess whether restricting a person's human rights

The relevant Charter Human Rights that departmental AOs need to be aware of that may be affected by a decision:

Charter Right	Obligation
Right to life	• This includes a duty to take appropriate steps to protect the right to life and steps to ensure that the person in detention is in a safe environment and has access to services that protect their right to life
Right to protection from torture and cruel, inhuman or degrading treatment	• This includes protecting persons in detentions from humiliation and not subjecting persons in detention to medical treatments without their consent
Right to freedom of movement	• while detention limits this right, it is done to

Charter Right	Obligation
	minimise the serious risk to public health as a result of people travelling to Victoria from overseas
Right to privacy and reputation	• this includes protecting the personal information of persons in detention and storing it securely
Right to protection of families and children	• this includes taking steps to protect families and children and providing supports services to parents, children and those with a disability
Property Rights	• this includes ensuring the property of a person in detention is protected
Right to liberty and security of person	• this includes only be detained in accordance with the PHWA and ensuring steps are taken to ensure physical safety of people, such as threats from violence
Rights to humane treatment when deprived of liberty	• this includes treating persons in detention humanely.

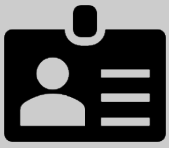
Airport

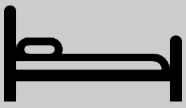
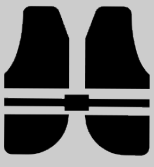
Key points

- AO must follow mandatory requirements first (e.g show ID card, etc).
- AO must check that a direction and detention notice is filled in properly.
- AO must provide factsheet and privacy collection notice to person.

Key responsibilities

The following outlines required procedures at the airport for departmental Authorised officers.

Authorised Officers* Responsibility		Mandatory obligation	Section (PHWA)
	• must declare they are an Authorised Officer and show AO card	Yes	Section 166
	• must provide a copy of the Direction and Detention Notice to each passenger (notification to parent/guardian may need to be conducted over the phone and interpretation services may be required) and: – explain the reasons for detention – warn the person that refusal or failure to comply with a reasonable excuse is an offence and that penalties may apply – **remind the person they must keep their detention notice.** • if practicable at this time, provide the person with a copy of the department's privacy collection notice. If not practicable, this can be provided at the hotel.	Yes. If it is not practicable to explain the reason for detention prior to subjecting the person to detention, the AO must do so as soon as practicable. This may be at the hotel, however every effort should be made to provide the reason at the airport [s. 200(3)] **(mandatory AO obligation)**.	Section 200(2) and 200(4)

	• ensure the Direction and Detention Notice: – states the name/s of the person being detained, date of birth and mobile phone number (if applicable) – states the name of AO – contains signature of person being detained – contains signature of AO – contains the hotel name at which the person will be detained – contains date the person will be detained till (14 days).		
	• record issue and receipt of the notice through a scanned photograph and enter into COVID19 Compliance application[2] • request person subject to detention present to AO at hotel		
	• facilitate any reasonable request for communication, such as a phone call or email and including if necessary, organising a translator to explain the reasons for detention (call Victorian Interpretation and translation service on 9280 1955. PIN code is 51034	Yes	Section 200(5)
	• provide a fact sheet about detention (what a person in detention can and can't do, who to contact for further information)		
	• record any actions taken in writing, including the above mandatory obligations, use of translator and any associated issues.		
	• use the list of arriving passengers to check off the provision of information to each arrival. • This will help ensure all arrivals have been provided the information in the Direction and Detention Notice.		
	• check the vehicle transporting a person in detention is safe (in accordance with the review of transport arrangements procedure).		

** DHHS Authorised Officer under the PHWA that has been authorised for the purposes of the emergency order*

[2] The Business system referred to here is the Quarantine and Welfare System COVID-19 Compliance Application

Supplementary roles

Authorised Officer review of transport arrangements to hotel

While these matters are not mandatory compliance obligations, as a matter of good practice AO should check the following:

Direction and detention notice	Sufficient physical distance	Vehicle is sanitised	Is PPE required?
Check the person has been issued with the notice before boarding vehicle Check there are welfare check survey forms available for each person to be detained to complete enroute or at the hotel	Check the distance between the driver and person to be detained. If not sufficient, wait for next transport. Windows should be slightly open	Check vehicle has been sanitised before people board If the vehicle has not been sanitised, it must be cleaned in accordance with department advice	If physical distance of >1.5m can be maintained no PPE required. If this cannot be maintained, then mask and hand hygiene (no gloves).

Other airport issues

People who are unwell at the airport

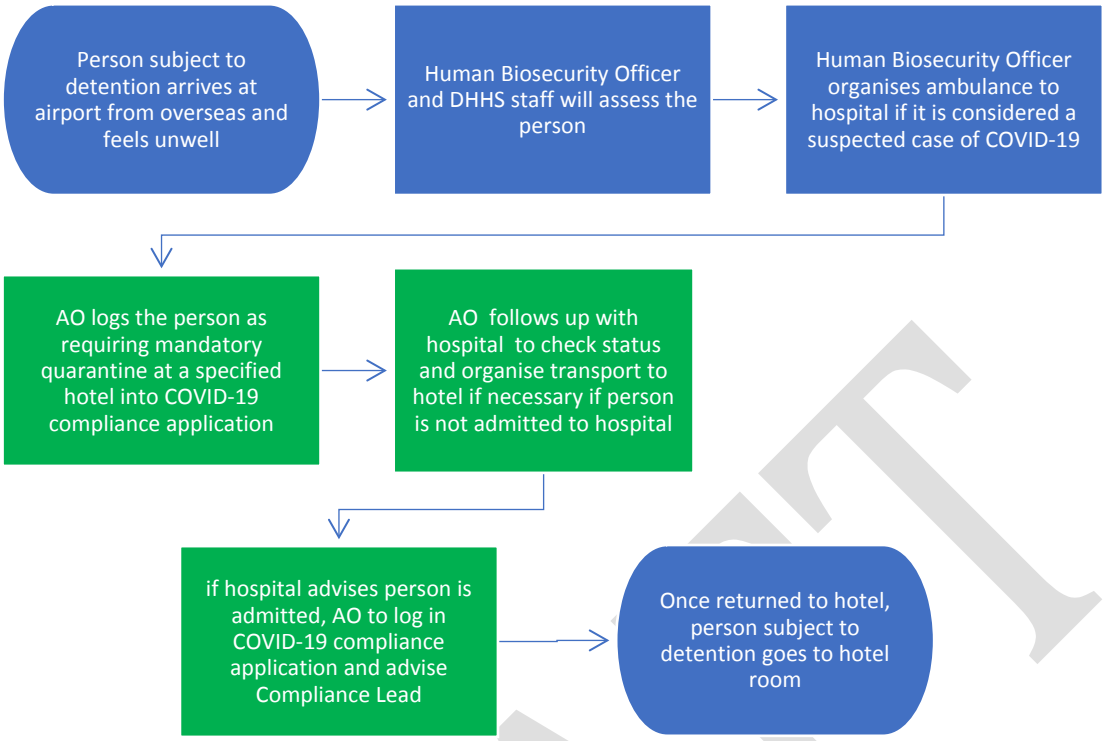
The lead for this situation is the Human Biosecurity Officer on behalf of the Deputy Chief Health Officer (Communicable Disease).

Any person who is unwell at the airport will be assessed by a departmental staff member and biosecurity officer at the airport.

After discussion with the human biosecurity officer, if it is determined that the person meets the criteria as a suspected case, the following actions should take place:

- The human biosecurity officer should organise an ambulance transfer to the Royal Melbourne Hospital or Royal Children's Hospital for testing and assessment
- The department AO at the airport should log the person as requiring mandatory quarantine at a specified hotel and then should follow-up with the hospital to update on whether the person has been found to be negative, so a transfer by (patient transfer/ambulance/ maxi taxi etc) can be organised to return to the hotel
- If the person is unwell and requires admission, they should be admitted and the AO lead informed
- If the person is well enough to be discharged they should return to the hotel through an arrangement by the authorised officer, (refer to points above) and be placed in a COVID-19 floor if positive, or in a general part of the hotel if tested negative for COVID-19. An AO may need to make contact with the hospital to confirm arrangements.

Figure 1 – person subject to detention is unwell at airport (AO roles in green)



Transfer of uncooperative person to be detained to secure accommodation (refer to Authorised Officer review of transport arrangements procedure)

It is recommended that a separate mode of transport is provided to a person who is to be detained who is uncooperative to a hotel or other location for the 14-day isolation. Contact Compliance Lead to discuss the situation and possibility of alternative transport.

Ensure appropriate safety measures are taken including child locks of doors and safety briefing for drivers etc.

At the hotel

Key points

- AO reiterates detention requirements and the penalties that apply for non-compliance.
- AO oversees and provides advice on compliance and works with security, hotel staff, other staff and medical staff.

Key responsibilities at check-in

At hotel check-in:

- Person to be detained provides Direction and Detention Notice to hotel staff; hotel staff to write on the notice:
  - room number
  - the date that the person will be detained until (14 days after arrival at place of detention).
- Person to be detained provides completed Direction and Detention Notice to AO to confirm that the following details on the notice are correct:
  - the hotel name;
  - hotel room number and arrival date, time and room on notice;
  - the date that the person will be detained until (14 days after arrival at place of detention).
- AO reiterates detention requirements
- AO retains the copy of the person's Direction and Detention Notice and enters details of this into COVID-19 Compliance Application (to be confirmed)*. Please note that this process may not be achievable at the current time and is to be confirmed. In future, data entry staff may undertake this process.
- Following any medical and welfare check of the person, AO to liaise with nurses to identify persons being detained with medical or special needs.
- AO to note persons being detained with medical or special needs, such as prescription and medical appointments.

Persons being detained will be sent to their allocated room and informed that a person will contact them in the afternoon or next day

AOs to make themselves known to on-site security.

Possible changes to hotel-check in process

As of 14 April 2020, DHHS is exploring using data entry staff at each hotel to input scanned copies of the direction and detention notice and data into the Compliance Application. This would mean that the AO at the hotel is primarily responsible for compliance related issues and associated notes.

Monitoring compliance related issues at the hotel

- AOs should check that security are doing some floor walks to encourage compliance and deter non-compliance.
- AO will oversee and provide advice on compliance-related issues such as requests for temporary leave, a person refusing to comply and a person demanding to be removed from detention. AOs may be called upon by security, hotel staff, or nursing staff to remind a person the reason for the detention and the penalties if they do not comply. There may be a need, in consultation with a nurse or medical

practitioner, to refer a person for a welfare check or further assistance. Help of this nature may support compliance and a person's wellbeing.

- AOs may need to answer questions from hotel staff, security and police as to what persons may be permitted or not permitted to do.
- AOs must facilitate any reasonable requests for communication. For translation, call Victorian Interpretation and translation service on REDACTED
- AOs are to make notes of compliance related issues and actions. The means of recording notes are dependent of the availability and use of technology and could include the Compliance Application, written contemporaneous notes in a notebook or other electronic records.
- AO should provide a handover (verbal and high-level information) to the incoming AO to get an update of any problems or special arrangements. For example, some people are permitted to attend cancer therapy at Peter Mac etc. This information should be also uploaded as high-level notes in the COVID 19 Compliance Application.

Non- compliance matters outside scope of Authorised Officer

- AOs should be aware that their role and scope is related to administration of, and compliance with, the direction and detention notice under the PHWA. Being aware of other non-compliance related issues in a hotel may be helpful, however they are outside the scope. Non-compliance related issues may include food quality, organising transport, removing items from care packs such as perishables and alcohol and ordering food such as Uber eats.
- AOs may request DHHS concierge staff escalate non-compliance related issues.

Compliance Lead to undertake review each day

- A Compliance Lead will – at least once every 24 hours – review whether the continued detention of the person is reasonably necessary to protect public health [s. 200(6)] **(mandatory AO obligation).**
- A Compliance Lead will undertake an electronic review of detainment arrangements by viewing COVID-19 Compliance Application. This includes reviewing:
  - the date and time of the previous review (to ensure it occurs at least once every 24 hours)
  - number of detainees present at the hotel
  - duration each detainee has been in detention for, to ensure that the 14-day detention period is adhered to
  - being cleared of COVID-19 results while in detention
  - determining whether continued detention of each detainee is reasonably necessary to eliminate or reduce a serious risk to health
  - consideration of the human rights being impacted – refer to 'Charter of Human Rights' obligations
  - any other issues that have arisen.

Decision making

To inform decision-making, the Compliance Lead should:

- consider that the person is a returned overseas traveller who is subject to a notice and that they are obliged to comply with detainment
- consider that detainment is based on expert medical advice that overseas travellers are of an increased risk of COVID-19 and form most COVID-19 cases in Victoria
- note the date of entry in Australia and when the notice was given
- consider any other relevant compliance and welfare issues the AO becomes aware of, such as:
  - person's health and wellbeing
  - any breaches of self-isolation requirement
  - issues raised during welfare checks (risk of self-harm, mental health issues)

  - actions taken to address issues
  - being cleared of COVID-19 results while in detention
  - any other material risks to the person
- record the outcomes of their review (high level notes) for each detained person (for each 24-hour period) in the **COVID-19 Compliance Application** . This allows ongoing assessment of each detainee and consideration of their entire detention history

To ascertain any medical, health or welfare issues, the Compliance Lead may need to liaise with on-site nurses and welfare staff and specialist areas within the department.

Mandatory reporting (mandatory AO obligation)

A Compliance Lead will give written notice to the Chief Health Officer as soon as is reasonably practicable that:

- a person has been made subject to detention
- following a review, whether continued detention is reasonably necessary to eliminate or reduce the serious risk to public health.

The notice to the CHO must include:

- the name of the person being detained
- statement as to the reason why the person is being, or continues to be, subject to detention.

To streamline, the reporting process will involve a daily briefing to the CHO of new persons subject to detention and a database of persons subject to detention. The database will specify whether detention is being continued and the basis for this decision.

The CHO is required to advise the Minister for Health of any notice [s. 200(9)].

Possible release from detention based on review

The daily review by the Compliance Lead could identify that detention may no longer be required (with the approval of the Compliance Lead and Public Health Commander). These matters will be referred to the Physical Distancing Compliance Lead and Public Health Command for review and decision.

Grant of leave from detention

Key points

- AOs must be aware of how requests for exemption from quarantine are escalated.
- AO can make decisions on temporary leave for simple requests such as exercise.
- AO must complete Permission for Temporary Leave from detention form / enter in COVID-19 compliance Application and the Permissions Register must be filled in.

Considerations

Temporary leave from the place of detention (Detention notice)

Any arrangements for approved leave would need to meet public health (and human rights) requirements. It will be important that the AO balances the needs of the person and public health risk.

For example, if the person needs immediate medical care, public health risks need to be managed appropriately, but the expectation is that the leave would automatically be granted. This would be more nuanced and complex when the request is made on compassionate grounds where there is a question about how public health risks might be managed. However, again, human rights under the Charter need to be considered closely.

For temporary leave, AOs are NOT required to escort people from and to their place of detention. Taxis should be organised for transport to and from their leave (unless an ambulance is required).

AO should refer to the '*Permission for Temporary Leave from Detention'* guide at **Appendix 2.**

There are four circumstances under the Direction and Detention Notice in which permission to leave the room may be granted:

1. For the purpose of attending a medical facility to receive medical care
2. Where it is reasonably necessary for physical or mental health
3. On compassionate grounds
4. Emergency situations

COVID-19 Escalation procedure for requests for leave from people in quarantine

Persons emailing covidquarantine@dhhs.vic.gov.au

People in detention should email their request, with as much detail as possible, to COVIDdirections@dhhs.vic.gov.au

- If the request relates to a person in a quarantine hotel seeking an exemption to complete their quarantine elsewhere or to be allowed to vary their quarantine (e.g. in order to go to hospital or to leave their room for a fresh air break), COVIDdirections staff will forward the request on to the COVIDQUARANTINE email address.
  - NB All requests from people in quarantine that do not relate specifically to requesting an exemption from quarantine as per the above will be dealt with by COVIDdirections staff.
- Staff on the COVIDQUARANTINE email will forward the request to the AO rostered on at the hotel. The AO should do an initial assessment of whether they are able to deal with the matter themselves or that the request requires more information (e.g. from nurses / EM staff) and escalation to be considered.

- If it is a basic request covered by the detention and direction notice (i.e. needing to go to hospital, wanting a fresh air break) the AO can make the decision and action accordingly. Where the decision requires transportation of the person, the AO is to inform the onsite Team Leader that transport will be required.
- More complex requests should be escalated by email to the relevant Compliance Manager assigned to that hotel (see AO Hotel Roster) and cc'd to COVIDQUARANTINE
- If the Compliance Manager;
  - makes a decision they delegate the implementation of that decision accordingly and cc COVIDQUARANTINE and the Compliance Lead. Where the decision requires the transportation of the person the Compliance Lead will also cc SEMC.
  - does not believe they are authorised to make a decision on the request they should escalate it to the Compliance Lead (Anthony Kolmus) and cc COVIDQUARANTINE.
- If the Compliance Lead;
  - makes a decision on the request they delegate the decision accordingly and cc COVID QUARANTINE and the Compliance Lead. Where the decision requires the transportation of the person, the Compliance Lead will also cc SEMC
  - does not believe they have the authority to make the decision (e.g. any exemptions relating to travelling interstate or overseas must go to the CHO/DCHO), the matter is to be escalated directly to COVIDQUARANTINE with a recommendation and seeking a decision from the CHO/DCHO.
- Once a decision is received from the CHO/DCHO, they inform COVIDQUARANTINE who informs the Compliance Lead who delegates implementation of the decision and notifies SEMC as relevant.
- Details of the exemption given should also be forwarded to the COVID Policy area for consideration as a potential future protocol.

Recommendation for leave by on-site nurse, medical practitioner of welfare staff

Where the request for an exemption comes from or is recommended by the onsite nurses or EM welfare staff:

- The person recommending the exemption contacts the AO and outlines why they believe an exemption should be considered.
  - The default position is that the person on whose behalf the request has been suggested should be consulted about the request but there may be times where this is not appropriate.
- Remainder of process as per third dot point under "Persons emailing covidquarantine@dhhs.vic.gov.au' above.

Urgent medical attention

- If medical care is deemed urgent by an on-site nurse or medical practitioner, the AO should prioritise and approve leave immediately.
- Please see Hospital Transfer Plan.

Other requests

- Requests are also sometimes received from external sources such as Members of Parliament. These should be sent to COVIDQUARANTINE and triaged as per the above guidance.

Physical health (exercise) – see procedure at end of this chapter

- AO will consider the circumstances on a case-by-case basis to determine if permission is granted. Considerations include:
  - willingness and availability of security to facilitate exercise
  - site layout and capability to ensure persons are in a cordoned off area
  - maintaining infection control.

- AO may wish to seek advice from Compliance Lead for advice.
- AO to make decision and action accordingly.

Recording leave

If AO or Compliance Lead approves leave be granted, the AO:

- should complete a Permission for Temporary Leave from detention form for the person, **Appendix 1** and Register of leave form, **Appendix 10,** or
- enter in Compliance Application if available.

Emergency situations

- Department AOs and Victoria Police officers may need to determine the severity of any emergency (such as a building fire, flood, natural disaster etc) and the health risk they pose to persons in detention.
- If deemed that numerous persons in detention need to leave the premises due to an emergency, a common assembly point external to the premises should be utilised; persons in detention should be accompanied at all times by a department authorised officer or a Victoria Police officer, and infection prevention and control and social distancing principles should be adhered to
- The accompanying departmental AO or a Victoria Police officer should ensure that all relevant persons in detention are present at the assembly point by way of a register of persons in detention.
- AO's should make notes.

Procedure for a person in detention / resident to leave their room for exercise or smoking

Request for temporary leave will be considered in the context of what other activities are being undertaken (arrivals/departures and staffing considerations) and may not always be able to be accommodated. This may be site and capacity dependant.

A person must be compliant and must not have symptoms before they could be allowed to have supervised exercise or a smoking break. Only well residents from the same room should be able to go out to exercise at the same time.

Role of AO

AO should:

- confirm security is prepared and available to facilitate exercise or smoking break
- instruct security on the dates and time permitted for leave
- provide procedural guidance to security and the person in detention, such as exercising in a cordoned off area not access by members of the public
- seek feedback on implementation of temporary leave and note any issued raised
- confirm appropriate infection control measures are in place
- advise on physical distancing requirements.

Guidance for person in detention

The steps that must be taken by the person in detention are:

- Confirm to the person who will escort them that they are well.
- Confirm to the person who will escort them that they have washed their hands immediately prior to leaving the room.

- Don a single-use facemask (surgical mask), to be supplied by the security escort prior to leaving the room.
- Perform hand hygiene with alcohol-based handrub as they leave, this will require hand rub to be in the corridor in multiple locations.
- Be reminded to – and then not touch any surfaces or people within the hotel on the way out, and then not actually do it.
- They return immediately to their hotel room.

Guidance for security escort

Security escort should:

- Don a single-use facemask (surgical mask) if a distance of >1.5 metres cannot be maintained when escorting the person;
- Perform hand hygiene with an alcohol-based handrub or wash hands in soapy water;
- Remind the person they are escorting to not touch any surfaces or people within the hotel on the way out or when coming back in
- Be the person who touches all surfaces if required such as the lift button or door handles (where possible using security passes and elbows rather than hands);
- Wherever possible, maintain a distance (1.5 metres) from the person;
- Perform hand hygiene with an alcohol-based handrub or wash hands in soapy water at the end of each break and when they go home
- Exercise should be undertaken in a cordoned off area with no public access or interaction.

Other considerations

Points to remember when using a single-use facemask (surgical mask):

- Always perform hand hygiene before donning the mask.
- Mould the metal clip over the bridge of the nose and ensure the bottom of the mask fits snuggly under the chin.
- Avoid touching or adjusting the mask once it has been donned.
- Unless damp or soiled, masks may be worn for the duration of a shift for up to four hours.
- Masks must be removed and disposed of for breaks and then replaced if needed.
- Masks must never be partially removed (for example, top tie undone and left dangling around the neck) and then re-worn.
- Perform hand hygiene immediately before and after removal of the mask.

There is no requirement to wear gloves and this is not recommended, as many people forget to take them off and then contaminate surfaces. Hand hygiene is one of the most effective ways to prevent the spread of infection and gloves should not be seen as a substitute for hand hygiene. If gloves are worn, remove the gloves immediately after the person is back in their room and then wash your hands.

In addition:

- Family groups may be taken out in a group provided it is only 2 adults and less than 5 in total.
- They can be taken to an outside area with sunlight, for up to 15 minutes outside of the hotel.
- Smokers can take up to 2 breaks per day if staffing permits.
- Rostering to be initiated by the departmental staff/AO present.

Supporting smokers to quit smoking

The preferred option is support smokers to quit or manage withdrawal while confined to their hotel room. This would mean that smokers be supported to manage cravings while they are unable to smoke but would not be forced to quit.

Further work to support to support this approach would include provision of approved nicotine replacement therapies (NRT) with meal deliveries, accompanied by counselling through the Quitline. DHHS to explore opportunities to incorporate provision of NRT and counselling.

Hospital transfer plan

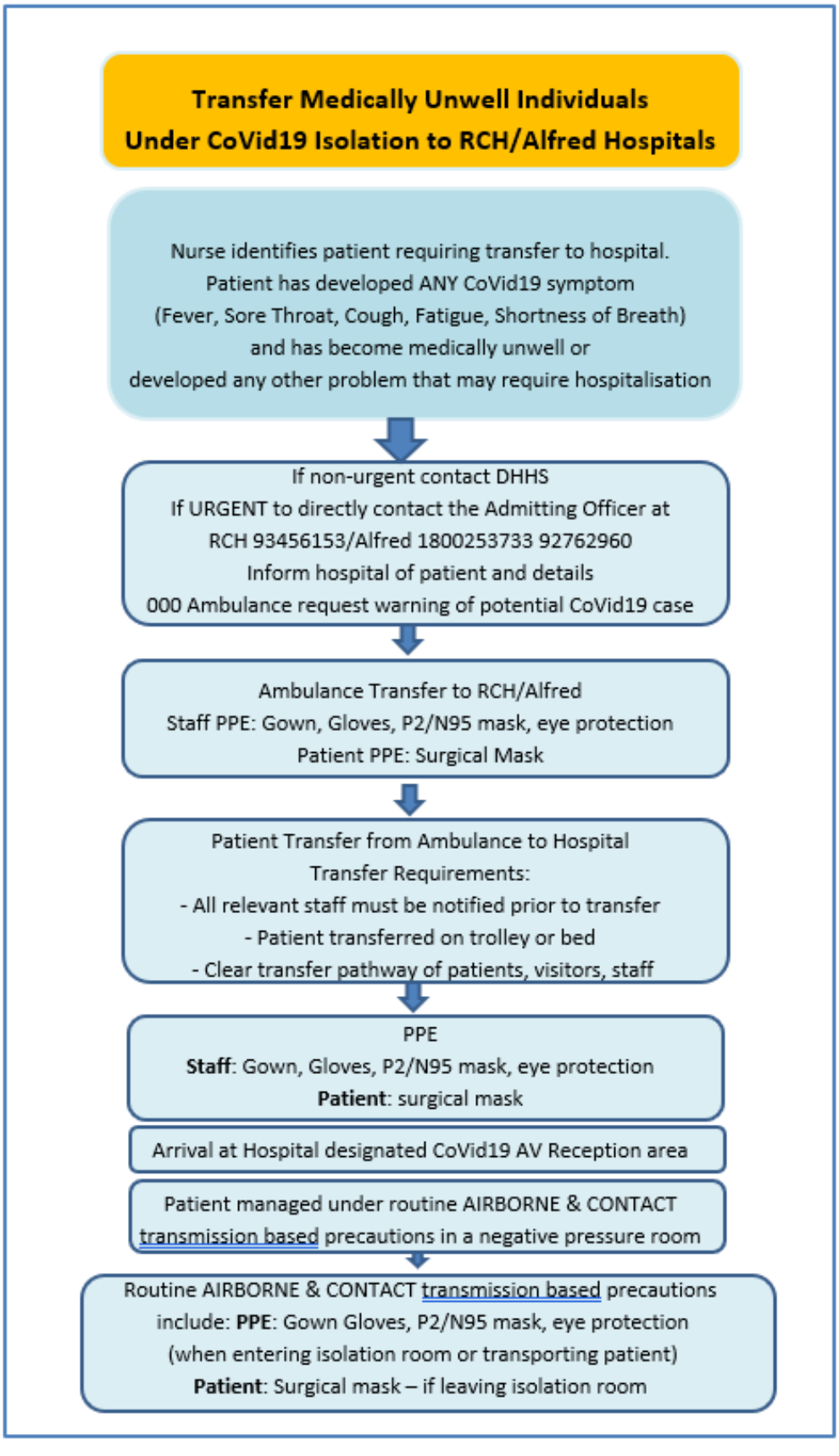
The following is a general overview of the transfer of a patient to hospital involving nurses, doctors, AOs, Ambulance Victoria (AV) and hospitals. AOs are not responsible for arranging transport.

The bold highlight AO interactions.

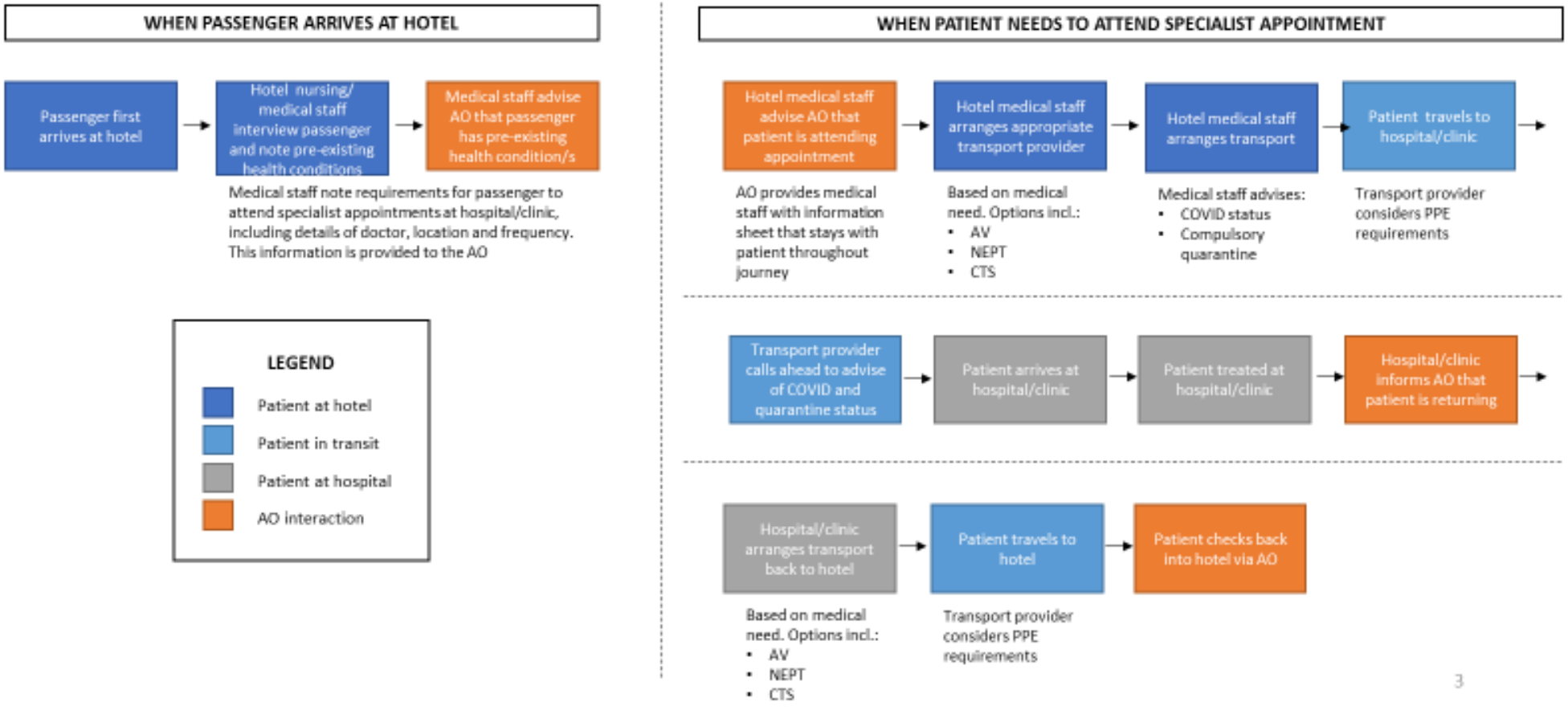
- Nurse/doctor assess that patient requires hospital care
- **There is also a one pager to explain to AO how to grant permission at Appendix 2 Permission to temporarily leave. Leave should be recorded on the COVID-19 Compliance Application or register.**
- **All relevant staff including AO must be notified prior to the transfer.**
- Patient is transferred to the appropriate hospital. Patients requiring hospital assessment/treatment for suspected or confirmed COVID-19 or other conditions, should be transferred to either the Royal Melbourne Hospital (RMH) or The Alfred Hospital, depending on proximity **(note children should be transferred to the Royal Children's Hospital).**
- If the hospital transfer is urgent call 000 to request ambulance and inform them that the passenger is a suspected (or confirmed) case of COVID-19. This takes priority over any AO requirements.
- Contact the Admitting Officer at RCH/RMH/the Alfred, inform the hospital of patient and details.
- Staff should don full PPE and the passenger must wear a single-use surgical mask if tolerated.
- The passenger should be transferred on a trolley or bed from ambulance into the designated COVID-19 ambulance reception area.
- The patient should be managed under routine airborne and contact transmission-based precautions in a negative pressure room if available. The patient should wear a single-use surgical mask if leaving the isolation room.
- Ambulance services will list the hotels as an area of concern in case of independent calls and will ask on site staff to assess need for attendance in the case of low acuity calls.
- All residents who are: in high risk groups, unwell, breathless or hypoxic (O2 sats <95%) should be considered for hospital transfer.
- Assessment and diagnosis made as per medical care and plan made for either admission to same hospital or more appropriate medical care or for discharge. (receiving hospital ED)
- Prior to any movement of the patient out of the ED a new plan or detention approval must be sought for either return or admission to different location in consultation with compliance team (receiving hospital and compliance team).
- AO to provide contact number of AO t update if the patients will return to the hospital.

The flow diagrams below outline the processes, including interactions with AO for the transfer and return of a patient.

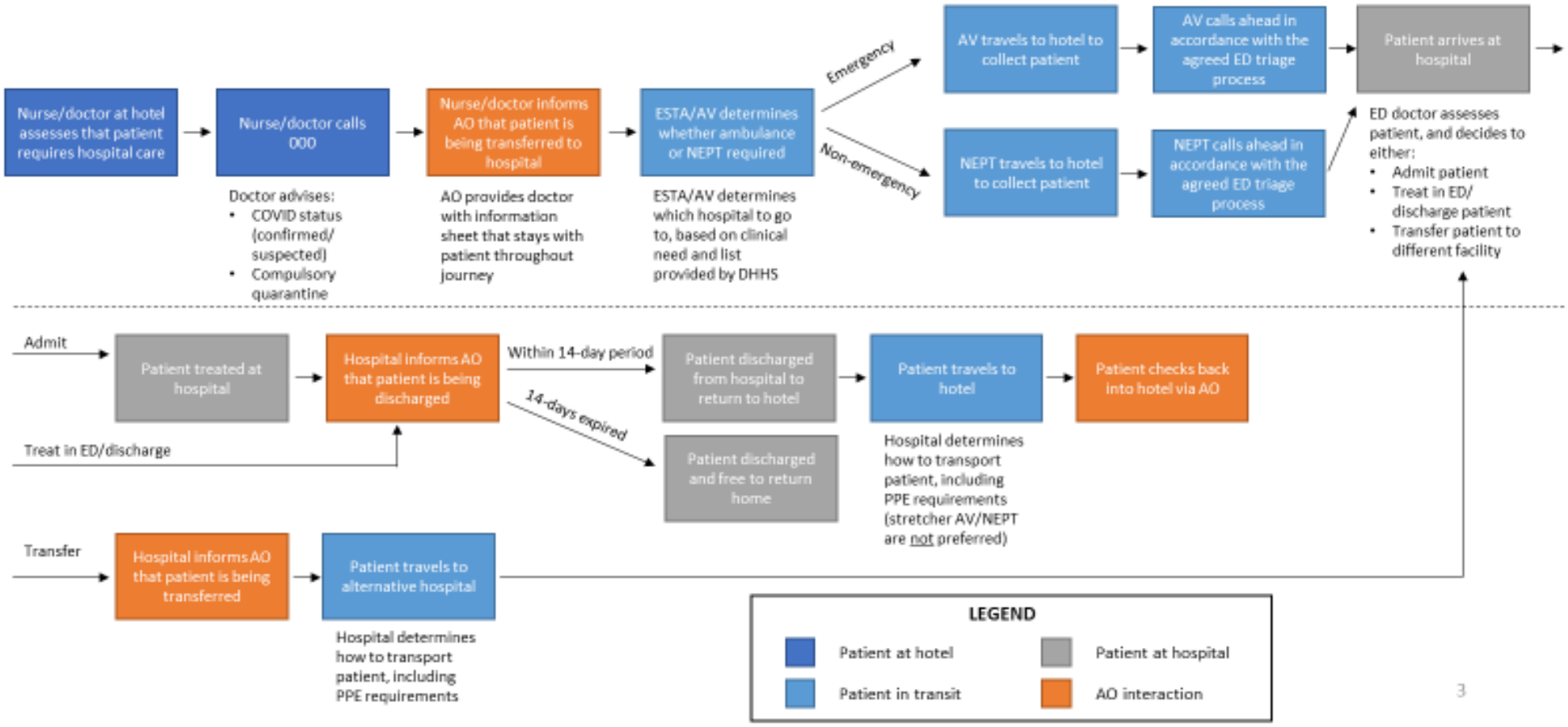
DHHS is endeavouring to organise patient transport arrangements.



Process to transfer passengers to hospital (planned)



Process to transfer passengers to hospital (unplanned)



Compliance

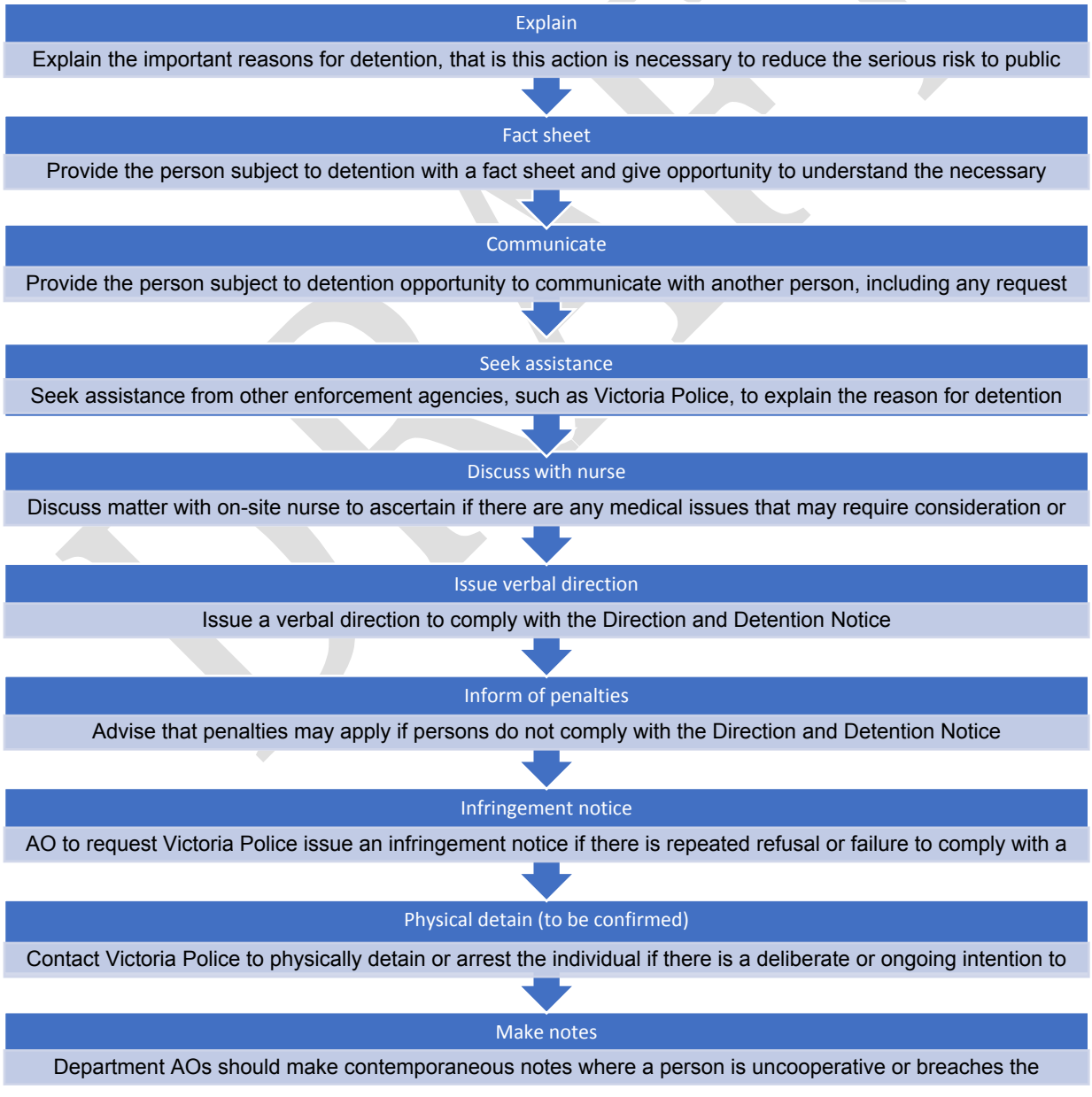
Key Point

- **The role of an AO in compliance is only to exercise the powers under section 199 of the PHWA. We are seeking advice on any arrests, including moving people into detainment or physical contact with a person must be managed by Victoria Police.**

Options to facilitate compliance

Department AOs should make every effort to inform the person of their obligations, facilitate communication if requested and explain the important rationale for the direction. Non-compliance could take the form of a person refusing to comply with the direction at the airport or hotel.

The following graduated approach should guide AOs:



Unauthorised departure from accommodation

If there is reason to believe a person subject to detention is not complying with the direction and detention notice, the AO should:

- notify on-site security and hotel management
- organise a search of the facility
- consider seeking police assistance
- notify the compliance lead if the person subject to detention is not found

If the person is located, the AO should:

- seek security or Victoria Police assistance if it is determined the person poses a risk of trying to leave
- provide an opportunity for the person to explain the reason why they left their room
- assess the nature and extent of the breach, for example:
  - a walk to obtain fresh air
  - a deliberate intention to leave the hotel
  - mental health issues
  - escaping emotional or physical violence
- consider issuing an official warning or infringement through Victoria Police
- reassess security arrangements
- report the matter to the Director, Regulation Reform.

Departmental AOs should make contemporaneous notes where a person is uncooperative or breaches a direction.

Infringements

On 28 March 2020, the Public Health and Wellbeing Regulations 2019 were amended to create four new infringement offences. These are:

Table 1 List of infringements

Section (PHWA)	Description	Amount
s.183	Hinder or obstruct an authorised officer exercising a power without reasonable excuse (5 penalty units).	5 penalty units (PU)
s.188(2)	Refuse or fail to comply with a direction by CHO to provide information made under s.188(10 without a reasonable excuse.	10 PU natural person, 30 PU body corporate
s.193(1)	Refuse or fail to comply with a direction given to, or a requirement made or, a person in the exercise of a public health risk powers (10 penalty units for natural person and 60 penalty units for body corporate).	10 PU natural person, 30 PU body corporate
s.203(1)	Refuse or fail to comply with a direction given to, or a requirement made or, a person in the exercise of a public health risk powers (10 penalty units for natural person and 60 penalty units for body corporate).	10 PU natural person, 30 PU body corporate

Policy and procedure on unaccompanied minors

Key points

- unaccompanied minors will be dealt with on a case by case basis.
- If an unaccompanied minor is detained in a hotel without parents, specific processes must apply.

Instances where an unaccompanied minor is captured by a detention order must be managed on a case by case basis.

In general, there is a presumption that there are no exemptions granted to mandatory quarantine. The issues in relation to mandatory quarantine of unaccompanied minors include: where this occurs, and with what adult supervision.

Preliminary legal advice is that the State could issue a detention order to a person under 18 years who is unaccompanied outside the home (a person in the care of the state) if certain conditions are met. These must include:

- AO has to check in regularly
- Person can easily contact parent / guardian
- Has adequate food
- Remote education is facilitated.

A detention notice for minors to undertake detention outside of a hotel will be supplied in this protocol shortly.

There is guidance for AOs on how to comply with the Charter of Human Rights in relation to unaccompanied minors at Appendix 4.

When an unaccompanied minor normally resides outside Victoria

It is proposed that where there is no clear alternative, an unaccompanied minor who normally resides outside of Victoria may be facilitated to undertake detention in their normal home state of residence, with appropriate risk management of any possible exposures to others on a domestic flight out of Victoria to that state. The department will need to be satisfied that the receiving state will take the person under 18 years and manage public health risks.

When an unaccompanied minor is normally resident in Victoria

It is proposed that an adult (who is not themselves a returned overseas traveller) who supervises a minor should join that minor at a place of detention. If that occurs, the adult should then remain with that person in quarantine although there is no legislative power to issue a direction to that adult to detain the adult.

If an unaccompanied minor who normally resides in Victoria is unable to be joined by a parent / guardian (for example because that parent / guardian has other caring duties and cannot thus join the minor in detention) then on a case by case basis, an assessment will be undertaken to identify whether detention is to be served in the home.

An alternative arrangement (i.e. parents join them in quarantine or quarantine at home) to self detention is to be considered for an unaccompanied minor. Please also see **Appendix 3.**

If a child is quarantined at home with their parents, a detention notice should still be provided to the child and parents outlining the same requirements for children as if they were in quarantine in

a hotel, together with the guidance about advice to close contacts in quarantine. Legal services will adapt notices for that purpose.

AOs monitoring unaccompanied minors should have current Working with Children Checks and understand their reporting requirements under the Reportable Conduct Scheme.

When a minor is detained at their home

If it is determined to be appropriate to detain a child at home after a risk assessment, the arrangement will involve:

- Issuing a detention order naming the specific home and / or parts of the home, and
- The detention order will be accompanied by advice on minimising risk of transmission to others in the home where the minor is detained (equivalent to advice to close contacts in quarantine); and
- An Authorised Officer will undertake a process to undertake a review each day in the manner required by the Act.

When an unaccompanied minor is detained in a hotel

If an unaccompanied minor is detained in a hotel without parents, a specific notice and process is below.

- A Detention Notice – Solo Children, is found at **Appendix 5.**
- A guideline for authorised officers in this respect is found at **Appendix 4**.

This is a more intensive process for the authorised officers, which is commensurate with the additional risk of quarantining a child because the child is subject to the care of the Chief Health Officer and the department.

Escalation of issues

Should an AO become aware of any concern about a child, the AO must:

- contact the department's welfare teams immediately. Child Protection contact details for each Division: https://services.dhhs.vic.gov.au/child-protection-contacts. West Division Intake covers the City of Melbourne LGA: 1300 664 977.
- contact after hours child protection team on 13 12 78 if an AO thinks a child may be harmed and Victoria Police on 000 if the immediate safety of a child is at risk.

Departure – release from mandatory detention

Key points

- AOs are responsible for the compliance check out.

Background

Prior to release of a person being detained, they will be provided with an End of Detention Notice, **Appendix 8** or an End of Detention Notice (confirmed case or respiratory illness symptoms), **Appendix 9** that confirms release details and specifies requirements to follow. Detention is 14 days from the date of arrival and ends at 12am on the last day. No-one will be kept past their end of detention.

Pre check-out

- Exit Notices and associated materials prepared and dropped to hotel.
- Early hours releases transport booked (DJPR).
- Early hours releases documentation actioned by AO evening prior.
- Notices for all persons subject to detention placed under doors (by Security).

The person in detention will be:

- notified they are due for release from detention in 48 hours
- notified that a health check to determine their status is recommended
- provided information for people exiting quarantine on transport and other logistical matters.

Health check

- The health checks on the second last day prior to the 14-day period ending must be used to make an assessment of whether the person is well, symptomatic or positive.
- Everyone will be offered a voluntary temperature and symptom check by a nurse around 24 hours before release.
- If people being detained have a temperature or other symptoms of coronavirus before leaving or at the health check, this will not affect the completion of their detention. They will not be detained for longer than the 14-day quarantine period, even if they have symptoms consistent with coronavirus. However, if they do have symptoms at the health check, when they are released, they will need to seek medical care and self-isolate as appropriate, as do all members of the community.

Day of release

- Security door knocks early departures and they can leave
- Security door knocks exiting detainees at agreed time and brings people to exit location.

Checkout process

- The release process will consist of an organised check out procedure (the compliance check out). This will mean people being detained will be released in stages throughout a set time period on the day of release. Travelling parties will be brought down to reception in stages to complete the check out process. People being detained will also need to settle any monies owing to the hotel for additional meals and drinks if they have not already done so. Physical distancing must be maintained throughout this process.
- At check-out, the AO will:
  - request to see identification and the End of Detention notice
  - confirm the person's identification and room number on exit sheet

- confirm the period of detention and explain detention period has ceased, including highlighting other requirements
- site and sign the End of Detention notice and provide to the person
- mark the person off an exit list as being discharged and request that they sign the list confirming discharge
- provide cab charge
- update the Compliance Application (note this may be a data entry update after the process has been completed).

Occupational health and safety (OHS) for Authorised Officers

Key points

- OHS is a shared responsibility of both the employer and the employee. AOs must raise hazards, concerns and incidents.
- AOs must take steps to protect themselves from transmission of covid-19 and adhere to physical distancing protocols wherever possible

Purpose

The purpose of this section is to provide an occupational health and safety procedure for department AOs when attending off site locations during the current State of Emergency.

Health Emergency

Coronaviruses are a large family of viruses that cause respiratory infections. These can range from the common cold to more serious diseases. COVID-19 is the disease caused by a new coronavirus. It was first reported in December 2019 in Wuhan City in China.

Symptoms of COVID-19 can range from mild illness to pneumonia. Some people will recover easily, and others may get very sick very quickly which in some cases can cause death.

Compliance Activity

On 16 March 2020 a State of Emergency was declared in Victoria to combat COVID-19 and to provide the Chief Health Officer with the powers he needs to eliminate or reduce a serious risk to the public.

Under a State of Emergency, Authorised Officers, at the direction of the Chief Health Officer, can act to eliminate or reduce a serious risk to public health by detaining people, restricting movement, preventing entry to premises, or providing any other direction an officer considers reasonable to protect public health.

Using a roster-based system, AOs will be placed on call to exercise authorised powers pursuant to section 199 of the PHWA. **AOs compliance role is only to exercise the powers under section 199 of the Act, any arrests, including moving people into detainment or physical contact a person must be managed by Victoria Police**.

OHS

OHS is a shared responsibility of both the employer and the employee. Officers must raise hazards, concerns and incidents with REDACTED

One of the foremost issues associated with site attendance is the 'uncontrolled environment' that exists. AOs can be exposed to infectious diseases (such as COVID-19), confrontational and/or aggressive members of the public who may be drug affected, mentally ill or intellectually impaired. The very nature of this work is likely to be perceived as invasive and can provoke a defensive response.

Risks can be minimised by maintaining routine safe work practices and proper planning. Prior to any site visit, risks and hazards should be identified and assessed.

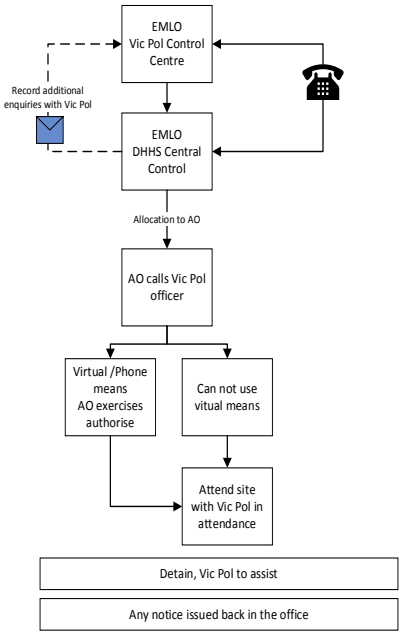
Officers and managers both have a shared responsibility for occupational health and safety. All employees have a responsibility to report and discuss hazards or perceived hazards, by bringing this to the managers attention.

Fatigue

AOs will be rostered on a rotating basis, with the aim of mitigating the risk of fatigue. Fatigue may impede decision making capability and when driving a motor vehicle to a location. When fatigue is identified please make this known to your manager.

To mitigate the risk of fatigue, AOs should be aware of any fatigue they may have. A good tool to use to help officers identify their level of fatigue is to use the following calculator:
http://www.vgate.net.au/fatigue.php

AOs are required to hold a valid motor vehicle licence and are required to adhere to the requirements of the department's driving policy. Information about this policy can be found on the DHHS intranet site.



Risk assessment before attendance | Personal Protection

Officers must only take a direction to attend a site with the approval of the Central DHHS Emergency Management Liaison Officer or DHHS management.

In the first instance, officers are required to use technology (i.e: mobile phone, Facetime, Skype) to exercise their authority. This aims to protect officers from attending an uncontrolled environment, where the risk of harm is increased.

Before attending a site, whether an airport or a hotel, the officer should make themselves familiar with the recommendations produced by the Australian Government and the Department of Health and Human Services, in the protection against COVID-19.

Interventions are known as 'transmission reduction, or 'physical distancing' measures. Officers can take the following personal measure to reduce their risk of exposure to COVID-19. Officers with pre-existing medical conditions that put them more at risk of COVID-19, should discuss this with their medical practitioner and manager.

Personal measures to reduce risk the risk of exposure to COVID

AO must take steps to protect themselves from transmission of covid-19 and adhere to physical distancing protocols wherever possible. Example include:

- Stay healthy with good nutrition, regular exercise, sensible drinking, sleeping well, and if you are a smoker, quitting.
- Wash your hands often with soap and water for at least 20 seconds, especially after you have been in a public place, or after blowing your nose, coughing, sneezing, or using the toilet. If soap and water are not readily available, use a hand sanitiser that contains at least 60 per cent alcohol.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Cover your nose and mouth with a tissue when you cough or sneeze. If you don't have a tissue, cough or sneeze into your upper sleeve or elbow.
- Stop shaking hands, hugging or kissing as a greeting.
- Ensure a **distance of 1.5 metres** is kept between yourself and others.
- Get vaccinated for flu (influenza) as soon as available. This could help reduce the risk of further problems. *Note: the department covers expenses for vaccines, speak to your manager for more details.*
- Clean and disinfect high touch surfaces regularly, for example: telephones, keyboards, door handles, light switches and, bench tops.

When an officer is called to attend the airport or a hotel to exercise powers in relation to the Direction and Detention notice they should take a **risk-based approach** and assess the most suitable way to reduce harm to themselves. Before attending, the officer must obtain information such as:

- Is the person being detained a positive case of COVID-19?
- Has the person being detained been recently in close contact with a positive case of COVID-19?
- Has the person being detained recently returned from overseas within the last 14 days?

Officers are required to use their discretion and take into account their own personal safety. The Department of Health and Human Services has provided the following PPE:

- Single-use surgical mask
- Gloves
- Hand Sanitizer.

AOs going onto floor of hotel

AOs going onto hotel the floors with persons subject to detention must wear masks. There should be P2/N95 respirators/masks for AO's at the hotels (in addition to the surgical masks).

AO's should not enter the room in which a person is being detained. Communication should be from the corridor or outside the room.

Relocating covid-19 positive person

- This process is lead by the nurses/medical staff, who are trained and prepared for it.
- The nurses and security staff are to go up to the patient's room and collect the patient in full PPE. Again, security are just there to ensure the nurses are safe.
- The AO will then go up in a SEPARATE lift in PPE and meet them on the new floor where the patient is going to be. From a safe distance (over 1.5 meters away, the AO is then to very briefly state that the patient was in room(x) and now has been moved to room(y) as a result of their positive result. The AO WILL THEN LEAVE IN A SEAPARATE LIFT TO THE SECURITY/NURSING STAFF.
- The Team Leader can assist in this process by facilitating the room change from an admin perspective and helping with coordinating the nursing staff etc.

Measures and guides to enhance occupational health and safety

PPE/measure	Guide
Single-use face mask (surgical mask)	When there is known case of COVID-19, or a person subject to detention has been recently exposed to COVID-19 and a distance of at least 1.5 metres cannot be maintained.
Gloves	If contact with the person or blood or body fluids is anticipated.
Hand hygiene / Hand Sanitizer Soap and water	Always
Physical distancing of at least 1.5 meters	Always

Known risks and hazards

Hazard	Risk	Mitigate
COVID-19 infection	Serious illness / death	Follow personal protective measures
Fatigue	Impaired decisions / driving to site	In the first instance use virtual technology to perform duties Use fatigue calculator http://www.vgate.net.au/fatigue.php
Physical Injury	Low / Medium	Only attend a site with Victoria Police or with security.
Other infectious agents		Follow personal protective measures

Appendix 1 - Permission for temporary leave from detention

PERMISSION FOR TEMPORARY LEAVE FROM DETENTION

Public Health and Wellbeing Act 2008 (Vic)

Section 200

An Authorised Officer has granted you permission to leave your room based on one of the grounds set out below. This is temporary. You will be supervised when you leave your room. You must ensure you comply with all the conditions in this permission and any directions an Authorised Officer gives you. You must return to your room at the time specified to finish your detention. Speak to your supervising Authorised Officer if you require more information.

Temporary leave

(1) You have arrived in Victoria from overseas, on or after midnight [on 28 March 2020 or 13 April 2020] and have been placed in detention, pursuant to a Direction and Detention Notice that you were provided on your arrival in Victoria (**Notice**).

(2) This Permission for Temporary Leave From Detention (**Permission**) is made under paragraph 4(1) of the Notice.

Reason/s for, and terms of, permission granting temporary leave

(3) Permission for temporary leave has been granted to: _____ _____ [insert name] for the following reason/s [tick applicable]:

☐ (a) for the purpose of attending a medical facility to receive medical care:

Name of facility: _____

Time of admission/appointment:_____

Reason for medical appointment:_____

☐ (b) where it is reasonably necessary for physical or mental health:

Reason leave is necessary:_____

Proposed activity/solution:_____

☐ (c) on compassionate grounds:

Detail grounds:_____

(4) The temporary leave starts on _____

and ends on _____ [insert date and time].

_____ **Signature of Authorised Officer**

Name of Authorised Officer: _____

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

Conditions

(5) You must be supervised **at all times**/may be supervised *[delete as appropriate]* while you are out of your room. You are not permitted to leave your hotel room, even for the purpose contained in this Permission, unless you are accompanied by an Authorised Officer.

(6) While you are outside your room you must practice social distancing, and as far as possible, maintain a distance of 1.5 metres from all other people, including the Authorised Officer escorting you.

(7) When you are outside your room you must refrain from touching communal surfaces, as far as possible, such as door knobs, handrails, lift buttons etc.

(8) When you are outside your room you must, at all times, wear appropriate protective equipment to prevent the spread of COVID-19, if directed by the Authorised Officer escorting you.

(9) When you are outside your room you must, at all times, comply with any direction given to you by the Authorised Officer escorting you.

(10) At the end of your temporary leave, you will be escorted back to your room by the Authorised Officer escorting you. You must return to your room and remain there to complete the requirements under the Notice.

(11) Once you return to the hotel, you must proceed immediately to the room you have been allocated above in accordance with any instructions given to you.

(12) You must comply with any other conditions or directions the Authorised Officer considers appropriate.

(Insert additional conditions, if any, at Annexure 1)

Specific details

(13) Temporary leave is only permitted in limited circumstances, to the extent provided for in this Permission, and is subject to the strict conditions outlined at paragraph 3. You must comply with these conditions at all times while you are on temporary leave. These conditions are reasonably necessary to protect public health, in accordance with section 200(1)(d) of the Public Health and Wellbeing Act 2008 (Vic).

(14) Permission is only granted to the extent necessary to achieve the purpose of, and for the period of time noted at paragraph 2 of this Permission.

(15) Nothing in this Permission, invalidates, revokes or varies the circumstances, or period, of your detention, as contained in the Notice. The Notice continues to be in force during the period for which you are granted permission for temporary leave from detention. The Notice continues to be in force until it expires.

Offences and penalties

(16) It is an offence under section 203 of the Act if you refuse or fail to comply with the conditions set out in this Permission, unless you have a reasonable excuse for refusing or failing to comply.

(17) The current penalty for an individual is $19,826.40.

Appendix 2 Guidance Note: Permission for Temporary Leave from Detention

How do you issue a Permission for Temporary Leave from Detention?

It is recommended that Authorised Officers take the following steps when issuing a Permission for Temporary Leave from Detention:

Before you provide the Permission for Temporary Leave from Detention

- carefully consider the request for permission and consider the grounds available under paragraph 4(1) of the Direction and Detention Notice – which include:
  - for the purposes of attending a medical facility to receive medical care; or
  - where it is reasonably necessary for your physical or mental health; or
  - on compassionate grounds.
- complete all sections of the Permission, including clearly documenting the reasons for the Permission, date and time when the temporary leave is granted from and to, and whether the person will be supervised by the authorised officer during the temporary leave
- ensure the reference number is completed.

When you are provide the Permission for Temporary Leave from Detention

- you must warn the person that refusal or failure to comply without reasonable excuse, is an offence;
- explain the reason why it is necessary to provide the Permission and the conditions which apply to the temporary leave (including that the person is still subject to completing the remainder of the detention once the temporary leave expires, and the Permission is necessary to protect public health);
- provide a copy of the Permission to the person, provide them with time to read the Permission and keep the completed original for the department's records.

NB If it is not practicable to explain the reason why it is necessary to give the Permission, please do so as soon as practicable after Permission has been exercised.

What are the requirements when you are granting a permission to a person under the age of 18?

The same requirements set out above apply when issuing a Permission to an unaccompanied minor. However, the supervising Authorised Officer must have Working With Children Check, have regard to the special conditions in the Direction and Detention Notice as well as the person's status as a child.

What other directions can you give?

Section 200(1)(d) of the PHWA sets out an emergency power that allows an authorised officer to give any other direction that the authorised officer considers is reasonably necessary to protect public health.

What are your obligations when you require compliance with a direction?

Exercising this power imposes several obligations on departmental authorised officers including that an authorised officer must, before exercising any emergency powers, warn the person that refusal or failure to comply without reasonable excuse, is an offence.

Appendix 3 Guidance: Exemptions under Commonwealth law

Australian Government
Department of Health

Coronavirus disease (COVID-19)

Exemptions to the 14 day mandatory quarantine period for international travellers

The Australian Health Protection Principal Committee (AHPPC) recognise that there should be some exemptions from quarantine requirements for specific industry groups, provided they adhere to specified risk mitigations measures. These specific exemptions are recommended because of the industry infection prevention requirements, training these groups have undergone, and the vital role of these industries in Australia.

While these are national recommendations, mandatory quarantine is enforced under state and territory public health legislation. Individual states and territories may choose to implement additional requirements at the point of arrival.

Some jurisdictions may also have additional quarantine requirements upon entry to the state or territory. Depending on the jurisdiction, this could mean that an international traveller is required to go into mandatory quarantine at the first point of arrival into Australia, and further quarantine upon entry to another jurisdiction.

The following groups are recommended to be exempt from the 14 day mandatory quarantine requirements when entering Australia. While these groups are exempt from mandatory quarantine, **all** arrivals into Australia **must** continue to practise social distancing, cough etiquette and hand hygiene. Other requirements, such as self-isolation, may still apply and are outlined below.

Aviation crew

International flight crew (Australian residents/citizens)

- Are not required to undertake 14 days of mandatory quarantine on arrival.
- Are not required to complete the Isolation Declaration Card.
- Are not required to self-isolate.

International flight crew (foreign nationals)

- Are not required to undertake 14 days of mandatory quarantine on arrival.
- Are not required to complete the Isolation Declaration Card.
- Must self-isolate in their hotel on arrival until their next flight.
- Must use privately organised transport to transfer to and from hotels between flights.
- May fly domestically to their next point of departure from Australia if required.

Domestic flight crew

- Exempt from self-isolation requirements *except when a state or territory specifically prohibits entry.*

Maritime crew (excluding cruise ships)

- Are not required to undertake 14 days of mandatory quarantine on arrival into Australia. They are therefore not required to complete the Isolation Declaration Card.
- Must proceed directly to the vessel on arrival.

Exemptions to the 14 day mandatory quarantine period, version 2 (06/04/2020)
Coronavirus Disease (COVID-19) 1

- If access to the vessel is not immediate, crew must self-isolate at their accommodation during any lay-over period.
- May travel domestically and/or take a domestic flight to meet their vessel at the next point of departure if required.
- At the completion of their shifts, they are not required to go into mandatory 14 days quarantine, but must undertake 14 days self-isolation.
- Time at sea counts towards the 14 days of self-isolation if no illness has been reported on-board. Therefore crew signing off commercial vessels that have spent greater than 14 days at sea, with no know illness on-board, do not need to self-isolate on arrival.

Unaccompanied minors

Unaccompanied minors will be allowed to travel domestically after entering Australia to self-quarantine with a parent or guardian at their home.

Transit passengers

- International transit passengers arriving into Australia are able to depart on another international flight if the following conditions are met:
  - If the individual has up to 8 hours until the departing international flight, they must remain at the airport and be permitted to onward travel, maintaining social distancing and hand hygiene.
  - If 8-72 hours before the departing flight, they must go to mandatory quarantine at the state designated facility until the time of the departing flight.
- No domestic onward travel is allowed, even if this is to meet a departing international flight. These people should go into mandatory quarantine at the state designated facility at the first point of arrival.

Diplomats

- Australia has legal obligations under the Vienna Convention to ensure diplomats freedom of movement and travel, and protection from detention. Diplomats are not required to undertake 14 days of mandatory quarantine on arrival into Australia. They are therefore not required to complete the Isolation Declaration Card.
- Diplomats should self-isolate at their mission or in their usual place of residence on arrival for 14 days.
- Diplomats must continue to practise social distancing, cough etiquette and hand hygiene.

Compassionate or medical grounds

Applications on medical or compassionate grounds should be submitted to the relevant state or territory who will consider requests on a case-by-case basis.

Contact details for state or territory public health agencies are available at www.health.gov.au/state-territory-contacts.

Where can I get more information?

For the latest advice, information and resources, go to www.health.gov.au.

Call the National Coronavirus Helpline on 1800 020 080. This line operates 24 hours a day, seven days a week. If you require translating or interpreting services, call 131 450.

Appendix 4 - Guidance note: Ensuring physical and mental welfare of international arrivals in individual detention (unaccompanied minors)

Introduction

You are an officer authorised by the Chief Health Officer under section 199(2)(a) of the *Public Health and Wellbeing Act 2008* (Vic) to exercise certain powers under that Act. You also have duties under the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**Charter**).

These Guidelines have been prepared to assist you to carry out your functions in relation to Victorian unaccompanied minors who have arrived in Victoria and are subject to detention notices, requiring them to self-quarantine in a designated hotel room for 14 days in order to limit the spread of Novel Coronavirus 2019 (**2019-nCoV**) where no parent, guardian or other carer (**parent**) has elected to join them in quarantine (a **Solo Child Detention Notice**).

As part of your functions, you will be required to make decisions as to whether a person who is subject to a Solo Child Detention Notice should be granted permission to leave their room:

- for the purposes of attending a medical facility to receive medical care; or
- where it is reasonably necessary for their physical or mental health; or
- on compassionate grounds.

Authorised Officers are also required to review the circumstances of each detained person at least once every 24 hours, in order to determine whether their detention continues to be reasonably necessary to eliminate or reduce a serious risk to public health.

Your obligations under the Charter of Human Rights and Responsibilities Act 2006

You are a public officer under the Charter. This means that, in providing services and performing functions in relation to persons subject to a Detention Notice you must, at all times:

- act compatibly with human rights; and
- give 'proper consideration' to the human rights of any person(s) affected by your decisions.

How to give 'proper consideration' to human rights

'Proper consideration' requires you to:

- **first**, understand in general terms which human rights will be affected by your decisions (these rights are set out below under 'relevant human rights');
- **second**, seriously turn your mind to the possible impact of your decisions on the relevant individual's human rights, and the implications for that person;
- **third**, identify the countervailing interests (e.g. the important public objectives such as preventing the further spread of 2019-nCoV, which may weigh against a person's full enjoyment of their human rights for a period of time); and
- **fourth**, balance the competing private and public interests to assess whether restricting a person's human rights (e.g. denying a person's request to leave their room) is justified in the circumstances.

Relevant human rights

The following human rights protected by the Charter are likely to be relevant to your functions when conducting daily wellbeing visits and when assessing what is reasonably necessary for the physical and mental health of children who are subject to Solo Child Detention Notices:

- The right of children to such protection as is in their best interests (s 17(2)). As the Solo Child Detention Notices detain children in circumstances where no parent has elected to join them in quarantine, greater protection must be provided to these children in light of the vulnerability that this creates. Where possible the following additional protection should be provided:
- You should undertake two hourly welfare checks while the child is awake and once overnight. You should ask the child to contact you when they wake each morning and let you know when they go to sleep so that this can be done.
- You should ask the child if they have any concerns that they would like to raise with you at least once per day.
- You should contact the child's parents once per day to identify whether the parent is having contact with the child and whether the parent or child have any concerns.
- You should ensure that where the child does not already have the necessary equipment with them to do so (and their parent is not able to provide the necessary equipment) the child is provided with the use of equipment by the department to facilitate telephone and video calls with their parents. A child must not be detained without an adequate means of regularly communicating with their parents.
- You should ensure that where the child does not already have the necessary equipment with them to do so (and their parent is not able to provide the necessary equipment) the child is provided with the use of equipment by the department to participate in remote education if that is occurring at the school they are attending. Within the confines of the quarantine you should obtain reasonable assistance for the child in setting up that computer equipment for use in remote education.
- You should allow the child's parents to bring them lawful and safe items for recreation, study, amusement, sleep or exercise for their use during their detention. This should be allowed to occur at any time within business hours, and as many times as desired, during the detention.
- The rights to liberty (s 21) and freedom of movement (s 12), and the right to humane treatment when deprived of liberty (s 22). As the Solo Child Detention Notices deprive children of liberty and restrict their movement, it is important that measures are put in place to ensure that the accommodation and conditions in which children are detained meet certain minimum standards (such as enabling parents to provide detained children with food, necessary medical care, and other necessities of living). It is also important that children are not detained for longer than is reasonably necessary.
- Freedom of religion (s 14) and cultural rights (s 19). Solo Child Detention Notices may temporarily affect the ability of people who are detained to exercise their religious or cultural rights or perform cultural duties; however, they do not prevent detained persons form holding a religious belief, nor do they restrict engaging in their cultural or religious practices in other ways (for example, through private prayer, online tools or engaging in religious or cultural practices with other persons with whom they are co-isolated). Requests by children for additional items or means to exercise their religious or cultural practices will need to be considered and accommodated if reasonably practicable in all the circumstances.
- The rights to recognition and equality before the law, and to enjoy human rights without discrimination (s 8). These rights will be relevant where the conditions of detention have a disproportionate impact on detained children who have a protected attribute (such as race or disability). Special measures may need to be taken in order to address the particular needs and vulnerabilities of, for example Aboriginal persons, or persons with a disability (including physical and mental conditions or disorders).
- The rights to **privacy, family and home** (s 13), **freedom of peaceful assembly** and **association** (s 16) and the **protection of families** (s 17). Solo Child Detention Notices are likely to temporarily

restrict the rights of persons to develop and maintain social relations, to freely assemble and associate, and will prohibit physical family unification for those with family members in Victoria. Children's rights may be particularly affected, to the extent that a Solo Child Detention Notice results in the interference with a child's care and the broader family environment. It is important, therefore, to ensure children subject to Solo Child Detention Notices are not restricted from non-physical forms of communication with relatives and friends (such as by telephone or video call). Requests for additional items or services to facilitate such communication (e.g. internet access) will need to be considered and accommodated if reasonably practicable in all the circumstances.

Whether, following 'proper consideration', your decisions are compatible with each these human rights, will depend on whether they are reasonable and proportionate in all the circumstances (including whether you assessed any reasonably available alternatives).

General welfare considerations

All persons who are deprived of liberty must be treated with humanity and respect, and decisions made in respect of their welfare must take account of their circumstances and the particular impact that being detained will have on them. Mandatory isolation may, for some people, cause greater hardship than for others – when performing welfare visits you will need to be alert to whether that is the case for any particular person.

In particular, anxieties over the outbreak of 2019-nCoV in conjunction with being isolated may result in the emergence or exacerbation of mental health conditions amongst persons who are subject to Detention Notices.

If you have any concerns about the mental health of a detained person, you should immediately request an assessment of mental health be conducted and ensure appropriate support is facilitated. Hotel rooms are not normally used or designed for detention, so you should be aware that a person who is detained in a hotel room could have greater opportunity to harm themselves than would be the case in a normal place of detention.

Additional welfare considerations for children

Children differ from adults in their physical and psychological development, and in their emotional and educational needs. For these reasons, children who are subject to Solo Child Detention Notices may require different treatment or special measures.

In performing functions and making decisions with respect to a detained person who is a child, the best interests of the child should be a primary consideration. Children should be given the opportunity to conduct some form of physical exercise through daily indoor and outdoor recreational activities. They should also be provided with the ability to engage in age-appropriate activities tailored to their needs.

Each child's needs must be assessed on a case-by-case basis. Requests for items or services to meet the needs of individual children will need to be considered and accommodated if reasonably practicable in all the circumstances.

Where available, primary school age children should be allocated rooms that have an outside area where it is safe for active physical play to occur (not a balcony) and consideration should be given to allowing small children access to any larger outdoor areas that are available within the hotel, where possible within relevant transmission guidelines. Although each child’s needs must be assessed daily and individually, it can be assumed that it will have a negative effect on a child’s mental health to be kept in the same room or rooms for two weeks without access to an adequate outdoor area in which to play.

Balancing competing interests

However, the best interests of children and the rights of anyone who is subject to a Solo Child Detention Notice will need to be balanced against other demonstrably justifiable ends; for example, lawful, reasonable and proportionate measures taken to reduce the further spread of 2019-nCoV.

It is your role to undertake this balance in your welfare checks, based on the information and advice that you have from the department and on the information provided to you by the children that you are assessing.

Appendix 5 Direction and Detention Notice – Solo Children

To be added

Appendix 6 Other issues

Welfare and health service provision

- DHHS Welfare team to conduct a welfare check (as specified below) each day.
- DHHS welfare officers conducting welfare checks phone and email covid-19.vicpol@dhhs.vic.gov.au and AO individually to alert AO of medical and welfare issue.
- Residents will be provided with a resident satisfaction survey to complete each week.
- Residents can seek review by the nurse 24 hours a day if required.
- 24 hour on-call medical support will be available for on call subject to demand. This will initially be provided by a Field Emergency Medical Officer, and subsequently through a locum general practice service.
- Medical care is organised by Deputy State Health Coordinator. Deliverables include:
  - Primary care assessments;
  - Prescription provision;
  - 24 hour access to a general practitioner;
  - 24 hour access to nursing assessment.
- It is advisable that where possible, individuals who are in detention are linked to receive telehealth care from their normal general practice provider.

Safety / mental health

If there are concerns about the safety or mental health of passengers, the process is as follows:

- The nurse will review via phone (or in person if required with appropriate PPE).
- If escalation is required, the nurse will contact the Anxiety Recovery Centre Victoria for psychosocial support.
- Mental health triage at RMH/the Alfred can be contacted as a back-up.
- If the person is acutely unwell or at serious risk, urgent ambulance should be arranged by calling 000.
- Daily welfare check phone calls should be implemented thereafter if not already implemented.

Family violence (FV)

If there are concerns about family violence / the safety of women and children, the process is as follows:

- Case worker is called to review via phone initially or in person if required (with appropriate PPE).
- A separate room may need to be organised to facilitate the review away from the other family members.
- If deemed necessary, separate rooms should be organised to separate the family members.
- Case worker to review again as required.

Alcohol and other drugs

If there are concerns about alcohol or other substance abuse or withdrawal:

- Consider nurse/medical review.
- Provide numbers for support services (listed below).
- Preference for provision of standard drinks to a limit rather than prescribing diazepam for alcohol withdrawal.
- Prescriptions – Schedule 8 prescriptions for drug-dependent patients can only be provided after discussion with the DHHS Medicines and Poisons Branch.

Appendix 7: End of Detention Notice

Public Health and Wellbeing Act 2008 (Vic)

Section 200

Subject to the conditions below, this Notice is evidence that this detainee has completed their period of detention under a *Direction and Detention Notice* issued to reduce or eliminate the serious public health risk posed by COVID-19.

1. Detention Notice

You have arrived in Victoria from overseas, on or after midnight on 28 March 2020 or 13 April 2020 and have been placed in detention, pursuant to a Direction and Detention Notice that you were provided on your arrival in Victoria (**Notice**).

2. Details of Detention Notice

Name of Detainee:_____

Date of Detainment and Detention Notice:_____

Place of Detention:_____

3. End of Detention Notice

In accordance with section 200(6) of the Public Health and Wellbeing Act 2008, I have reviewed your continued detention.

On review of the Notice, I have made the following findings:

- you will have served the required detention period by _____[*insert date*]; and
- you have not started exhibiting any symptoms of COVID-19.

In consideration of the above circumstances, I have decided that your continued detention is not reasonably necessary to eliminate or reduce a serious risk to public health.

I advise that your detention pursuant to section 200(1)(a) of the *Public Health and Wellbeing Act 2008* (Vic) and the Notice will end on _____ [*insert date*] after you have been discharged by an Authorised Officer from _____ [*insert place of detention*] and have commenced transportation to your ordinary residence.

[*If lives in Victoria*] Although you are no longer to be detained pursuant to the Notice, you are required to comply with all directions currently in force in Victoria. This includes the Stay at Home Directions (No 2) (**Direction**), as amended from time to time. Pursuant to the Direction, you are required to travel directly to the premises where you ordinarily reside within Victoria, and remain there unless you are leaving for one of the reasons listed in the Direction.

[*If lives outside Victoria*] I note that you are ordinarily a resident in _____ [*insert State or Territory*] and that arrangements have been made for you to return home. While you remain in the State of Victoria, you are required to comply with all directions in operation in Victoria. Once you have returned home, you are required to comply with the Directions and/or Orders in place in your home jurisdiction, including any directions that may require you to isolate for a further 14 day period.

In the event that you start to experience symptoms of COVID-19, it is important that you self-isolate and, if necessary, contact your General Practitioner or local Public Health Unit.

4. End of Detention Instructions

Your detention **does not end** until the time stated in paragraph 0 of this notice. Until that time, at which you will be discharged from detention, you must continue to abide by the requirements of your detention, as contained in the Notice.

You **must not** leave your hotel room until you have been collected by an Authorised Officer [*OR*] You **must not** leave your hotel room until _____ [*insert time and date*], at which time you are permitted to travel to the hotel lobby to meet an Authorised Officer to be discharged from detention.

When leaving detention you **must** adhere to the following safeguards:

- if provided to you, you must wear personal protective equipment;
- you must refrain, as far as possible, from touching communal surfaces, such as handrails, elevator buttons and door handles;
- you must where possible, engage in social distancing, maintaining a distance of 1.5 metres from other people; and
- upon leaving your hotel room, you must go straight to the foyer for discharge and then immediately after travel to your transportation and travel directly to your ordinary residence.

These steps are to ensure your protection, and reduce the risk of you becoming infected with COVID-19 by any persons detained in the hotel, or in the community, who may have COVID-19.

Until your detention has concluded, you must follow instructions from Authorised Officer/s and any other conditions set out.

5. Offence and penalty

It is an offence under section 203 of the Act if you refuse or fail to comply with the directions set out in this notice, unless you have a reasonable excuse for refusing or failing to comply.

The current penalty for an individual is $19,826.40.

_____ Signature of Authorised Officer

Name of Authorised Officer: _____

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

Appendix 8: End of Detention Notice (confirmed case or respiratory illness symptoms)

Public Health and Wellbeing Act 2008 (Vic)

Section 200

An Authorised Officer has decided to end your Direction and Detention Notice. This decision has been made following the mandatory review of your Direction and Detention Notice because you [*have returned a positive test for COVID-19*] *or* [*have started displaying symptoms of respiratory illness*].

1. Detention Notice

You have arrived in Victoria from overseas, on or after midnight on 28 March 2020 or on or after midnight on 13 April 2020 and have been placed in detention, pursuant to a Direction and Detention Notice that you were provided on your arrival in Victoria (**Notice**).

2. Details of End of Detention Notice

Name of Detainee:_____

Date Notice Made:_____

Date Notice Expires:_____

Place of Detention:_____

Medical Facility:_____
(if medical care is required)

COVID-19 Status or respiratory illness symptoms [tick applicable]:

COVID-19 confirmed: _____ *[insert date of test]*	☐	coughing	☐
fever or temperature in excess of 37.5 degrees	☐	sort throat	☐
congestion, in either the nasal sinuses or lungs	☐	body aches	☐
runny nose	☐	fatigue	☐

3. End of Detention Notice

In accordance with section 200(6) of the Public Health and Wellbeing Act 2008, I have reviewed your continued detention.

On review of the Notice, I have noticed that you [have been diagnosed with COVID-19] or [have exhibited the symptoms of respiratory illness, as outlined above at paragraph 2(8) *[delete as applicable*].

In consideration of the above, I do not believe that continued detention is reasonably necessary to eliminate or reduce a serious risk to public health because:

a) [*if applicable*] You have been confirmed to have COVID-19 and will be required to self-isolate in accordance with the Isolation (Diagnosis) Direction, in a premises that is suitable for you to reside in, or a medical facility, until such a time you are notified that you no longer need to self-isolate and a clearance from isolation (self-isolation) is given;

b) [*if applicable*] You are showing symptoms of respiratory illness and will be required to self-isolate in accordance with the Stay at Home Direction currently in force in Victoria and will need travel directly to your ordinary residence once you leave detention, and remain there unless you are permitted to leave for a reason specified in the Stay at Home Direction; and

c) You are ordinarily a resident in Victoria.

Compliance with Directions made by the Deputy Chief Health Officer is required to reduce or eliminate the serious risk to public health posed by COVID-19. It is essential that you [self-isolate in accordance with the Isolation (Diagnosis) Direction until such time as you are notified that you no longer need to self-isolate and a clearance from self-isolation is given] OR [return to your ordinary residence and remain there unless you are permitted to leave for a reason specified in the Stay at Home Direction. Please monitor your symptoms and seek appropriate medical care if required]. *[delete as applicable*].

The Notice is ended subject to the directions below under paragraph 4. Non-compliance with these directions is an offence.

4. Conditions

- You will be transited from the hotel where you have been detained to your ordinary residence / Premises for Isolation pursuant to Isolation (Diagnosis) Direction / medical facility [*delete as appropriate*] by an Authorised Officer. You may / will [*delete as appropriate*] be supervised during transit.
- While you are transiting to your ordinary residence / Premises for Isolation pursuant to Isolation (Diagnosis) Direction / medical facility [*delete as appropriate*], you must refrain from touching communal surfaces, as far as possible, such as door knobs, handrails, lift buttons etc.
- When you are transiting to your ordinary residence / Premises for Isolation pursuant to Isolation (Diagnosis) Direction / medical facility [*delete as appropriate*], you must, **at all times**, wear appropriate protective equipment to prevent the spread of COVID-19, if directed by the Authorised Officer.
- You must practice social distancing, and as far as possible, maintain a distance of 1.5 metres from all other people, including any Authorised Officer escorting you.
- When you are transiting to your ordinary residence / Premises for Isolation pursuant to Isolation (Diagnosis) Direction / medical facility [*delete as appropriate*], you must, **at all times**, comply with any direction given to you by any Authorised Officer escorting you.

5. Offence and penalty

It is an offence under section 203 of the Act if you refuse or fail to comply with the directions and requirements set out in this notice and/or the Isolation (Diagnosis) Direction *[if applicable*], unless you have a reasonable excuse for refusing or failing to comply.

The current penalty for an individual is $19,826.40.

_____ **Signature of Authorised Officer**

Name of Authorised Officer: _____

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

Appendix 9: Guidance Note

How to conclude a person's detainment under a *Direction and Detainment Notice* if they have served the required period of detainment, become a confirmed case of COVID-19 or have symptoms of respiratory illness

What do you have to do before you issue an End of Detention Notice?

- if the person has served 14 days of detention you must decide how to administer the completion of that person's detention arrangements:
  - selecting a time for the person to attend a foyer after the 14 day period has concluded - it is recommended that this occur in small groups of people who are practicing appropriate social distancing and with sufficient time between groups to avoid crowds. This will ensure Authorised Officers can safely discharge each detainee
  - collecting a person from their hotel room after the 14 day period has concluded – this approach should be carefully administered to ensure Authorised Officers can safely discharge and escort each person to their transport
- if a person's detainment is concluding because they have a confirmed case of COVID-19 or symptoms of respiratory illness they must be discharged when it is safe to do so – e.g. when other detained people are in their rooms, under full supervision etc.
- complete all sections of the Notice, including clearly documenting the reasons for the end of detention and the details recorded on the Direction and Detention Notice
- update all the registers and relevant records about the person's detainment arrangements
- ensure the reference number is completed.

When should you issue an End of Detention Notice?

- It is preferable that an End of Detention Notice be issued the day before a person's detainment is set to conclude – this will give the person adequate time to prepare (e.g. to pack their belongings) and ensure the orderly discharge of large groups of people.
- A notice may be provided earlier but it creates a risk that a person may develop COVID-19 symptoms before the day the detainment period must end.

What do you have to do when you issue an End of Detention Notice?

When you issue an End of Detention Notice you must:

- explain the reason why detention has ceased and is no longer necessary to eliminate or reduce a serious risk to public health
- advise that person of the arrangements being made for their discharge from detention (e.g. at an allocated time at the foyer; when they are escorted from their room etc)
- notify they person that although they are no longer subject to detention when they are discharged and leave the premises of their detention, they are still subject to the directions which are in force in Victoria, including
  - if they are ordinarily resident in Victoria, they are required to return immediately to their ordinary residence, where they must remain, in accordance with the Stay at Home Directions (No 2)
  - if they have a confirmed case of COVID-19, they must isolate at home in accordance with the Isolation (Diagnosis) Direction

if the person is ordinarily resident outside of Victoria, notify the person of their travel arrangements and that they are to immediately travel to the airport to leave the State

Appendix 10: Release Process 'Running Sheet'

Evening prior to release

- Exit Notices and associated materials prepared and dropped to hotel
  [Separate process to be developed on preparation of materials]
- Early hours releases transport booked (DJPR)
- Early hours releases documentation actioned by AO evening prior, including signing of exit checklist
  If issues or lack of exit time, contact: _____
- Notices for all other exiting detainees placed under doors (by Security)

Day of release

- Security door knocks early departures and they can leave
- Security door knocks exiting detainees at agreed time and brings people to exit location

Release process

- AO to sight ID and notice (notice clearly states both items must be available at release. All parties incl infants should have a notice)
- Confirmation of ID check noted on exit sheet
- If any issues, a blank End of Detention Notice can be filled out and signed by the AO
- AO to inform detainee of release (highlight conditions etc)
- Detainee signs exit sheet
- Welfare staff provide cab charge, facilitate transport etc

Appendix 11 Register of permissions granted under 4(1) of the *Direction and Detention Notice*

Authorised officer:_____

Ref No.	Date	Name of detained person	Reason	Time-Out	Time-In

COVID-19 Mandatory Quarantine Health and Welfare Plan – Operation Soteria

17 April 2020

VICTORIA State Government | Health and Human Services

Contents

Introduction

Mandatory quarantine for all people arriving from overseas into Victoria was introduced on 28 March 2020.

Purpose

This plan outlines the policy for welfare and, medical, nursing and mental healthcare to individuals detained in mandatory quarantine.

Scope

This plan will outline healthcare and welfare arrangements for people in mandatory quarantine as part of Operation Soteria.

This should be read in conjunction with the *COVID-19 Policy and Procedure – Mandatory Quarantine (Direction and Detention Notice)* and the *Operation Soteria – Operational Plan.*

Audience

This document is intended for use by DHHS staff, all departments and organisations involved in Operation Soteria and the governing bodies described below.

Governance and oversight

Operation Soteria

A diagram indicating the governance of strategy / policy and operation of the mandatory quarantine program is described in **Appendix 1**.

Roles and responsibilities

The Public Health Commander (through the Deputy Public Health Commander / delegate) will take responsibility for approving this plan.

The State Controller Health (through the Deputy State Controller Health) operating through the Emergency Operations Centre (EOC) has operational accountability.

The Deputy State Health Coordinator is responsible for:

- provision of healthcare to individuals in mandatory quarantine;
- provision of welfare to individuals in mandatory quarantine (delegated to a Director Health Protection and Emergency Management);
- ensuring the safety and wellbeing of individuals in mandatory quarantine and DHHS staff;
- ensuring a safe detention environment at all times.

Co-ordination of medical care – Requirement for a DHHS Medical Lead

Due to the large number of individuals in mandatory quarantine, the high risk environment and length of time in detention, and the potentially complex needs of this cohort, a DHHS Medical Lead should be appointed to oversee medical care, including care through general practitioners and any nursing – including mental health nursing – care provided. The DHHS Medical Lead should have a healthcare background and have experience managing complex programmes for vulnerable populations. The DHHS Medical Lead should oversee the staffing of the various sites, reassess medical workforce needs, provide advice to staff, and ensure the minimum standards of care are being met.

The DHHS Medical Lead should identify any risks or issues and refer these to the Compliance Lead and State Control Centre Emergency Operations Centre for urgent action. They should be a senior point of contact in relation to medical and nursing care for the Compliance Lead, the State Emergency Controller / DHHS Commander, and the Public Health Commander and Deputy Public Health Commander for Physical Distancing.

Standards for healthcare and welfare provision

Meeting the needs of people in detention

The health and welfare of persons in detention is the highest priority and the main purpose of this plan. Mandatory detention removes some safeguards for health and welfare (such as free access to medical care of choice) and requires the highest standard of medical care at all times. This is in addition to the elevated risk of COVID-19 infection in returned travellers.

All reasonable requests should be facilitated where possible, to ensure that all people in detention are as comfortable as possible during their mandatory quarantine period.

Physical examinations and telemedicine

When a quarantined individual requires medical assessment, they are entitled to receive the highest standard of medical care including a physical examination if indicated. It is not appropriate to defer or delay physical examination (if it is indicated), because the person is in mandatory quarantine. All requests for, and findings from physical examinations should be documented in the medical record, as described above. If a healthcare provider refuses to see a patient that the have been requested to see, the reason should be record in the notes.

Sufficient and appropriate PPE should be provided. If this is not available, it should be flagged immediately to the team leader/site manager to arrange for urgent stock to be delivered from another site. It may be possible to contact a nearby quarantine hotel and arrange for urgent PPE stock to be brought over to that hotel. If appropriate PPE is worn and used correctly, there should be no additional risk to the health care provider, or the patient (quarantined individual).

Any request for medical review should be carefully considered before determining whether telemedicine or physical review is most appropriate in that scenario. Phone consults or telemedicine should not be used as a substitute for direct clinical review if it is clinically indicated. If healthcare providers are concerned for their own safety, the case should be escalated to the DHHS Team Leader.

Clinical handover

All clinical interactions must be documented, and important/ongoing issues handed over to the team covering the next shift. Nurses should hand over to the nurses on the next shift, and also the team leader so they are aware of the outstanding issues. GPs who review patients (over the phone or in person) must handover the outcome of the assessment and ongoing management plan to the nurses, and to the GPs on the next shift (or the clinical lead) if relevant. GPs contracted by Medi7 also have a Clinical Lead who is a Medi7 doctor acting as the coordinating point for these doctors. It would be advisable for a daily morning meeting to occur between the team leader, nursing cohort, medical officer and AO for every hotel. During this meeting, current issues that require escalation may be flagged to the team leader and escalated as appropriate. Documentation of the morning meeting and allocation of special tasks should be recorded in the DHHS notes.

Triage and waiting times

Requests for medical care must be actioned within a specific time frame, in keeping with the acuity of the issue and the availability of services. Where staffing allows the doctor may see patients before the nurse, particularly if the request is deemed urgent.

- For physical medical issues requiring urgent medical review but not 000, the quarantined individual must be reviewed within 30 minutes by the hotel nurse (by contacting the hotel nurse direct line) who should review the patient in person and alert the on-call doctor to arrange urgent review if required. The GP should attend as soon as possible and within two hours.

- For matters requiring medical review (require assessment and management) that is not classified as urgent or emergency, the quarantined individual must be reviewed by a nurse (within four hours) first, then the on-call doctor must be contacted to arrange review depending on the acuity of the issue but within an eight hour period.
- For urgent mental health issues, the patient should be reviewed by the nurse or doctor-on-call within one hour. Where a quarantined individual may pose a risk of harm to themselves or others, a full risk assessment must be conducted by the doctor-on-call and escalation as per current policy – see safety and mental health section. The mental health risk assessment form must be completed – see **Appendix XX**.
- For all other issues, review by the on-call doctor should be arranged within 24 hours.
- For new prescriptions of regular medications, these should be arranged within a 24-hour turnaround period.
- For urgent prescriptions required same day, these should be arranged within 8 hours.

Acuity of issue	Time frame for response
Minor health issue, non-urgent	Phone review as soon as practicable Nurse assessment within 8 hours GP review (if required) within 24 hours
Non-urgent issue requiring review and management	Nurse review within 4 hours GP review (if required) within 12 hours
Urgent request by quarantined individual or mental health concerns	Nurse / mental health nurse review as soon as practicable (within 30 minutes) GP review within 1 hour
Emergency: serious health concern / life-threatening issue	Immediate - call 000 ASAP

Information and data management

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

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

- The Public Health Event Surveillance System (PHESS);
- The healthcare and wellbeing database for mandatory quarantine (Dynamic CRM Database);
- Best Practice general practice software;
- Paper records (until transitioned to systems above).

The State Controller Health (or delegate) and Public Health Commander (or delegate) should be able to access any record within these systems to enable oversight of the health and welfare of people in detention.

The Department of Jobs Precincts and Regions (DJPR) will provide a list of people arriving internationally that populates PHESS and the Dynamic CRM Database. In turn, medical information is then stored in PHESS and Best Practice. Welfare and Compliance information is stored in the Dynamic CRM Database. Within 24 hours of arrival, both the Dynamic CRM Database and PHESS will contain a complete list of people in detention. PHESS will be the complete record for all medical and compliance records for a person who was in detention in Victoria as part of this program.

An Intelligence Cell will be introduced into the EOC to oversee reporting arrangements.

Medical records

Requirement for accessible medical records

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

Confidentiality and access to medical records

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

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

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

Follow-up of results

It is the responsibility of the doctor who orders any test (COVID-19 or otherwise) to follow up on the result and notify the patient in a timely manner. If they are not able to do so, they must handover this task to the next doctor on-call, inform the nurse, and record this in the medical record. A list/spreadsheet of all individuals in mandatory quarantine who have had COVID-19 swabs should be sent to the department each day by the DHHS Team Leader. This will also serve as a safety net for the department to notify the patient if the treating doctor hasn't already.

If a detainee has been reviewed by their personal GP or has received a specialist consult via telehealth whilst detained, a letter from the GP/specialist must be provided within four hours following the review and documentation of this consult, outcome and plan should be transcribed into the Best Practice medical record. The name of the external reviewing doctor, time and contact details must also be documented into the detainee's DHHS notes by the hotel general practitioner. There must be clear communication and documentation regarding who will follow up and review any plans made by external clinicians.

Provision of healthcare

Medical care

Access to regular general practitioners and specialists

A person in detention should be able to access care through their normal general practitioner and specialist through telehealth arrangements if they request it. If that is to occur, the person should indicate who their provider is and should provide the contact details of the general practitioner to the nursing lead / Team Leader for their time in detention, so that the general practitioner can act as an advocate for, and communicate with, the nursing team about the health of the person in detention.

Provider of general practice services

General practitioners (GPs) are provided by Medi7 and Doctor Doctor. **[MORE DETAILS – point of contact, contact information, ABN]**

General practitioners (GPs) supplied by Medi7 and Doctor Doctor are providing 24-hour medical support to individuals in mandatory quarantine. GPs should be engaged at a ratio proportionate to the burden of healthcare problems across the hotels. The directors of the contracting companies should teleconference with the Deputy State Health Coordinator twice weekly to review workload and vary this ratio if necessary.

GPs attend in person from 8.00am to 6.00pm daily and revert to telehealth arrangements at night.

GPs are contactable via the nurses at each location. From 6pm on a weeknight, the nurse may contact the on-call GP. The on-call GP can provide telehealth services as required or attend the relevant hotel. Over weekends and on public holidays, a group of 8-10 deputising GPs is accessible to the on-site GPs should further assistance be required.

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

Clinical lead for general practice services

Medi7 has now appointed a clinical lead to oversee and coordinate the doctors working across all hotels participating in mandatory quarantine each day. The number of doctors per cluster of hotels is reviewed each morning before determining where each doctor is allocated. The Medi7 GPs can report issues to the clinical lead and seek advice and additional support. The Medi7 clinical lead should update and report concerns to the Deputy State Health Coordinator.

Pathology and pharmacy services

Pharmacy arrangements

Specific pharmacies in proximity to each hotel should be engaged to allow for prompt procurement of necessary medications and equipment for quarantined individuals. The address, contact details, and operational hours of the pharmacy for each hotel should be distributed to all staff working in that hotel and should be easily accessible. Each hotel should know which pharmacy can be used for urgent scripts out of hours, if their usual pharmacy cannot provide this service.

These pharmacies will accept prescriptions emailed by the resident's usual GP or made by the on-site GP and will have delivery arrangements in place to the relevant hotel.

These pharmacies have a billing arrangement in place with the department.

Should the existing complement of pharmacies prove incapable of meeting demand, extra pharmacies will be sought through engagement with the Pharmacy Guild.

Prescriptions

Both prescribed and over-the-counter (OTC) medications can be ordered from the pharmacies described above. A record should be kept of all medications dispensed to quarantined individuals.

Prescribing benzodiazepines

When prescribing benzodiazepines for anxiety in mandatory detention, GPs should exercise a high degree of caution. Care should be taken to ensure that benzodiazepines are not prescribed to individuals who are consuming alcohol, or who have other contraindications to these medications. These medications should only be required after careful history taking and assessment, to individuals who are regularly prescribed them. If they are required to be prescribed, no more than four (5mg) tablets should be prescribed at any time. Repeat prescriptions for benzodiazepines should not be given unless there is clear justification.

All new medication prescriptions for benzodiazepines, opioids, anxiolytics and antipsychotics must be discussed with the medical clinical lead by the prescribing general practitioner. A risk assessment should be performed by the prescribing general practitioner and medication changes should be documented and followed up by the prescribing doctor or handed over to the shift doctor next on call. General practitioners will take full responsibility and indemnity for all new prescriptions or medication changes.

Pathology arrangements

Swabs

Each site should have a twice-daily pathology courier pickup, transporting swabs taken from that site to VIDRL.

Currently, the delivery of swabs to each hotel and the arrangement of couriers is being undertaken by REDACTED

The marking requirements for each swab in order to ensure appropriate delivery of results and prioritisation of testing are as follows:

- The pathology request slip must be clearly marked as a hotel quarantine swab – this could be included in the clinical details section or at the top of the form (e.g. “Swab for a person in mandatory quarantine in hotel Crown Metropol, room 1234”);
- There must be three identifiers on every swab and pathology request (name, DOB, address);
- The address must be listed as the hotel where the person is being quarantined, not their usual home address;
- A phone number must be provided for every patient being swabbed;
- The name and phone number of the testing clinician **and** the responsible authorised officer for the hotel should be included.

Provision of swab information to public health

Within each hotel there should be a spreadsheet, case list or other record of all quarantined individuals who have had COVID-19 testing carried out. This should record the following details as a minimum dataset for each swab taken:

- Testing doctor (and time)
- Name of quarantined individual tested
- Date of birth

- Usual address
- Contact number
- Email address
- Hotel address and room number
- Date of arrival
- Date of expected release from detention

All COVID-19 swabs taken should be documented in this spreadsheet, even if the person has already had swabs taken while in quarantine.

A daily record of all individuals in mandatory quarantine who have had swabs done and their details should be forwarded by the DHHS Team Leader to publichealth.operations@dhhs.vic.gov.au each day.

Following up results

It is the responsibility of the requesting medical practitioner to chase the result of the test and to notify the department (in addition to the testing laboratory). If the COVID-19 operations team are provided with this information (see next section), then they will be able to follow-up the result too.

Negative swab results

Quarantined individuals who are suspected cases of COVID-19 may receive negative test results. This may lead to confusion and distress for the individual, as they may believe that they can now leave mandatory quarantine. In these situations, the nurse or doctor should explain to the person the implications of a negative swab, and reaffirm the public health need for the person to remain in mandatory quarantine.

Other pathology

Other pathology requests (such as routine blood tests) should be deferred if possible until after the quarantine period. If other tests are required (as per the treating clinician – on-site doctor or person's own GP), this should be coordinated by the team leader in consultation with the GP/nurse. Equipment for taking bloods should be available at (or available to be transported to) the hotel. These specimens should be labelled as per the procedure for labelling COVID-19 swabs (same requirement for identifiers). The preferred provider for these types of pathology specimen is Melbourne Pathology.

Nursing care

Minimum nursing requirement

Nurses (including mental health nurses) are provided by Your Nursing Agency (YNA).

Nurses should be onsite at each hotel across the full 24 hour period. The required nursing complement should be continually reviewed and adapted according to need. This should be based on the number of individuals in quarantine at that site, the current workload and burden of healthcare and mental health issues expected and reported at that site, and the skillset and experiences of the nurses rostered at that site.

There should be one emergency department (ED) trained nurse available 24 hours, two general registered nurses during the day, one general registered nurse on overnight, and one mental health nurse on during the day. Where nurses report that their workload is not safe and that additional nursing support is required, staffing should be reviewed and adapted as necessary.

There should be a nurse coordinator or nurse team leader each day at each site, who is rostered on a longer shift (e.g. 12 hours). This is to ensure the other nurses are adequately managed and supported, to

ensure continuity of care and handover of outstanding tasks / concerns. In general, longer nursing shifts are preferable for this reason.

Mental health care

Mental health nurses

Mental health registered or enrolled nurses should be rostered to each hotel. The number and coverage should be increased at hotels where a growing mental health caseload is identified.

Contacting a nurse at each site

A department-supplied mobile phone should be provided to all nurses at each site. Residents should be able to contact the nurse either directly by phone, or via the hotel concierge. The nurse phone numbers should be accessible on the hotel roster (accessible on Sharepoint). Where the nurse deems a quarantined person to have significant needs, significant requirement for medical care, or be at risk of mental health issues, they may give the quarantined individual their mobile number so that they can contact them directly if needed. Nurses may instigate daily, twice daily, or more frequent phone-calls to check up on the individual. This is in addition to any required welfare phone call. This provides an additional safety net for the health and welfare of quarantined individuals. If a person who normally frequently calls the nurse stops calling, the nurse for that individual needs to contact the individual to check on their health and welfare.

Summary of available mental health services

Mental health services are available to people in mandatory quarantine through the following sources:

1. Calling Lifeline or Beyond Blue;
2. Nurse or mental health nurse on site for initial assessment;
3. Doctor on-call for non-urgent or urgent review;
4. NorthWestern Mental Health triage service (phone 1300 TRIAGE);
5. Referral to CART (Complex Assessment and Referral Team) [Method for calling / contact];
6. Calling 000 for emergency care;
7. Quarantined individuals can also contact their usual mental health provider or be assisted to contact that provider. This includes a psychologist, counsellor, psychiatrist or other provider. Care can then be provided via telehealth.

Phone support services

Individuals in mandatory quarantine can contact Beyond Blue (1300 22 4636) and Lifeline (13 11 14) whilst in detention but must also be reviewed by the on-call doctor and a risk assessment performed if there are mental health concerns. The department's Mental Health and Drugs Branch is exploring further proactive mental health resources with Beyond Blue. [Update]

Nurses and doctors

Nurses and doctors can review persons with mental health concerns upon request from the individual or from other sources for example if a concern is flagged by the welfare check, the authorised officer, security or by another resident. Mental state examination and risk assessment should be performed by the general practitioner allocated to the hotel.

The mental health nurse may assist with this process but the outcome of the risk assessment must be reviewed by the hotel general practitioner unless the detainee has received urgent CATT assessment or has required a transfer to a mental health unit or hospital. Psychiatric input regarding additions or

changes to existing antipsychotic and anxiolytic medications may be required and should be sought by the hotel general practitioner as indicated.

Refer to the Nursing section above for further information on mental health nursing presence in the hotels.

NorthWestern Mental Health triage service

Melbourne Health's NorthWestern Mental Health triage service has been engaged from 28 March 2020 to provide specialist mental health support through direct or secondary consultation for persons in quarantine. Nurses and residents can contact **1300 TRIAGE** (**1300 874 243**) for specialist mental health support. The person making the initial referral should request the specialist priority line.

Complex Assessment and Referral Team

CART is a new service set up by DHHS which can provide advice and support for mental health issues, drug and alcohol problems, family violence and other concerns. This service is currently staffed by two clinicians, one working 8am-2pm, and the other 2pm-8pm. If a full assessment is required CART does not currently have the capacity to complete this, and if more than phone support/advice is required, they will have to refer back to the nurse to arrange for assessment and further management from another source (e.g. NorthWestern Mental Health triage).

Mental health emergency

If there is concern about a mental health emergency in a quarantined individual (i.e. acute suicidal ideation, thoughts of self-harm, or psychosis), and there is a delay in contacting the psychiatric triage team (**1300 TRIAGE**), the quarantined individual should be reviewed by the general practitioner as a matter of urgency and have a risk assessment completed within an hour.

The general practitioner should then assess the quarantined individual to determine if transfer to hospital via ambulance is required for urgent psychiatric assessment or if psychiatric advice can be obtained over the phone. If the quarantined individual is deemed as needing urgent psychiatric review and is not willing to be transferred for assessment, the doctor on call will need to decide if enacting provisions within the *Mental Health Act 2014* is required.

As for other medical emergencies, the authorised officer, reception or other parties do not need to be contacted before 000 is called. First responders should not be denied access to people in mandatory quarantine who make a 000 call.

Who can alert the welfare team to mental health concerns relating to a quarantined person?

A quarantined person, authorised officer, nurse or doctor, security, Vic Police, family members, or anyone else who has a concern about the mental health or wellbeing of a quarantined person can raise this concern to the welfare team. All concerns should be escalated as necessary and documented/recorded in the database.

Escalating medical, nursing or mental health concerns

See section on Escalation for situations requiring escalation.

Emergency services

In the case of an emergency, a nurse, doctor or DHHS staff member can call 000. As soon as is practicable the person should inform the operator that the call is from a mandatory quarantine hotel and

the person may be at increased risk of infection with COVID-19, so that appropriate precautions can be taken. The current hotels in operation are in the catchment of three major hospitals:

- The Alfred;
- Royal Melbourne Hospital;
- Royal Children's Hospital.

As per other medical emergencies, the authorized officer, reception or other parties do not need to be contacted before 000 is called. First responders must not be denied access to people in mandatory quarantine who make a 000 call.

Transport to/from hospital

Transfer to hospital for people with suspected of confirmed COVID-19

- Passengers requiring hospital assessment/treatment for suspected or confirmed COVID-19 or other conditions, should be transferred to either the Royal Melbourne Hospital (RMH) or The Alfred Hospital, depending on proximity (**note children should be transferred to the Royal Children's Hospital**).
- If the hospital transfer is non-urgent, the nurse, doctor or AO may assist in arranging the transfer.
- If the hospital transfer is urgent, call 000 to request ambulance and inform them that the passenger is a suspected (or confirmed) case of COVID-19.
- Contact the Admitting Officer at RCH/RMH/the Alfred and inform the hospital of patient and details.
- Staff should don full PPE (droplet and contact precautions) and the passenger must wear a single-use surgical mask if tolerated.
- All relevant staff including AO must be notified prior to the transfer (but this should not delay the provision of urgent medical assistance or the request for an ambulance if needed).
- AO must view appropriate authorisation.
- The passenger should be transferred on a trolley or bed from ambulance into the designated COVID-19 ambulance reception area.
- The patient should be managed under routine droplet and contact transmission-based precautions in a negative pressure room if available. The patient should wear a single-use surgical mask if leaving the isolation room. Further PPE considerations should be determined by the treating doctors.
- Ambulance services will list the hotels as an area of concern in case of independent calls and will ask on site staff to assess need for attendance in the case of low acuity calls.
- All residents who are: in high risk groups, unwell, breathless or hypoxic (O2 sats <95%) should be considered for hospital transfer.

Unplanned transfers to hospital

Unplanned transfers occur via a phone call to Ambulance (AV) via 000 from the nurse, doctor, other staff member or quarantined person. The nurse or doctor then notifies an authorised officer of the transport. The authorised officer then provides an information sheet to stay with the patient throughout the journey. The patient is then treated and transported by AV or Non-Emergency Patient Transport (NEPT) to hospital.

Planned transfers to hospital

Planned transfers occur via clinical staff at each hotel notifying the authorised officer of the transport and arranging transport via the most appropriate transport provider (e.g. AV, NEPT, Clinic Transport Service etc). The transport then occurs to the relevant location.

Summary of hospital transfer

The following is a general overview of the transfer of a patient to hospital involving nurses, doctors, Authorised Officers (AOs), Ambulance Victoria (AV) and hospitals.

1. Nurse/doctor makes assessment that patient requires hospital care.
2. The AO grants permission for the individual to temporarily leave mandatory quarantine. Leave should be recorded on the business system or register.
3. All relevant staff including the AO must be notified prior to the transfer (however this should not delay the transfer if it is urgent/an emergency).
4. Patient is transferred to the appropriate hospital. Patients requiring hospital assessment/treatment for suspected or confirmed COVID-19 or other conditions, should be transferred to either the Royal Melbourne Hospital (RMH) or The Alfred Hospital, depending on proximity **(note children should be transferred to the Royal Children's Hospital).**
5. If the hospital transfer is urgent call 000 to request an ambulance and inform them that the passenger is a in mandatory quarantine. Let them know if the person is a suspected (or confirmed) case of COVID-19.
6. Contact the Emergency Department Admitting Officer at RCH/RMH/the Alfred to inform the hospital of patient and details.
7. Staff should don full PPE and the passenger must wear a single-use surgical mask if tolerated.
8. The passenger should be transferred on a trolley or bed from the ambulance into the designated COVID-19 ambulance reception area.
9. The patient should be managed under routine droplet and contact transmission-based precautions in a negative pressure room if available. The patient should wear a single-use surgical mask if leaving the isolation room.
10. Ambulance services will list the hotels as an area of concern in case of independent calls and will ask on site staff to assess need for attendance in the case of low acuity calls.
11. All residents who are in high risk groups, unwell, breathless or hypoxic (O_2 sats <95%) should be considered for hospital transfer.
12. Assessment and diagnosis are made by the treating team at the hospital. A plan is made for either admission to the hospital or discharge back to the hotel (possibly for more appropriate medical care to be arranged at the hotel).
13. Prior to any movement of the patient out of the ED, a new plan or detention approval must be sought for either return to the hotel or admission to a different location in consultation with the compliance team (receiving hospital and compliance team).
14. Hospitals will need to contact the AO at the relevant hotel, then the AO team lead will advise Lead Executive Compliance to obtain any necessary approvals.

Discharge from hospital

Discharge from hospital should be at the behest of the treating team. Refer to the current 'Guidelines for health services and general practitioners.'

Transfers from hospital back to the hotel are arranged by the hospital in liaison with the DHHS Team Leader.

Anaphylaxis

Where individuals in mandatory quarantine have severe allergies and a history of anaphylaxis, this must be recorded and flagged in the welfare survey completed on the way to or at the hotel at the beginning of the stay. All individuals who require medications including antihistamines, corticosteroids and epipens should have an adequate supply of these. If they require an additional prescription for these this should be facilitated by the healthcare providers at the hotel and the nominated pharmacy as a matter of urgency.

If a person reports that they are having an anaphylactic reaction, 000 should be called immediately. This does not need to be escalated to an AO (or any other member of staff, medical or non-medical) first – the urgent ambulance should be called immediately by whoever is first aware of the situation. The health of the quarantined individual and the provision of urgent healthcare is the priority in any medical emergency. The authorised officer can be informed as soon as is practicable thereafter.

Note: persons may call 000 themselves in the event of an emergency, they do not need to do this via an AO, a nurse or reception in an emergency.

Provision of welfare

Airport screening process

At the airport, DHHS nurses and Department of Agriculture, Water and the Environment (DAWE) biosecurity officers will screen all passengers arriving from overseas for symptoms of COVID-19. Nurses will perform a temperature check on each passenger.

Management of an unwell person at the airport

Any passengers who screen positive on this health check will trigger the DAWE biosecurity officer to contact the Human Biosecurity Officer (HBO) on-call for the department. After discussion with the HBO, if it is determined that the person meets the criteria for a suspected case of COVID-19, the following actions should take place:

- The HBO should organise an ambulance transfer to the Royal Melbourne Hospital (or Royal Children's Hospital) for testing and assessment.
- The AO at the airport should log the person as requiring mandatory quarantine at a specified hotel and then should follow-up with the hospital to update on whether the person has been found to be negative, so a transfer by (patient transfer/ambulance/ maxi taxi etc.) can be organised to bring the person to the assigned hotel.
- If the person is unwell and requires admission to hospital, the Compliance Lead should be informed.
- If the person is well enough to be discharged they should return to the hotel through an arrangement by the AO.
- If they are a confirmed case they should be placed on a COVID-19 floor. If they are not, they can be placed in a general part of the hotel.

Transfer of uncooperative individuals

It is recommended that a separate mode of transport to the hotel is provided for a person who is uncooperative/non-compliant. Ensure appropriate safety measures are taken (e.g. child locks on doors, a safety briefing for drivers etc.).

If a person refuses testing for COVID-19 at a hospital and they are well enough to return to the hotel, they should be transported back to the hotel and treated as if they are COVID-19 positive (i.e. they must be situated on the COVID floor of the hotel and the necessary precautions taken). Every effort should be made to encourage them to get tested before this happens. However, they cannot be forcibly tested.

If a person refuses testing and treatment at a hospital and is too unwell to be released from hospital, a Human Biosecurity Control Order (HBCO) may need to be considered.

Assessment at the hotel

All quarantined individuals will be given a survey to complete on the way to or at the hotel. This will include questions about past medical history, mental health history, allergies, medications, next of kin/emergency contact, dietary requirements, and other important health and welfare needs. A doctor and nurse will be available on site to urgently review anyone who reports illness or an urgent medical need on arrival at the hotel. Nurses will review the surveys and contact all individuals who are identified as having significant health needs, as soon as is practicable. After initial phone contact is made, further assessment/management can be organised as needed.

Initial information on options for accommodation

Policy on separation of people in travelling parties to promote effective quarantine

There are a number of options for people – such a couple or family – for rooms to promote effective quarantine. Because a person needs to commence a further 14 days of quarantine when a person within a party or group is identified as positive for COVID-19, there should be an option to separate people – if they consent – at various points in the quarantine journey.

Option 1 – Parties stay together

A couple or family stay together and share a suite or room. If a person becomes positive, an extension of quarantine will be required on a tailored basis for the other persons.

Option 2 – Parties separate from the outset

A couple or family are separated from the outset. If a person becomes positive, the other parties do not need to recommence 14 days of quarantine.

Option 3 – Parties are separated once one person becomes positive

A couple or family separate into different rooms (with no contact thereafter) after a person becomes positive for COVID-19. The non-infected persons then start a new 14 day quarantine period, which is served at home once they complete the mandatory 14 day period in the hotel.

Option 4 – Parties stay together after one person becomes positive

The parties stay together. At the end of the 14 day period, they both leave to home isolation, and the non-infected persons commence a further 14 day quarantine period, as long as they separate in the house to which they go.

Communication of these options to people in mandatory quarantine

The DHHS Team Leader should communicate these options to people at booking, with the default option being that parties stay together unless they indicate a preference to separate from the outset.

Assessment during detention

Medical care should be available 24 hours a day to individuals in mandatory quarantine.

The need for medical care can be identified through the following channels:

- Via the daily welfare check
- By the person contacting the concierge or nurse directly
- Nurse phone call to the individual
- The 1800 government services number (DJPR), the physical distancing hotline, the COVID hotline, or any other DHHS phone line
- Family members directly contacting the hotel/team/COVID quarantine inbox

Individuals in mandatory quarantine should be supported to contact their regular health care provider by phone or telemedicine if appropriate. In these instances, the healthcare provider should be provided with the contact details of the hotel nurse or GP so that the outcome of the assessment or management plan can be communicated with the medical team on site.

Tiers of risk for people in mandatory quarantine for welfare checks

Individuals in mandatory quarantine will be triaged into three tiers of risk. The type of welfare check will depend on the tier the person falls into.

The following table is an initial framework for triaging the type and frequency of welfare check required:

Table 1: Risk Characterisation for Welfare Checks

Risk Tier	Risk factors	Welfare check type
Tier 1	Residents with suspected or confirmed COVID-19 Families with children < 18 years Passengers aged > 65 years Aboriginal and Torres Strait Islander peoples Residents with underlying comorbidities (e.g. respiratory or cardiac conditions) Residents with a history of mental illness	Daily phone call
Tier 2	Those who indicate they require a phone call but do not have any other risk factors. Residents who are by themselves.	Phone call every second day
Tier 3	Low risk – everyone else.	Daily text message (via Whispr)

For phone calls (tier 1 and tier 2), translators must be available as needed. Language requirements should be recorded on arrival at the hotel and provisions made as required.

Automated text messages are sent to all passengers in Tier 3 via Whispr.

Individuals may be moved between risk tiers throughout their quarantine period as need dictates.

Requirement for a welfare check

As part of the welfare check process, quarantined individuals should be provided with a satisfaction survey (available at **Appendix XX**) to complete each week. This satisfaction survey is more comprehensive than the regular daily welfare check. Any concerns raised on the survey should be escalated to the DHHS Team Leader for action.

Each individual in mandatory quarantine should receive a welfare check each day by a DHHS welfare officer (employee or contractor). A welfare check will allow people in detention to be assessed for medical and social issues. Concerns can be flagged and responded to. These issues include but are not limited to health, mental health, safety and family violence concerns. Referrals to the nurse, social supports, mental health and other services can be made as a result.

Welfare checks are made from the DHHS welfare call centre by a DHHS welfare officer – the script for these checks is in **Appendix XX**).

Smoking

Smoking is not permitted within the hotel rooms. The following actions should occur:

- Nicotine Replacement Therapy should be promoted strongly for smokers;
- Smoking restrictions should remain in relation to the room;

- Only where absolutely necessary, and in exceptional circumstances, a person in mandatory quarantine could be granted permission to leave their room under specific circumstances, where public health risk is managed:
  - The Authorised Officer is aware and grants permission;
  - They are accompanied by security, who are provided PPE to wear;
  - They are instructed to – and follow the instruction – not to touch surfaces en-route to the smoking area and coming back;
  - They return immediately to their hotel room.
- Smokers should be provided with the Quitline number to access telephone counselling - 13 78 48
- People can also contact their regular general practitioner via telehealth for support.

Fresh air and exercise

Individuals in quarantine should have access to fresh air where feasible.

- If the room has a balcony, ensure the residents can access it for fresh air.
- Advise residents to open windows/balconies where possible for fresh air and ventilation.
- If it is possible for residents to go outside to take some exercise for organised/supervised short periods of time, this should be facilitated where possible. Residents should ensure physical distancing is practised during this period. Only well residents from the same room should be able to go out to exercise at the same time.

Exercise is important for physical and mental health, particularly in the mandatory quarantine environment. Requests for exercise equipment / yoga mats should be facilitated where possible, but equipment should be thoroughly cleaned and disinfected after use. Resources for exercise routines and yoga/meditation should ideally be provided to individuals in mandatory quarantine upon request.

Alcohol and drugs

Alcohol is permitted within hotels. Excessive alcohol consumption should be discouraged and should not be facilitated.

If there are concerns about alcohol or other substance abuse or withdrawal:

- Request nurse or medical review.
- Provide numbers for support services.
- Preference for provision of standard drinks to a limit rather than prescribing diazepam for alcohol withdrawal.
- Prescriptions – Schedule 8 prescriptions for drug-dependent patients can only be provided after discussion with the DHHS Medicines and Poisons Branch.
- If there are concerns about acute alcohol withdrawal, confusion or mental state/mental illness, escalate for urgent medical review (consider calling 000).

Note: Alcohol should not be provided to persons who are under 18 years of age (including in the hotel room minibar).

Nutrition and food safety (including allergies)

Individuals in quarantine should be provided with a well-balanced and plentiful diet, with options provided for those with specific dietary requirements.

- Ensure a well-balanced diet with options provided for those with specific dietary requirements.
- Ensure access to essentials within the room (e.g. snacks, tea and coffee) to limit the amount of interactions/contact required with hotel staff.
- Ensure access to additional food if required.

- Ensure that food allergies are recorded and communicated to the catering providers.

If there are substantial concerns that someone is not eating, this should be flagged with the medical team, and appropriate review/referral arranged (e.g. for mental health assessment).

Food allergies

Individuals in mandatory quarantine should report all allergies in their initial health and welfare survey, and indicate if they are severe, have a history of anaphylaxis, or have been prescribed Epipens. This must be filled out by every quarantined individual. If no allergies are reported, they should record “no known allergies”. Dietary requirements should be carefully recorded and communicated to the catering providers. It is the responsibility of the welfare team to ensure that food safety arrangements are in place and that this information is communicated to the catering staff.

Food safety process

Food safety questionnaires (along with the welfare questionnaire) should be distributed to individuals at the airport. Individual with specific dietary requirements (who are eligible for this process) should be contacted and advised of the process for self-organising suitable meals (through uber eats and by submitting a claim following their stay). Uber Eats Drivers should drop meals off at the hotel, and security staff should deliver the meals directly to the requestors’ rooms. The Uber Eats Driver/Rider should not drop the delivery to the person’s room directly.

Please refer to the following documents for further details:

- Process for people with food allergies
- Food safety questionnaire

Care packages

A public health risk assessment has been conducted that indicates that care packages, such as food or toys, can be delivered for provision to people in mandatory quarantine. The reason for quarantine is to prevent risk of COVID-19 transmission from people in detention to other parties and does not mean a person needs to be prevented from receiving packages.

The care package should be provided to the hotel reception or other party for conveyance to the person in mandatory quarantine and should not be directly handed to the person in quarantine by the person gifting the care package. Ensuring the package passes to the person in quarantine without misdirection or tampering is essential. There is no public health reason for an inspection of any care package.

Safety and family violence

If there are concerns about family violence / the safety of women and children the following should occur:

- Arrange for separate rooms for the person to be assessed and access phone support services (separate rooms may also be indicated for the remainder of the quarantine period)
- Refer to CART
- Refer to phone support services
- Engage case worker to contact person and make an assessment

Social and communications

- All residents should have access to **free** wifi/internet.
- All residents should have access to entertainment such as television and streaming services (e.g. Netflix).
- All residents should have access to communications so that they can keep in regular contact with family and friends throughout the quarantine period.

- Toys and equipment should be provided for small children if possible.

Negative permission/exemption outcomes

When a person submits a request for release from detention (temporary or permanent) that is denied/declined, a CART team support worker should be present (on the phone) to provide support (if the person consents to this, and if CART are already working with the person).

- The CART team can support the person before and after the exemption discussion with the doctor which is a separate discussion, in anticipation of some emotional distress upon hearing the outcome.
- The CART worker can help the person gain insight into the public health risk, understand the information they are receiving, and provide insight into what they can and can't do whilst they remain a public health risk.
- This will also inform the doctor/nurse and CART team of further risk management and support required for the person going forth.

Assessment in preparation for exit

All persons departing mandatory quarantine will be offered a health check with a nurse 24-48 hours prior to exiting. This health check is voluntary. This will consist of questions about symptoms of COVID-19 and a temperature screening.
If a person screens positive on the health check:

- They will not be detained longer than the 14 day mandatory quarantine period
- A swab will be sent and they will be informed that they need to self-isolate after exiting, until the result of the swab is known
- If they do not have appropriate accommodation to self-isolate after release, they will be assisted to find such accommodation

If a person screens negative on the health check, no further action will be taken.

Infection control and hygiene

COVID floors/hotels

Each hotel should have a COVID-19 positive floor or area (a "**RED ZONE**"). Any person who is a confirmed case should be relocated to this area of the hotel when the test result is known. Appropriate signage, PPE and other consumables should be available at the entrance to this area of the hotel. Where there are large numbers of confirmed cases arriving on a flight, a COVID hotel may be considered. Where the infrastructure allows, suspected cases may also be moved to an area of the hotel away from well individuals.

Personal protective equipment

A supply of P2/N95 masks and gowns should be maintained, in addition to single-use face masks and gowns. PPE stocks should be checked regularly by the team leader/ manager, and urgently requested if needed. Regular stocktake should be undertaken to pre-empt additional orders.

PPE should be available in the donning section of the hotel. Biohazard bags for waste disposal, and hand hygiene stations, should be available at the doffing section of the hotel.

PPE protocols should be available to all staff working in the hotels, so that there is clear instruction on what type of PPE to wear and in what circumstances, how to don and doff it, and how to dispose of it.

Laundry

Staff may wear PPE when handling dirty laundry. Laundry should be washed on the highest possible setting and thoroughly dried before use. Staff should not overly handle the linen – it should be put straight into the washing machines. Staff should follow hand hygiene procedures after handling dirty linen.

Cleaning

Though not directly medical care, all quarantined individuals have the right to a safe and comfortable room and environment. Quarantined individuals may not be able to upkeep their rooms for various reasons, which may affect their physical and mental health. If cleaning cannot be regularly provided, all efforts should be made to assist the quarantined individual with cleaning their room. In rare instances the quarantined individual may need to be moved out of the room, and staff don full PPE to provide a rapid cleaning of the room. This should only occur in rare instances where the quarantined individual is not capable of doing so themselves. Any persons for whom there is a concern about room hygiene and safety should be flagged to the team leader.

Please refer to the department document 'Cleaning and disinfecting to reduce COVID-19 transmission'.

Housekeeping services will not be provided routinely to residents. Fresh linen, towels and additional amenities can be left outside of rooms for residents to then collect. Biohazard bags can be left for residents to place dirty linen in and to leave outside their rooms for collection. Terminal cleaning is required on vacation of each room. Rooms that have been vacated will not be repurposed during the quarantine period.

COVID-19 in people in mandatory quarantine

Actions for confirmed cases of COVID-19 in people in mandatory detention

Overall actions

The following actions should be taken:

- Residents with confirmed COVID-19 should be accommodated / cohorted in a separate section/floor of the hotel, away from the non-COVID-19 infected passengers → the **RED ZONE.**
- A designated COVID-19 hotel should be available when there are large numbers of cases coming off of flights (e.g. high risk repatriation flights with a high burden of suspected or confirmed COVID-19).

Personal protective equipment (PPE)

Staff who engage with monitoring or assisting persons in mandatory detention in person:

1. Apply standard infection prevention and control precautions at all times:
    a. maintain 1.5 metre distance
    b. wash your hands or use anti-bacterial agents frequently
    c. avoid touching your face.
2. Every situation requires a risk assessment that considers the context and client and actions required.

3. If you are not able to maintain a 1.5 metre distance and the person has symptoms (for example coughing) or is known to be a COVID-19 case use:
    a. fluid-resistant surgical mask (replace when moist or wet)
    b. eye protection
    c. disposable gloves.
4. If you need to be in a confined space (<1.5 metre) with a known COVID-19 case for more than 15 minutes, wear a single use facemask, eye protection and gloves.

Current infectious cases

- In the situation that an arriving passenger is a current infectious case of COVID-19, they will still be handed the detention notice and will be placed in mandatory quarantine.
- They will be given a single use face mask to wear and will be kept separate from the other passengers where possible.
- At the hotel, they will be asked to provide confirmation of their diagnosis. If there is any doubt surrounding the certainty of the diagnosis of COVID-19, they may be tested again.

Recovered cases

- In the situation that an individual states that they are a confirmed case of COVID-19 and have recovered from the infection, they will still be handed the detention notice and placed in mandatory quarantine.
- The onus on them is to provide the evidence that they have a confirmed case of COVID-19 and the required amount of time has passed such that they are no longer considered infectious.
- The department will decide on a case-by-case basis whether evidence from other sources (from testing done overseas) can be considered sufficient proof to inform clinical and public health decision-making.
- If they meet the criteria for release from isolation (see below) and the testing and medical reports provided are considered sufficient by the department, they may be considered for release from detention.
- They will still be handed the detention notice until this can be verified and the request has been approved.

Note – there are no automatic exemptions for persons who are recovered cases. These requests need to be assessed on a case-by-case situation.

Release from isolation

Criteria for release from isolation

Confirmed cases of COVID-19 will be considered for release from mandatory quarantine, once they meet the department's criteria for release from isolation of a confirmed case:

- the person has been afebrile for the previous 72 hours, and
- at least **ten days** have elapsed after the onset of the acute illness, and
- there has been a noted improvement in symptoms, and
- a risk assessment has been conducted by the department and deemed no further criteria are needed

Clearance testing is not required for release from isolation, either in the home or in mandatory quarantine.

Process for release from isolation

As per the DHHS guidelines for health services and general practitioners, the department will determine when a confirmed case no longer requires to be isolated in hospital or in their own home, in consultation with the treating clinician.

- In this case, the treating clinician is considered the medical practitioner looking after the cases in that hotel.
- Every confirmed case that is diagnosed in Victoria is notified to the department, and assigned a case and contact officer (CCO), regardless of whether they are diagnosed in detention or outside of detention. Every confirmed case receives daily contact from the case and contact team.
- The CCO will advise when it is appropriate for consideration for release from isolation, and will issue a clearance certificate (via email) to the case when they meet the criteria for release from isolation.

Nurses looking after confirmed cases in detention should temperature check and review symptoms of confirmed cases daily. The date of acute illness onset should be clearly documented in their records.

If a confirmed case is due for release from mandatory quarantine but does not meet the department's criteria for release from isolation, they will not be detained longer than the 14-day quarantine period. They will be released from detention at the agreed time, but will be required to self-isolate at home or at other accommodation until they meet the required criteria. In this case they will be subject to the self-isolation direction. They will be given a single-use face mask to wear when checking-out from the hotel and in transit to their next destination. They will be provided with a 'confirmed case' information sheet.

Exit planning for individuals with confirmed COVID-19

Non-emergency ambulance transport

When a confirmed case of COVID-19 who is considered still infectious but is stable is assessed as appropriate for transition to isolation in their home, Ambulance Victoria will be requested by the Operational lead for mandatory quarantine to provide a non-emergency patient transport for that person to a destination in Victoria that is the assessed appropriate home isolation location

If there are multiple persons to be transitioned to home isolation on the same day, subject to compliance-related logistics being able to be handled and any privacy considerations being met, it is permissible for two or more potentially infectious confirmed cases of COVID-19 to be transported together in one NEPT, i.e. to cohort confirmed cases

Room sharing - COVID incongruent couples

In instances where one person in a room share situation is a confirmed case and one person is COVID-19 negative, the confirmed case should self-isolate in a separate room away from the person who does not have COVID-19. The quarantine period (but not the mandatory detention period) for the COVID-negative person starts from their last contact with the confirmed case while the confirmed case is infectious. This may mean that they need to self-isolate for an additional number of days after the mandatory detention period ends, but they may do this in their own homes or in alternate accommodation, not in detention.

Room sharing - well persons

In instances where two or more well people who are not suspected or confirmed cases of COVID-19 wish to share a room in advance of check-in at the hotel, this can be facilitated.

If this request is made after the persons have been initially been in separate rooms for a period of time, they should be informed that this may increase their risk of infection with COVID-19 if the other person is incubating the infection, and that COVID-19 infection may result in serious illness and death in some

cases. If the persons still insist, then it must be documented in the database that the risks have been discussed with them (e.g. by a nurse), before facilitating this request.

Exit arrangements

The following table documents the exit management plans for quarantined individuals in different scenarios.

Scenario	Exit plan
Well person who has served 14 days of quarantine	• Can leave – gets end of detention notice (universal version).
Confirmed case of COVID-19 who has met criteria for release from isolation (i.e. is declared no longer infectious)	• Can leave – must not be prevented from leaving if the AO is aware they are cleared and the person demands to leave – they are non-infectious and therefore not a public health risk. • Gets clearance from isolation letter from PHC (as per Isolation (Diagnosis) Direction).
Confirmed case of COVID-19 who is still potentially infectious and has been in detention less than 14 days	• Must stay in detention.
Confirmed case of COVID-19 who is still potentially infectious but has reached the end of their 14 day detention period	• Can leave detention but is now subject to the Isolation (Diagnosis) Direction. • Safe travel should be arranged by EOC to place of home isolation in Victoria (mask, stay separate, go straight to home; but preferred travel by non-emergency patient transport with PPE'd ambulance officers) • Not permitted to travel interstate / not permitted to fly domestically but no detention order needed to prevent that (in keeping with all other confirmed cases) • If no place to isolate, DHHS should keep person in hotel voluntarily to reduce risk until cleared, or until safe home isolation environment identified
Well close contact of a confirmed case of COVID-19 (i.e. room-mate at hotel), where the room-mate has reached the end of their 14 day detention period	• Case and Contact Sector to do assessment, assign a new 14 day period (from date of last contact with infectious case) and issue a requirement to quarantine until that 14 days ends – factsheet, lodge new date in PHESS, reverting person to effective close contact status • No detention order required, and no legal order preventing flying, but must be advised by CCM Sector not to fly and needs to quarantine • If lives interstate, DHHS could offer hotel if person would otherwise be homeless.
Symptomatic suspected case of COVID-19 who has reached the end of their 14 day detention period.	• Allowed to leave detention safely (mask, separate; ideally NEPT transport to home isolation). • DHHS Case and Contact Management to follow-up result to convey (as DHHS oversaw this testing so is obliged to follow-through).

Reporting / escalating concerns

Principles

- Decisions about medical care should be left to the nurses and doctors and should not be determined by any other staff.
- In any emergency situation, the priority is to call 000 before notifying any other managing or governing figure.
- If there is any doubt over whether an issue or concern should be escalated to senior management, escalate the concern.

Clinical escalation

This is described in **Appendix 2**.

Escalation for mental health concerns

Chain of escalation for mental health concerns and issues

The following table indicates the chain of escalation for concerns about the mental health of people in mandatory quarantine.

Situation	Responded to by	Escalated to	Reported to
Non-urgent mental health concern	Nurse or GP Regular healthcare provider by telemedicine	Mental health nurse Psychiatric triage	Medical lead General practitioner
Repeated mental health concerns / acute mental health concern	Mental health nurse or GP, urgent review Psychiatric triage urgent review Daily physical welfare review thereafter	Ongoing mental health nurse management	Welfare lead Medical lead Compliance lead
Risk of self-harm / serious mental health concerns	Immediately phone 000 → Emergency Department Call GP/nurse to attend urgently	Emergency inpatient tertiary care	Welfare lead Team leader Medical lead Compliance lead Deputy Public Health Commander

Specific events to escalate

The following mental health-related events or situations should lead to an escalation to the Deputy Commander - Welfare at EOC who will also notify the Deputy Public Health Commander:

- A person identified as high risk for mental health concerns due to a past history, medication or recent bereavement;
- Detainees with suicide or homicide risk or recent psychosis;
- Any instances where physical or chemical restraint have been required.

Escalation for medical reasons

An escalation flowchart is at **Appendix 2**.

Nurse or doctor to escalate

In the following circumstances, the nurse / general practitioner should call the DHHS Team Leader:

- There is any practical issue arising from the medical consultation that needs the assistance of DHHS;
- A patient needs to access an alternative medical or welfare service such as mental health nursing, a medical specialist or acute hospital care;
- A patient needs to be admitted to hospital in an emergency;
- A patient has suffered any form of life-threatening injury or health event;
- A patient has died.

DHHS Team Leader to escalate

The following concerns or events must be escalated by the DHHS Team Leader to the Deputy Commander - Welfare at EOC within one hour, who will also notify the Deputy Public Health Commander within two hours:

- A person identified as high risk for mental health concerns due to a past history, medication or recent bereavement;
- Detainees with suicide or homicide risk or recent psychosis;
- Any instances where physical or chemical restraint have been required;
- A serious act of non-compliance;
- A new COVID-19 diagnosis;
- An acute medical deterioration;
- Any hospital admission or emergency transfer to hospital;
- A serious risk to the health and safety of a person in mandatory quarantine (or a staff member);
- Serious illness/harm/injury (including assault) to a person in mandatory quarantine;
- A severe allergic reaction (anaphylaxis);
- A death.
- An unauthorised absence from mandatory detention (a missing person)
- A fire or other emergency in a hotel;
- A potential outbreak of COVID-19 or another infectious disease.

Daily health and welfare report to Public Health Commander

A daily health and welfare report should be provided to the Deputy Public Health Commander for Physical Distancing. This is to ensure oversight and accountability for the mandatory quarantine process. This report should include but is not limited to the following:

- Total number of people in mandatory detention
- Total number of confirmed COVID-19 cases (cumulative and new)
- Total number requesting exemptions to leave mandatory quarantine (temporary and permanent)
- The number of persons in mandatory detention receiving:
  - A nurse review
  - A mental health assessment
  - A GP review
  - Referral to hospital

  - A 000 call
- The number of persons awaiting:
  - A mental health assessment
  - A GP review
- The number of persons in the following groups:
  - Significant psychiatric history - mild/moderate/severe mental health issues (as per the risk stratification)
  - Serious/life-threatening medical conditions (e.g. anaphylaxis, stage 4 cancer)
  - Age < 16 years or > 70 years
  - Pregnant women
- The number of calls from the hotels to:
  - 000
  - VicPol
  - Other DHHS phone lines
- The number of risk incidents logged in the database.
- Other major concerns flagged.

Audit

Healthcare audit

Medical care provided by doctors and nurses contracted by DHHS will be audited regularly. This should be reported to the EOC Commander and Deputy Public Health Commander. The audit process may consist of, but is not limited to, the following:

- Assessing waiting times for delivery of care;
- Record-keeping and review of medical records;
- Medical care satisfaction surveys;
- Number of repeat requests for medical care/escalation;
- Number of risks reported;
- Feedback from authorised officers and other organisations involved/staff.

Welfare audit

Audit of welfare procedures should be performed by the Welfare Lead at the EOC on a regular basis. The audit process may consist of:

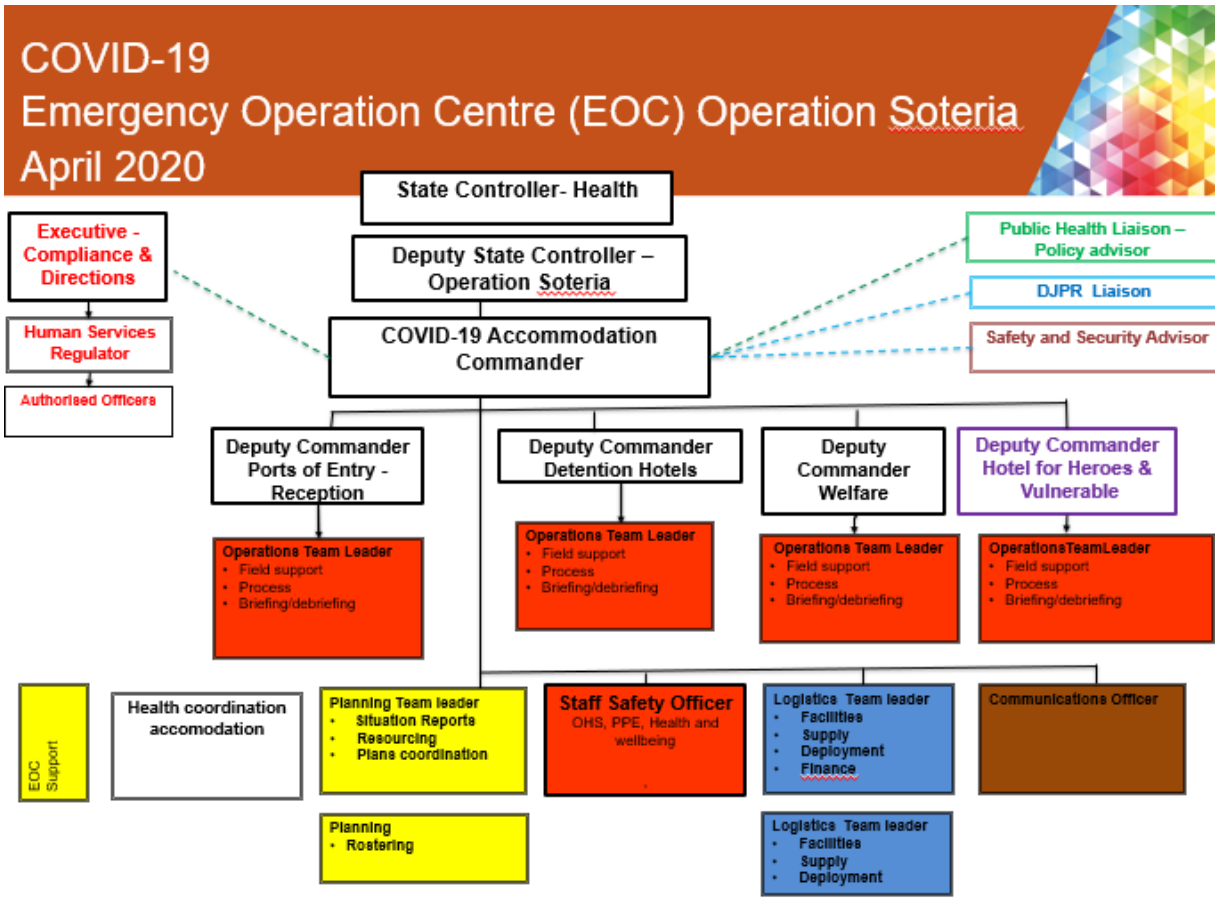
- Review of weekly satisfaction surveys;
- Feedback from staff;
- Audit of welfare check calls (review of a sample of recorded calls).

Appendices

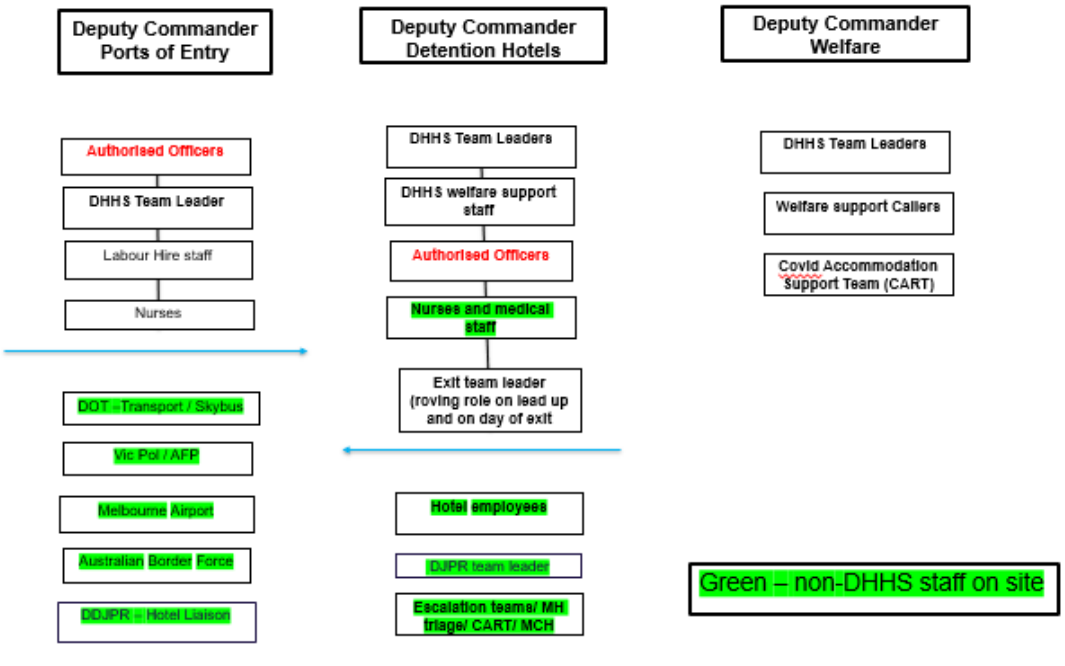
List of possible appendices / supporting documents to add:

- Compliance plan (Meena's team – AO operational guide)
- Nursing operational guide
- GP operational guide
- Team leader operational guide
- Sample daily health and welfare report
- Welfare survey
- Weekly satisfaction survey
- Welfare call centre guide / script
- Hotel isolation medical screening form
- COVID-19 assessment form
- Nursing documentation (from YNA)
- COVID-19 testing factsheet
- COVID-19 return travellers testing at VIDRL
- Swab record spreadsheet
- Escalation pathway/governance flow diagram
- Transfer to hospital flow chart
- Unwell passenger at airport flow chart
- HBO airport protocol
- Mental health documents
- Flow chart of command structure (EOC/PHC etc. etc.)

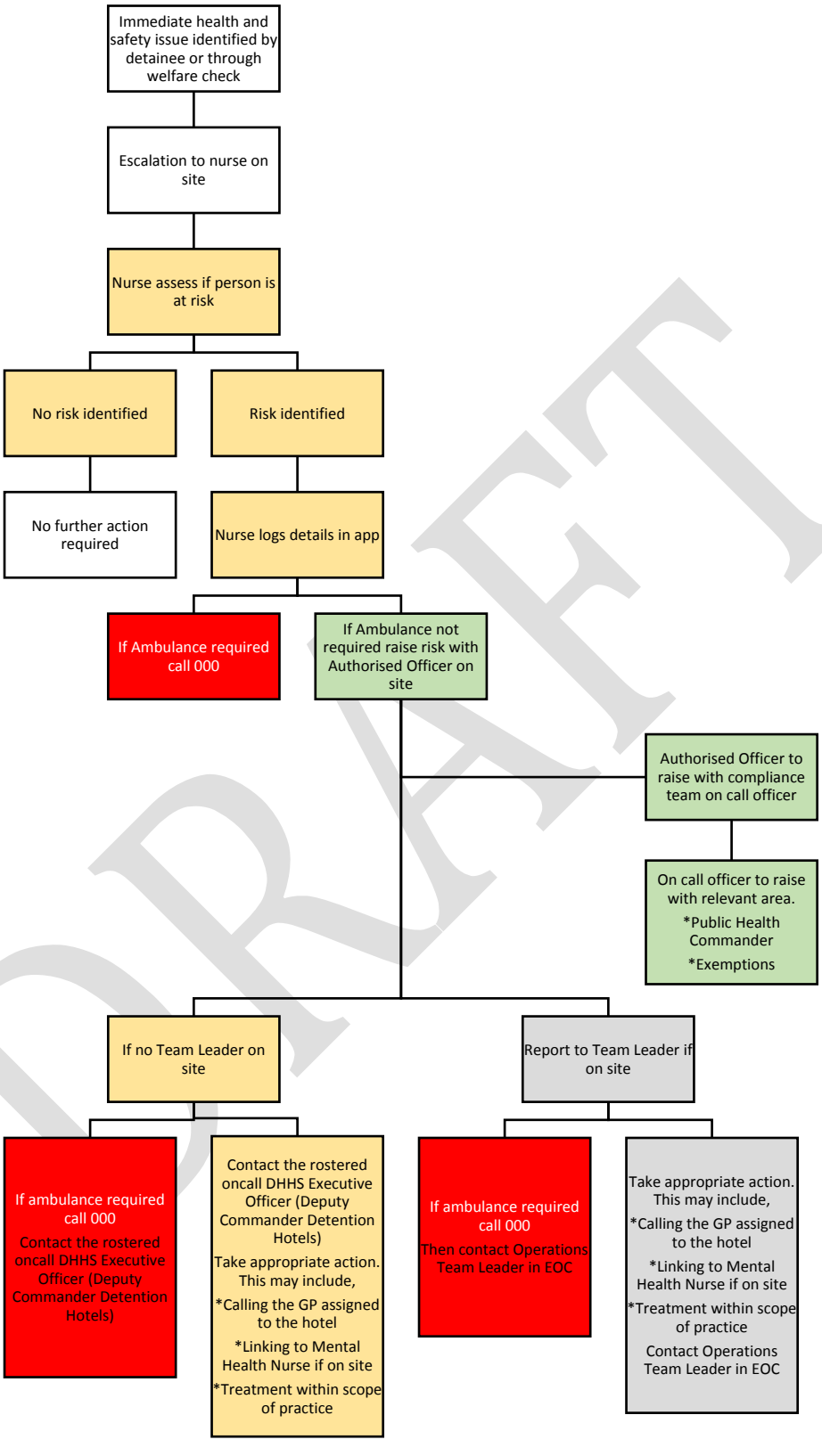
Appendix 1 - Governance



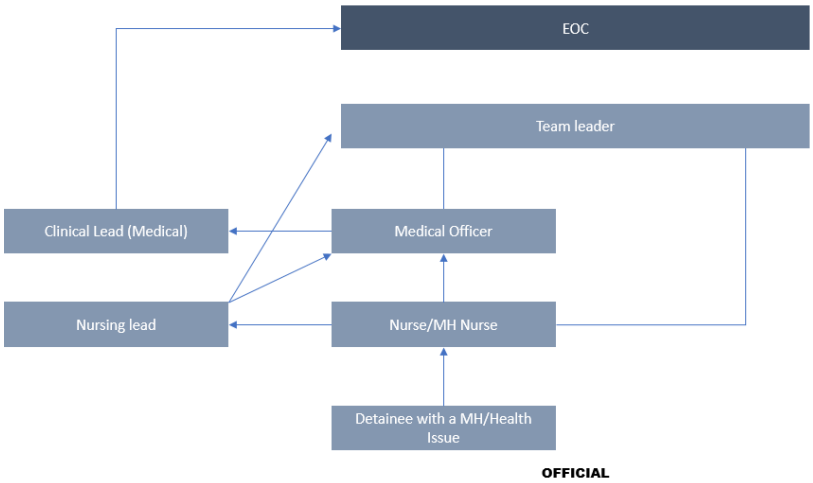
Operation Soteria – on site teams



Appendix 2 – Escalation Process



Clinical referral pathway



MANDATORY Team leader notification for escalation:
- Transfer of detainee to hospital
- Adverse outcome
- Deterioration of detainee (mentally or physically)

URGENT MO ESCALATION +/- AMBULANCE
- Suicidal/homicidal ideation or intent
- Acute psychosis or delirium
- Chest Pain (If currently ongoing – call 000)
- Breathing difficulty
- Sedation, loss of consciousness, stroke
- HR > 100
- SBP < 90
- RR > 30 or <12
- Spo2 < 94
- Or other clinical concern (seizure, anaphylaxis etc)

MANDATORY MO ESCALATION:
- Medication review
- Concerns re: COVID-19 symptoms
- Clinical or mental health deterioration
- Aggression
- Intoxication or drug interaction
- More than 3 calls for review daily
- Hypoglycaemia

Nursing actions:
- Welfare / clinical reviews
- Examination + observations
- Referral to CART, beyond blue, ambulance (see above)

OFFICIAL

Saved in TRIM Operation Soteria - Draft Healthcare and Welfare Plan for Mandatory Quarantine

From: "Finn Romanes (DHHS)" REDACTED

To: "Pam Williams (DHHS)" <

Cc: "SCC-Vic (State Controller Health)" <sccvic.sctrl.health@scc.vic.gov.au>, "Simon Crouch (DHHS)" REDACTED >, "Meena Naidu (DHHS)" REDACTED , "Annaliese Van Diemen (DHHS)" REDACTED "Brett Sutton (DHHS)" 'Claire Harris (DHHS)" "Euan Wallace (DHHS)" .au>

Date: Sat, 18 Apr 2020 22:54:17 +1000

Attachments: Draft Mandatory Quarantine Health and Welfare Plan - 18 April 2020.docx (2.38 MB)

Dear Pam and REDA / REDACTED – Operation Soteria

A number of people in various roles, especially my colleagues Claire Harris and others, have worked through today to get this draft plan ready for use.

There are only a small number of residual issues, which are listed now as comments in the margin, that are beyond my role to resolve. As you know, Public Health Command is very keen to provide the response with the best advice in the space of healthcare and welfare, and I commend this plan to you.

I recommend this plan is endorsed as an interim plan, the comments are addressed through decision of the DHHS Commander / State Health Coordinator or deputy (as I understand it the leads for the actual provision of medical care specifically and the roles – through REDACTED that commissioned general practitioners) and then the interagency Soteria group could be provided the plan by REDACTED – Operation Soteria for awareness and any comments and endorsement.

Can you / RED take it from here?

Kind regards

Finn

Dr Finn Romanes
Public Health Commander
Novel Coronavirus Public Health Emergency
REDACTED
Department of Health and Human Services
State Government of Victoria

COVID-19 Mandatory Quarantine Health and Welfare Plan – Operation Soteria

17 April 2020

VICTORIA State Government | Health and Human Services

Contents

Introduction

Mandatory quarantine for all people arriving from overseas into Victoria was introduced on 28 March 2020.

Purpose

This plan outlines the policy for welfare and, medical, nursing and mental healthcare to individuals detained in mandatory quarantine.

Scope

This plan will outline healthcare and welfare arrangements for people in mandatory quarantine as part of Operation Soteria.

This should be read in conjunction with the *COVID-19 Policy and Procedure – Mandatory Quarantine (Direction and Detention Notice)* and the *Operation Soteria – Operational Plan.*

Audience

This document is intended for use by DHHS staff, all departments and organisations involved in Operation Soteria and the governing bodies described below.

Governance and oversight

Operation Soteria

A diagram indicating the governance of strategy / policy and operation of the mandatory quarantine program is described in **Appendix 1**.

Roles and responsibilities

The Public Health Commander (through the Deputy Public Health Commander / delegate) will take responsibility for approving this plan.

The State Controller Health (through the Deputy State Controller Health) operating through the Emergency Operations Centre (EOC) has operational accountability.

The DHHS Commander – Operation Soteria is responsible for:

- provision of welfare to individuals in mandatory quarantine (delegated to a Director Health Protection and Emergency Management);
- ensuring the safety and wellbeing of individuals in mandatory quarantine and DHHS staff;
- ensuring a safe detention environment at all times.

The Deputy State Health Coordinator is responsible for:

- provision of healthcare to individuals in mandatory quarantine.

Co-ordination of medical care – Requirement for a DHHS Medical Lead

Due to the large number of individuals in mandatory quarantine, the high risk environment and length of time in detention, and the potentially complex needs of this cohort, a DHHS Medical Lead should be appointed to oversee medical care, including care through general practitioners and any nursing – including mental health nursing – care provided. The DHHS Medical Lead should have a healthcare background and have experience managing complex programmes for vulnerable populations. The DHHS

Medical Lead should oversee the staffing of the various sites, reassess medical workforce needs, provide advice to staff, and ensure the minimum standards of care are being met.

The DHHS Medical Lead should identify any risks or issues and refer these to the Compliance Lead and State Control Centre Emergency Operations Centre for urgent action. They should be a senior point of contact in relation to medical and nursing care for the Compliance Lead, the State Emergency Controller / DHHS Commander, and the Public Health Commander and Deputy Public Health Commander for Physical Distancing.

Standards for healthcare and welfare provision

Meeting the needs of people in detention

The health and welfare of persons in detention is the highest priority and the main purpose of this plan. Mandatory detention removes some safeguards for health and welfare (such as free access to medical care of choice) and requires the highest standard of medical care at all times. This is in addition to the elevated risk of COVID-19 infection in returned travellers.

All reasonable requests should be facilitated where possible, to ensure that all people in detention are as comfortable as possible during their mandatory quarantine period.

Physical examination and telemedicine

People in quarantine are entitled to receive the highest standard of medical assessment and care, including a physical examination if indicated. It is not appropriate to defer or delay physical examination because a person is in mandatory quarantine. All requests for and findings from physical examinations should be documented in the medical record, as described above. If a healthcare provider refuses to see a patient that they have been requested to see, the reason should be recorded in the notes.

Sufficient and appropriate PPE should be provided. If this is not available, it should be flagged immediately to the team leader/site manager to arrange for urgent stock to be delivered from another site. It may be possible to contact a nearby quarantine hotel and arrange for urgent PPE stock to be brought over to that hotel. If appropriate PPE is worn and used correctly, there should be no additional risk to the health care provider, or the patient (quarantined individual).

Any request for medical review should be carefully considered before determining whether telemedicine or physical review is most appropriate in that scenario. Phone consults or telemedicine should not be used as a substitute for direct clinical review if it is clinically indicated. If healthcare providers are concerned for their own safety, the case should be escalated to the DHHS Team Leader.

Clinical handover

All clinical interactions must be documented, and important/ongoing issues handed over to the team covering the next shift. Nurses should hand over to the nurses on the next shift, and also the team leader so they are aware of the outstanding issues. GPs who review patients (over the phone or in person) must handover the outcome of the assessment and ongoing management plan to the nurses, and to the GPs on the next shift (or the clinical lead) if relevant. GPs contracted by Medi7 also have a Clinical Lead who is a Medi7 doctor acting as the coordinating point for these doctors. It would be advisable for a daily morning meeting to occur between the team leader, nursing cohort, medical officer and AO for every hotel. During this meeting, current issues that require escalation may be flagged to the team leader and escalated as appropriate. Documentation of the morning meeting and allocation of special tasks should be recorded in the DHHS notes.

Triage and waiting times

Commented [FR(1)]: The Deputy State Health Coordinator should use this policy to build these expectations in, and communicate them to the medical providers. The DSHC presumably holds the contracts. If not met, escalate to Deputy State Controller and decide whether to choose a new provider (but obtain medical records on detainees first from Best Practice).

Requests for medical care must be actioned within a specific time frame, in keeping with the acuity of the issue and the availability of services. Where staffing allows, the doctor may see patients before the nurse, particularly if the request is deemed urgent.

- For emergency/life-threatening issues, the patient, family member, doctor, nurse, DHHS personnel or hotel staff should call 000 immediately
- For urgent physical health issues that do not require 000, the quarantined individual must be reviewed within 30 minutes by the hotel nurse (by contacting the hotel nurse direct line) who should review the patient in person and alert the on-call doctor to arrange urgent review if required. The GP should attend as soon as possible and within one hour.
- For urgent mental health issues, the patient should be reviewed by the nurse or doctor-on-call within one hour. Where a quarantined individual may pose a risk of harm to themselves or others, a full risk assessment must be conducted by the doctor-on-call and escalation as per current policy – see safety and mental health section.
- For non-urgent issues (require assessment and management), the quarantined individual must be reviewed by a nurse (within four hours) first, then the on-call doctor must be contacted to arrange review depending on the acuity of the issue but within a 12 hour period.
- For all other issues, review by the nurse should be within eight hours and the on-call doctor (if required) within 24 hours.
- For prescriptions of regular medications, these should be arranged within a 24-hour turnaround period.
- For urgent prescriptions required same day, these should be arranged within 8 hours.

Acuity of issue	Time frame for response
Emergency: serious health concern / life-threatening issue	Immediate – call 000 ASAP
Urgent physical health concerns	Nurse review as soon as practicable (within 30 minutes) GP review within 1 hour
Urgent mental health issue	Doctor or nurse review within 1 hour
Non-urgent issue requiring review and management	Nurse review within 4 hours GP review (if required) within 12 hours
Minor health issue, non-urgent	Phone review as soon as practicable Nurse assessment within 8 hours GP review (if required) within 24 hours

Information and data management

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

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

- The Public Health Event Surveillance System (PHESS);
- The healthcare and wellbeing database for mandatory quarantine (Dynamic CRM Database);
- Best Practice general practice software;
- Paper records (until transitioned to systems above).

The State Controller Health, DHHS Commander - Operation Soteria (or delegate) and Public Health Commander (or delegate) should be able to access any record within these systems to enable oversight of the health and welfare of people in detention.

The Department of Jobs Precincts and Regions (DJPR) will provide a list of people arriving internationally that populates PHESS and the Dynamic CRM Database. In turn, medical information is then stored in PHESS and Best Practice. Welfare and Compliance information is stored in the Dynamic CRM Database. Within 24 hours of arrival, both the Dynamic CRM Database and PHESS will contain a complete list of people in detention. PHESS will be the complete record for all medical and compliance records for a person who was in detention in Victoria as part of this program.

An Intelligence Cell will be introduced into the EOC to oversee reporting arrangements.

Medical records

Requirement for accessible medical records

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

Confidentiality and access to medical records

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

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

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

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

Follow-up of results

It is the responsibility of the doctor who orders any test (COVID-19 or otherwise) to follow up on the result and notify the patient in a timely manner. If they are not able to do so, they must handover this task to the next doctor on-call, inform the nurse, and record this in the medical record.

Provision of healthcare

Medical care

Access to regular general practitioners and specialists

A person in detention should be able to access care through their normal general practitioner and specialist through telehealth arrangements if they request it. If that is to occur, the person should indicate who their provider is and should provide the contact details of the general practitioner to the nursing lead / Team Leader for their time in detention, so that the general practitioner can act as an advocate for, and communicate with, the nursing team about the health of the person in detention.

If a detainee has been reviewed by their personal GP or has received a specialist consultation via telehealth whilst detained, a letter from the GP/specialist should be requested within four hours following the review and documentation of this consult, outcome and plan should be transcribed into the Best Practice medical record. The name of the external reviewing doctor, time and contact details must also be documented into the detainee's DHHS notes by the hotel general practitioner. There must be clear communication and documentation regarding who will follow up and review any plans made by external clinicians.

Provider of general practice services

General practitioners (GPs) are provided by Medi7 and Doctor Doctor. **[MORE DETAILS – point of contact, contact information, ABN]**

Commented [FR(2]: Deputy State Health Coordinator (or role that organised medical services) should include this information, including where the contracts re held)

General practitioners (GPs) supplied by Medi7 and Doctor Doctor are providing 24-hour medical support to individuals in mandatory quarantine. GPs should be engaged at a ratio proportionate to the burden of healthcare problems across the hotels. The directors of the contracting companies should teleconference with the Deputy State Health Coordinator twice weekly to review workload and vary this ratio if necessary.

GPs attend in person from 8.00am to 6.00pm daily and revert to telehealth arrangements at night.

GPs are contactable via the nurses at each location. From 6pm on a weeknight, the nurse may contact the on-call GP. The on-call GP can provide telehealth services as required or attend the relevant hotel. Over weekends and on public holidays, a group of 8-10 deputising GPs is accessible to the on-site GPs should further assistance be required.

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

Clinical lead for general practice services

Medi7 has now appointed a clinical lead to oversee and coordinate the doctors working across all hotels participating in mandatory quarantine each day. The number of doctors per cluster of hotels is reviewed each morning before determining where each doctor is allocated. The Medi7 GPs can report issues to the clinical lead and seek advice and additional support. The Medi7 clinical lead should update and report concerns to the Deputy State Health Coordinator.

Pathology and pharmacy services

Pharmacy arrangements

Specific pharmacies in proximity to each hotel should be engaged to allow for prompt procurement of necessary medications and equipment for quarantined individuals. The address, contact details, and operational hours of the pharmacy for each hotel should be distributed to all staff working in that hotel and should be easily accessible. Each hotel should know which pharmacy can be used for urgent scripts out of hours, if their usual pharmacy cannot provide this service.

These pharmacies will accept prescriptions emailed by the resident's usual GP or made by the on-site GP and will have delivery arrangements in place to the relevant hotel.

These pharmacies have a billing arrangement in place with the department.

Should the existing complement of pharmacies prove incapable of meeting demand, extra pharmacies will be sought through engagement with the Pharmacy Guild.

See Appendix 8 - Hospital and pharmacy contacts for each hotel

Prescriptions

Both prescribed and over-the-counter (OTC) medications can be ordered from the pharmacies described above. A record should be kept of all medications dispensed to quarantined individuals.

Prescribing benzodiazepines

When prescribing benzodiazepines for anxiety in mandatory detention, GPs should exercise a high degree of caution. Care should be taken to ensure that benzodiazepines are not prescribed to individuals who are consuming alcohol, or who have other contraindications to these medications. These medications should only be required after careful history taking and assessment, to individuals who are regularly prescribed them. If they are required to be prescribed, no more than four (5mg) tablets should be prescribed at any time. Repeat prescriptions for benzodiazepines should not be given unless there is clear justification.

All new medication prescriptions for benzodiazepines, opioids, anxiolytics and antipsychotics must be discussed with the medical clinical lead by the prescribing general practitioner. A risk assessment should be performed by the prescribing general practitioner and medication changes should be documented and followed up by the prescribing doctor or handed over to the shift doctor next on call. General practitioners will take full responsibility and indemnity for all new prescriptions or medication changes.

Pathology arrangements

Swabs

Each site should have a twice-daily pathology courier pickup, transporting swabs taken from that site to VIDRL.

Currently, the delivery of swabs to each hotel and the arrangement of couriers is being undertaken by REDACTED

The marking requirements for each swab in order to ensure appropriate delivery of results and prioritisation of testing are as follows:

- The pathology request slip must be clearly marked as a hotel quarantine swab – this should include the clinical details section or at the top of the form (e.g. "Swab for a person in mandatory quarantine in hotel Crown Metropol, room 1234");
- There must be three identifiers on every swab and pathology request (name, DOB, address);

- The address must be listed as the hotel where the person is being quarantined, not their usual home address;
- A phone number must be provided for every patient being swabbed;
- The name and phone number of the testing clinician **and** the responsible authorised officer for the hotel should be included.

Provision of swab information to public health

Within each hotel there should be a spreadsheet, case list or other record of all quarantined individuals who have had COVID-19 testing carried out. This must record the following details as a minimum dataset for each swab taken:

- Testing doctor (and time)
- Name of quarantined individual tested (full name)
- Date of birth
- Usual address
- Contact number
- Email address
- Hotel address and room number
- Date of arrival
- Date of expiry of 14 days of detention

All COVID-19 swabs taken should be documented in this spreadsheet, even if the person has already had swabs taken while in quarantine.

Following up results

It is the responsibility of the medical practitioner who ordered the test to follow-up the result of the test and ensure arrangements are in place to advise the patient of the result, whether negative or positive. If the result is positive, the requesting medical practitioner must notify the department on 1300 651 160.

Negative swab results

Quarantined individuals who are tested for COVID-19 may receive negative test results. This may lead to confusion and distress for the individual, as they may believe that they can now leave mandatory quarantine. In the event of a negative result, the nurse or doctor must explain to the person the implications of the result and reaffirm the public health need for the person to remain in mandatory quarantine until they reach 14 days from the start of their mandatory quarantine.

Other pathology

Other pathology requests (such as routine blood tests) should be deferred if possible until after the quarantine period. If other tests are required (as per the treating clinician – on-site doctor or person's own GP), this should be coordinated by the team leader in consultation with the GP/nurse. Equipment for taking bloods should be available at (or available to be transported to) the hotel. These specimens should be labelled as per the procedure for labelling COVID-19 swabs (same requirement for identifiers). The preferred provider for these types of pathology specimens is Melbourne Pathology.

Nursing care

Minimum nursing requirement

Nurses (including mental health nurses) are provided by Your Nursing Agency (YNA).

Nurses should be onsite at each hotel across the full 24 hour period. The required nursing complement should be continually reviewed and adapted according to need. This should be based on the number of

individuals in quarantine at that site, the current workload and burden of healthcare and mental health issues expected and reported at that site, and the skillset and experiences of the nurses rostered at that site.

There should be one emergency department (ED) trained nurse available 24 hours, two general registered nurses during the day, one general registered nurse on overnight, and one mental health nurse on during the day. Where nurses report that their workload is not safe and that additional nursing support is required, staffing should be reviewed and adapted as necessary.

There should be a nurse coordinator or nurse team leader each day at each site, who is rostered on a longer shift (e.g. 12 hours). This is to ensure the other nurses are adequately managed and supported, to ensure continuity of care and handover of outstanding tasks / concerns. In general, longer nursing shifts are preferable for this reason.

Mental health care

Mental health nurses

Mental health registered or enrolled nurses should be rostered to each hotel. The number and coverage should be increased at hotels where a growing mental health caseload is identified.

Contacting a nurse at each site

A department-supplied mobile phone should be provided to all nurses at each site. Residents should be able to contact the nurse either directly by phone, or via the hotel concierge. The nurse phone numbers should be accessible on the hotel roster (accessible on Sharepoint). Where the nurse deems a quarantined person to have significant needs, significant requirement for medical care, or to be at risk of mental health issues, they may give the quarantined individual their mobile number so that they can contact them directly if needed. Nurses may instigate daily, twice daily, or more frequent phone-calls to check up on the individual. This is in addition to any required welfare phone call. This provides an additional safety net for the health and welfare of quarantined individuals. If a person who normally frequently calls the nurse stops calling, the nurse for that individual needs to contact the individual to check on their health and welfare.

Summary of available mental health services

Mental health services are available to people in mandatory quarantine through the following sources:

1. Calling Lifeline or Beyond Blue;
2. Nurse or mental health nurse on site for initial assessment;
3. Doctor on-call for non-urgent or urgent review;
4. NorthWestern Mental Health triage service (phone 1300 TRIAGE);
5. Referral to CART (Complex Assessment and Referral Team) [Method for calling / contact];
6. Calling 000 for emergency care;
7. Quarantined individuals can also contact their usual mental health provider or be assisted to contact that provider. This includes a psychologist, counsellor, psychiatrist or other provider. Care can then be provided via telehealth.

Commented [FR(3]: REDACTED
should provide numbers / method for contact

Phone support services

Individuals in mandatory quarantine can contact Beyond Blue (1300 22 4636) and Lifeline (13 11 14) whilst in detention but must also be reviewed by the on-call doctor and a risk assessment performed if there are mental health concerns. The department's Mental Health and Drugs Branch is exploring further proactive mental health resources with Beyond Blue. [Update]

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Nurses and doctors

Nurses and doctors can review persons with mental health concerns upon request from the individual or from other sources for example if a concern is flagged by the welfare check, the authorised officer, security or by another resident. Mental state examination and risk assessment should be performed by the general practitioner allocated to the hotel.

The mental health nurse may assist with this process but the outcome of the risk assessment must be reviewed by the hotel general practitioner unless the detainee has received urgent CATT assessment or has required a transfer to a mental health unit or hospital. Psychiatric input regarding additions or changes to existing antipsychotic and anxiolytic medications may be required and should be sought by the hotel general practitioner as indicated.

Refer to the Nursing section above for further information on mental health nursing presence in the hotels.

NorthWestern Mental Health triage service

Melbourne Health's NorthWestern Mental Health triage service has been engaged from 28 March 2020 to provide specialist mental health support through direct or secondary consultation for persons in quarantine. Nurses and residents can contact **1300 TRIAGE** (**1300 874 243**) for specialist mental health support. The person making the initial referral should request the specialist priority line.

Complex Assessment and Referral Team

CART is a new service set up by DHHS which can provide advice and support for mental health issues, drug and alcohol problems, family violence and other concerns. This service is currently staffed by two clinicians, one working 8am-2pm, and the other 2pm-8pm. If a full assessment is required CART does not currently have the capacity to complete this, and if more than phone support/advice is required, they will have to refer back to the nurse to arrange for assessment and further management from another source (e.g. NorthWestern Mental Health triage).

Mental health emergency

If there is concern about a mental health emergency in a quarantined individual (i.e. acute suicidal ideation, thoughts of self-harm, or psychosis), and there is a delay in contacting the psychiatric triage team (**1300 TRIAGE**), the quarantined individual should be reviewed by the general practitioner as a matter of urgency and have a risk assessment completed within an hour.

The general practitioner should then assess the quarantined individual to determine if transfer to hospital via ambulance is required for urgent psychiatric assessment or if psychiatric advice can be obtained over the phone. If the quarantined individual is deemed as needing urgent psychiatric review and is not willing to be transferred for assessment, the doctor on call will need to decide if enacting provisions within the *Mental Health Act 2014* is required.

As for other medical emergencies, the authorised officer, reception or other parties do not need to be contacted before 000 is called. First responders should not be denied access to people in mandatory quarantine who make a 000 call.

Who can alert the welfare team to mental health concerns relating to a quarantined person?

A quarantined person, authorised officer, nurse or doctor, security, Vic Police, family members, or anyone else who has a concern about the mental health or wellbeing of a quarantined person can raise this concern to the welfare team. All concerns should be escalated as necessary and documented/recorded in the database.

Escalating medical, nursing or mental health concerns

See section on Escalation for situations requiring escalation.

See Appendix 3- Clinical escalation/referral pathway

Emergency services

In the case of an emergency, a nurse, doctor or DHHS staff member can call 000. As soon as is practicable the person should inform the operator that the call is from a mandatory quarantine hotel and the person may be at increased risk of infection with COVID-19, so that appropriate precautions can be taken. The current hotels in operation are in the catchment of three major hospitals:

- The Alfred;
- Royal Melbourne Hospital;
- Royal Children's Hospital.

As per other medical emergencies, the Authorised Officer, reception or other parties do not need to be contacted before 000 is called. First responders must not be denied access to people in mandatory quarantine who make a 000 call.

Transport to/from hospital

Transfer to hospital for people with suspected or confirmed COVID-19

- Adult passengers requiring hospital assessment/treatment for suspected or confirmed COVID-19 or other conditions, should be transferred to either the Royal Melbourne Hospital (RMH) or The Alfred Hospital, depending on proximity
- Children should be transferred to the Royal Children's Hospital accompanied by a parent or guardian
- If the hospital transfer is non-urgent, the nurse, doctor or AO may assist in arranging the transfer.
- If the hospital transfer is urgent, call 000 to request ambulance and inform them that the passenger is a suspected (or confirmed) case of COVID-19.
- Contact the Admitting Officer at RCH/RMH/The Alfred and inform the hospital of patient and details.
- Staff should don full PPE (droplet and contact precautions) and the passenger must wear a single-use surgical mask if tolerated.
- All relevant staff including AO must be notified prior to the transfer (but this should not delay the provision of urgent medical assistance or the request for an ambulance if needed).
- AO must view appropriate authorisation.
- All residents who are: in high risk groups, unwell, breathless or hypoxic (O2 sats <95%) should be considered for hospital transfer.

Unplanned transfers to hospital

Unplanned transfers occur via a phone call to Ambulance (AV) via 000 from the nurse, doctor, other staff member or quarantined person. The nurse or doctor then notifies an Authorised Officer of the transport. The patient is then treated and transported by AV or Non-Emergency Patient Transport (NEPT) to hospital.

Planned transfers to hospital

Planned transfers occur via clinical staff at each hotel notifying the Authorised Officer of the transport and arranging transport via the most appropriate transport provider (e.g. AV, NEPT, Clinic Transport Service, etc). The transport then occurs to the relevant location.

Summary of hospital transfer

The following is a general overview of the transfer of a patient to hospital involving nurses, doctors, Authorised Officers (AOs), Ambulance Victoria (AV) and hospitals.

1. Nurse/doctor makes assessment that patient requires hospital care.
2. The AO grants permission for the individual to temporarily leave mandatory quarantine. Leave should be recorded on the business system or register.
3. All relevant staff including the AO must be notified prior to the transfer (however this should not delay the transfer if it is urgent/an emergency).
4. Patient is transferred to the appropriate hospital. Patients requiring hospital assessment/treatment for suspected or confirmed COVID-19 or other conditions, should be transferred to either the Royal Melbourne Hospital (RMH) or The Alfred Hospital, depending on proximity **(note children should be transferred to the Royal Children's Hospital).**
5. If the hospital transfer is urgent call 000 to request an ambulance and inform them that the passenger is in mandatory quarantine. Let them know if the person is a suspected (or confirmed) case of COVID-19.
6. Contact the Emergency Department Admitting Officer at RCH/RMH/the Alfred to inform the hospital of patient and details.
7. Staff should don full PPE and the passenger must wear a single-use surgical mask if tolerated.
8. All residents who are in high risk groups, unwell, breathless or hypoxic (O_2 sats <95%) should be considered for hospital transfer.
9. Assessment and diagnosis are made by the treating team at the hospital. A plan is made for either admission to the hospital or discharge back to the hotel (possibly for more appropriate medical care to be arranged at the hotel).
10. Prior to any movement of the patient out of the ED, a new plan or detention approval must be sought for either return to the hotel or admission to a different location in consultation with the compliance team (receiving hospital and compliance team).
11. Hospitals will need to contact the AO at the relevant hotel, then the AO team lead will advise Lead Executive Compliance to obtain any necessary approvals.

See Appendix 7- Ambulance transfer flowcharts

Discharge from hospital

Discharge from hospital should be at the behest of the treating team. Refer to the current 'Guidelines for health services and general practitioners (see https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19).'

Transfers from hospital back to the hotel are arranged by the hospital in liaison with the DHHS Team Leader.

Anaphylaxis

Where individuals in mandatory quarantine have severe allergies and a history of anaphylaxis, this must be recorded and specifically flagged during the welfare survey completed on the way to or at the hotel at the beginning of the stay. All individuals who require medications including antihistamines, corticosteroids and EpiPens should have an adequate supply of these. If they require an additional prescription for these this should be facilitated by the healthcare providers at the hotel and the nominated pharmacy as a matter of urgency.

If a person reports that they are having an anaphylactic reaction, 000 should be called immediately. This does not need to be escalated to an AO (or any other member of staff, medical or non-medical), an ambulance should be called immediately by whoever is first aware of the situation. The health of the quarantined individual and the provision of urgent healthcare is the priority in any medical emergency. The Authorised Officer can be informed as soon as is practicable thereafter.

Note: persons may call 000 themselves in the event of an emergency, they do not need to do this via an AO, a nurse or reception in an emergency.

Provision of welfare

Airport screening process

At the airport, DHHS nurses and Department of Agriculture, Water and the Environment (DAWE) biosecurity officers will screen all passengers arriving from overseas for symptoms of COVID-19. Nurses will perform a temperature check on each passenger.

Management of an unwell person at the airport

Any passengers who screen positive on this health check will trigger the DAWE biosecurity officer to contact the Human Biosecurity Officer (HBO) on-call for the department via 1300 651 160. After discussion with the HBO, if it is determined that the person meets the criteria for a suspected case of COVID-19, the following actions should take place:

- The HBO should organise an ambulance transfer to the Royal Melbourne Hospital (or Royal Children's Hospital) for testing and assessment.
- The AO at the airport should log the person as requiring mandatory quarantine at a specified hotel and then should follow-up with the hospital to update on whether the person has been found to be negative, so a transfer by (patient transfer/ambulance/maxi taxi etc.) can be organised to bring the person to the assigned hotel.
- If the person is unwell and requires admission to hospital, the Compliance Lead should be informed.
- If the person is well enough to be discharged they should return to the hotel through an arrangement by the AO.
- If they are a confirmed case they should be placed on a COVID-19 floor. If they are not, they can be placed in a general part of the hotel.

Transfer of uncooperative individuals

It is recommended that a separate mode of transport to the hotel is provided for a person who is uncooperative/non-compliant. Ensure appropriate safety measures are taken (e.g. child locks on doors, a safety briefing for drivers, etc.).

If a person refuses testing for COVID-19 at a hospital and they are well enough to return to the hotel, they should be transported back to the hotel and treated as if they are COVID-19 positive (i.e. they must be situated on the COVID floor of the hotel and the necessary precautions taken). Every effort should be made to encourage them to get tested before this happens. However, they cannot be forcibly tested.

If a person refuses testing and treatment at a hospital and is too unwell to be released from hospital, a Human Biosecurity Control Order (HBCO) may need to be considered.

Assessment at the hotel

All quarantined individuals will be given a survey to complete on the way to or at the hotel. This will include questions about past medical history, mental health history, allergies, medications, next of kin/emergency contact, dietary requirements, and other important health and welfare needs. A doctor and nurse will be available on site to urgently review anyone who reports illness or an urgent medical need on arrival at the hotel. Nurses will review the surveys and contact all individuals who are identified as having significant health needs, as soon as practicable. After initial phone contact is made, further assessment/management can be organised as needed.

Initial information on options for accommodation

Policy on separation of people in travelling parties to promote effective quarantine

There are a number of options for people – such a couple or family – for rooms to promote effective quarantine. Because a person needs to commence a further 14 days of quarantine when a person within a party or group is identified as positive for COVID-19, there should be an option to separate people – if they consent – at various points in the quarantine journey.

Option 1 – Parties stay together

A couple or family stay together and share a suite or room. If a person becomes positive, an extension of quarantine will be required on a tailored basis for the other persons.

Option 2 – Parties separate from the outset

A couple or family are separated from the outset. If a person becomes positive, the other parties do not need to recommence 14 days of quarantine.

Option 3 – Parties are separated once one person becomes positive

A couple or family separate into different rooms (with no contact thereafter) after a person becomes positive for COVID-19. The non-infected persons then start a new 14 day quarantine period, which is served at home once they complete the mandatory 14 day period in the hotel.

Option 4 – Parties stay together after one person becomes positive

The parties stay together. At the end of the 14 day period, they both leave to home isolation, and the non-infected persons commence a further 14 day quarantine period, as long as they separate in the house to which they go.

Communication of these options to people in mandatory quarantine

The DHHS Team Leader should communicate these options to people at booking, with the default option being that parties stay together unless they indicate a preference to separate from the outset.

Assessment during detention

Medical care should be available 24 hours a day to individuals in mandatory quarantine.

The need for medical care can be identified through the following channels:

- Via the daily welfare check (See Appendix 6- Welfare Survey)
- By the person contacting the concierge or nurse directly
- Nurse phone call to the individual
- The 1800 government services number (DJPR), the physical distancing hotline, the COVID hotline, or any other DHHS phone line
- Family members directly contacting the hotel/team/COVID quarantine inbox

Individuals in mandatory quarantine should be supported to contact their regular health care provider by phone or telemedicine if appropriate. In these instances, the healthcare provider should be provided with the contact details of the hotel nurse or GP so that the outcome of the assessment or management plan can be communicated with the medical team on site.

Tiers of risk for people in mandatory quarantine for welfare checks

Individuals in mandatory quarantine will be triaged into three tiers of risk. The type of welfare check will depend on the tier the person falls into.

The following table is an initial framework for triaging the type and frequency of welfare check required:

Table 1: Risk Characterisation for Welfare Checks

Risk Tier	Risk factors	Welfare check type
Tier 1	Residents with suspected or confirmed COVID-19 Families with children < 18 years Passengers aged > 65 years Aboriginal and Torres Strait Islander peoples Residents with underlying comorbidities (e.g. respiratory or cardiac conditions) Residents with a history of mental illness	Daily phone call
Tier 2	Those who indicate they require a phone call but do not have any other risk factors. Residents who are by themselves.	Phone call every second day
Tier 3	Low risk – everyone else.	Tailored contact

For phone calls (tier 1 and tier 2), translators must be available as needed. Language requirements should be recorded on arrival at the hotel and provisions made as required.

Individuals may be moved between risk tiers throughout their quarantine period as need dictates.

Requirement for a welfare check

As part of the welfare check process, quarantined individuals should be provided with a satisfaction survey (available at **Appendix** 6) to complete each week. This satisfaction survey is more comprehensive than the regular daily welfare check. Any concerns raised on the survey should be escalated to the DHHS Team Leader for action.

Each individual in mandatory quarantine should receive a welfare check each day by a DHHS welfare officer (employee or contractor). A welfare check will allow people in detention to be assessed for medical and social issues. Concerns can be flagged and responded to. These issues include but are not limited to health, mental health, safety and family violence concerns. Referrals to the nurse, social supports, mental health and other services can be made as a result.

Welfare checks are made from the DHHS welfare call centre by a DHHS welfare officer – the script for these checks is in **Appendix 6)**

Smoking

Smoking is not permitted within the hotel rooms. The following actions should occur:

- Nicotine Replacement Therapy should be promoted strongly for smokers;
- Smokers should be provided with the Quitline number to access telephone counselling - 13 78 48;
- People can also contact their regular general practitioner via telehealth for support;
- Smoking restrictions should remain in relation to the room;

- Only where absolutely necessary, and in exceptional circumstances, a person in mandatory quarantine could be granted permission to leave their room under specific circumstances where public health risk is managed:
  - The Authorised Officer is aware and grants permission;
  - They are accompanied by security, who are provided PPE to wear;
  - They are instructed to – and follow the instruction – not to touch surfaces en-route to the smoking area and coming back;
  - They return immediately to their hotel room.

Fresh air and exercise

Individuals in quarantine should have access to fresh air where feasible.

- If the room has a balcony, ensure the residents can access it for fresh air.
- Advise residents to open windows/balconies where possible for fresh air and ventilation.
- If it is possible for residents to go outside to take some exercise for organised/supervised short periods of time, this should be facilitated where possible. Residents should ensure physical distancing is practised during this period. Only well residents from the same room should be able to go out to exercise at the same time.

Exercise is important for physical and mental health, particularly in the mandatory quarantine environment. Requests for exercise equipment / yoga mats should be facilitated where possible, but equipment should be thoroughly cleaned and disinfected after use. Resources for exercise routines and yoga/meditation should ideally be provided to individuals in mandatory quarantine upon request.

Alcohol and drugs

Alcohol is permitted within hotels. Excessive alcohol consumption should be discouraged and should not be facilitated.

If there are concerns about alcohol or other substance abuse or withdrawal:

- Request nurse or medical review.
- Provide numbers for support services.
- Preference for provision of standard drinks to a limit rather than prescribing diazepam for alcohol withdrawal.
- Prescriptions – Schedule 8 prescriptions for drug-dependent patients can only be provided after discussion with the DHHS Medicines and Poisons Branch.
- If there are concerns about acute alcohol withdrawal, confusion or mental state/mental illness, escalate for urgent medical review (consider calling 000).

Note: Alcohol should not be provided to persons who are under 18 years of age (including in the hotel room minibar).

Nutrition and food safety (including allergies)

Individuals in quarantine should be provided with a well-balanced and plentiful diet, with options provided for those with specific dietary requirements.

- Ensure a well-balanced diet with options provided for those with specific dietary requirements.
- Ensure access to essentials within the room (e.g. snacks, tea and coffee) to limit the amount of interactions/contact required with hotel staff.
- Ensure access to additional food if required.
- Ensure that food allergies are recorded and communicated to the catering providers.

If there are substantial concerns that someone is not eating, this should be flagged with the medical team, and appropriate review/referral arranged (e.g. for mental health assessment).

Food allergies

Individuals in mandatory quarantine should report all allergies in their initial health and welfare survey, and indicate if they are severe, have a history of anaphylaxis, or have been prescribed EpiPens. This must be filled out by every quarantined individual. If no allergies are reported, they should record “no known allergies”. Dietary requirements should be carefully recorded and communicated to the catering providers. It is the responsibility of the welfare team to ensure that food safety arrangements are in place and that this information is communicated to the catering staff.

Some form of marking or sign on the door should be used to indicate a person in the room has a significant allergy as a safeguard.

Food safety process

Food safety questionnaires (along with the welfare questionnaire) should be distributed to individuals at the airport. Individuals with specific dietary requirements (who are eligible for this process) should be contacted and advised of the process for self-organising suitable meals (through uber eats and by submitting a claim following their stay). Uber Eats Drivers should drop meals off at the hotel, and security staff should deliver the meals directly to the requestors’ rooms. The Uber Eats Driver/Rider should not drop the delivery to the person’s room directly.

Please refer to the following documents for further details:

- Process for people with food allergies (Appendix 9)
- Meal order information for people with allergies (Appendix 10)
- Food safety questionnaire (Appendix 11)

Care packages

A public health risk assessment has been conducted that indicates that care packages, such as food or toys, can be delivered for provision to people in mandatory quarantine. The reason for quarantine is to prevent risk of COVID-19 transmission from people in detention to other parties and does not mean a person needs to be prevented from receiving packages.

The care package should be provided to the hotel reception or other party for conveyance to the person in mandatory quarantine and should not be directly handed to the person in quarantine by the person gifting the care package. Ensuring the package passes to the person in quarantine without misdirection or tampering is essential. There is no public health reason for inspection of any care package.

Safety and family violence

If there are concerns about family violence / the safety of women and children the following must occur:

- Arrange for separate rooms for the person to be assessed and access phone support services (separate rooms may also be indicated for the remainder of the quarantine period)
- Refer to CART
- Refer to phone support services
- Engage case worker to contact person and make an assessment
- Ensure the affected person has access to contact Victoria Police to report family violence or other safety concerns, if they chose

Social and communications

- All residents should have access to **free** wifi/internet.

- All residents should have access to entertainment such as television and streaming services (e.g. Netflix).
- All residents should have access to communications so that they can keep in regular contact with family and friends throughout the quarantine period.
- Toys and equipment should be provided for small children if possible.

Requests for exemption from mandatory quarantine

The types of situations where an exemption from mandatory quarantine is generally granted include:

- Unaccompanied minors in transit to another state
- Unaccompanied minors where a parent or guardian does not agree to come into the hotel
- Foreign diplomats coming into the country
- ADF staff travelling for essential work
- People with a terminal illness
- People whose health and welfare cannot be safely accommodated in a hotel environment (eg mental health or require in-facility health treatment)
- People who are transiting directly to another country (and who do not need to travel domestically first)
- Air crew
- Maritime workers who have come off a boat and will be leaving by boat
- Maritime workers who have come off a plane and will be leaving by boat within the quarantine period

In the above circumstances the passenger will either a) be released from quarantine if they were already detained or b) will be required to complete quarantine in another location (at home or in another facility) and be subject to quarantine monitoring and penalties.

Negative permission/exemption outcomes

When a person submits a request for release from detention (temporary or permanent) that is denied/declined, a CART team support worker should be present (on the phone) to provide support (if the person consents to this, and if CART are already working with the person).

- The CART team can support the person before and after the exemption discussion with the doctor which is a separate discussion, in anticipation of some emotional distress upon hearing the outcome.
- The CART worker can help the person gain insight into the public health risk, understand the information they are receiving, and provide insight into what they can and can't do whilst they remain a public health risk.
- This will also inform the doctor/nurse and CART team of further risk management and support required for the person going forth.

Temporary leave from mandatory quarantine

Permission for temporary leave from mandatory quarantine in hotels may be granted in the following circumstances:

- Attendance at a funeral
- Medical treatment
- Seeing family members who are about to pass away
- Smoking breaks where people are suffering extreme anxiety and where it is safe to do so from a public health and infection control perspective- see 'Smoking' above
- Exercise breaks for those suffering extreme anxiety and where it is safe to do so

Where health and welfare issues exist in any of the above cases, particularly in the case of extreme anxiety, the on-site health staff will assess individual and assist in providing recommendations as to the most appropriate supports for the individual.

Assessment in preparation for exit

All persons departing mandatory quarantine will be offered a health check with a nurse 24-48 hours prior to exiting. This health check is voluntary. This will consist of questions about symptoms of COVID-19 and a temperature screening.
If a person screens positive on the health check:

- They will not be detained longer than the 14 day mandatory quarantine period
- A swab will be sent and they will be informed that they need to self-isolate after exiting, until the result of the swab is known
- If they do not have appropriate accommodation to self-isolate after release, they will be assisted to find such accommodation

If a person screens negative on the health check, no further action will be taken.

Infection control and hygiene

COVID floors/hotels

Each hotel should have a COVID-19 positive floor or area (a “RED ZONE”). Any person who is a confirmed case should be relocated to this area of the hotel when the test result is known. Appropriate signage, PPE and other consumables should be available at the entrance to this area of the hotel. Where there are large numbers of confirmed cases arriving on a flight, a COVID hotel may be considered. Where the infrastructure allows, suspected cases may also be moved to an area of the hotel away from well individuals.

Personal protective equipment

A supply of P2/N95 masks and gowns should be maintained, in addition to single-use face masks and gowns. PPE stocks should be checked regularly by the DHHS Team Leader/ manager, and urgently requested if needed. Regular stocktake should be undertaken to pre-empt additional orders.

PPE should be available at the hotel. Biohazard bags for waste disposal, and hand hygiene stations, should be available at the doffing section of the hotel.

PPE protocols should be available to all staff working in the hotels, so that there is clear instruction on what type of PPE to wear and in what circumstances, how to don and doff it, and how to dispose of it.

See Appendix 5- PPE advice for hotel-based healthcare workers

Laundry

Staff may wear PPE when handling dirty laundry. Laundry should be washed on the highest possible setting and thoroughly dried before use. Staff should not overly handle the linen – it should be put straight into the washing machines. Staff should follow hand hygiene procedures after handling dirty linen.

Cleaning

Though not directly medical care, all quarantined individuals have the right to a safe and comfortable room and environment. Quarantined individuals may not be able to upkeep their rooms for various reasons, which may affect their physical and mental health. If cleaning cannot be regularly provided, all efforts should be made to assist the quarantined individual with cleaning their room. In rare instances the quarantined individual may need to be moved out of the room, and staff don full PPE to provide a rapid cleaning of the room. This should only occur in rare instances where the quarantined individual is not capable of doing so themselves. Any persons for whom there is a concern about room hygiene and safety should be flagged to the team leader.

Please refer to the department document ‘Cleaning and disinfecting to reduce COVID-19 transmission’.

Housekeeping services will not be provided routinely to residents. Fresh linen, towels and additional amenities can be left outside of rooms for residents to then collect. Biohazard bags can be left for residents to place dirty linen in and to leave outside their rooms for collection. Terminal cleaning is required on vacation of each room. Rooms that have been vacated will not be repurposed during the quarantine period.

Room sharing

Well persons

In instances where two or more well people who are not suspected or confirmed cases of COVID-19 wish to share a room in advance of check-in at the hotel, this can be facilitated. However, they should be informed that sharing a room may have implications for the amount of time they are required to quarantine (although not their mandatory detention period) should their roommate become a confirmed case.

If a request to share a room is made after an initial period in separate rooms, they should be informed that this may increase their risk of infection with COVID-19 if the other person is incubating the infection, and that COVID-19 infection may result in serious illness and death in some cases. They should also be informed, as above, that such an arrangement may have implications for the amount of time they are required to quarantine for if their roommate goes on to develop infection. If the persons still insist, then it must be documented in the Dynamic CRM Database that the risks have been discussed with them (e.g. by a nurse), before facilitating this request.

COVID discordant couples

In instances where one person in a room share situation is identified as a confirmed case and the other person is asymptomatic or has a negative COVID-19 test, the confirmed case should self-isolate in a separate room away from the person who does not have COVID-19. The 14-day quarantine period (but not the mandatory detention period) for the COVID-negative person starts from their last contact with the confirmed case during the confirmed case’s infectious period. This may mean that they need to self-quarantine for an additional number of days after the mandatory detention period ends, but they may do this in their own home or in alternate accommodation, not in detention. The self-isolation arrangements for the confirmed case are outlined in the section below (“Exit arrangements for confirmed COVID-19 cases”).

COVID-19 in people in mandatory quarantine

Actions for confirmed cases of COVID-19 in people in mandatory detention

Overall actions

The following actions should be taken:

- Residents with confirmed COVID-19 should be accommodated / cohorted in a separate section/floor of the hotel, away from the non-COVID-19 infected passengers → the **RED ZONE.**
- A designated COVID-19 hotel should be available when there are large numbers of cases coming off flights (e.g. high risk repatriation flights with a high burden of suspected or confirmed COVID-19).

Personal protective equipment (PPE)

See Appendix 5- PPE advice for hotel-based healthcare workers

Staff who engage with monitoring or assisting persons in mandatory detention in person should:

1. Apply standard infection prevention and control precautions at all times:
    a. maintain 1.5 metre distance
    b. wash your hands or use anti-bacterial agents frequently
    c. avoid touching your face.
2. Every situation requires a risk assessment that considers the context and client and actions required.
3. If you are not able to maintain a 1.5 metre distance and the person has symptoms (for example coughing) or is known to be a COVID-19 case use:
    a. fluid-resistant surgical mask (replace when moist or wet)
    b. eye protection
    c. disposable gloves.
4. If you need to be in a confined space (<1.5 metre) with a known COVID-19 case for more than 15 minutes, wear a single use facemask, eye protection and gloves.

Current infectious cases

- In the situation that an arriving passenger is a current infectious case of COVID-19, they will still be handed the detention notice and will be placed in mandatory quarantine.
- They will be given a single use face mask to wear and will be kept separate from the other passengers.
- At the hotel, they will be asked to provide confirmation of their diagnosis. If there is any doubt surrounding the certainty of the diagnosis of COVID-19, they may be tested again.

Recovered cases

- In the situation that an individual states that they are a confirmed case of COVID-19 and have recovered from the infection, they will still be handed the detention notice and placed in mandatory quarantine.

- The onus on the individual to provide the evidence that they have a confirmed case of COVID-19 and the required amount of time has passed such that they are no longer considered infectious.
- The department will decide on a case-by-case basis whether evidence from other sources (from testing done overseas) can be considered sufficient proof to inform clinical and public health decision-making.
- If they meet the criteria for release from isolation (see below) and the testing and medical reports provided are considered sufficient by the department, they may be considered for release from detention.
- They will still be handed the detention notice until this can be verified and the request has been approved.

Note – there are no automatic exemptions for persons who are recovered cases. These requests need to be assessed on a case-by-case situation.

Release from isolation

Criteria for release from isolation

Confirmed cases of COVID-19 will be considered for release from mandatory quarantine, once they meet the department's criteria for release from isolation of a confirmed case:

- the person has been afebrile for the previous 72 hours, and
- at least **ten days** have elapsed after the onset of the acute illness, and
- there has been a noted improvement in symptoms, and
- a risk assessment has been conducted by the department and deemed no further criteria are needed

Clearance testing is not required for release from isolation, either in the home or in mandatory quarantine.

Process for release from isolation

As per the DHHS guidelines for health services and general practitioners (see https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19), the department will determine when a confirmed case no longer requires to be isolated in mandatory quarantine, hospital or in their own home.

- Every confirmed case that is diagnosed in Victoria is notified to the department, and assigned a case and contact officer (CCO), regardless of whether they are diagnosed in detention or outside of detention. Every confirmed case receives daily contact from the case and contact team.
- The CCO will advise when it is appropriate for consideration for release from isolation, and will issue a clearance certificate (via email) to COVID.quarantine@dhhs.vic.gov.au for the case when they meet the criteria for release from isolation.

Nurses looking after confirmed cases in detention should temperature check and review symptoms of confirmed cases daily. The date of acute illness onset should be clearly documented in their records.

If a confirmed case is due for release from mandatory quarantine but does not yet meet the department's criteria for release from isolation, they will not be detained longer than the 14-day quarantine period. They will be released from detention at the agreed time, but will be subject to the Isolation (Diagnosis) Direction and should be assisted to self-isolate wat home or in another suitable premises in Victoria until they meet the required criteria. A premises is considered suitable if it has a facility/room where the person can be isolated so as not to cause undue a risk for another householder (i.e. not a hostel or dormitory accommodation). They will be given a single-use face mask to wear when checking-out from the hotel and in transit to their next destination. They will be provided with a 'confirmed case' information sheet.

Exit planning for individuals with confirmed COVID-19

Non-emergency ambulance transport

When a confirmed case of COVID-19 who is considered still infectious but is stable is assessed as appropriate for transition to isolation in their home, Ambulance Victoria will be requested by the DHHS Team Leader for mandatory quarantine to provide non-emergency patient transport for that person to a destination in Victoria that is the assessed appropriate home isolation location.

If there are multiple persons to be transitioned to home isolation on the same day, subject to compliance-related logistics being able to be handled and any privacy considerations being met, it is permissible for two or more potentially infectious confirmed cases of COVID-19 to be transported together in one NEPT, i.e. to cohort confirmed cases

Exit arrangements

The following table documents the exit management plans for quarantined individuals in different scenarios.

Scenario	Exit plan
Well person who has served 14 days of quarantine	• Can leave – gets end of detention notice (universal version).
Confirmed case of COVID-19 who has met criteria for release from isolation (i.e. is declared no longer infectious)	• Can leave – must not be prevented from leaving if the AO is aware they are cleared and the person demands to leave – they are non-infectious and therefore not a public health risk. • Gets clearance from isolation letter from PHC (as per Isolation (Diagnosis) Direction).
Confirmed case of COVID-19 who is still potentially infectious and has been in detention less than 14 days	• Must stay in detention.
Confirmed case of COVID-19 who is still potentially infectious but has reached the end of their 14 day detention period	• Can leave detention but is now subject to the Isolation (Diagnosis) Direction. • Safe travel should be arranged by the authorised officer at the hotel via the Operations Soteria EOC to place of home isolation in Victoria (mask, stay separate, go straight to home; but preferred travel by non-emergency patient transport with PPE'd ambulance officers) • Not permitted to travel interstate or to fly domestically but no detention order is needed to prevent that (in keeping with all other confirmed cases) • If no place to isolate, DHHS should keep person in hotel voluntarily to reduce risk until cleared, or until safe home isolation environment identified
Well close contact of a confirmed case of COVID-19 (i.e. roommate at hotel), where the roommate has reached the end of their 14 day detention period	• Case and Contact Sector to do assessment, assign a new 14 day period (from date of last contact with infectious case) and issue a requirement to quarantine until that 14 days ends – factsheet, lodge new date in PHESS, reverting person to effective close contact status

	• No detention order required, and no legal order preventing flying, but must be advised by case and contact management sector not to fly and that they need to quarantine • If lives interstate, the authorised officer at the hotel can arrange via the Operations Soteria EOC a hotel if a person would otherwise be homeless.
Symptomatic suspected case of COVID-19 who has reached the end of their 14 day detention period.	• Allowed to leave detention safely (mask, separate; ideally NEPT transport to home isolation). • EOC should follow-up result to convey result (as DHHS oversaw this testing so is obliged to follow-through).

Exit arrangements for suspected cases

- • Any suspected case of COVID-19 who is in mandatory quarantine who has reached 14 days from the start of their mandatory quarantine period (midnight) may leave and should be assisted to safely isolate in a safe environment until COVID-19 is excluded.
- • Any suspected case of COVID-19 who is in mandatory quarantine who has NOT reached 14 days from the start of their mandatory quarantine period (midnight) needs to remain in mandatory quarantine.

Reporting / escalating concerns

Principles

- Decisions about medical care should be left to the nurses and doctors and should not be determined by any other staff.
- In any emergency situation, the priority is to call 000 before notifying any other managing or governing figure.
- If there is any doubt over whether an issue or concern should be escalated to senior management, escalate the concern.

Clinical escalation

This is described in **Appendix 3- Clinical escalation/referral pathway**.

Escalation for mental health concerns

Chain of escalation for mental health concerns and issues

The following table indicates the chain of escalation for concerns about the mental health of people in mandatory quarantine.

Situation	Responded to by	Escalated to	Reported to
Non-urgent mental health concern	Nurse or GP Regular healthcare provider by telemedicine	Mental health nurse Psychiatric triage	Medical lead General practitioner
Repeated mental health concerns / acute mental health concern	Mental health nurse or GP, urgent review Psychiatric triage urgent review Daily physical welfare review thereafter	Ongoing mental health nurse management	Welfare lead Medical lead Compliance lead
Risk of self-harm / serious mental health concerns	Immediately phone 000 → Emergency Department Call GP/nurse to attend urgently	Emergency inpatient tertiary care	Welfare lead Team leader Medical lead Compliance lead

			Deputy Public Health Commander

Specific events to escalate

The following mental health-related events or situations should lead to an escalation to the Deputy Commander - Welfare at EOC who will also notify the Deputy Public Health Commander:

- A person identified as high risk for mental health concerns due to a past history, medication or recent bereavement;
- Detainees with suicide or homicide risk or recent psychosis;
- Any instances where physical or chemical restraint have been required.

Escalation for medical reasons

An escalation flowchart is at **Appendix 3**.

Nurse or doctor to escalate

In the following circumstances, the nurse / general practitioner should call the DHHS Team Leader:

- There is any practical issue arising from the medical consultation that needs the assistance of DHHS;
- A patient needs to access an alternative medical or welfare service such as mental health nursing, a medical specialist or acute hospital care;
- A patient needs to be admitted to hospital in an emergency;
- A patient has suffered any form of life-threatening injury or health event;
- A patient has died.

DHHS Team Leader to escalate

The following concerns or events must be escalated by the DHHS Team Leader to the Deputy Commander - Welfare at EOC within one hour during business hours, or Operation Soteria Deputy Commander Reception after hours, who will also notify the Deputy Public Health Commander within two hours:

- A person identified as high risk for mental health concerns due to a past history, medication or recent bereavement;
- Detainees with suicide or homicide risk or recent psychosis;
- Any instances where physical or chemical restraint have been required;
- A serious act of non-compliance;
- An acute medical deterioration;
- Any hospital admission or emergency transfer to hospital;
- A serious risk to the health and safety of a person in mandatory quarantine (or a staff member);
- Serious illness/harm/injury (including assault) to a person in mandatory quarantine;
- A severe allergic reaction (anaphylaxis);
- A death.
- An unauthorised absence from mandatory detention (a missing person)
- A fire or other emergency in a hotel;
- A potential outbreak of COVID-19 or another infectious disease

See also Appendix 4- Chain of command re detainee with physical/mental health issue

Daily health and welfare report to Public Health Commander

A daily health and welfare report should be provided to the Deputy Public Health Commander for Physical Distancing by the Deputy Commander Welfare. This is to ensure oversight and accountability for the mandatory quarantine process. This report should include but is not limited to the following:

- Total number of people in mandatory detention
- Total number of confirmed COVID-19 cases (cumulative and new)
- Total number requesting exemptions to leave mandatory quarantine (temporary and permanent)
- The number of persons in mandatory detention receiving:
  - A nurse review
  - A mental health assessment
  - A GP review
  - Referral to hospital
  - A 000 call
- The number of persons awaiting:
  - A mental health assessment
  - A GP review
- The number of persons in the following groups:
  - Significant psychiatric history - mild/moderate/severe mental health issues (as per the risk stratification)
  - Serious/life-threatening medical conditions (e.g. anaphylaxis, stage 4 cancer)
  - Age < 16 years or > 70 years
  - Pregnant women
- The number of calls from the hotels to:
  - 000
  - VicPol
  - Other DHHS phone lines
- The number of risk incidents logged in the database.
- Other major concerns flagged.

Audit

Healthcare audit

Medical care provided by doctors and nurses contracted by DHHS will be audited regularly. This should be reported to the EOC Commander and Deputy Public Health Commander. The audit process may consist of, but is not limited to, the following:

- Assessing waiting times for delivery of care;
- Record-keeping and review of medical records;
- Medical care satisfaction surveys;
- Number of repeat requests for medical care/escalation;
- Number of risks reported;
- Feedback from authorised officers and other organisations involved/staff.

Welfare audit

Audit of welfare procedures should be performed by the Welfare Lead at the EOC on a regular basis. The audit process may consist of:

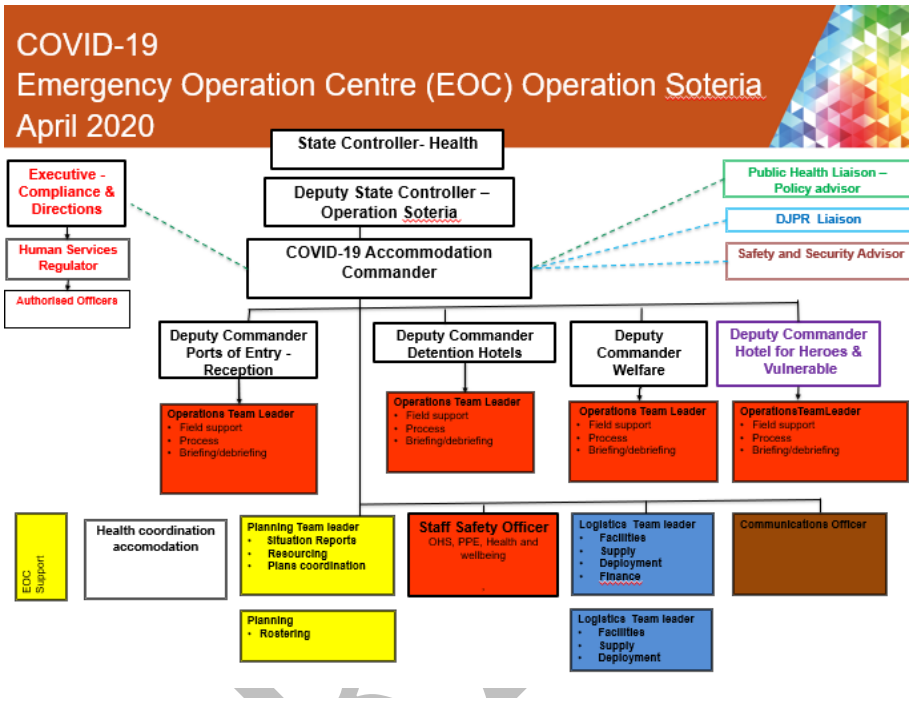
- Review of weekly satisfaction surveys;
- Feedback from staff;
- Audit of welfare check calls (review of a sample of recorded calls).

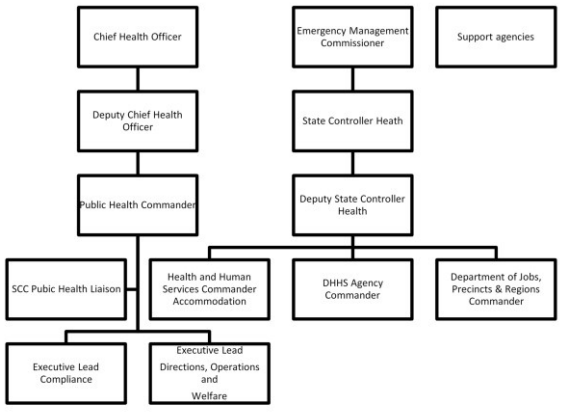
Appendices

List of appendices currently attached

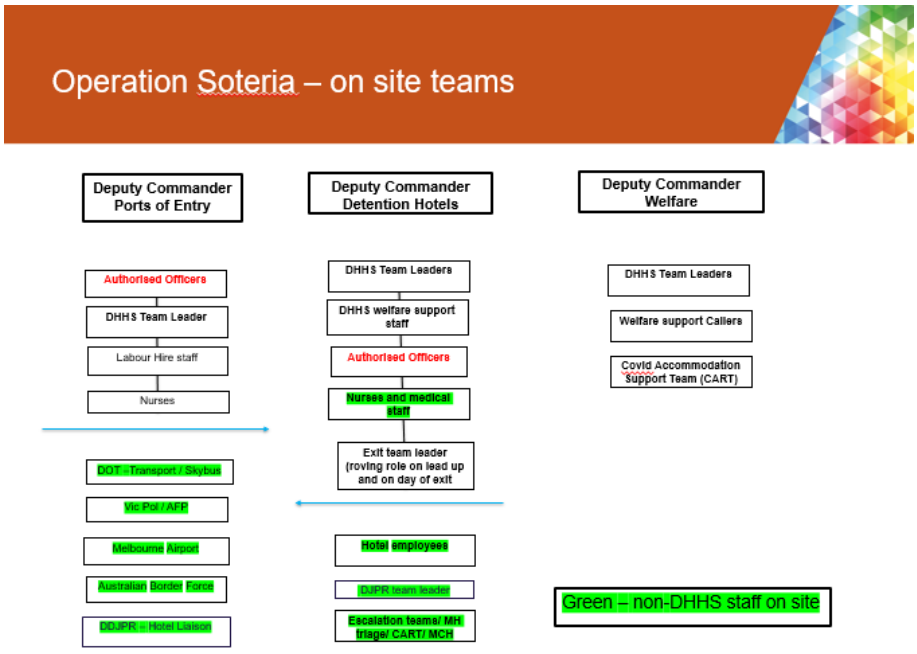
1. EOC Operation Soteria governance flowchart
2. Operation Soteria on site teams
3. Clinical escalation/referral pathway
4. Chain of command re detainee with physical/mental health issue
5. PPE advice for healthcare workers in hotels
6. Welfare survey
7. Ambulance transfer flowcharts
8. Hospital and Pharmacy contacts for each hotel
9. Food safety factsheet- process for people with food allergies,
10. Meal order information for people with food allergies
11. Food Safety Questionnaire

Appendix 1 - Governance

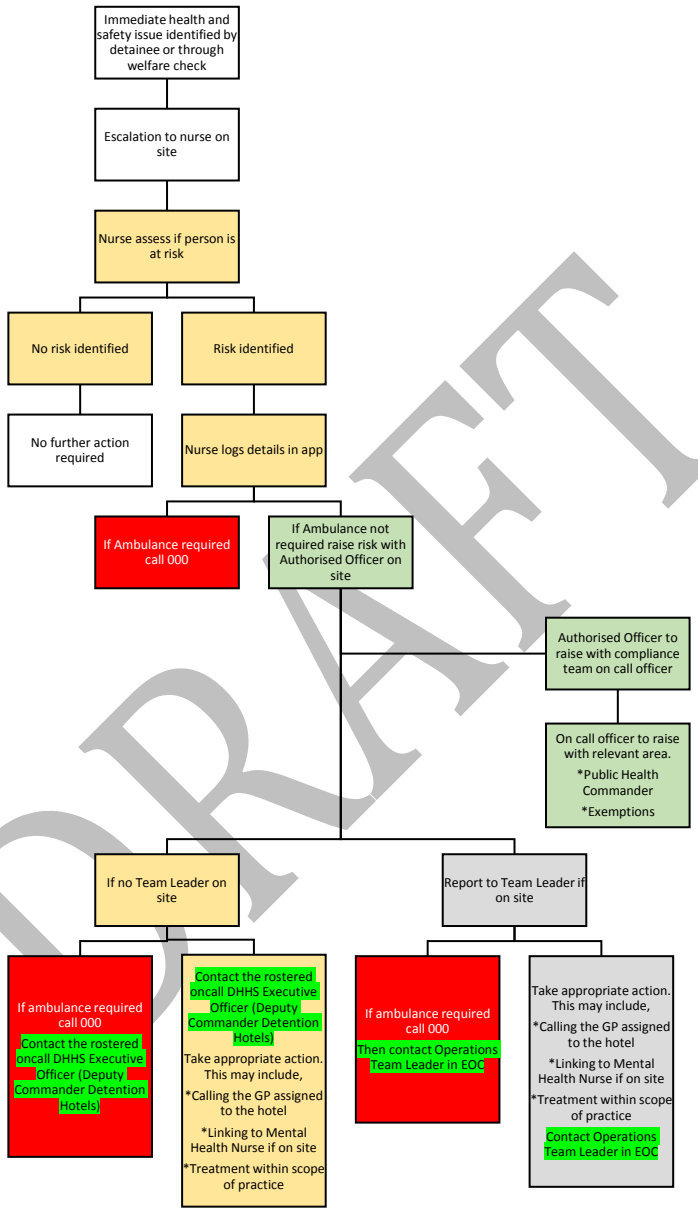




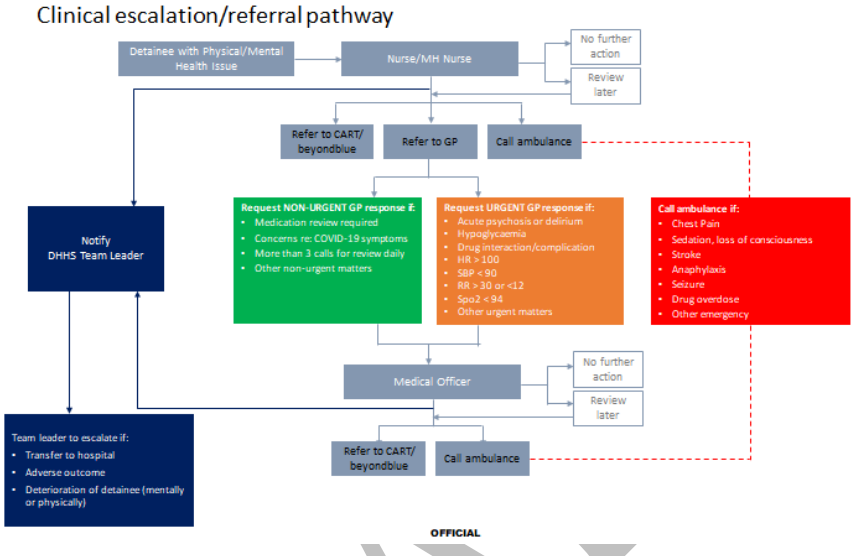
Appendix 2 – Operation Soteria on site teams



Appendix 2 – Escalation Process



Appendix 3- Clinical Escalation/Referral Pathway



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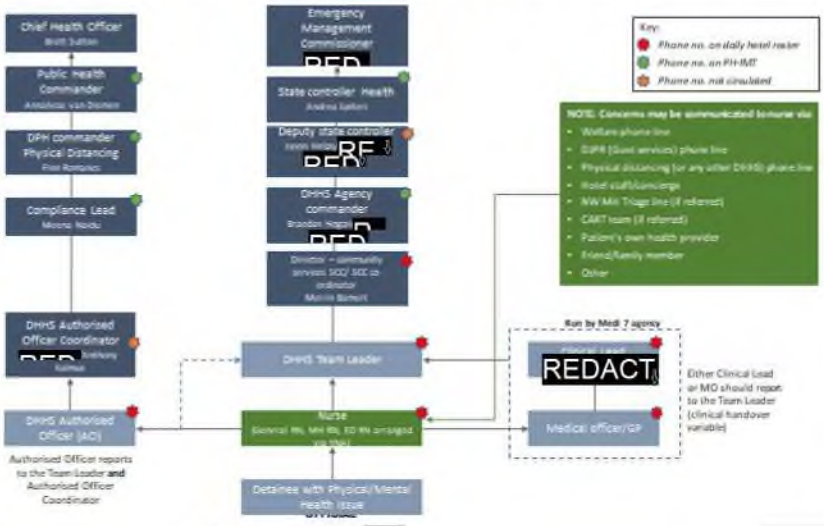
Appendix 4- Chain of command for detainee identified as having physical/mental health issue

Chain of command re: Detainee Physical/Mental Health Issues



Appendix 5- PPE advice for hotel-based healthcare workers

PPE advice for hotel-based healthcare worker (HCW) for contact with COVID-19 quarantine clients

Adapted from: Infection Prevention Australia

Note: P2 or N95 masks are only recommended for use when aerosol generating procedures are being undertaken or will occur. In all other instances don a surgical face mask for direct client contact.

Recommended HCW PPE use according to type of activity and client COVID-19 symptomology

Setting	Target personnel or patients or clients	Activity	Type of PPE or procedure
Hotel quarantine floor **Not entering the client/s room or having direct contact with client/s.**	Health care worker	Telephone or online triage to check for recent change in condition or development of symptoms. No direct client contact.	No PPE
	Health care worker	Any visit	Maintain physical distance of at least 1.5 meters. When physical distance is not feasible and yet no patient contact, use surgical face mask and eye protection.

Setting	Target personnel or patients or clients	Activity	Type of PPE or procedure
Perform hand hygiene before and after every client contact	Patients with symptoms suggestive of COVID-19 (e.g. cough, fever, shortness of breath)	Doorway indirect contact by HCW	Surgical face mask Eye protection Gown Gloves Request client/s to wear surgical face mask if tolerated and remind client to perform hand and respiratory hygiene
	Patients/clients without symptoms suggestive of COVID-19	Doorway indirect contact by HCW (e.g. taking electronic temperature)	Surgical face mask Eye protection Perform hand hygiene and have the patient/client perform hand hygiene and wear a surgical face mask
Client/s room **Entering the client/s room** *Examples of aerosol generating procedures include:* *Collecting nasopharyngeal swabs* *Cardiopulmonary resuscitation* *Nebulisation of medication* *Intubation* *Suctioning airways* **Perform hand hygiene before and after every client contact**	Patients with symptoms suggestive of COVID-19 (e.g. cough, fever, shortness of breath)	Providing direct care or any close contact in the absence of aerosol generating procedures	Ask client/s to wear a surgical face mask if tolerated Surgical face mask Gown Gloves Eye protection (goggles or face shield)
	Patients/clients without symptoms suggestive of COVID-19	Providing direct care or any close contact in the absence of aerosol generating procedures	Ask client/s to wear a surgical face mask if tolerated Surgical face mask Gown Gloves Eye protection (goggles or face shield)
	Any client - confirmed or unconfirmed COVID-19 case	Providing direct care to in the presence of aerosol generating procedures	Respirator N95/P2 standard Gown Gloves Eye protection Maintain physical distance of at least 1.5 meters. Ask client/s to wear a surgical face mask if tolerated Immediately move the client to an separate room or separate area away from others; if this is not feasible, ensure spatial distance of at least 1.5 meters from other household/room members. Perform hand hygiene and have the patient perform hand hygiene

Isolation *is used to separate ill persons who have an infectious disease from those who are healthy (e.g. tuberculosis and confirmed COVID-19 cases).*
Quarantine *is used to separate and restrict the movement of well persons who may have been exposed to an infectious disease to see if they become ill (e.g. returned travelers, cruise line crew and passengers.*

Compliance & Welfare Management System (applies to Welfare Survey below)

Release Notes: 17/04/2020

The following is a summary of key changes included this release:

	Area	Change	Application
1	Welfare Survey	Change made to wording and flow of existing health question: • "Have you been seen by a nurse today?" – default: NO, if the answer is yes, then it pops up a box: "reason why" • "Have you been seen by a nurse on another day?" – default: NO, if the answer is yes, then it pops up a box: "reason why"	Welfare Management System
2	Welfare Survey	Change made to an existing health question: • "Are you a lone occupant in your hotel room?" Sibling and Other (eg. Friend) are now selectable options.	Welfare Management System
3	Welfare Survey	Change made to an existing health question: • "Have you or your fellow occupants had any signs or symptoms of COVID-19, including fever, cough, shortness of breath, chills, body aches, sore throat, headache, runny nose, muscle pain or diarrhoea?" A text field has been added to notes, in addition to the current selectable options.	Welfare Management System
4	Welfare Survey	Change made to an existing final question: • Existing questions "Do you have any other needs that we may be able to help you with?", "Do you have any other concerns " have been merged to one question. "Do you have any other needs or concerns that we may be able to help you with?"	Welfare Management System
5	Welfare Survey	Change made to wording of existing health questions: • "Do you, or anyone in your group (including children) have any immediate health concerns?" • "What sort of things that help you to live well every day before COVID-19? For example, do you exercise every day, do you eat at the same time every day?"	Welfare Management System
6	Welfare Survey	Change made to wording of an existing wellbeing question: • "What kind of things have you been doing to occupy yourself while you're in quarantine, e.g. yoga, reading books, playing games, playing with toys?"	Welfare Management System

Appendix 6– Welfare Survey

Survey questions – daily check-in

Date:	
Time:	
Call taker name:	
Passenger location:	Hotel: Room number:
location (room number):	
Confirm passenger name:	
Passenger DOB:	
Contact number:	Mobile: Room:
Interpreter required:	Yes/no Language:

Script

Good morning / afternoon, I'm XXX. Can I confirm who I'm speaking with?

I am working with the Department of Health and Human Services to support people in quarantine following their arrival in Australia, and I'm giving you a call to check on your welfare. We know that this may be a stressful time for you, and our aim is to make sure that you are as comfortable as you can be during this quarantine period.

I am a Victorian Public Servant and any information that you provide to me is subject to privacy legislation.

We will be checking in with you and the people you have been travelling with every 24 hours to make sure that you are ok and to find out if you have any health, safety or wellbeing concerns that we can address.

There are 23 questions in total, and it should take only a few minutes to go through these with you.

When you answer, we would like to know about you as well as any other occupants in your room.

If you have needs that require additional support, we will connect you with another team who can provide this support.

Introductory questions

1. Are you still in Room XXX at the hotel? Circle YES / NO

2. Are you a lone occupant in your hotel room? Yes/No if No:
5. Who are your fellow occupants, including your partner or spouse, children or fellow travellers?

Name	Relationship	Age (children/dependents)

3. Have you or your fellow occupants had to leave your room for any reason? If so, what was the reason? YES /N0

Health questions

4. Have you had contact with a medical staff nurse whilst in quarantine? If yes, can you please provide details and is it being monitored?

5. Have you or your fellow occupants had any signs or symptoms of COVID-19, including fever, cough, shortness of breath, chills, body aches, sore throat, headache, runny nose, muscle pain or diarrhoea)?

6. Do you or anyone you are with have any medical conditions that require immediate support? (ie smokers requiring nicotine patches)

7. Do you, or anyone in your group (including children) have any immediate health or safety concerns?

8. Do you have any chronic health issues that require management?

9. Do you or anyone you are with have enough prescribed medication to last until the end of the quarantine period?

10. Are you keeping up regular handwashing?

11. What sort of things help you to live well every day? For example, do you exercise every day, do you eat at the same time every day?

Safety questions

12. How is everything going with your family or the people you are sharing a room with?

13. Is there anything that is making you feel unsafe?

14. Are there any concerns that you anticipate in relation to your own or other occupant's safety that might become an issue in the coming days?

If the person answers yes to either question 10 or the one above, you could say:

1. You have identified safety concerns -would you like me to establish a safe word if you require additional support regarding your safety?

If yes…

2. The word I am providing is <xxx> (different word for each individual). You can use that word in a conversation with me and I will know that you need immediate support/distance from other occupants in the room or may be feeling a high level of distress.

Where family violence, abuse or acute mental health is identified as an issue refer to specific guidance / escalate for specialist support.

Wellbeing questions

15. How are you and any children or other people that you are with coping at the moment?

16. Do you have any immediate concerns for any children / dependents who are with you?

17. Do you have any additional support needs that are not currently being met, including any access or mobility support requirements?

18. Have you been able to make and maintain contact with your family and friends?

19. What kind of things have you been doing to occupy yourself while you're in isolation, e.g. yoga, reading books, playing games, playing with toys?

20. Have you been able to plan for any care responsibilities that you have in Australia? Can these arrangements be maintained until the end of the quarantine period?

Final

21. What has the hotel's responsiveness been like? Have you had any trouble getting food, having laundry done, room servicing etc.?

22. Do you have any other needs that we may be able to help you with?

23. Do you have any other concerns?

End of survey

Thank you for your time today. We will contact you again tomorrow.

Office use only

8. Referral details

Nurse	
Authorised officer	
Complex Client Specialist	
Other	

9. NOTES:

10.Enter on spreadsheet

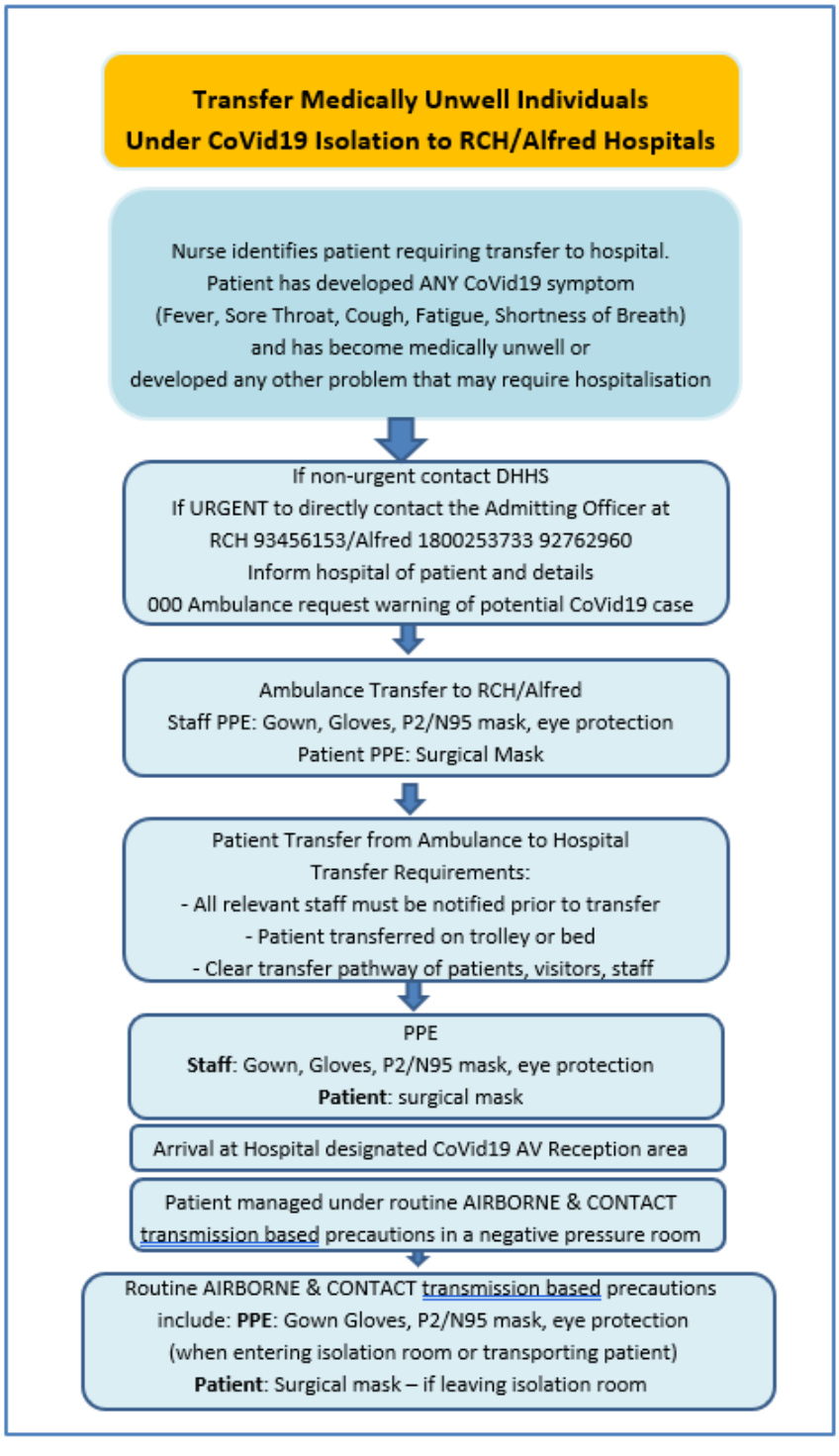
Any referrals or issues

Short or long survey for the next call contact (short may be by text message so they will need a mobile phone number)

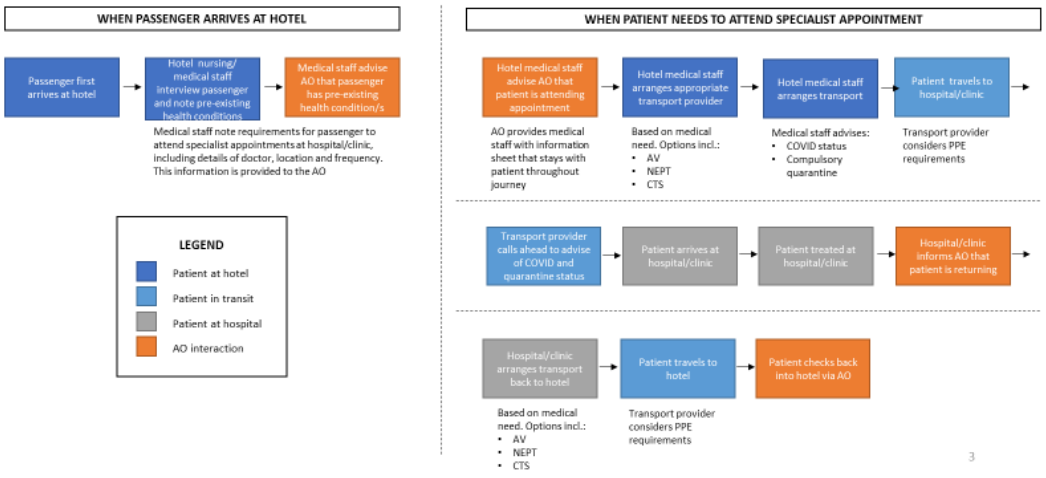
Safe word documented

Make note of mobile number or if they don't have one.

Appendix 7- Ambulance transfer flowcharts


Transfer Medically Unwell Individuals
Under CoVid19 Isolation to RCH/Alfred Hospitals
Nurse identifies patient requiring transfer to hospital.
Patient has developed ANY CoVid19 symptom
(Fever, Sore Throat, Cough, Fatigue, Shortness of Breath)
and has become medically unwell or
developed any other problem that may require hospitalisation
If non-urgent contact DHHS
If URGENT to directly contact the Admitting Officer at
RCH 93456153/Alfred 1800253733 92762960
Inform hospital of patient and details
000 Ambulance request warning of potential CoVid19 case
Ambulance Transfer to RCH/Alfred
Staff PPE: Gown, Gloves, P2/N95 mask, eye protection
Patient PPE: Surgical Mask
Patient Transfer from Ambulance to Hospital
Transfer Requirements:
- All relevant staff must be notified prior to transfer
- Patient transferred on trolley or bed
- Clear transfer pathway of patients, visitors, staff
PPE
Staff: Gown, Gloves, P2/N95 mask, eye protection
Patient: surgical mask
Arrival at Hospital designated CoVid19 AV Reception area
Patient managed under routine AIRBORNE & CONTACT
transmission based precautions in a negative pressure room
Routine AIRBORNE & CONTACT transmission based precautions
include: PPE: Gown Gloves, P2/N95 mask, eye protection
(when entering isolation room or transporting patient)
Patient: Surgical mask – if leaving isolation room

Process to transfer passengers to hospital (planned)



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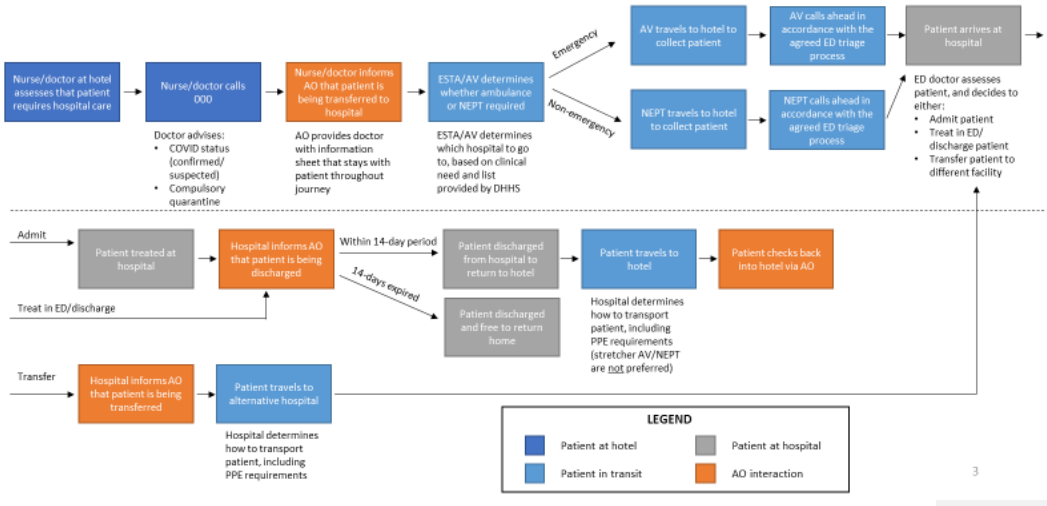
Process to transfer passengers to hospital (unplanned)



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Appendix 8- Hospital and Pharmacy contacts for each hotel

Hotel	Pharmacy and contact person	Pharmacy phone	Pharmacy email	Hospital	Hospital ED phone	Hospital MH phone	Hospital liaison name and number
Crowne	Southgate pharmacy [redacted]	[redacted]	[redacted]	The Alfred	[redacted]	[redacted]	[redacted] ED unit manager [redacted]

Appendix 9- Process for people with food allergies

COVID-19 – Hotel isolation:

Process for people with food allergies

Upon arrival at Melbourne Airport, passengers will be provided with two questionnaires that must be completed and handed in to DHHS staff at the hotel on arrival. These questionnaires are:

- Welfare questionnaire
- Food safety questionnaire

For airport staff

Please ensure that arriving passengers are provided with both forms and are instructed to complete one form for every passenger prior to arrival at their hotel.

For hotel staff

Passengers arriving at the hotel will be in possession of two completed questionnaires and these should be handed in to DHHS Team Leader at the hotel on arrival:

- a welfare questionnaire
- a food safety questionnaire

The DHHS Team Leader will liaise with the hotel and request 3 copies of each questionnaire for distribution to the following:

  - The ED Nurse at the hotel
  - The hotel
  - The Authorised Officer at the hotel
  - The original should be kept by the DHHS Concierge Team Leader

Food Safety Questionnaire - IMPORTANT

DHHS Team Leaders should check all Food Safety questionnaire forms and identify those where a person has answered 'Yes' to Question 1 or 4. In these cases the individual should be contacted and advised that we cannot guarantee the dietary needs can be met by the hotel and therefore the department asks that the guest

purchase food consistent with their dietary needs using the Uber Eats online service. The DHHS Team Leader will also advise the hotel Duty Manager regarding the arrangement so they can coordinate this with the hotel kitchen.

Individuals are permitted to purchase meals up to the value of:

- $20 per meal for breakfast
- $25 per meal for lunch
- $40 per meal for dinner.

Guests who are advised to purchase meals through Uber Eats must be advised to purchase meals using their own funds but retain receipts for all purchases to enable reimbursement by the Victorian Government. They should be provided with the reimbursement form at Attachment A and advised to return this form to the Department of Health and Human Services within 60 days of the end of their isolation period at the hotel. Only people who answer 'Yes' to Question 1 or 4 on the Food Safety questionnaire are permitted to purchase food in this way, and have it paid for by the department.

Under individual arrangements at hotels, other individuals may be permitted to purchase meals through an outside service if the hotel kitchen is unable to fulfil their specific dietary needs. In these cases however, the guest will not be reimbursed for the cost of the meal.

The Department of Justice, Precincts and Regions has put in place arrangements across all hotels to permit Uber Eats drivers to deliver food to the hotel and for security staff to assist in the delivery of meals to rooms.

Reconciliation of reimbursement forms will be made against the Food Safety questionnaire when receipts are received to ensure only those eligible for reimbursement will be reimbursed.

Questions

Why not pay direct to a DHHS set-up account?

- There is a risk that the account details will be released beyond those authorised to use it and significant purchases will be made using the department's account. There is no way to control purchases once this account number gets out and if the purchasing becomes excessive the only control would be to shut the account down.

Why not have the Concierge Team Leader make the purchases on behalf of people?

- There is no way of knowing the volume of people who may need to book through Uber Eats and therefore the logistical demands on Team Leaders may simply be too large to effectively manage.

- Concierge Team Leaders may be held unfairly responsible for any errors that may be made in purchases. Responsibility for correct purchasing should remain with the individual consumer.

ATTACHMENT A

COVID-19 – Victorian Hotel Isolation

Reimbursement Form for meal purchases

Name:	
Hotel:	
Room Number:	
Date Checked-in:	
Date Checked-out:	
Breakfast	
Total number of breakfasts to reimburse	
Total value of breakfasts to reimburse	$
Lunch	
Total number of lunches to reimburse	
Total value of lunches to reimburse	$
Dinner	
Total number of dinners to reimburse	
Total value of dinners to reimburse	$
TOTAL	
Total Claim Amount	$

Bank Account details (for reimbursement purposes):

BSB Number:

Account Number:

Banking Institution:

Account Name:

Please ensure you attach original receipts for all purchases included on this form as reimbursement cannot be provided without receipts. The completed form with attached receipts must be sent to the following address within 60 days of the conclusion of your stay in the hotel:

Emergency Management Branch

Department of Health and Human Services

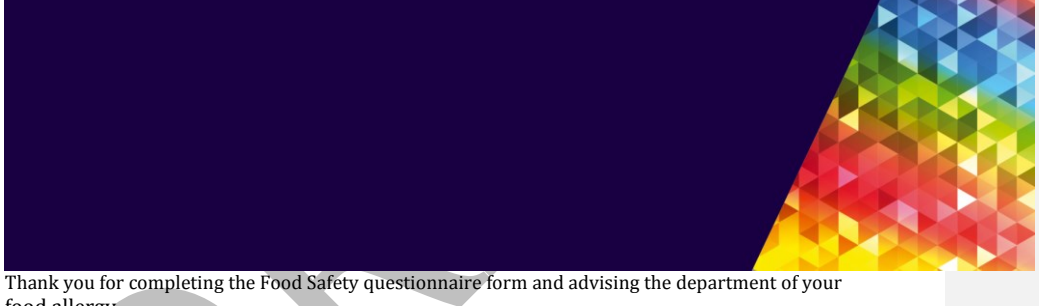
Level 16, 50 Lonsdale Street

Melbourne, 3000

Appendix 10- Meal order information for people with food allergies

COVID-19 – Hotel isolation:

Meal order information for people with food allergies



Thank you for completing the Food Safety questionnaire form and advising the department of your food allergy.
The hotel and government cannot guarantee that your dietary needs can be met by the hotel. Those with food allergies will need to purchase food consistent with their dietary needs using the UberEats online service, as suitable hotel catering will not be available.

This information sheet will provide you with information about how to order meals through UberEats, the amounts reimbursable for meals and the process for reimbursement. **Please note that you will be responsible for purchasing meals that meet your dietary requirement and the hotel and government accept no liability if the meals do not meet those requirements.**

The DHHS Team Leader will advise the hotel Duty Manager regarding this arrangement so they and the hotel kitchen are aware you will be sourcing your own meals.

To make an order through UberEats, download the application on the Apple store (for iPhone) or Google Play store (for Android). Create your account and place your order as appropriate. Issues with the app can be supported through UberEats customer support line - 1300 091 272.
Guests are permitted to purchase meals up to the value of:

- $20 per meal for breakfast
- $25 per meal for lunch
- $40 per meal for dinner.

Guests who will be purchasing meals through Uber Eats must purchase meals using their own funds but **retain receipts** for all purchases to enable reimbursement by the Victorian Government. A reimbursement form is attached at Attachment A. You should return this form and all original receipts to the Department of Health and Human Services within 60 days of the end of your isolation period at the hotel.

Please note only those individuals who have declared a food allergy at the beginning of their stay and have been approved to use this process will be permitted to purchase food though UberEats and have it reimbursed by the department.

The Department of Jobs, Precincts and Regions has put in place arrangements across all hotels to permit UberEats drivers to deliver food to the hotel. Security staff will receive meals from UberEats drivers and deliver directly to your room.

Thank you for your understanding. If you have any questions about this process, please direct to the DHHS Team Leader located at your hotel.

ATTACHMENT A
COVID-19 – Victorian Hotel Isolation
Reimbursement Form for meal purchases

Name:	
Hotel:	
Room Number:	
Date Checked-in:	
Date Checked-out:	
Breakfast	
Total number of breakfasts to reimburse	
Total value of breakfasts to reimburse	$
Lunch	
Total number of lunches to reimburse	
Total value of lunches to reimburse	$
Dinner	
Total number of dinners to reimburse	
Total value of dinners to reimburse	$
TOTAL	
Total Claim Amount	$

Bank Account details (for reimbursement purposes):

BSB Number:
Account Number:
Banking Institution:
Account Name:

Please ensure you attach original receipts for all purchases included on this form as reimbursement cannot be provided without receipts.

The completed form with attached receipts must be sent to the following address within 60 days of the conclusion of your stay in the hotel:
Emergency Management Branch
Department of Health and Human Services
Level 16, 50 Lonsdale Street
Melbourne, 3000

Appendix 11- Food Safety Questionnaire

Food Safety Questionnaire

To be provided to DHHS Team Leader at hotel once completed

This form needs to be completed for each individual staying at a hotel under quarantine in Victoria (i.e. children staying with parents should have their own form). Completed forms should be provided to DHHS staff member.

Name:_____ Room number:_____

Contact number ph:_____

Q1. Do you have anaphylaxis?
☐Yes (please indicate)
☐Single allergen
☐Multiple allergens
☐No, go to Q4

Q2 Do you have an EpiPen (in date) with you? ☐Yes ☐No

Q3. Is your anaphylaxis caused by food? ☐Yes (please specify) ☐no (please specify below)
☐sulphites
☐cereals containing gluten (wheat, rye, barley, oats, spelt & their hybridised strains)
☐crustacea
☐egg
☐fish
☐milk
☐peanuts
☐soybeans
☐sesame seeds
☐lupin
☐tree nuts (please indicate) ☐almonds
☐brazil nuts
☐cashews
☐chestnuts
☐hazelnuts
☐macadamia nuts
☐pecans
☐pine nuts
☐pistachios
☐shea nuts
☐walnuts
☐Other food/cause (please specify): _____

Q4. Have you ever experienced a reaction after eating food and needed to take medication, like Ventolin or antihistamines?
☐Yes (please specify food/s): _____ ☐No

If you answered yes to any of the above these details, hotel catering may not be able to meet your requirements and we will provide further information.

Q5. Do you have a medically prescribed modified diet (please specify diet required)?
☐No
☐Coeliac disease _____
☐Crohn's disease_____
☐Diabetic _____
☐Other condition (please specify): _____

Q6. Do you have a medically diagnosed food intolerance?
☐No
☐Lactose
☐Fructose
☐Other food (please specify): _____

Q7. Do you have a non-diagnosed food intolerance? (e.g. never good after eating onions)
☐No
☐Food/s (please specify):

Q8. Do you have any dietary preferences?
☐No
☐vegetarian
☐vegan
☐gluten free by preference
☐low fodmap diet
☐halal
☐kosher
☐other (please specify):

Please note this information may be provided to the hotel, catering services, on-site nurses and Authorised Officers.

THE ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS

RACGP

Standards for health services in Australian immigration detention centres

Our standards Our health service

RACGP

Standards

for health services in Australian immigration detention centres

THE ROYAL AUSTRALIAN
COLLEGE OF
GENERAL PRACTITIONERS

The RACGP *Standards for health services in Australian immigration detention centres*

Based on the RACGP *Standards for general practices* (3rd edition) and supported by funding from the Australian Government Department of Immigration and Citizenship

Prepared by Dr Ronelle Hutchinson and Ian Watts for The Royal Australian College of General Practitioners National Expert Committee on Standards for General Practices

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Contents

Acknowledgments

This is the Royal Australian College of General Practitioners (RACGP) *Standards for health services in Australian immigration detention centres*. These *Standards* have been based on the RACGP *Standards for general practices* (3rd edition) and have been customised for use by health services in Australian immigration detention centres.

In developing the RACGP *Standards for health services in Australian immigration detention centres*, the RACGP would like to thank:

- the members of the National Expert Committee on Standards for General Practices (NECSGP), whose deep commitment to standards of quality and safety has resulted in this final publication:
  - Dr Lynton Hudson (Chair)
  - Dr Noela Whitby AM (previous Chair)
  - Dr John Aloizos AM
  - Dr Karen Douglas
  - Dr Chris Mitchell
  - Mr Gary Smith
  - Ms Robin Toohey AM
  - Dr Howard Watts OAM
- Dr Leanne Rowe, the RACGP's nominee to the Detention Health Advisory Group (DeHAG) for the Department of Immigration and Citizenship (DIAC)
- the general practitioner experts in refugee health who provided comment on drafts of these *Standards*
- the members of the DeHAG who provided advice during the development of these *Standards*, including nominees from:
  - Australian Dental Association
  - Australian Medical Association
  - Australian Psychological Society
  - Commonwealth Ombudsman
  - Forum of Australian Services for Survivors of Torture and Trauma
  - Immigration Detention Advisory Group
  - Mental Health Council of Australia
  - Public Health Association of Australia
  - Royal Australian and New Zealand College of Psychiatrists
  - The Royal Australian College of General Practitioners
  - Royal College of Nursing, Australia
  - Victorian Healthcare Association
- the staff from Professional Support Services and International Health and Medical Services, who participated in a pilot of a draft version of these *Standards* at the Maribyrnong Immigration Detention Centre, and a subsequent focus group
- all the health professionals working in health services in Australian immigration detention centres who provided comment on the revisions required to make these *Standards* applicable and appropriate for use by these services.

The RACGP *Standards for health services in Australian immigration detention centres* were principally authored by Dr Ronelle Hutchinson and Mr Ian Watts on behalf of the NECSGP. Development work has been supported by the RACGP GP Advocacy and Support team.

Foreword

I am pleased to introduce The Royal Australian College of General Practitioners (RACGP) *Standards for health services in Australian immigration detention centres*.

Appropriate health care is a basic human right in any civil society, and the RACGP has long advocated that all people living in Australia should have access to high quality general practice and primary health care.

For more than 10 years, the RACGP has been working with consumers, members of our profession and a wide range of stakeholders to articulate standards for the settings in which we work.

Two recent instances of the unlawful detention of Australian citizens within immigration detention centres and a report from the Human Rights and Equal Opportunity Commission have highlighted concerns about the provision of health care to people detained in these facilities. The recommendations from the Commonwealth *Inquiry into the circumstances of the immigration detention of Cornelia Rau* ('the Palmer report') and *Inquiry into the circumstances of the Vivian Alvarez matter* ('the Comrie report') provide valuable guidance in ensuring the quality and safety of primary health care for people detained in immigration detention centres.

Initially the RACGP proposed that its *Standards for general practices* (3rd edition) were applicable to immigration detention centres, and that the general practice profession could assist in ensuring that the standards of health care in these facilities meet the expectations of the Australian community.

In 2006, when the Australian Government Department of Immigration and Citizenship (DIAC) sought the RACGP's assistance to work with health professionals, their employers and the DIAC to develop standards for use in health services in immigration detention centres, the RACGP was pleased to have the opportunity to assist.

The RACGP supports the reforms within the DIAC in response to the Palmer and Comrie reports. After consultation, customisation of the RACGP's *Standards for general practices* (3rd edition) and pilot testing, the RACGP *Standards for health services in Australian immigration detention centres* have been finalised. These *Standards* mirror the quality and safety principles in the *Standards for general practices* (3rd edition).

As recently elected president of the RACGP, and a migrant to Australia, I commend these RACGP *Standards* to the people who care for patients in Australian immigration detention centres. I particularly want to acknowledge the commitment and advocacy of Dr Leanne Rowe and her peers in our college, including members of the National Expert Committee on Standards for General Practices and their colleagues on the DIAC Detention Health Advisory Group, and to pay tribute to their contribution to our shared professional ideals.

Dr Vasantha Preetham
President
April 2007

Introduction

The Department of Immigration and Citizenship (DIAC) has a duty of care toward those whom it detains. A primary responsibility is to protect the health of people in immigration detention and, when health care is required, to provide health care services that are timely, appropriate and effective. The quality of care in immigration detention should be consistent with the quality of health service provision in the general Australian community.

The duration of detention depends on many factors and may be brief or prolonged. The population in immigration detention is characterised by cultural and linguistic diversity. The fact of detention and the experiences of some people before detention contribute to increased vulnerability to the development of health problems. The provision of high quality health care in the context of detention is a challenging undertaking. The ethical complexity of providing health care, particularly mental health care in a detention environment, has been extensively discussed. The major expansion of detention options that has occurred in recent times has substantially improved capacity for health service provision that is responsive to the individual health care needs of people in immigration detention.

These *Standards* represent a substantial advance in the capacity of the DIAC to discharge its duty of care to people in immigration detention. They are a clear statement of the department's commitment to high quality health care and to openness and accountability in health service provision. The *Standards* are a valuable guide to practice for health service providers. The linkage of standards in immigration detention with general community standards is a welcome development.

The application of these *Standards* will result in improvement in the quality of health care in immigration detention and will contribute to the prevention of failures in health care such as those that have been the subject of multiple inquiries.

The Detention Health Advisory Group is pleased to have had the opportunity to work with the RACGP in the production of these *Standards*. We now look forward to the systematic implementation of the *Standards* and to evaluation of the impact of them on the quality of health service provision in immigration detention.

Harry Minas
Chair, Detention Health Advisory Group
April 2007

Preamble

The RACGP is keen to support health professionals, their employer organisations and the Australian Government Department of Immigration and Citizenship (DIAC) through the Detention Health Advisory Group (DeHAG) in their endeavours to provide high quality health care to people detained in Australian immigration detention centres.

The development of health care standards for use in immigration detention centres falls within the responsibility of the Detention Health Advisory Group (DeHAG). In July 2006, DeHAG members agreed that DIAC should progress the development of health care standards based on the RACGP *Standards of general practices*. Members of the DeHAG have worked closely with the RACGP and the DIAC in the development of the RACGP *Standards for health services in Australian immigration detention centres*.

Who are these *Standards* for?

Indicators of quality can be developed for a variety of stakeholders with different, sometimes overlapping or conflicting perspectives[1,2,3] who emphasise different priorities and who may wish to use indicators in different ways.[4] Indicators of quality and safety are only legitimate and useful if they are accepted by the stakeholders they affect, including those who use such indicators.[2]

Standards can focus on different levels of the health care system: the patient, the practitioner, the organisation, the region or the country. This is because the conditions for error and harm can occur at all levels.[5]

With process factors being pervasive contributors to medical error in primary care,[6] there is sound reason to focus on the setting and process of care as the unit of analysis.

These *Standards* have been written principally for the multidisciplinary teams of health professionals who provide care to people detained in Australian immigration detention centres. These services provide and coordinate initial, continuing, comprehensive and coordinated medical and allied health care (including mental health care) for individuals, families and communities within detention centres, and provide care which integrates biomedical, psychological, social and environmental understandings of health. Throughout the *Standards*, mental health professionals are referred to as 'clinical staff members' or 'allied health staff members' as appropriate. Please refer to the glossary for more information on how different types of health care professionals are defined in these *Standards*.

When detaining people in immigration detention centres, the Australian Government bears a special responsibility to provide adequate health care (including mental health care) through the health services in these centres. The government has committed itself to ensuring that people in detention are able to access timely and effective primary health care, including mental health services (including counselling) and dental health services, in a culturally responsive framework. Where a health condition cannot be managed within the centre, the government is committed to ensuring that care is facilitated by referral to external advice and/or treatment. The government requires that a person in detention who sustains serious injury or becomes seriously ill while in detention be provided with a level of care commensurate with their condition and with the health care that would be available to the Australian community.

In this context, the Australian Government and the employers of the health professionals in immigration detention centres are important secondary audiences for these *Standards*.

These *Standards* are based on the RACGP *Standards for general practices* (3rd edition), and the whole scope of those *Standards* are applicable to health services in immigration detention centres. The challenge for the RACGP has been to ensure that the *Standards* are appropriate to the particular

context in which care is provided and the particular patient populations for whom care is provided in immigration detention centres.

Health services within immigration detention centres provide health care in a unique and challenging environment. Some of these challenges include:

- the potential for language or cultural differences to create misunderstandings and misinterpretations during consultations
- the process of detaining individuals which may erode their trust in the health care system and make them hesitant to access care. This hesitancy needs to be recognised in the context of the individual's cultural, religious and sociopolitical background
- an individual's health and illness framework which may arise from a complex interaction of past experiences, and an individual's religious, cultural and sociopolitical background and which needs to be understood if comprehensive health care is to be provided
- cultural awareness which is obviously paramount in these health care settings. 'Culture', however, is a complex issue and it is important to acknowledge that many individuals detained in immigration detention centres may belong to minority groups in their home countries and may have been persecuted for this reason. These individuals may not therefore be representative of the mainstream culture of their country of origin (see criterion 2.1.1).

An appreciation and understanding of how these complex issues impact on an individual's perception of physical and psychological health is important in achieving good quality health care from a whole person perspective. The RACGP recognises that the people who are detained in these centres also have a critical stake in the *Standards*, and recognises that they are another important secondary audience.

What is the purpose of these *Standards*?

Indicators of quality can have a number of purposes: to provide accountability, to assist in quality improvement and to inform consumers to help them make wiser purchasing decisions.[7]

The purpose of these *Standards* is to engage primary health care professionals in a comprehensive, continuous quality improvement process.

How do the *Standards* reflect the principles of quality and safety?

These *Standards* aim to address the quality and safety of the health care provided to people detained in Australian immigration detention centres. They are, in essence, the same *Standards* that apply to and are expected of general practice health care delivered to the Australian community.

Quality and safety in health care depends on more than the performance of individual health professionals working in isolation. Efforts to assess and enhance quality also need to consider how health services are structured and organised.[8]

In recent years there has been a growing recognition of the role of the health care system (including both small and large scale systems) as a precursor to safety and quality. In focusing on the service as the unit of analysis, service structures and processes are considered to lie within the scope of the *Standards*.

Safety related behaviours are affected by informal aspects of an organisation (such as its attitudes to safety)[9] and there is a need for indicators of processes and structures that support a safety culture. For example, it is important that infection control processes are documented in a meaningful way (eg. a written policy), however it is arguably more important that the relevant staff members know and understand the infection control processes.

> 'Viewing and analysing health care as a system has practical implications. Firstly, improvements in the quality of health care delivery are unlikely without changes to the systems: working harder within the same system is unlikely to result in improvements. Secondly, change in a system is more likely to be successful if it is first undertaken on a small scale. It is then possible to determine whether the change achieves its intended outcome and whether any unintended consequences also result.'[10]

Quality in care can be described in terms of the structure, process and outcomes of the health service:

- structure relates to material resources, facilities, equipment and the range of services provided at the health service
- process relates to what is done in giving and receiving care (eg. the consultation, ordering tests or prescribing)
- outcomes relate to the effects of care on patients and communities (eg. immunisation coverage rates, diabetes management, or cervical screening).[11]

Structure, process and outcomes are all important in defining quality in primary health care. Most of the content of these *Standards* refers to structure and process issues within a health service, as these factors are within the direct control of each health service.

These *Standards* do not, and cannot, address all the impacts on the health and wellbeing of people detained in Australian immigration detention centres. A range of issues impact on health and wellbeing (such as housing, nutrition, physical activity) that reinforce the effects of high quality and safe health care provided by the health service. These issues are beyond the scope of these *Standards* and will need to be addressed by the Australian Government and the companies contracted to manage the day to day operations of immigration detention centres.

What are the *Standards*?

The RACGP *Standards for health services in immigration detention centres* outline the hallmarks of safe, high quality care. The *Standards* are based on the RACGP *Standards for general practices* (3rd edition), which are internationally accredited by the International Society for Quality in Health Care (ISQua) and have been used as the basis for development of standards for general practices in both New Zealand and Ireland. Furthermore, other health care sectors are looking to the RACGP *Standards* as a viable framework for quality improvement, and in recent years the Australian optometry profession has used the *Standards* as a basis for developing their own practice standards.

The RACGP *Standards for health services in Australian immigration detention centres* form one of the benchmarks of quality and safety in primary care and provide future directions for quality improvement. The *Standards* outline the aspects of a health service that support high quality and safe comprehensive care, including attention to the services that are provided, the rights and needs of patients, quality improvement and education processes, management, and the physical aspects of the health service.

The *Standards* reflect a move away from viewing one health care professional as being solely responsible for the structures, systems and processes that deliver quality and safety, and a move toward recognising that each member of the team – and the team as a whole – contributes to quality improvements within a health service.

The *Standards* concentrate on the principles of quality and safety rather than prescribing exactly how a health service should provide care. The *Standards* are written so as to apply to the diverse forms of health services in immigration detention centres. The *Standards* also recognise that

different patients have different health care needs, and that services may provide different types of care. The *Standards* do not focus on current government programs (such as health or immigration policies or programs) or require services to participate in such programs in order to meet the *Standards*.

Where possible, the *Standards* are based on evidence from clinical trials or large scale research into improvements in quality and safety in practice and patient care, and from current professional consensus where no other evidence is available. The *Standards* concentrate on those areas of a health service that are considered critical in supporting quality and safety.

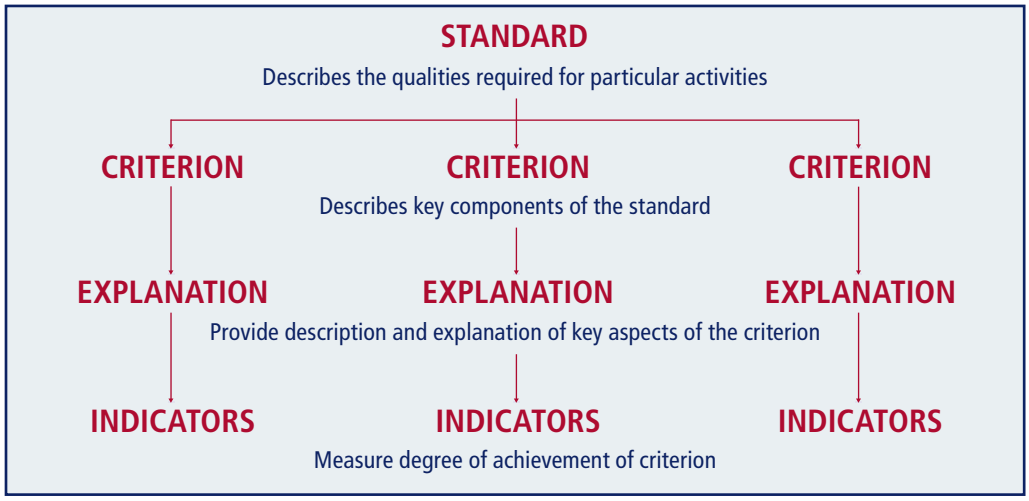
There is limited information about the health care needs of people detained in immigration detention centres. There is some evidence that detention itself may impact on mental health and that the detention context, immigration administrative processes (eg. appeals processes) and associated stressors may exacerbate symptoms of psychological morbidity for people detained in immigration detention facilities.[12–14] There are several clinical observations published about asylum seekers who have been detained in Australian immigration detention centres, but more systematic or scientific studies are rare. A number of studies have demonstrated higher than average levels of mental illness and psychiatric morbidity including high rates of suicide, depression, hunger strikes, post-traumatic stress, anxiety and panic among asylum seeker populations worldwide.[15–18]

Legal advice sought by the RACGP during the preparation of the *Standards for general practices* (3rd edition) suggested that the indicators of quality in those *Standards* could potentially help identify a widely held, peer professional view (currently the tort law test for the standard of care in at least one Australian state).[19] As a result, the RACGP considered it critical that the indicators not unreasonably 'raise the bar' without proper regard to all the circumstances of the services being assessed. It was decided that the indicators should reflect the norm for good quality general practice in Australia – a principle that extends to the standards for health services in Australian immigration detention centres.

Why are the *Standards* important to our health service?

Striving for – and achieving – standards are important to health services for a number of reasons:

- all health professionals want to improve care and patient safety, and the *Standards* provide an overview of the important components of a health service that are central to these improvements
- the *Standards* provide a structured way for health services to assess themselves in relation to quality and safety, before considering what changes may need to be made
- achieving the *Standards* is an indication that a health service is providing high quality, safe and effective care
- engaging in a quality improvement cycle and periodically returning to the *Standards* can help health services keep their development on track and determine if quality improvement changes have achieved their intended outcomes
- using the *Standards* provides an opportunity for health service staff to come together as a team to consider quality improvement. The *Standards* cover many areas and achieving them requires the collaborative effort of the whole team
- engaging in quality improvement and meeting the RACGP *Standards* demonstrates to the community that the health service is serious about providing the highest quality and most comprehensive care possible.



How does our service use the *Standards*?

Services can self assess against the *Standards* as part of their quality improvement process, or they might collaborate with other services to assess each other. Services can also have an external party assess and certify the degree to which they meet the *Standards*.

The chart above shows the hierarchical relationship between standards, criteria, explanations and indicators.

Each standard describes an element of the health service's activity that is critical to quality and safety, with specific criteria separating each standard into a number of components. Each criterion describes a process that health services can use to meet the standard and offers explanatory notes to assist health services in assessing against the criterion.

The explanatory notes provide detailed descriptions of the RACGP's position on issues related to the criterion and are the authoritative view on how criterion should be interpreted.

Each criterion is followed by a number of indicators to help services demonstrate how they have achieved that criterion. There are indicators that require services to demonstrate the processes they have used to meet the criterion, indicators that require staff to be aware of those processes, indicators that require services to document their processes, and indicators that require services to demonstrate feedback mechanisms to ensure that processes are working properly.

The indicators seek to focus on principles of quality. For example, the indicator for scheduling care does not require the use of an 'appointment book'; the indicator instead requires that care is scheduled effectively. This approach allows services to focus on achieving timely access to care based on clinical need, rather than on the mechanism of booking appointments.

There are advantages and disadvantages to using structure, process and outcome measures.[20] Most process measures require less risk adjustment for patient illness than do most outcome measures.[4] This is important in the immigration detention context, where the population of people in detention may change rapidly. Process indicators are preferable where the determinants of the outcome are beyond the control of the health provider,[21,22] and the RACGP has decided to focus on process indicators that are within the direct control of health services in immigration detention centres. In many instances, outcome indicators are the ideal measures of quality, however consideration needs to be given to causality, and whether there are intervening variables affecting the outcome that are beyond the control of the setting under assessment.

The *Standards* are written as an integrated whole. For example, indicators relating to privacy appear in more than one place in the *Standards*. This indicates that services should consider a number of different systems that contribute to the protection of patient privacy, eg:

- the way your service uses recall and reminder systems (criterion 1.3.1)
- how your service stores patient health information (criterion 1.7.1)
- how your information technology provides protection from unauthorised access (criterion 4.2.2)
- if your service provides screens, curtains, gowns or sheets to protect the privacy of patients when they undress (criterion 5.1.1)
- how the physical structure of your service protects privacy during consultations (criterion 5.1.2).

Services can assess themselves against each criterion and associated indicators to determine whether they have achieved the standard. At times, services may find that some indicators are not applicable; in these cases, services should consider why the indicators do not apply and if their peers would agree.

Health services can use the following means to demonstrate how they achieve the standards, criteria and indicators:

- interviews with all staff (medical, clinical, allied health and administrative)
- interviews with the medical staff (doctors) in the service
- interviews with staff who provide clinical care (such as nurses and allied health professionals)
- interviews with administrative staff in the service (such as receptionists)
- direct observation of the service
- reviewing patient health records
- reviewing documentation (such as policy and procedures manuals, information sheets, continuing professional development data or appointment schedules).

The use of different sources of information means that information can be 'triangulated', allowing more robust assessments of whether a service meets the *Standards*.

Are some criteria and indicators in the *Standards* more important than others?

Some standards are easy to measure; and others are more difficult to assess. There is evidence that experienced health professionals can – and do – make accurate, relevant and informed judgments about those aspects of a service that are not easily measured or quantified. These might be important aspects of quality that could be improved in the health service.

Some indicators are of central importance to quality and safety. These 'key' indicators are marked with a flag symbol. This assists services to determine that they have achieved the critical aspects of the criterion. Indicators that are not flagged are still important, and provide guidance to services about other ways in which they might demonstrate quality and safety. These are often indicators that are important to include in the *Standards*, but which are more challenging for some health services to achieve.

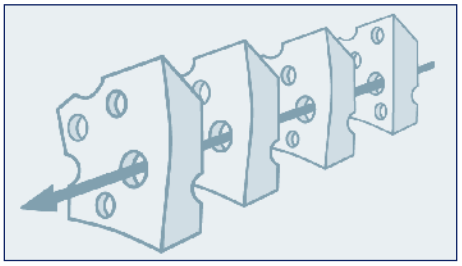
The Palmer and Comrie reports suggest that some clinical risks are magnified when delivering health care to patients detained in immigration detention centres. As such, some of the criteria in these *Standards* relate to systems and processes that require extra attention to ensure the provision of high quality and safe care to patients within immigration detention centres. These include:

- informed patient decision (criterion 1.2.2)
- interpreter services (criterion 1.2.3)
- clinical autonomy for medical, clinical and allied health staff (criterion 1.4.2)
- continuity of comprehensive care (criterion 1.5.1)
- continuity of the therapeutic relationship (criterion 1.5.2)
- engaging with other services (criterion 1.6.1)
- respectful and culturally appropriate care (criterion 2.1.1)
- confidentiality and privacy of health information (criterion 4.2.1)
- transfer of health information (criterion 4.2.3).

How do *Standards* help reduce risk?

Every system in a health service is vulnerable to errors. Ideally, each system would operate perfectly. The reality, however, is that equipment, policies and procedures, external systems (such as other health professionals), patients, doctors and other staff are all vulnerable to mistakes, errors and 'failures'. For example, the thermostat on the vaccine refrigerator may stop operating properly and cause the temperature of the vaccines stored in the refrigerator to decrease to freezing.

Not all vulnerabilities in a health service have an adverse impact on patient care. The vaccine in the example above may continue to be effective if the temperature did not decrease sufficiently to deactivate it. However, vulnerabilities can occur in sequence: the temperature of the vaccine refrigerator in the example above is not recorded when the thermostat became faulty, the potency of varicella vaccine is compromised due to the decrease in temperature, and the vaccine is administered to a patient who subsequently contracts chicken pox.



Source: Reason J. Human error: models and management. BMJ 2000;320:768–70. Reproduced and amended with permission: BMJ Publishing Group

Such a sequence of vulnerabilities has been likened to the lining up of holes in Swiss cheese.[5]

Safeguards need to be put in place in each system to reduce the likelihood of an error occurring – the aim is to prevent the 'holes' from lining up.

With this in mind, the *Standards* provide ways of checking for vulnerabilities in systems that are important to safety and quality. Meeting each of the integrated criteria establishes a form of safeguard for patients and health services, closing the holes in the system.

It is essential that health services meet all the standards and criteria to be confident that they have minimised the chance of an error occurring and have increased the safety and quality of the care they provide. When assessing against these *Standards*, services might identify areas in which they could improve. Services may wish to prioritise these improvements if there are a number of changes they wish to make. Some improvements may take a period of time to implement and evaluate; the important issue is that services actively work toward those improvements.

What is the value of peer review in our service?

Services that undertake their own assessment against the *Standards* might consider discussing the assessment informally with trusted colleagues. A 'fresh set of eyes' can assist services in identifying areas in which they perform well, as well as areas where improvements are needed. Peers can make judgments that take into account all factors, and offer more than just the inspection of a checklist that could be conducted by a trained person. Peers can also provide feedback on innovative ways in which services can improve, and provide an opportunity to exchange ideas about what will work best in a particular environment. Most importantly, peers can provide feedback on quality improvement activities – they can help services identify whether changes have brought about the intended outcomes or if there are other things the service can do to improve quality.

Health services may be assessed against the *Standards* by a third party to gain formal 'accreditation' against the RACGP *Standards*. The only model of third party review supported by the RACGP for these *Standards* is by peers working in primary care. Any formal assessment process against the RACGP *Standards* needs to be based on common sense and shouldn't seek to penalise or exclude health services on the basis of technicalities.

Does meeting the *Standards* protect our service legally?

During the review of the *Standards for general practices* (2nd edition), the RACGP commissioned a legal opinion on a number of areas of the *Standards*. In addition, all medical defence organisations in Australia were consulted as to the priority areas they thought needed to be included. The RACGP considered these views and weighed the medicolegal risk, the benefits to patient safety and the feasibility of services implementing these systems.

Regarding issues of high medicolegal concern (such as the follow up of tests and results in criterion 1.5.4), the RACGP has endeavoured to prepare standards that reflect what would reasonably be expected of a health service in an immigration detention centre and a general practice within the community. Health services that have concerns about a particular issue are encouraged to seek further advice from their doctor's medical defence organisation, the relevant professional indemnity insurers and the DIAC.

The *Standards* concentrate on principles of quality and safety in the delivery of health care, however health services should be aware of relevant and changing state, territory or federal legislation that may impact on the way in which they work.

The RACGP National Expert Committee on Standards for General Practices welcomes feedback regarding possible improvements to these *Standards*. Any comments or ideas about the RACGP *Standards for health services in immigration detention centres* can be forwarded to:

Chair, National Expert Committee on Standards for General Practices
The Royal Australian College of General Practitioners
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South Melbourne, Victoria 3205
Tel 03 8699 0414
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section one
SERVICES

Standard 1.1 ACCESS TO CARE

Our service provides timely care and advice.

Standard 1.2 INFORMATION ABOUT THE HEALTH SERVICE

Our service provides the opportunity for patients to communicate their health problems and concerns, and to receive sufficient information to enable them to make informed decisions regarding their care.

Standard 1.3 HEALTH PROMOTION AND PREVENTION OF DISEASE

Our service provides health promotion and illness prevention services that are based on best available evidence.

Standard 1.4 DIAGNOSIS AND MANAGEMENT OF SPECIFIC HEALTH PROBLEMS

Our service provides patient care that is effective, and in broad agreement with best available evidence.

Standard 1.5 CONTINUITY OF CARE

Our service provides continuity of care for our patients.

Standard 1.6 COORDINATION OF CARE

Our service engages with a range of relevant external services to improve patient care.

Standard 1.7 CONTENT OF PATIENT HEALTH RECORDS

Our patient health records contain sufficient information to identify the patient and to document the reason for visit, assessment, management, progress and outcomes.

CRITERION 1.1.1

Scheduling care in opening hours

Our service has a flexible system that enables us to accommodate patients with urgent, non-urgent, complex, planned chronic care and preventive health needs.

Explanation

The needs of patients vary widely and health services need* to have flexible systems that can accommodate urgent, non-urgent, complex, planned chronic care and preventive health needs during normal opening hours.

There are times when patients need urgent access to primary medical care, and health services need to have systems that anticipate this (eg. an appointment system could include reserving unbooked appointment times for patients with urgent medical needs). Patients also value the opportunity to see a medical or clinical staff member within a reasonable time for non-urgent and preventive health matters.

Health services need to be able to identify patients who have an urgent health need and facilitate care for them appropriately. The system used to identify patients with urgent matters needs to be efficient and prompt. Medical, clinical and administrative staff need to be able to describe the service's policy and procedures for identifying patients with urgent medical matters and the procedures for seeking urgent medical assistance from a clinical staff member. Staff also need to be able to describe how the health service deals with patients who have urgent medical needs when the health service is operating at full capacity (eg. when staff are fully occupied).

Actual length of individual consultations will vary according to clinical need. There is a body of evidence suggesting that longer consultation times are associated with better health outcomes and improved patient satisfaction. Much of the benefit is thought to arise from the improved communication between doctors and their patients that occurs in longer consultations. Research also suggests that preventive care, effective record keeping, patient satisfaction and patient participation in the consultation can be compromised when consultations are too short. Data from the Bettering the Evaluation and Care of Health (BEACH) study shows that the average consultation time in Australian general practice is approximately 14 minutes. Similarly, consultations with mental health experts (such as psychologists) will vary according to clinical need.

The system for scheduling care needs to include consultations of appropriate length for patients with more complex needs. Longer consultations may be required if the patient has complex medical needs or if an interpreter is present. Patients need to be encouraged to ask for a longer consultation if they think it is necessary. Staff need to have the skills and knowledge to assist in determining the most appropriate length and timing of consultations at the time of the request. Although it is difficult to predict how much time will be needed for a particular consultation, this criterion requires that health services have systems that endeavour to predict and meet this need.

* Where these *Standards* use phrases such as 'a health service needs…', the RACGP's position is that what 'needs' to be done in any situation is determined by what is reasonable in all the circumstances. In interpreting the *Standards*, care must be taken to be sensitive to the often highly variable circumstances of any particular situation.

Key indicators for appropriate consultation length include not only the duration of the consultation, but other factors such as the adequacy of patient health records. Decision about whether a health service meets this criterion need to be made in the context of other indicators in the health service. Assessment of this criterion needs to take into account the specific circumstances of the health service.

Health services that do not have a formal appointment system can meet this criterion if there is adequate communication to patients on anticipated waiting times and if the service prioritises patients according to urgency of need.

It is important that patients have direct access to the health service to make an appointment and do not rely on other parties (such as the detention service provider) to mediate their request for access. Direct access allows for greater assurances of confidentiality and privacy for patients as well as minimising any medicolegal risk to the health service that may arise from relying on non-health staff to identify medical needs. Health services may need to make arrangements for both telephone and written access mechanisms if the health service staff do not speak a patient's preferred language.

It is also important for health services to document in a patient's health record if there is a delay between the patient requesting health care and the provision of that health care (for whatever reason). It may be useful (for medicolegal purposes) to document the reason for the delay and what follow up occurred as a result.

Indicators

- A. **There is evidence that our service has a flexible system to accommodate patients with urgent, non-urgent, complex, planned chronic care and preventive health needs** (document review).
- B. **Our staff can describe how they identify urgent medical matters and their procedures for obtaining urgent medical attention** (interview).
- C. **Our service has a written policy for dealing with urgent medical matters** (document review).
- D. **Our service can demonstrate that patients can directly access the health service by telephone and written request during normal opening hours** (direct observation).

CRITERION 1.1.2

Visits to patient living quarters by appropriate clinical staff members

Patients of our service are able to obtain visits from a medical or clinical staff member in their living quarters where such visits are safe and reasonable.

Explanation

Visits to patients in their living quarters in the immigration detention centre need to be available where such visits are safe and reasonable.

People in immigration detention need to see their housing or rooms as their 'home', and in that context it is reasonable that health services in immigration detention centres have the capacity to provide visits to patients in their living quarters if necessary. It is recognised that because the service is located within the facility, the need for visits to patients' rooms is likely to be infrequent. It is also recognised that there may be security and safety considerations involved in visiting living quarters of the centre. Indicator B requires that the service have the capacity to provide visits to patients' living quarters by an appropriate clinical or medical staff member – where it is safe and reasonable – and that staff understand the policy for these 'home visits'.

Staff need to be able to describe the conditions under which a visit to a living quarters is deemed appropriate. Examples include deciding which types of problems that necessitate such visits. A definition of 'safe and reasonable' has not been provided here, as this is a decision that each health service needs to make in their local context (eg. with regard to location of living quarters, patient population) and in light of what peers would agree was safe and reasonable.

Indicators

- **A. There is evidence that patients of our service access visits in their living quarters** (health records review, document review).
- **B. Our staff can describe our service's policy on visits to living quarters and the situations in which a visit is appropriate** (interview).
- **C. Our service has a written policy on visits to living quarters** (document review).

CRITERION 1.1.3

Care outside normal opening hours

Our service ensures reasonable arrangements for medical care for patients outside our normal opening hours.

Explanation

Sometimes patients require medical care outside the normal opening hours of the detention centre's health service. Health services are required to make and be able to demonstrate reasonable arrangements for access to primary medical care services for their patients at these times.

It is important that people can access appropriate primary and emergency care when the health service is not normally open. The nature of detention means that patients have a restricted ability to contact and use mainstream primary health and emergency services compared with people within the community, and it is important that health services in immigration detention centres make arrangements to provide timely and appropriate health care to all people detained in the centre at all times.

It may be necessary for health services to consider the quality and sustainability of these arrangements and to make judgments about which options will provide the highest quality of care while maintaining the safety of patients and staff. In these circumstances, medical staff may want to discuss how they balance these needs with peer surveyors in accreditation.

Regardless of the arrangements used to provide care outside normal opening hours, the service needs to provide documentary evidence of the system it uses to provide such care. If the health service uses other doctors to provide care (such as a medical deputising service or cooperative), the health service needs to have evidence of how and when it receives information about any care provided to their patients outside normal opening hours, and how the doctors providing care can contact the health service in an emergency or in exceptional circumstances. It may be of substantial benefit if the doctor providing care is able to contact a doctor within the health service for clarification or help regarding background information relating to that patient (especially in an emergency).

Care outside normal opening hours needs to be performed by a recognised general practitioner (either a Fellow of the RACGP or a vocationally recognised GP) where clinically necessary. In some areas it may not be possible to recruit recognised GPs. In such circumstances, doctors who provide general practice care outside normal opening hours and who are not recognised GPs need to be appropriately trained and qualified to meet the needs of the health service community. Doctors performing general practice care who are not recognised GPs need to have been assessed for entry to general practice and be supervised, mentored and supported in their education to the national standards of the RACGP (as outlined in criterion 3.2.1).

When the health service's medical staff cannot safely or reasonably deliver care outside normal opening hours, the health service must be able to clearly document the alternative system of care that is available for patients at these times. Assessment of this criterion needs to take into account the approach of similar health services. It is necessary that the care is appropriate to the needs of the patient, that it is timely and reliable, and that any care that is claimed to be available is actually provided. A definition of 'safe and reasonable' has not been provided here, as this is a decision that each health service needs to make in their local context (eg. with regard to location, patient population) and in light of what peers would agree was safe and reasonable.

Criterion 1.1.3 Care outside normal opening hours (continued)

Arrangements for medical care outside normal opening hours need to be communicated clearly to patients of the health service.

Health services need to have after hours arrangements in place to allow abnormal and life threatening results identified by pathologists to be conveyed to a medical practitioner who will ensure that an informed appropriate medical decision is made and acted on promptly.

The Australian Competition and Consumer Commission has developed an information kit for the medical profession (see reources). This may be of assistance to health services who want to ensure that their arrangements comply with the *Trade Practices Act* (ie. are not anticompetitive as defined within the *Trade Practices Act*).

Indicators

A. There is evidence of one (or a combination) of the following for our patients:

i. **our medical staff provide their own care for patients outside normal opening hours of the service either individually or through a roster**
ii. **formal arrangements for cooperative care outside the normal opening hours of our service exist through a cooperative of one or more local health services**
iii. **formal arrangements exist with an accredited medical deputising service**
iv. **formal arrangements exist with an appropriately accredited local hospital or an after hours facility in circumstances in which we do not use an accredited medical deputising service or cooperative.**

Where a health service is providing care as indicated by ii, iii or iv above, the documentation of the arrangement must include:

- **reference to the timely reporting of the care provided back to the health service**
- **a defined means for the deputising practitioner to access patient health information and our medical staff in exceptional circumstances**
- **assessment by our service that the care outside normal opening hours will be provided by appropriately qualified health professionals** (document review).

B. Patient health records contain reports or notes of consultations occurring outside normal opening hours by or on behalf of our service (health records review).

C. Our service has a written policy for the provision of medical care outside normal opening hours (document review).

D. A notice in all living quarters of the immigration detention centre provides multilingual information to patients on how to obtain care from the health service (both within and outside normal opening hours) (document review).

CRITERION 1.2.1

Health service information

Our service provides patients with adequate information about our service to facilitate access to care.

Explanation

Providing written information about the health service is useful to patients as it provides an opportunity to inform patients about the range of services the health service provides. It is important that the information sheet is clearly marked as relating to the health service (as opposed to the Department of Immigration and Citizenship [DIAC] or the detention service provider) through the use of logos or other branding symbols.

It is also important for patients to know the first names of the medical and clinical staff in the health service. For privacy reasons, health services may decide that their information sheet should include only first names (not surnames) of staff providing clinical care.

It is very important that patients are encouraged to provide feedback to the health service, and an explanation in the information sheet about how patients can do this signifies that the health service welcomes feedback.

Because there are a number of parties involved in the health care and the detention of people in immigration detention centres, it is important that the health service be transparent about the relationship between the service and other parties (eg. detention service provider and the DIAC). This will build trust between patients and staff in the health service. This parallels the process in general practice, which requires transparency between general practices and any other services with which the practices have contractual agreements (eg. pathology and imaging services).

The health service needs to find alternative ways to provide or discuss health service information with patients who are unable to read or understand the information sheet (eg. people with literacy problems or with visual impairment).

It is appropriate for health services that deliver care to defined ethnic communities to make written information available in the most common languages within the health service population – this is one way in which the health service can provide health care in a culturally appropriate manner. This is particularly important for health services in immigration detention centres where patients come from culturally and linguistically diverse backgrounds and who will be unfamiliar with the health service and with the system of health care provision in Australia.

The information sheet needs to comply with the Australian Medical Association *Code of ethics 2004* (see resources). This is distinct from other information services provided by the health service (eg. health promotion information or 'tailor made' health information magazines) which may contain local advertising.

Privacy of patient information is particularly important for health services in immigration detention centres. These *Standards* recognise the patient's 'ownership' of their personal health information; however, it is recognised that there may be some circumstances in which the detention services provider or DIAC staff may need information relating to a patient's physical and mental health to enable them to properly care for that person (eg. where the patient is at risk of self harm). Patients need to be informed that their health information will be treated as private and confidential and will only be released to third parties with their consent or in compelling legal circumstances (eg. concern about imminent harm to the patient or to others).

Standard 1.2

Our service provides the opportunity for patients to communicate their health problems and concerns, and to receive sufficient information to enable them to make informed decisions regarding their care.

Criterion 1.2.1 Health service information (continued)

Indicators

A. Our health service information sheet is available to patients and contains at a minimum:

- **a feature that distinguishes the material as belonging to the health service**
- **first names of the staff working in our service**
- **our consulting hours and arrangements for care outside our service's normal opening hours**
- **an explanation of how patients can directly contact the health service to make an appointment**
- **an explanation of the arrangements in place for interpreters**
- **an explanation of the relationship between our health service, the detention service provider and the Department of Immigration and Citizenship**
- **an explanation of how to provide feedback or complain to the health service**
- **the health service's policy on the use of patient health information** (document review).

B. Our health service information sheet is prepared and delivered to patients by our health service staff (document review, interview).

C. Our staff can describe how essential service information is provided to patients who are unable to read or understand our written information sheet (interview).

CRITERION 1.2.2

Informed patient decisions

Our service gives patients sufficient information about the purpose, importance, benefits and risks associated with proposed investigations, referrals or treatments to enable patients to make informed decisions about their health.

Explanation

It is important that patients have sufficient information to make appropriate decisions about their own health care. Information about the purpose, importance, benefits and risks of proposed investigations, referrals or treatments need to be tailored to the individual patient's needs. This information needs to be delivered in language appropriate to the patient's cultural understanding of health and determinants of health and illness – without jargon or complicated terms – and where necessary including clear diagrams and written information. Consideration also needs to be given to the patient's physical, visual and/or cognitive capacities, which may impact on their ability to understand the information, make decisions or provide consent. Consideration needs to be given to how information about potentially sensitive investigations or tests is communicated (eg. sexually transmitted infections, blood borne viruses, fetal abnormality screening and pregnancy tests). In cross cultural situations, special care must be taken to ensure that there is a shared understanding between the medical or clinical staff member and the patient about the information provided.

The Australian Council for Quality and Safety in Health Care encourages patients to actively discuss with their health care provider the purpose, importance, benefits and risks associated with their health care. The publication '10 tips for safer health care' provides further detail (see resources). Health services may find it useful to refer patients to this information to help create an understanding of shared responsibility between the patient and the health service.

The provision of information about medicines and medicine safety (including Consumer Medicines Information) may assist patients to make informed decisions about their medicines. Health professionals need to be confident that patients understand any reasons for changes to their medications and, if a particular medication is not available, the implications of using an alternative medication. Consumer Medicines Information provides an online version of leaflets produced by pharmaceutical companies for the general public (see resources). When it is not possible for a patient to continue using the medication they had been taking prior to detention, it is important that the reasons for this be explained to patients to encourage trust, compliance and open communication.

If a patient decides not to follow the advice of the medical or clinical staff member after receiving sufficient information to make an informed decision about their care, their refusal and their awareness of its implications should be documented in the patient health record and an attempt made to provide alternative culturally appropriate care (criterion 2.1.1).

Some people in immigration detention centres may take or consider taking self destructive or self harming behaviour (eg. over or under medicating, hunger striking). Where a patient considers, or embarks on a self destructive or self harming behaviour, a medical staff member may need to make judgments about the competence of the person to form an unimpaired and rational judgment concerning the consequences of such an action. Staff may need to explain to the patient the consequences of such actions so that the patient can make an informed decision about

Criterion 1.2.2 Informed patient decisions (continued)

their actions. The Australian Medical Association (AMA) position statement on health care for asylum seekers and refugees (see resources) provides guidance to medical staff on appropriate management of hunger striking patients.

In some circumstances, it is the responsibility of other medical specialists and health care providers to give patients information about the actual costs of any treatments or investigations that they provide. In the detention context, these circumstances are relatively uncommon, and usually arise where the care is elective.

Medical and clinical staff can help patients to make informed decisions about referrals to other specialists or health care providers by advising if there may be a cost involved. Patients need to be informed of the possibility of incurring costs arising from referrals, investigations (eg. pathology, diagnostic imaging or other investigations) or consultations with other practitioners (eg. dentists). Patients should be advised to ask the service or specialist to whom they have been referred about the exact fees that may arise. Medical and clinical staff are not required to know the actual fee for each referred test or treatment, but they need to indicate to patients that there is the potential for a fee to be incurred. If no fee for health services is charged, this should be communicated to patients.

When medical or clinical staff refer patients to institutions or services in which the staff member has a direct financial interest, the staff member needs to provide full disclosure of such interest. Medical staff are referred to the AMA *Code of ethics 2004* (see resources) for further information.

Indicators

A. **Our medical and clinical staff can describe how they inform patients about the purpose, importance, benefits and risks of proposed investigations, referrals or treatments** (interview).

B. **Our medical and clinical staff can describe how they use leaflets, brochures or written information to support their explanation of the diagnosis and management of conditions when appropriate** (interview).

C. **Our medical and clinical staff can describe how they provide information (printed or otherwise) about medicines and medicine safety to patients** (interview).

D. **Our medical and clinical staff can describe how patients are advised of any potential costs when they are referred for investigation, or for initial consultation with a medical specialist or allied health professional** (interview).

CRITERION 1.2.3

Interpreter services

Our service has policies and procedures for communicating with patients who are not proficient in the primary language of our medical staff.

Explanation

Health care staff have a professional obligation to ensure that they understand their patients' problems, and that their patients understand the health care staff's information and recommendations. The use of interpreters is sometimes challenging and time consuming; in some situations, however, the use of interpreters is essential to providing quality care, and health care staff need to be comfortable and trained in the use of interpreter services.

The Australian Government provides a Translating and Interpreting Service (TIS) to assist health services in immigration detention centres to provide care to patients. The Australian Government also funds a free interpreting service for patients who are deaf and use Australian Sign Language (AUSLAN) (see resources for more information about TIS and AUSLAN services).

All reasonable arrangements need to be made to access an interpreter with a dialect and of an acceptable ethnic group compatible with that of the patient and of the gender requested by the patient. Inadequate access to appropriate interpreters may discourage patients from seeking care from the health service.

Indicators

A. **Our medical, clinical and allied health staff who provide clinical care can describe how they communicate with patients who do not speak the primary language of our medical staff** (interview).

B. **Our health service has a list of contact numbers for interpreter services** (document review).

CRITERION 1.3.1

Health promotion and preventive care

Our service provides health promotion and illness prevention services that are based on best available evidence.

Explanation

Health services in immigration detention centres need a systematic approach to health promotion, preventive care and early detection and intervention. The health service also has the potential to coordinate with other health professionals and key agencies to achieve health promotion and preventive care objectives. This holistic approach to care allows for each patient's individual circumstances to be considered when providing health promotion, preventive care, early detection and intervention.

Health services are encouraged to provide patients with information about health promotion and illness prevention. Health promotion is distinct from the education and information that medical and clinical staff use to support their diagnosis and choice of treatment. Such prevention, education and health promotion may be delivered by doctors, dentists, nurses or other allied health professionals and reinforced through the use of written materials and resources.

It is useful for patients to self select information on a range of health issues that may affect or interest them. The provision of written material is recommended as patients remember only three to four key messages from a consultation. This criterion refers to the many health pamphlets and brochures available from sources such as departments of health, nongovernment organisations, health promotion programs, local community organisations, and support and self help groups. Some educational materials are also produced in audiovisual format, which may complement the written material in the health service. Health services are encouraged to be selective about the leaflets, brochures and pamphlets they provide; these materials may vary in quality and reliability. Providing information about health issues through the use of the internet is also becoming more common. Health services need to consider the quality of the information available on internet sites before recommending them to patients. Health services are encouraged to use the checklist in the current edition of the RACGP 's *Putting prevention into practice* (the 'green book') (see resources) to help determine whether patient education materials – including those on the internet – are of sufficient and high quality (eg. HealthInsite at www.healthinsite.gov.au). The Australian Psychological Association also has resources for use by psychologists in health promotion (available at www.psychology.org.au) and the Multicultural Mental Heath Australia website has health promotion materials in a range of languages (available at www.mmha.org.au).

This criterion also requires health services to have a systematic process for providing preventive care to patients. This may occur through the use of formal preventive activities such as patient prevention surveys, or the use of disease registers and recall and reminder systems. It may also occur when patient presentations at the health service are used as an opportunity to provide health promotion and illness prevention activities additional to those relating to the specific reason for the patient's visit.

Preventive activities need to be based on the best available evidence. Reminder systems need to operate in such a way as to protect the privacy and confidentiality of patient health information. Health services also need to consider their responsibility to their patients if the health service ceases using a reminder system.

Some information may also be transferred to national registers (eg. immunisation data) or state and territory based systems (eg. cervical screening or familial cancer registries) in order to improve care. Many state and national registers (such as immunisation and cervical screening registers) can register people living in Australia who are not legal residents of Australia. Health services should be encouraged to use these registers (with the patient's consent) for patients detained in immigration detention centres, as it is possible that these people may become part of the Australian community, and it is also possible that they may be detained for extended periods and therefore benefit from the reminders that are in place in such registers.

Health services might also use data collected in clinical software or paper based systems to improve the targeting and use of prevention activities (eg. smoking cessation, sexually transmitted infections). They may use collected information transferred from private pathology providers (eg. diabetes screening, cervical screening). This is not only a quality improvement activity (criterion 3.1.1) but it also provides a check that the health service is identifying all relevant patients for their health promotion and preventive care activities.

Further information regarding health promotion and preventive activities is available in the current editions of the RACGP *Guidelines for preventive activities in general practice* (the 'red book'), the green book, and the RACGP *Smoking, nutrition, alcohol and physical activity (SNAP): a population health guide to behavioural risk factors in general practice* (see resources).

Multilingual prompt cards might be displayed in consulting rooms to help the health service engage the most appropriate interpreter for the patient.

Indicators

- **A. There is evidence that our service provides multilingual information about health promotion and illness prevention to patients** (health records review, document review).
- **B. There is a range of multilingual posters, leaflets, and brochures about health issues available or on display in the waiting area or consulting areas** (direct observation).
- **C. Our medical and clinical staff can describe how they provide information to patients on issues relating to health promotion and illness prevention, including issues relevant to common patient presentations** (interview).
- **D. Our service uses one or more of the following:**
  - **flagging of patient health records for opportunistic preventive activities**
  - **paper or electronic system showing due dates for preventive activities (subject to informed patient consent)**
  - **paper or electronic reminder system with appropriate informed patient consent** (health records review, document review).
- **E. Our service participates in national/state or territory reminder systems/registers (subject to informed patient consent)** (document review).

CRITERION 1.4.1

Evidence based practice

Our service ensures that our approaches to common and serious conditions are consistent with best available evidence.

Explanation

Contemporary practice is based on best available evidence in the current Australian context. This criterion recognises that in the absence of well conducted clinical trials or other higher order evidence, the opinion of consensus panels of peers is an accepted level of evidence and may be the best available evidence at that time.

Clinical practice guidelines must be up to date and may include recommendations from sources such as:

- *Australian medicines handbook* (www.amh.net.au)
- *Australian Prescriber* (www.australianprescriber.com)
- Australian Psychological Association resources (www.psychology.org.au)
- Central Australian Rural Practitioners Association (CARPA) treatment and reference manuals (www.carpa.org.au)
- Cochrane database
- Foundation House in Victoria (www.foundationhouse.org.au) and STARTTS in NSW (www.startts.org) resources for refugees who have experienced trauma and/or torture in their countries of origin
- RACGP 'Safety every time – our general practice checklist' (a checklist to reduce the risk of errors in medical procedures) (see resources)
- Multicultural Mental Health Australia (www.mmha.org.au)
- National Health and Medical Research Council (www.nhmrc.gov.au)
- National Prescribing Service (www.nps.org.au)
- RACGP *Smoking, nutrition, alcohol and physical activity (SNAP): a population health guide to behavioural risk factors in general practice* (see resources)
- RACGP *Guidelines for preventive activities in general practice* ('red book') (see resources)
- RACGP *Infection control standards for office based practices* (4th edition) (see resources)
- RACGP *Putting prevention into practice* (the 'green book') (see resources)
- RACGP *Medical care of older persons in residential aged care facilities* (the 'silver book') (see resources)
- Rational Assessment of Drugs and Research (RADAR)
- *Therapeutic Guidelines* (www.tg.com.au)
- Victorian Transcultural Psychiatry Unit for culturally sensitive evidence based guidelines (www.vtpu.org.au).

It is important that medical, clinical and allied health staff in health services in immigration detention centres have access to a range of relevant resources relating to mental health and the care of people who may be detained in the centre (such as refugees or asylum seekers).

Standard 1.4

Our service provides patient care that is effective, and in broad agreement with best available evidence.

It may be important for medical staff – especially those undertaking procedural work and minor surgery – to use the 'Safety every time – our general practice checklist' (see resources) or an equivalent protocol that incorporates the five steps. Compliance with the protocol reduces the risk of error for medical staff who perform procedures in health services.

Medical and clinical staff find it valuable – both for their treatment of patients and for their own professional development – to have access to resources about a range of clinical issues including resources relevant to care provided to patients detained in immigration detention centres. These may include paper based resources (eg. textbooks and peer reviewed journals) and electronic resources (eg. access via the internet or CD-ROM). These resources may relate to clinical matters (eg. infectious diseases or female genital mutilation) and information about cultural beliefs and health practices of various cultural groups, but might not be limited to what the profession would consider to be references on 'evidence based practice'.

This criterion does not require access to the most recent editions of texts, materials or publications, nor does it require those resources to be in electronic format. However, resources need to contain information that is consistent with current practice and not recommend management that is no longer applicable.

Patients often use complementary and alternative medicines. This may be a particularly important consideration for people detained in immigration detention centres, who may come from non-Western countries and have a history of treatment with non-Western medicines (eg. Chinese medicine). Health services are referred to the RACGP/Australian Integrative Medicine Association joint position statement on complementary medicine, the Australian Medical Association statement on complementary medicine, and the Medical Council of New Zealand statement on complementary and alternative medicines (see resources).

Indicators

- **A. Our service can demonstrate that we have ready access to a range of current references relevant to primary care (including mental health care)** (direct observation).
- **B. There is evidence in our patient health records that our service provides care of common and serious conditions that is consistent with clinical practice based on best available evidence** (health records review).
- **C. Our medical and clinical staff can describe how they ensure that their approaches to common and serious conditions are broadly consistent with clinical practice based on best available evidence** (interview).
- **D. Our medical and clinical staff can describe and have access to the clinical practice guidelines used to assist in the management of serious and common conditions** (interview).

CRITERION 1.4.2

Clinical autonomy for medical, clinical and allied health staff

Our service ensures that all medical, clinical and allied health staff in our service can exercise autonomy in decisions that affect clinical care.

Explanation

The intent of this criterion is that medical, clinical and allied health staff are free – within the parameters of evidence based care – to make decisions that affect the clinical care they provide, rather than having these decisions imposed upon them. The Australian Medical Association *Code of ethics 2004* (see resources), which has been endorsed by the RACGP, indicates that in order to provide high quality health care, clinical independence and professional integrity must be safeguarded from increased demands from society, third parties, individual patients and governments.

Staff need to be free to care for their patients without having their ability for independent professional judgment challenged by obligations or pressures placed on them by third parties. There are international guidelines for health professional practice in such circumstances.[23]

This criterion also means that the health service needs to discuss with the medical and clinical staff their individual preferences for the systems the health service uses to provide clinical care (including investigation options, appointment scheduling, patient load, equipment, length of counselling sessions), rather than requiring them to use systems that impact on their ability to provide care as individual practitioners.

This criterion is not intended to conflict with criterion 1.4.1, and does not preclude adherence to valid guidelines for clinical care of an individual patient based on clinical judgment and best available evidence.

Some organisations have developed codes of practice so that health service systems do not restrict the abilities of medical and clinical staff to provide clinical care. For example, there is a code of conduct for corporations involved in the provision of management and administrative services in medical centres in Australia (see resources), which emphasises the importance of general practitioners having professional independence and not being compelled to use certain providers or services, and outlines processes for complaint about such matters.

The choice of some providers of services may not be within the control of health service staff (eg. there may be corporate level agreements about the provision of pathology services). Where this is the case, medical, clinical and allied health staff need to have clear avenues for raising concerns about the quality of the services provided under these arrangements and for expressing their desire to use alternatives (eg. criterion 3.1.2).

Health services in immigration detention centres concerned about impediments to exercising appropriate clinical autonomy or about the quality of ancillary services need to have clear protocols for notifying the detention service provider, the Department of Immigration and Citizenship (DIAC) and, if needed, the Human Rights and Equal Opportunity Commission and/or Commonwealth Ombudsman. This process needs to be understood by all staff. Any such notification would need to be documented in the patient's health record.

Standard 1.4

Our service provides patient care that is effective, and in broad agreement with best available evidence.

Indicators

A. **Our medical, clinical and allied health staff are free to determine:**
   - **the specialists and other health professionals to whom they refer**
   - **the pathology, diagnostic imaging or other investigations they order, and the provider they use**
   - **how and when to schedule follow up appointments with individual patients** (interview).

B. **Our medical, clinical and allied health staff are consulted about:**
   - **the scheduling of appointments**
   - **the equipment and supplies that our service uses** (interview).

C. **Our service has a written policy that confirms that our staff can exercise autonomy in decisions that affect clinical care, within the parameters of evidence based medicine** (document review).

D. **Our staff can describe the notification process if they believe a third party has restricted or is restricting their ability to provide or coordinate health care** (interview).

E. **Our service has a documented protocol for the notification of concerns regarding the provision of health care** (document review).

CRITERION 1.5.1

Continuity of comprehensive care

Our service facilitates continuity of comprehensive care to patients.

Explanation

Health services in immigration detention centres provide initial, continuing, comprehensive and coordinated medical care (including mental health and dental health care), and it is important that patients have the opportunity to develop an ongoing relationship with the service while they are detained in the immigration detention centre. Continuity is the degree to which a series of discrete health care events is experienced by the patient as coherent and connected, and consistent with the patient's medical needs and personal context. Continuity of care is distinguished from other attributes of care by two core elements: care over time and a focus on individual patients.

There are a number of types of continuity:

- the sense of affiliation between the patient and their health professional ('my doctor', 'my nurse', 'my psychologist', 'my dentist' or 'my patient'), sometimes called 'relational continuity' (criterion 1.5.2)
- consistency of care by the various people involved in a patient's care (ie. not working at 'cross purposes'), sometimes called 'management continuity' (criterion 1.5.3)
- continuity of information across health care events, particularly through documentation, handover and review of notes from previous consultations, sometimes called 'informational continuity' (criterion 1.5.4).[48]

The health service acts as the coordinator and advocate of all health and allied health services for patients detained in Australian immigration detention centres. These patients have a restricted capacity to choose health care providers and rely on the health service to provide, coordinate and/or facilitate primary health care (including mental health care), specialist health care, dental health care, allied health care and emergency health care. As such, coordination and continuity of 'comprehensive' care for these patients is critical.

Indicator

A. **Our service has strategies or policies that encourage continuity of comprehensive care** (interview, document review).

CRITERION 1.5.2

Continuity of the therapeutic relationship

Patients attending our service are able to see the medical or clinical staff member of their choice, if available.

Explanation

Relational continuity refers to a sustained relationship between a single practitioner and a patient (or sometimes more than one practitioner and a patient) that extends beyond individual consultations or episodes of illness. This can be described as a sense of affiliation between a patient and their doctor ('my doctor', 'my nurse', 'my psychologist', 'my patient'). It is often viewed as the basis for continuity of care. Health services in immigration detention centres may need to consider the ways in which they can build trust and confidence with patients who are detained in the immigration detention centres.[49,50]

It is acknowledged that some health services do not have formal, written appointment schedules through which patients are booked to see a medical or clinical staff member. However, such services need to be able to demonstrate that they have a 'system' or a 'rationale' for determining how patients may see the health professional of their choice, if requested.

The expectation of patients may not always be realistic for some health services, but the health service needs to be able to demonstrate that patients are able to see their health professional of choice when it is fair and reasonable for them to do so. This is particularly important if the patient requests to see a health professional of their own gender. While nurses may triage many clinical issues in health services in immigration detention centres, patients need to be able to request to see a doctor or other health professional, and reasonable arrangements must be made to accommodate the patient's request.

Many health services employ nurses or allied health professionals as part of the team. The principles in this criterion relate to the patient's right to see their preferred medical or clinical staff member, nurses and allied health professional.

Coordination of care is a critical issue in providing safe, quality care to patients detained in Australian immigration detention centres. Coordination is a significant factor where multiple health professionals provide episodic and isolated care with no individual professional taking leadership of the coordination and follow up of care. The health service needs to identify a particular person (medical staff member or otherwise) who coordinates the clinical care for individual patients.

Indicators

- **A. Our staff can describe how patients can request their preferred medical or clinical staff member when making an appointment or attending our service** (interview).
- **B. A sample of patient health records indicates that patients generally see the same medical or clinical staff member** (health records review).
- **C. Our medical, clinical and allied health staff can identify the person who coordinates the clinical care for each individual patient** (interview).

CRITERION 1.5.3

Consistent approach

Within our service there is a consistent approach to diagnosing and managing common and serious conditions of individual patients.

Explanation

A consistent approach to diagnosing and managing care across the various people involved in the clinical care of an individual patient (ie. the people involved do not work at 'cross purposes') is an important aspect of continuity of care. Patients value consistency in the quality of treatment they receive from a health service and expect that treatment and advice given by different health professionals within the service will not be in conflict. If the health service employs nurses, psychologists or allied health professionals, patients expect that advice provided by these professionals is consistent with the diagnosis and management approach of the treating doctor. Providing consistency in diagnosing and managing health issues across a multidisciplinary team assists in ensuring that the health service provides continuity of care for patients (criterion 1.5.1).

This consistency is just as important in a small health service where the receptionist or nurse needs to have an approach (eg. to providing information) that is consistent with that of the doctor, psychologist or other mental health professional, as it is in large services with numerous clinical and allied health staff.

In addition to ensuring that clinical care is consistent with the best available evidence (criterion 1.4.1) it is important that there is continuity in the clinical care provided to the patient. Management continuity involves having a consistent and coherent approach to the management of a health condition that is responsive to the patient's changing needs, and assists to ensure that the people providing services are not working at 'cross purposes'. An example is ensuring that doctors and psychologists treating a patient with depression provide consistent advice to the patient about their treatment and care. Management continuity is particularly important for people with chronic or complex diseases. For example, it may involve having a plan for the patient's care that is shared by the people providing the care.

Another way of ensuring that the members of the team who are providing clinical care to patients adopt a consistent approach (within the parameters of evidence based practice) is by discussing clinical issues in a meeting.

Indicators

- A. **Our medical, clinical and allied health staff can describe how they ensure consistency of diagnosis and management of common and serious conditions (within the parameters of evidence based care) within our service** (interview).
- B. **Our service has regular meetings to discuss clinical care** (interview, document review).
- C. **Our medical, clinical and allied heath staff can describe how they 'hand over' or transfer care of individual patients between staff in our health service** (interview).

CRITERION 1.5.4

System for follow up of tests and results

Our service has a system for the follow up and review of tests and results.

Explanation

This criterion focuses on the systems that health services need to use to follow up tests and results as part of their duty of care to patients.

The information gained from tests and results can have considerable impact on the choices patients and health professionals make in patient care.

'Follow up' can mean:

- following up the information
  - following up on expected tests and results that have not yet been received by the health service
- following up the patient
  - chasing or tracing the patient to discuss the report, test or results after they have been received by the health service and reviewed, or if the patient did not attend as expected.

The responsibilities of the individual health professional and the health service reflect the recognition that the health professional-patient relationship is based on trust and that the relationship is characterised by the health professional having special knowledge and skills that the patient generally does not have. While health services are not expected to follow up every test ordered or contact patients with the results of every test or investigation undertaken, there may be considerable risk in not following up clinically significant tests and results.

During the review of the *Standards for general practices* (2nd edition), members of the profession expressed concern about the way in which the RACGP would reflect the profession's standards in the area of follow up. Some within the profession felt the courts had inappropriately shifted patient responsibilities onto doctors. Others commented that the decisions of the courts were less important to them than the emotional consequences of missing clinically significant results. In response, the RACGP commissioned a legal opinion on the issue and considered that opinion and the views of the profession when preparing the *Standards*. The RACGP decided to provide lengthy detail in this explanation to assist in clarifying the issues.

Medical and clinical staff are not always legally responsible for failures for everything that goes wrong: the patient or a third party provider (eg. the pathology company) may be legally responsible instead of (or together with) the medical or clinical professional.

In some circumstances, people detained in immigration detention centres will require the detention service provider to assist in providing their care (eg. arrange transport to attend offsite services). Health services in immigration detention centres will need to have a system in place to follow up on this assistance as it represents a link in the chain of care which has the potential to be broken (eg. an activity is overlooked with the immigration detention centre management is busy).

The health service needs a system aimed at ensuring that:

- all received test results and clinical correspondence (eg. reports from other health care providers) relating to a patient's clinical care are reviewed
- clinically significant tests and results are followed up
- the system can anticipate individual cases requiring different levels of follow up depending on the clinical significance of the case.

Criterion 1.5.4 System for follow up of tests and results (continued)

The nature and extent of responsibility for following up tests and results will depend on what is reasonable in all of the circumstances. Overall, the following factors are important in determining if a test or result is clinically significant:

- the probability that the patient will be harmed if adequate follow up does not occur
- the likely seriousness of any potential harm
- the burden of taking steps to avoid the risk of harm.

The clinical significance of a test or result needs to be considered in the overall context of the patient's history and presenting problems. Clinically significant results are not necessarily restricted to 'abnormal' results. For example, a normal mammogram in a woman with a breast lump or a normal electrocardiogram in a patient with chest pain does not preclude the need for further consultation, investigation and management. 'Clinical significance' is a judgment made by the medical or clinical staff member that something is clinically important for that particular patient in the context of that patient's health care. The judgment may be that an abnormal result is clinically important and requires further action. On the other hand, the result may be normal but may still require further action.

The persistence required of the health service in following up with the detention service provider will similarly depend on the likelihood (as identified by the health professional) that the investigation, test or referral will be clinically significant and the degree of urgency of action required.

The health service needs to have in place a process or system for following up – even a system as basic as using a simple diary entry, or logbook containing 'worrying' or 'high risk' cases – so that a reminder occurs where there is a concern about the significance of the test or result. Medical and clinical staff do not necessarily need to supervise such a system directly, but the system needs to operate consistently where it is needed (although it will be the medical or clinical staff members who will identify the 'worrying' cases).

The health service needs to be able to identify unexpected significant results when they are received, particularly if the significance of such results was not raised in the consultation. In these circumstances, health services need to alert the patient, who may not anticipate or understand the significance of the result.

Problems in follow up can be avoided or minimised through interventions at earlier points in patient care. The relationship between health professional and patient is a special one, based on trust and communication. While the patient is the ultimate decision maker, it is important for the patient to be well informed in order to make such decisions. Decisions need to be based on information that the medical and clinical staff has a duty to provide, and the information needs to be conveyed to the patient in a way that helps the patient to understand it. A patient who makes a decision based on insufficient information is not making an informed decision. Once properly informed, however, the patient can offer legally effective informed consent and legally effective informed refusal.

Patients also have responsibility in their own health care; this includes seeking results. It is important to have follow up systems in the health service that are meaningful for patients, create a shared understanding of what is going to happen, define who is responsible for follow up, and encourage patients to discuss how they can help manage their own health. These systems might include outlining the health service's policy for follow up in the patient information sheet, and having medical and clinical staff routinely describe the health service's system for follow up to patients when requests for pathology or imagining tests are made. The standards for ensuring that patients have the information they need to make informed decisions are covered in criterion 1.2.2.

At an early stage in the patient's care, the health service needs to focus on reinforcing the respective rights and responsibilities of the patient and members of the health service team in following up tests and results. Developing this understanding with patients reinforces for patients that they should actively engage with their health provider, and that part of this requires them to think about the way they help manage their own health. Brief but accurate documentation of the discussion and outcome of such discussions is important.

Documenting relevant clinical information provides a trigger to the medical or clinical professional, or to others who may later view and rely upon the records. The standards for maintaining patient health records are covered in criteria 1.7.1, 1.7.2 and 1.7.3.

Relying on patient memory or motivation alone does not reduce the need for an effective follow up system in the health service. Patients may not follow the recommendations provided by the health service because of their particular circumstances, fear, ignorance, personality, expectations, beliefs, cultural background or a range of other factors. The health service needs to have systems to identify and respond to situations in which a particular patient is unlikely to, or may not understand or comply with, their responsibilities to proceed with a test or to follow up the results with the health service. Medical and clinical staff need to reflect on which patients, tests and results justify a suspicion or concern. The health service needs to have a system that will allow medical or clinical staff to take action to address their concerns. These concerns could be based on a suspicion that the information from a test is likely to be clinically significant, or that the patient might not have the test performed.

In the rare case where a patient indicates they do not intend to comply with the recommendation for a test, the health service needs to ensure that the patient has received sufficient information with which to make an informed decision and to understand the consequences of their actions (or inactions). This discussion needs to be recorded comprehensively in the patient health record (criterion 1.2.2).

In a case where the medical or clinical professional suspects that the results will be clinically significant, the health service needs to create additional safeguards to ensure that potentially clinically significant information does not get 'lost in the system'. One approach is to obtain a clearly expressed agreement from the patient (which is documented in the health record) that the patient will have the tests performed and/or receive the results. However, this alone might be insufficient for follow up in all circumstances. The health service needs to have a system that protects against both the health professional and the patient forgetting to follow up on tests or results. These systems need to allow for more intensive follow up if the circumstances require.

The location of the detention centre may also impact on the diligence needed for follow up. Both the regularity of the attendance of clinical staff (eg. the health service doctors and nurses), and the proximity of services such as consultant services to which patients are referred, may affect the way in which the follow up system needs to be designed in order to ensure that investigations, tests and referrals are followed up appropriately.

Review and action on results or reports needs to be completed in a timely manner. The speed with which results and reports are acted on, and the degree of effort taken to contact the patient to discuss the results, will depend on the health professional's judgment of the clinical significance of the result or report, and the context, duration and longevity of the clinical relationship. If the health service needs to initiate follow up contact with a patient, it needs to do so in a reasonable manner. The number and types of attempts will take into account all of the circumstances. These attempts at follow up need to be documented in the patient's health record.

Criterion 1.5.4 System for follow up of tests and results (continued)

A close analysis of how and when things go wrong in the follow up of patients with clinically significant tests or results often indicate a problem, or several problems, with the health service system, including:

- the quality and content of discussions with the patient
- the recording of those discussions
- the recording of the clinical encounter.

It is therefore useful for health services to understand that protecting patients and health professionals from errors involves a series of safeguards and involves devising, implementing and monitoring systems in the health service.

The RACGP recognises that information technology can be a useful tool in follow up, however, the current clinical information systems have limitations and may not provide sufficient and reliable safeguards in all cases.

Indicators

A. **Our patient health records contain evidence that pathology results, imaging reports, investigation reports and clinical correspondence received by our service have been:**
   - **reviewed by a medical staff member**
   - **initialled**
   - **acted upon in a timely manner where appropriate** (health records review).

B. **Our staff can describe the system by which pathology results, imaging reports, investigation reports, and clinical correspondence received by our service are:**
   - **reviewed**
   - **signed or initialled (or the electronic equivalent)**
   - **acted on in a timely manner**
   - **incorporated into the patient health record** (interview).

C. **Our service has a written policy describing the review and management of pathology results, imaging reports, investigation reports and clinical correspondence received by our service** (document review).

D. **Our staff can describe how patients are advised of the process for the follow up of results** (interview).

E. **Our staff can describe the procedure for follow up and recall of patients with clinically significant tests and results** (interview).

F. **Our service has a system to recall patients with clinically significant tests and results** (document review).

G. **Our service has a written policy to follow up and recall patients with clinically significant tests and results** (document review).

CRITERION 1.6.1

Engaging with other services

Our service engages with a range of services to plan and facilitate optimal patient care.

Explanation

Engaging other medical services (eg. diagnostic services, hospitals and consultants), allied health services (eg. dental services) and social, disability and community services can assist the health service to provide optimum care to patients whose health needs require integration with other services. For example, patients requiring rehabilitation or mental health services can benefit from the health service taking an active role in engaging other services to assist in their care. For health services in immigration detention centres, these other 'services' also include the detention service provider and the Department of Immigration and Citizenship (DIAC).

Health services in immigration detention centres are required to coordinate and integrate patient care across the primary health care setting into other health care, allied health care (eg. dental health) and social, disability and community services. The health service needs to have readily accessible written or electronic information about local health, disability and community services and how to engage with them to plan and facilitate patient care.

Health services may also need to be aware of different referral arrangements for public and private providers.

The health service responsible for coordinating care for a patient needs to engage with the detention service provider where it plays a role in matters such as facilitating travel, providing access to offsite services and assisting with access to medication or specific nutritional requirements, or following up on medical instructions provided to patients. It may be useful for the health service to schedule regular briefing meetings to discuss the role, responsibilities and obligations of the health service in providing health care to patients and invite DIAC or detention service provider staff to attend.

Indicators

A. **Our service demonstrates how it engages with the following:**
   - **medical services such as diagnostic services, hospitals and specialist consultant services**
   - **allied health services (eg. dental services)**
   - **disability and community services**
   - **health promotion and public health services and programs**
   - **the detention service provider**
   - **the DIAC** (document review, interview).

B. **There is evidence that our service refers patients to health, community or disability services** (health records review).

CRITERION 1.6.2

Referral documents

Our referral documents to other health care providers contain sufficient information to facilitate optimal patient care.

Explanation

Referral documents are a key tool in integrating the care of patients with external health care providers and therefore need to be legible (preferably typed) and contain sufficient information to allow the other health care provider to provide care to the patient. Most of the information needed for a referral may be found in the patient's health summary. Patients need to be aware that their patient health information is being disclosed in these referral documents.

In the case of an emergency or other unusual circumstance, a telephone referral may be appropriate. This telephone referral needs to be documented in the patient's health record.

For both medicolegal and clinical reasons, health services need to keep copies of important (nonroutine) referral letters – ie. new referrals or those for serious conditions – in the patient's health record. While the significance of individual letters is judged by medical and clinical staff, health services which have not retained any referral letters would have difficulty meeting this criterion.

In referring patients to external providers it is important to emphasise the independence of the primary health team within the immigration detention centre context. This will encourage adequate communication between external health care providers and the health service. Some external providers may be unclear about the immigration detention centre context and reluctant to provide information about a patient's health care back to the health service if they believe it will not be treated confidentially. This breakdown in communication has ramifications for continuity of care and should be minimised where possible.

Indicator

A. **Our service can demonstrate that referral letters are legible and where appropriate:**
   - **include the purpose of the referral**
   - **include relevant history, examination findings and current management**
   - **include a list of allergies and current medicines**
   - **are recorded on appropriate health service stationery**
   - **are documented in patients' health records** (health records review).

CRITERION 1.7.1

Patient health records

For each patient we have an individual patient health record containing all clinical information held by our service relating to that patient.

Explanation

Health services need to have an effective system for storing an individual patient's health information in a dedicated patient health record. Health records need to include the patient's contact details, name, date of birth and other demographic information, medical history, consultation notes (including any care outside normal opening hours of the health service and visits to patient's living quarters), letters received from hospitals or consultants, other clinical correspondence, investigations or referrals, and results. The patient health record may also contain relevant nonclinical information pertaining to the patient, such as relevant legal reports.

Medical errors and breaches of personal privacy can occur if information is accidentally recorded in or obtained from another patient's health record. As a result, it is important to have an accepted protocol for the ordering of given and family names, and ways of distinguishing the files of patients with similar or identical names.

For health services in immigration detention centres, the patient's health record needs to be independent and separate from that person's immigration records. The patient's health information should remain private and confidential (as outlined in criterion 4.2.1).

A patient health record may be solely electronic, solely paper based, or may be a combination (hybrid) of paper and electronic records. If health information about a patient is kept in two sites (as in the case of hybrid records), health services need to ensure they have a system in place to ensure all the information is available and accessible when needed.

The information required from each patient might be collected by having new patients complete a generic form or by having health service staff interview patients in a private environment prior to consultation.

It is critical that patient health records are legible (able to be read and understood) so that another practitioner can take over the care of the patient if necessary, and if the health service scans documents such as external reports, the scanning needs to be undertaken in a way that reproduces the legibility of the original document.

Health services also need to work toward the routine recording of the patient's preferred contact person in an emergency and the patient's self identified cultural background. Health services which have not been routinely recording this information need to demonstrate how they are improving the consistency with which they record this information in the patient health record.

Keeping separate, individual patient files is a risk reduction approach to managing patient health information. The RACGP encourages health services to keep individual patient health information filed in separate patient folders or on computer, rather than in family folders. Depending on the system of record keeping for family folders, there may be a risk that pathology results, diagnostic reports or other communication may be misfiled with the wrong family member. In a family file,

Criterion 1.7.1 Patient health records (continued)

the information needs to be stored and accessed in a way that maintains its confidentiality, privacy and security. If a health service keeps family folders, it needs to ensure that each family member's health information is separated within the folder, and that it contains all the information about that individual.

Indicators

A. **There is evidence that each patient has an individual patient health record containing all clinical information held by our service relating to that patient** (health records review).

B. **Our patient health records are legible** (health records review).

C. **Our active patient health records include contact and demographic information (where appropriate) including:**
- **the patient's full name**
- **date of birth**
- **gender**
- **contact details** (health records review).

D. **Our service can demonstrate that we are working toward recording the following information in our active patient health records:**
- **self identified cultural background**
- **the patient's preferred contact person in an emergency** (interview or health records review).

CRITERION 1.7.2

Health summaries

Our service incorporates health summaries into active patient health records.

Explanation

A health summary is a vital component of a quality health record. All active records should contain an up to date health summary. A good health summary assists the patient's own doctor, other doctors, allied health staff and clinical staff members in the health service to rapidly obtain an overview of all components of the patient's care. Health summaries reduce the risk of inappropriate management including medicine interactions and side effects (particularly when allergies are recorded). Health summaries provide the social and family overview vital to whole patient care. A health summary will assist with health promotion by highlighting lifestyle problems and risk factors (eg. smoking, alcohol, nutrition, physical activity status). It also helps disease prevention by tracking immunisation and other preventive measures.

An up to date health summary is critical in the smooth transfer of care from one practitioner (in the health service) to another (in the health service, or more importantly to a practitioner external to the immigration detention centre). As such, 90% of all patient records in immigration detention centres are required to contain a health summary.

While it is important to record all allergies in health summaries, it is particularly important to record allergies to medicines as this facilitates safer prescribing (especially when computer based) and reduces the likelihood of adverse patient outcomes. It is important also to record 'no known allergies' so that this is not assumed in the absence of recorded data.

The recording of recent important events covers a wide range of social events of importance to the patient, which may include changes in accommodation, family structure (eg. death of family members) and important events in the person's immigration process. Recent important events can alter patient preferences, values and the context of care.

Where a health service does not meet the 90% level in an element of a health summary (eg. risk factors), the health service needs to describe how it is attempting to improve the completeness of that element of the health summary. A health service that knows it has a deficit in the recording of any information needs to have a plan for improvement.

This criterion applies to active patient health records only. In the case of health services in immigration detention centres, an active health record is a record of a patient who currently resides in the immigration detention centre.

The RACGP appreciates that family and social history especially should only be recorded in a health summary where it assists patient care and does not impair patients' rights to privacy and, as such, not all health summaries will include all the items listed in indicator B.

Standard 1.7

Our patient health records contain sufficient information to identify the patient and to document the reason for visit, assessment, management, progress and outcomes.

Criterion 1.7.2 Health summaries (continued)

Indicators

- **A. At least 90% of our active patient health records contain a record of allergies in the health summary** (health records review).
- **B. At least 90% of our active patient health records contain a health summary. A satisfactory summary includes, where appropriate:**
  - **adverse medicines events**
  - **current medicines list**
  - **current health problems**
  - **past health history**
  - **risk factors**
  - **immunisations**
  - **relevant family history**
  - **relevant social history** (health records review).
- **C. Our patient health records show evidence that health summaries are updated to reflect recent important events** (health records review).
- **D. If our service uses both an electronic and paper based system for recording a patient's health summary, our service can demonstrate how the patient's health information is made accessible** (interview).

CRITERION 1.7.3

Consultation notes

Each of our patient health records contains sufficient information about each consultation to allow another health professional to carry on the management of the patient.

Explanation

A consultation is an interaction between the health service and the patient related to the patient's health issues. A consultation may be with a medical staff member (eg. general practitioner or other specialist doctor) or with another staff member who provides clinical care within the health service (eg. nurse or psychologist).

Patient health information needs to be of sufficient quality that another health professional could read and understand the terminology and abbreviations used, and be equipped to manage the care of the patient from the information provided. Documentation of all the items in Indicator A will not be required for every individual consultation (eg. consultations for repeat prescriptions).

Ideally, information about the consultation needs to be entered into the patient health record as soon as is practical at the time of the consultation, or as soon as information (eg. results) becomes available.

As part of the continuing care that health services in immigration detention centres provide, information concerning patients is gathered over more than one consultation. It is important that there is a connecting process so that information about clinically significant, separate events in a patient's life and in the care provided are not overlooked but are recorded and managed in a way that makes this information readily accessible. Regularly updated health summaries are one method of managing this information. Clinically significant information may include the patient's health needs and goals, medical condition(s), preferences and values. All this contributes to care that is responsive to patient needs.

Medical defence organisations have identified lapses in following up on problems and issues raised previously by patients as a considerable risk. This can occur when patients are not seen by their usual medical or clinical staff member, though it can also occur when a staff member is busy or distracted. It is useful for health services to have systems that reduce the risk of such lapses to ensure high quality patient care.

It is also important for health services to document in a patient's health record if there is a delay between the patient requesting health care and the provision of that health care (for whatever reason). It may be useful (for medicolegal purposes) to document the reason for the delay and what follow up occurred as a result.

Standard 1.7

Our patient health records contain sufficient information to identify the patient and to document the reason for visit, assessment, management, progress and outcomes.

Criterion 1.7.3 Consultation notes (continued)

Indicators

A. **Our patient health records document consultations – including consultations outside normal opening hours and visits to living quarters – comprising:**
- **date of consultation**
- **patient's reason for consultation**
- **relevant clinical findings**
- **diagnosis**
- **recommended management plan and where appropriate expected process of review**
- **any prescribed medicine (including medicine name, strength, directions for use, dose frequency, number of repeats, and date medicine was started, ceased or changed)**
- **any relevant preventive care undertaken**
- **documentation of any referral to other health care providers or health services**
- **any special advice or other instructions**
- **identification of who conducted the consultation, eg. by initial in the notes, or audit trail in electronic record** (health records review).

B. **Our patient health records show evidence that problems raised in previous consultations are followed up** (health records review).

The Royal Australian College of General Practitioners

section two

RIGHTS AND NEEDS OF PATIENTS

Standard 2.1 COLLABORATING WITH PATIENTS

Our service respects the rights and needs of patients.

CRITERION 2.1.1

Respectful and culturally appropriate care

Our service provides respectful and culturally appropriate care to patients.

Explanation

Patients have the right to respectful care which promotes their dignity, privacy and safety. Patients have a corresponding responsibility to give respect and consideration to their health service's staff and other patients. Staff need appropriate interpersonal skills to work with patients and others in the health service. This criterion requires that staff deal with patients in a respectful, polite and friendly manner.

Immigration detention centres create a challenging environment in which to provide health care. In this setting, transcultural awareness is central to a health care professional understanding an individual patient's perception of health and illness. This awareness requires an understanding of the multitude of patients' cultural, religious, sociopolitical and linguistic backgrounds. It is important to acknowledge that many patients within immigration detention centres may be from minority groups in their home countries and therefore may not subscribe to the same belief systems as the mainstream culture from their country of origin. It is also important to foster cultural sensitivity regarding a patient's past experiences (eg. time spent in refugee camps or in situations of persecution) which may influence their perception of the detention experience and therefore their trust of health care workers. There are many useful resources available to improve health professionals' understanding of culture and its impact on mental and physical health including www.cimh.unimelb.edu.au/links/psychologists and www.vtpu.org.au/links/#background, and www.foundationhouse.org.au and www.startts.org.

Demonstrating respect for patients extends beyond face to face interaction between the staff and the patient to the recording of patient's health information. Making or recording derogatory, prejudiced, prejudicial or irrelevant statements about patients has serious consequences for treatment, compensation and other legal matters, and may contravene antidiscrimination legislation. Such remarks are also prone to misinterpretation when records are used by other health professionals and will result in differential treatment for such patients. Health services need to be aware that the *Disability Discrimination Act* 1992 (Commonwealth) as well as the various state and territory *Disability Services Acts* and *Equal Opportunity Acts*, prohibit the discriminatory treatment of people based on their personal characteristics (such as gender or religion). The Human Rights and Equal Opportunities Commission provides further information, including guides to the relevant legislation and links to state and territory agencies with similar responsibilities (available at www.humanrights.gov.au).

The ideal health professional-patient partnership is a collaboration based on mutual respect and a mutual responsibility for the patient's health. The health professional's duty of care is to explain the benefits and potential harm of specific treatments and to clearly and unambiguously explain the consequences of not adhering to a recommended management plan. The use of interpreters should be considered in every consultation when the patient is known to have a non-English speaking background, to avoid misunderstandings and to assist in developing trust between the patient and health care professional. Patients need to be encouraged to notify their health care professional when they are choosing to follow another health care provider's management advice. This allows the original health care provider the opportunity to reinforce any potential risks of this decision. Where patients do seek further clinical opinions, an appropriate risk management strategy

for health services includes documenting this decision in the patient's health record. The health service is also encouraged to document in the patient's health record an explanation of the actions taken when a patient seeks a further clinical opinion, including referral to other care providers if arranged.

Where patients refuse advice, procedures or treatments, an appropriate risk management strategy for health services needs to include recording of such refusals in the patient's health record, including referrals to other care providers, if arranged. It is recommended that any action taken is documented in the patient health record. This includes the documentation of refusal of medical care if the patient is engaging or proposing to engage in self destructive behaviour (eg. hunger striking), and the assessment of the person's competence to make such decisions. If a patient refuses to act on medical advice, this needs to be seen with respect to the patient's cultural background as outlined above, and attempts need to be made to provide care in a culturally appropriate context.

Where a patient requests to be transferred to the care of another health care professional, a copy of the patient health information needs to be transferred to the other health professional in a timely manner to help facilitate the patient's care. Staff need to comply with the requirements of the state or territory legislation governing the transfer of patient health information. Where the health service produces a summary for transfer to another health provider, it is useful to keep a copy of the summary in the patient's health record. It is recommended that a copy of the patient health information be transferred and that the health service retain the original health information.

When patients detained in immigration detention centres are released or transferred into another detention placement (eg. residential housing accommodation), it is important that the health service arranges the transfer of care to another health care practitioner. A comprehensive health summary needs to be provided (with the patient's consent) to the health professional who will be coordinating the care for the patient outside the detention centre or to the patient (if no health professional has been identified). It is useful for this transfer of care to be managed by the person in the health service identified as leading the care for that individual patient (criterion 1.5.2, indicator D).

There may be patients the medical or clinical staff no longer consider it appropriate to treat (eg. where there has been some cause for a significant breakdown in the therapeutic relationship). The medical, clinical or allied health staff member has the right to discontinue treatment of that patient, especially when they think they can no longer give the patient their best care.

There are concerns about violence both within and outside general practice. One Australian study[52] suggests that violence toward doctors and staff in general practice is common. The most common forms of violence were 'low level' violence, such as verbal abuse (42.1% of general practitioners reported at least one incident in the previous year), property damage/theft (28.6%) and threats (23.1%). A smaller proportion of GPs had experienced 'high level' violence such as sexual harassment (9.3%) and physical abuse (2.7%). This study also found a significant association between high level violence and practices located in lower socioeconomic status areas, practices staffed by female GPs, practices in populations with a greater incidence drug-related problems, and practices that provided home visits during business hours. More experienced GPs encountered less violence for every additional 5 years of practice. This suggests that the area in which the service is situated, the gender of its GPs and staff, the experience of the GPs and staff, and the characteristics of the population served by the service are relevant considerations when considering the safeguards needed for the service.

Criterion 2.1.1 Respectful and culturally appropriate care (continued)

The health service is encouraged to have a risk management strategy detailing the steps taken to protect staff and to deal with these distressing situations, and the steps taken to assist patients with ongoing care, including referral to other health care providers. Some states and territories have introduced specific legislation governing the cessation of treatment (eg. when a health service closes down), and health services need to be aware of their obligations.

A patient in distress may feel more comfortable in a private area than in a public waiting area. Health services – even those with limited facilities – need to attempt to provide privacy for such patients (eg. by allowing them to sit in an unused room, staff room or other area). This does not mean that a health service needs to have a room permanently set aside for such patients, but that it does need to have a plan that can be implemented as the need arises to ensure the patient is treated respectfully.

Indicators

- **A. Our service does not discriminate against patients on the basis of their gender, race, disability, ethnicity, age, sexual preference, beliefs or medical condition** (interview).
- **B. Our staff can describe how they provide care for a patient who refuses a specific treatment, advice or procedure** (interview).
- **C. Our staff can describe what they do when a patient informs them that they intend to seek a further clinical opinion** (interview).
- **D. Our staff can describe what they do to transfer care to another health professional in our service or in another health service** (interview).
- **E. Our staff can describe arrangements for managing the transfer of care of a patient whom they no longer wish to treat** (interview).
- **F. Our staff can describe how our service provides privacy for patients in distress** (interview).
- **G. Our staff can identify important or significant cultural groups within our service, and outline our strategies for meeting their needs** (interview).

CRITERION 2.1.2

Patient feedback

Our service provides opportunities for, and responds to, patient feedback.

Explanation

Patients can provide unique information about patient needs and the quality of care provided by a health service. Openly discussing patient feedback and concerns helps staff to understand strengths in their health service, potential problems, and how to make improvements. It is helpful to know what patients think about a health service and what they are likely to tell other people. The more feedback a health service receives – whether it be complaints, compliments or suggestions – the better it will be able to provide care.

The 'Turning wrongs into rights: learning from consumer reported incidents project',[53] a national project funded under the auspices of the Australian Council for Safety and Quality in Health Care (ACSQHC), has undertaken research into the complains management practices of Australian health care organisations and has developed guidelines on complaints management in health care.

The importance and value of effective complaints management was expressed by the ACSQHC in its publication 'Better practice guidelines on complaints management for health care services':[54]

> 'Customers (including patients and carers) have a unique expertise in relation to their own health and their perspective on how care is actually provided. Consumer complaints are therefore a unique source of information for health care services on how and why adverse events occur and how to prevent them. As well as reducing future harm to patients, better management of complaints should restore trust and reduce the risk of litigation, through open communication and a commitment to learn from the problem and prevent its recurrence'.

The complexities of providing health care to patients detained in immigration detention centres mean that it is very important that the health service be transparent about the relationship between the health service and other parties (as discussed in criterion 1.2.1). It also means that gaining useful feedback (especially complaints) from patients about the health service (as distinct from other parties) may be challenging. The service needs to explicitly support and encourage patients to provide useful feedback, rather than allow service structures and processes to directly or indirectly impede the making of complaints. To this end, it is suggested that patients who wish to make a complaint to the service are encouraged to do so with the assistance of advocates who may assist in helping the patient and the service clarify the nature of the complaint and work to find a resolution. The health service needs to assure patients that they can make complaints against the service without fear of negative repercussions.

It is essential that health services provide a structured mechanism for obtaining patient feedback. It is recognised that obtaining valid feedback from patients who are detained in immigration detention centres can be challenging. Health services need to determine the most appropriate means of obtaining meaningful feedback about the health service for their context and patient population. This might include asking patients to complete a questionnaire about the health service, or obtaining feedback through focus group discussions (where patients are invited to come together to discuss their views on the health service), or through some other method that is appropriate to your patient population. Given the challenges in obtaining feedback from people in detention, the health service needs to demonstrate that it is working toward finding a structured mechanism to ask patients about a range of issues.

Criterion 2.1.2 Patient feedback (continued)

Patient feedback is critically important for identifying opportunities for improvement. It is important that health services demonstrate that they have used patient feedback in implementing improvements.

Indicators

- **A. Our service has a process for receiving and responding to feedback and complaints from patients and other people** (document review).
- **B. Our staff can describe the processes for receiving and responding to feedback and complaints from patients and other people** (interview).
- **C. Our service makes contact information for the Human Rights and Equal Opportunity Commission (HREOC), Commonwealth Ombudsman and state or territory health complaints agency readily available to patients on request** (interview, document review).
- **D. Our service can describe an improvement we have made in response to patient feedback or complaints** (interview).
- **E. Our practice is working toward a systematic way to elicit feedback from patients about our service, including whether:**
  - **patients are satisfied with the health service's process of scheduling care**
  - **health service staff discuss health promotion and illness prevention with patients**
  - **patients are able to see the health professional of their choice**
  - **health service staff treat patients in a respectful and culturally appropriately manner**
  - **patients receive sufficient information about the purpose, importance, benefits and risks of proposed investigations, referrals or treatments proposed by the health service staff to enable them to make informed decisions about their health**
  - **patients are confident that any feedback or complaint to the health service will be handled properly**
  - **the presence of a third party in a consultation occurs only with the patient's permission prior to the consultation**
  - **patients are offered the use of an interpreter**
  - **patients find it easy to contact the service**
  - **patients are satisfied with facilities in the consultation area(s)**
  - **patients think the service makes adequate provisions for their privacy** (document review).

CRITERION 2.1.3

Presence of a third party

The presence of a third party observing or being involved in the clinical care during a consultation occurs only with the permission of the patient prior to the consultation.

Explanation

The right to privacy and confidentiality of therapeutic treatment is usually accepted by health professionals and is explicitly supported within these *Standards*. Compromising on this aspect of patients' rights may affect the trust they have in the health service, and may reinforce power imbalances that are detrimental to health and wellbeing.

In some circumstances, however, the patient or the staff member may feel more comfortable if a third party is present during an examination. Appropriate consent needs to be obtained from the patient where the health professional requests the presence of a third party. Where a patient is accompanied to the health service by a third person (such as a detention service provider security staff member), it is also important to ensure that the patient consents to the presence of that person in their consultation.

Ideally, permission should be sought prior to the consultation. It is not acceptable to seek permission in the consulting room, as some patients may feel 'ambushed' and unable to refuse. The presence of a third party in the consultation (including an interpreter) should be documented in the patient's health record.

A tension may arise between respecting the rights to privacy and confidentially of the patient and the need to manage any security or safety risks that the patient may pose to the health staff during a consultation. Health services in immigration detention centres may need to negotiate their policy for managing these risks with the detention service provider, and with the Department of Immigration and Citizenship if necessary. The policy needs to outline the circumstances in which third parties need to be present during a consultation for security purposes, and the way in which the disclosure of personal health information to the third party will be minimised during the consultation.

Indicators

- **A. Our staff can describe how and when they inform patients and obtain their prior permission for the presence of a third party during consultations** (interview).
- **B. Our service has a policy about the presence of third parties in consultations** (documents review).

section three

SAFETY, QUALITY IMPROVEMENT AND EDUCATION

Standard 3.1 SAFETY AND QUALITY

Our service is committed to quality improvement.

Standard 3.2 EDUCATION AND TRAINING

Our service supports quality improvement through education and training.

CRITERION 3.1.1

Quality improvement activities

Our service supports quality improvement activities.

Explanation

It is very important that the *Standards for health services in immigration detention centres* encourage quality improvement and incorporate systems of continuous improvement.[55]

Health services that engage in quality improvement activities review the health service's structures, systems and processes to discover opportunities to make changes that will increase quality and safety for patients. It is critical that the health service also has a plan for carrying out any improvements it has identified as being necessary.

Quality improvement activities can range from activities designed to improve the day to day operations of the health service (eg. improving patient health record keeping, changing the way patient complaints are handled, or altering systems in response to 'near misses'), to those specifically designed to improve the health of the whole health service population (eg. improving rates of immunisation, improving care of patients with diabetes, or altering the systems used to identify risk factors for illnesses that are particularly prevalent in the health service's patient population). Quality improvement is not restricted to clinical areas and may include improvements made in response to feedback from patients (criterion 2.1.2) or other nonclinical aspects.

Quality improvement activities are underpinned by effective information management techniques that allow health services to analyse their data and make decisions for service changes based on the data collected. Innovative use of information technology can assist health services in performing quality improvement activities to improve the health of their population. Ideally, health services need to investigate their own data for quality improvement purposes.

Engaging in quality improvement activities is an opportunity for staff members to come together as a team to consider quality improvement. Quality improvement can relate to many areas of a health service, and achieving improvements may require the collaborative effort of the health service team.

Indicators

A. **Our staff can describe an aspect(s) of our service we have improved in the past 3 years** (interview).

B. **Our service uses data about our health service population for quality improvement** (interview or document review)

CRITERION 3.1.2

Clinical risk management system

Our service has a clinical risk management system to enhance the quality and safety of our patient care.

Explanation

Slip ups, lapses and mistakes in clinical care that might harm patients can occur in all health services. One review of studies about slips and lapses suggests that the frequency with which a general practitioner will be involved in an incident in which an error occurred will be between five and 80 times per 100 000 consultations.[56] The evidence about the frequency of slips, lapses and mistakes varies, and the better constructed studies suggest even higher rates of occurrence.

Most health services already manage clinical risk on a daily basis. Many have informal and ad hoc methods of trying to prevent slips, lapses and mistakes. Some medical or clinical staff talk to other trusted peers or supervisors. Other services have formal processes that include team discussions about the cause of the slip, lapse or mistake, and how to reduce the likelihood of it happening again, or using structured techniques to analyse the causes of the error and reduce the likelihood of its recurrence.

The same mistake can have different causes on different occasions. A quality improvement process involves having a consistent clinical risk management system so that the causes of slips, lapses and mistakes are identified and processes improved to reduce the likelihood of them occurring again.

If the health service does not make improvements after identifying a slip, lapse or mistake, patients may be exposed to an increased risk of adverse outcomes, and the staff may be exposed to an increased risk of medicolegal action. An example of this situation is where a clinically significant test result is not communicated to the patient or adequately followed up; the health service knows about this, and yet makes no attempt to prevent a recurrence. Another example might be if an important detail in a previous consultation is not considered or read by the medical or clinical staff member at that patient's next consultation, resulting in a problem being overlooked; the health service becomes aware of this, and yet does not act to prevent it happening again. This second example is more likely with the use of certain electronic based record systems that do not show the previous consultation record when a patient's record is opened.

The vast majority of slips, lapses and mistakes do not lead to patient harm as they are 'near misses' that are caught before any harm occurs. An example of this is when the doctor prescribes a medicine for a patient and then the patient tells the doctor that they are allergic to that medicine. Another is when a doctor notices that the nurse has prepared an incorrect vaccine before the vaccination takes place and replaces it with the correct vaccine. These 'near misses' can provide opportunities for quality improvement.

The health service needs to have a process by which health service staff – including nursing and other staff involved in clinical care – know how to (and who to) notify when a slip, lapse or mistake occurs, or when there is an unanticipated adverse outcome. A recent study[57] suggests that staff members who are able to hold discussions about difficult subjects such as disrespect, micromanagement, competence and error are likely to be involved with better patient health outcomes, remain longer in their positions, and be more satisfied with their work.

Health services will have very different systems in place to identify and reduce clinical risk; it is important however, for health services to be able to demonstrate how and why they have made changes to improve clinical care.

The RACGP recommends that medical and clinical staff notify their medical defence organisations of all events or circumstances that they perceive might give rise to a legal claim.

A number of parties are involved in caring for people detained in immigration detention centres. Health service staff need to know how to and who to report to if they have a concern that the actions of another party (eg. the Department of Immigration and Citizenship [DIAC] or the detention service provider) may compromise the quality and safety of care the health service provides to a patient.

The health service is also required to advise the DIAC of 'critical incidents' or adverse events and other risks to patient safety. In providing care to patients detained in immigration detention centres, it is critical that the health service have the capacity to notify the DIAC in the event that an administrative, detention or other immigration processing issue is likely to cause an error or risk to patient safety (as outlined in criterion 1.4.2).

Indicators

A. **Our medical and clinical staff can describe the process for identifying and reporting a slip, lapse or mistake in clinical care** (interview).

B. **Our medical and clinical staff can describe an improvement we have made to prevent slips, lapses and mistakes in clinical care from recurring** (interview).

CRITERION 3.2.1

Medical staff qualifications

All medical staff in our service are appropriately qualified and trained, have current registration, and participate in continuing professional development.

Explanation

All doctors providing care in the health service need to meet the standards of their relevant Australian specialist medical college – both in terms of their vocational training, and in terms of their continuing professional development.

General practice is a distinct discipline in medicine and requires specific training. Doctors providing general practice care need to be appropriately trained and qualified in the discipline of general practice, and be either vocationally recognised or have Fellowship of the RACGP (FRACGP). The RACGP defines a general practitioner as a registered medical practitioner who is qualified and competent for general practice in Australia, has the skills and experience to provide whole person, comprehensive, coordinated and continuing medical care, and who maintains professional competence for general practice (through continuing professional development).[58]

It may not be possible to recruit recognised GPs in some areas. In such circumstances, practice doctors who are not recognised GPs need to be appropriately trained and qualified to meet the needs of the patient population. Doctors who have not yet met the equivalent of the FRACGP need to be assessed for entry to general practice and be supervised, mentored and supported in their education to the national standards of the RACGP. Adequate professional and personal support for doctors entering general practice is critically important.

Doctors providing general practice care who are not participating in RACGP quality assurance and continuing professional development (QA&CPD) activities need to demonstrate recent and continuing participation in activities equivalent to Category 1 activities of the RACGP QA&CPD Program. The RACGP QA&CPD Program is based on adult learning principles (ie. knowledge is more likely to be gained when the adult undertaking the learning recognises a 'need to know', seeks knowledge and reviews what has been learnt) and requires GPs to undertake two Category 1 activities in each triennium (eg. small group learning or clinical audits). (Further information about the RACGP QA&CPD Program is available at www.racgp.org.au/qacpd).

The RACGP recognises that cardiopulmonary resuscitation (CPR) skills in particular are used infrequently, and there is evidence that these skills diminish without use. There may be additional medicolegal risk for a medical practitioner who is perceived not to have assisted a patient by providing CPR. The RACGP sought the view of the Australian Resuscitation Council and suggests that the health service consider how frequently it requires or provides CPR (refresher) training and how recently these skills have been used by its doctors.

The nature of detention means that patients have a restricted ability to directly contact and use mainstream primary health and emergency services compared to people within the community. As such, health services in immigration detention centres need to stock emergency care and resuscitation equipment (including an automated external defibrillator). Medical, clinical and allied health staff should be trained in CPR and the use of the defibrillator.

Standard 3.2

Our service supports quality improvement through education and training.

Indicators

- **A. All doctors can provide evidence of current state or territory based medical registration** (document review).
- **B. Our service demonstrates that all our doctors are recognised Fellows of their relevant medical colleges**

  OR

  where recruitment of Fellows of relevant specialist medical colleges has been unsuccessful, our service demonstrates that doctors have the qualifications and training necessary to meet the needs of patients (interview, document review).
- **C. Our service can provide evidence of satisfactory participation in the relevant specialist medical colleges continuing professional development program by all our doctors** (document review).
- **D. Our doctors have undertaken training in CPR in the past 3 years** (document review).
- **E. Our doctors can describe how to use our defibrillator** (interview).

CRITERION 3.2.2

Clinical staff qualifications

All staff involved in clinical care are appropriately trained for their role in our service.

Explanation

Nonmedical staff involved in clinical care may include nursing staff, psychologists, allied health professionals or other staff members who provide clinical care. All nonmedical staff involved in clinical care in the health service need to be appropriately trained for their roles and be trained in the use of any clinical equipment and tests required for their role (eg. electrocardiograph, spirometer, steriliser, psychological screening or testing). Training may be gained through participation in external courses or through 'on the job' training at the health service.

The RACGP recognises that cardiopulmonary resuscitation (CPR) skills in particular are used infrequently, and there is evidence that these skills diminish without use. The RACGP sought the view of the Australian Resuscitation Council and suggests that the health service consider how frequently it requires or provides CPR (refresher) training and how recently these skills have been used by its clinical staff.

The nature of detention means that patients have a restricted ability to directly contact and use mainstream primary health and emergency services compared to people within the community. As such, health services in immigration detention centres need to stock emergency care and resuscitation equipment (including an automated external defibrillator). Clinical and allied health staff should be trained in CPR and the use of the defibrillator.

Indicators

A. **Our clinical and allied health staff have appropriate training, qualifications and current registration, and participate in continuing education relevant to their profession** (interview, document review).

B. **Our staff who are involved in clinical care have appropriate training and qualifications, and participate in continuing education relevant to their role** (interview, document review).

C. **Our staff involved in clinical care have undertaken training in CPR in the past 3 years** (document review).

D. **Our staff involved in clinical care can describe how to use our defibrillator** (interview).

CRITERION 3.2.3

Training of staff who have nonclinical roles

Our administrative staff participate in training.

Explanation

Administrative staff (such as receptionists and managers who do not provide clinical care) need training to be successful in their roles. This may include formal training (eg. a computer course, training in the use of software programs, training in first aid, management, medical terminology, medical reception, cross cultural training) or 'on the job' training provided by staff in the health service (eg. making appointments, recognising urgent situations, confidentiality requirements, familiarisation with the policy and procedures manual).

Cardiopulmonary resuscitation (CPR) skills training for all members of the community has been shown to improve outcomes and is supported by the RACGP. Clinical, allied health and administrative staff should be trained in CPR.

The RACGP recognises that CPR skills in particular are used infrequently, and there is evidence that these skills diminish without use. The RACGP sought the view of the Australian Resuscitation Council and suggests that the health service consider how frequently it requires or provides CPR (refresher) training, dependent on how recently these skills have been used by its administrative staff.

The nature of detention means that patients have a restricted ability to directly contact and use mainstream primary health and emergency services compared to people within the community. As such, health services in immigration detention centres need to stock emergency care and resuscitation equipment (including an automated external defibrillator).

Indicators

- A. **Our administrative staff can describe training undertaken within the past 3 years that is relevant to their role in our health service** (interview).
- B. **There is evidence that our administrative staff have undertaken training within the past 3 years that is relevant to their role in our health service** (document review).
- C. **Our administrative staff have undertaken training in CPR in the past 3 years** (interview, document review).
- D. **Our administrative staff can describe how to use our defibrillator** (interview).

section four
SERVICE MANAGEMENT

Standard 4.1 SERVICE SYSTEMS

Our service demonstrates effective human resource management processes.

Standard 4.2 MANAGEMENT OF HEALTH INFORMATION

Our service has an effective system for managing patient information.

CRITERION 4.1.1

Human resource system

Our service has a system to manage its human resources.

Explanation

Research from both general practice and other industries supports the importance of giving attention to a range of aspects of human resources. For example, research in Australia and the United States confirms that teamwork is important to the quality of care. The research literature identifies teamwork as an important success factor in a number of safety initiatives across different industries. The authors of one study identified alignment of role, competence and licensing (where required) as a common element of high performing clinical teams.[59]

Staff need to have position descriptions that outline their roles, responsibilities and conditions of employment. A position description establishes the role of the employee within the organisation, documents the parameters of the responsibilities and duties associated with that position, and forms the basis for evaluation and lines of accountability. Recruitment, training and development, performance evaluation, remuneration management and succession planning can all be based on the measure of an individual against their position description.

It is important for the health service to have an induction program for new medical staff (including registrars and locums), allied health staff, other clinical staff and administrative staff. New staff need to understand the daily operations of the health service including the occupational health and safety issues (eg. infection control policies) relevant to their roles, as well as the processes by which the privacy and confidentiality of patient health information is maintained within the health service (including the kinds of information that can be released to the Department of Immigration and Citizenship or the Commonwealth Ombudsman). Medical, allied health and clinical staff in particular need to be aware of key public health regulations (eg. reporting requirements for communicable diseases) that will affect how they work. Medical and clinical staff need to be made aware of the existence of local health and community services (including pathology, hospital and other services they are likely to refer to in the course of normal consulting). Medical, clinical and administrative staff need to understand the role of the Commonwealth Ombudsman and the role of state or territory health complaints bodies. An induction program that covers these issues as well as the specific operational processes of the health service is essential to assist new staff to perform their roles.

It is important for health services in immigration detention centres to appropriately and sufficiently inform new staff members of a range of issues that are specific to that context of care. In particular, it is suggested that any induction program in immigration detention centres include the following:

- the rights and obligations (particularly relating to health care access) of people detained by the Department of Immigration and Citizenship (DIAC)
- processes for engaging with the detention service provider or the DIAC (criterion 1.6.1)
- the protocol for the notification of concerns about the provision of health care (criterion 1.4.2)
- the payment arrangements for the health service's clinical services and external health providers
- information about particular cultural groups within the patient population
- information about identifying previous trauma and clinical information when managing patients with a history of trauma or torture.

Health services that have not employed new staff in the past 3 years are not required to have already developed an induction program. However, these health services need to be able to describe how they plan to induct new staff members in the future.

Criterion 4.1.1 Human resource system (continued)

It is important that the health service team identify leaders[60] in areas such as clinical care and improvement, information management, complaints and feedback, and human resources. Clinical care leadership might include convening a health service meeting to review the quality of care provided to a patient or the mentoring of new staff. Clinical improvement leadership might involve instigating a plan to monitor the management of patients on particular treatments (eg. warfarin) with a view to improving the way the health service manages these patients. Sometimes, the person who leads the clinical care may not lead the clinical improvement strategy within the service, though both are important.

Health services need to identify the person in the health service who will be responsible for responding to patient feedback, examining issues raised by patients and facilitating improvements in the health service. It is possible that a single individual within the health service may assume all these leadership responsibilities (eg. a principal doctor, nurse or psychologist). In some health services however, different members of the health service team will undertake leadership in these areas. In these cases, the *Standards* require that health services provide a structured opportunity for staff to discuss and agree on clinical matters.

It is important that health service staff have the opportunity to discuss administrative issues with the health service management and/or owners when necessary. When a person or body other than the practising medical staff owns the health service, medical, allied health and clinical staff need to have defined methods of discussing health service administrative matters with the owner(s). This criterion does not require a formal staff meeting (although this is desirable, particularly in larger health services).

Further information about human resource issues can be obtained from:

- the Australian Association of Practice Managers (AAPM) publication *The guide: AAPM business manual for health care* (available for purchase from www.aapm.org.au)
- a variety of resources from the Australian Medical Association (www.ama.com.au)
- the RACGP *Employment kit: tips in negotiating an employment contract in general practice* (see resources)
- the Australian Competition and Consumer Commission's (ACCC) *Guide for general practitioners to the authorisation granted by the ACCC to The Royal Australian College of General Practitioners* (see resources).

Indicators

A. **Our staff can describe their roles within our service** (interview).

B. **Our service can identify the person/people who coordinate the seeking of feedback, and the investigation and resolution of complaints** (interview).

C. **Our service can identify the person/people leading its clinical improvement** (interview).

D. **Our health service can identify the person/people leading the clinical care for our service** (interview).

E. **Our staff are able to discuss administrative matters with the health service managers and/or owner(s) when necessary** (interview).

F. **Our service has an induction program for new staff** (document review).

G. **Our staff have position statements/job descriptions** (document review).

H. **We have a regular staff meeting** (interview or document review).

CRITERION 4.1.2

Occupational health and safety

Our service implements strategies to ensure the occupational health and safety of our staff.

Explanation

The occupational health and safety of health service staff is governed by state, territory and federal occupational health and safety legislation, and legislation may vary from state to state. Health services need to consider how they ensure the service is a safe working environment for all staff.

A doctor cannot be both a receptionist and a medical practitioner at the same time. To support occupational health, safety and wellbeing, health services need to be staffed by at least one additional person during normal opening hours. This person needs to be trained to take telephone calls, make appointments and assist with medical emergencies and cardiopulmonary resuscitation. (Normal opening hours are those the health service advertises as being its regular hours of opening for routine consultations during which patients can see a primary health care staff member).

The health and wellbeing of staff is an important issue and health services might find the following resources useful:

- AMA position statement on personal safety and privacy for doctors (see resources)
- AMA doctors health database (see resources)
- the RACGP publication *Keeping the doctor alive: a self care guidebook for medical practitioners* (see resources).

Additional resources are provided by the following organisations:

- Australian Association of Practice Managers (www.aapm.org.au)
- General Practice Registrars Australia (www.gpra.com.au)
- local divisions of general practice (www.adgp.com.au)
- NSW Rural Doctors Network (www.nswrdn.com.au)
- state and territory Doctors Health Advisory (www.doctorshealth.org.au).

Health services can support the health and wellbeing of all staff in many ways. For example, scheduling regular breaks in consulting time may reduce fatigue and support the health and wellbeing of the medical and clinical staff, as well as enhancing the quality of patient care. Fatigue and related factors (sometimes called 'human factors') can lead to increased risk of harm to patients. Health services can also make information available to their staff about support services in their state or territory. Another strategy is to have a plan for how to reallocate work flow (patient appointments) if a medical or clinical staff member is unexpectedly absent from the health service.

Supporting the psychological health and wellbeing of clinical staff is of growing concern to the medical and allied health care communities. Providing health care to people detained in Australian immigration detention centres may be emotionally and professionally challenging for health professionals.[63–65] Systems of professional support for medical and clinical staff working in these services are vital to supporting their health and wellbeing and, ultimately, to retaining their services.

Criterion 4.1.2 Occupational health and safety (continued)

Indicator D requires a health service to have a documented occupational health and safety policy. Given the infrequent (but possible) risks to the safety and security of health service staff posed by some patients detained in immigration detention centres, this policy needs to explicitly outline the processes and systems put in place to ensure safety. The security components of this policy need to be negotiated with the Department of Immigration and Citizenship (DIAC) and the detention service provider. The health service should have its own occupational health and safety policy that is consistent with, but does not rely on, the detention service provider's occupational health and safety policy.

The nature of providing care to patients who are detained in an immigration detention centre means that careful consideration needs to be given to occupational health and safety issues relating to security. Staff should have a mechanism to immediately alert others to any risk to their safety. This might be achieved through a duress alarm in consultation rooms or personal duress alarms for staff – or some other mechanism appropriate to the environment. Services are referred to the information about safety for GPs and their practice teams at www.racgp.org.au/gpissues/safety. Health services are advised to consider what action will be taken in the event of a security breach.

Indicators

- **A. Our service and office equipment is appropriate for its purpose** (direct observation).
- **B. At least one staff member, in addition to the medical or clinical staff member, is present when our service is open for routine consulting** (interview).
- **C. Our staff can explain how our service supports their health and wellbeing** (interview).
- **D. Our service has a documented occupational health and safety policy** (document review).
- **E. Our staff have mechanisms to immediately alert others of a risk to their safety** (direct observation).

CRITERION 4.2.1

Confidentiality and privacy of health information

Our service has a systematic approach to managing the confidentiality and privacy of patient health information.

Explanation

The *Privacy Act* 2001 (Cwlth) states that a patient's personal health information includes a person's name, address, account details and any health information (including medical or personal opinion) about the person. Sometimes, details about a person's medical history or other contextual information can identify them, even if no name is attached to that information. This is still considered to be 'personal health information' (more information is available from www.privacy.gov.au). Medical, clinical and allied heath staff have requirements relating to confidentiality in their professional registration and codes of conduct.

The RACGP *Handbook for the management of health information in private medical practice* describes minimum safeguards and procedures that need to be followed to meet appropriate legal and ethical standards concerning the privacy and security of patient records (see resources). Health services are encouraged to become familiar with relevant federal and state and territory privacy legislation as this will also impact on the way in which health services manage patient health information (see www.privacy.gov.au).

The health service needs to have a documented policy for managing patient health information. This policy needs to outline:

- the health service's procedures for informing new patients about privacy arrangements (including how patients are informed about the use of their information for quality assurance, research and professional development)
- the range of people (eg. doctors, nurses, psychologists) who may have access to their patient health records and the scope of that access
- the procedures for patients to gain access to their health information
- the way in which the health service gains patient consent before disclosing personal health information to third parties
- the health service's process of providing health information to another health professional if requested by the patient
- how the health service maintains the security of information held at the service
- how the health service addresses complaints about privacy related matters
- the policy for the retention of patient health records.

The policy also needs to detail the type of personal health information that may need to be relayed to the Department of Immigration and Citizenship (DIAC) or detention service provider during centre meetings or when assessing special needs of patients, and how confidentiality can be maximised if a third party is present in the consultation without the consent of the health professional or patient.

These *Standards* recognise the patient's 'ownership' of their personal health information; however, it is recognised that there may be some circumstances in which the detention service provider, the Commonwealth Ombudsman or the DIAC may require information relating to a patient's physical and mental health to enable them to properly care for that person. Patients need to be informed that their health information will be treated as private and confidential and will only be released to third parties with their consent or in compelling legal circumstances (eg. concern for the patient's safety or the safety of others).

Criterion 4.2.1 Confidentiality and privacy of health information (continued)

The health service, in conjunction with the DIAC and the detention service provider, needs to determine the types of risks or events that would warrant the transmission of information with or without the consent of the patient. A balance must be struck between confidentiality and privacy and the proper care and protection of the individual patient. There must be mechanisms in place to ensure that information flows freely between those who are involved in the day to day care of detained people and medical staff when necessary but within the bounds of the law. Any such transfer of information to a third party without the consent of the patient needs to be documented in the patient health record.

Patient consent is often provided at an early stage in the process of clinical care. As a result, health services need to ensure that patients develop a shared expectation about the use of the data in a number of different circumstances. This includes the degree of access that individual health service staff may have and the likelihood of the use of individual patient information during quality improvement activities within the service.

Research is an important component of primary health care activity in Australia. Health services are encouraged to participate in research both within their own services and through reputable external bodies. The RACGP *Handbook for the management of health information in private medical practice* provides advice about privacy related issues for health services seeking to be involved in research activities. Many hospitals, universities and professional organisations involved in research will have a human research ethics committee (HREC) to review research proposals. Further information about HRECs and research can be found in the National Health and Medical Research Council (NHMRC) *National statement on ethical conduct in research involving humans* (see resources). Research activities that require HREC approval are distinct from audits undertaken by a health service as part of a quality improvement activity. Health services involved in research need to consider how 'identifiable' their patient information will be. There is a difference between identifiable patient information (by which a patient can be individually identified), deidentified patient information (which cannot be traced back to the individual patient) and potentially identifiable information (which can possibly be traced back to that patient).

Privacy, confidentiality and security of patient health information are equally important for health services that have paper based, hybrid paper and electronic, and solely electronic based systems of information management. Each system will pose different challenges to privacy and information security, with hybrid systems having a distinct vulnerability to errors in information management as both electronic and paper materials always need to be congruent.

Indicators

- **A. Our staff can describe how they ensure confidentiality and security of patient health records** (interview).
- **B. Our staff can demonstrate that patient health records can be accessed by authorised staff at the time of consultation** (interview, direct observation).
- **C. Our staff can describe the processes we use to provide patients with access to their health information** (interview).
- **D. If our service participates in research, we can show evidence that this research has been approved by a HREC, constituted according to NHMRC guidelines** (document review).
- **E. Our service has a written policy for the management of patient health information** (document review).

CRITERION 4.2.2

Information security

The security of patient health information in our service is maintained.

Explanation

The RACGP *Handbook for the management of health information in private medical practice* (see resources) and the General Practice Computing Group's (GPCG) *Computer security self assessment guide and checklist for general practitioners* (see resources) provide information and explanations about the safeguards and procedures that need to be followed by general practices in order to meet appropriate legal and ethical standards concerning privacy and security of patient health information. These documents also contain suggestions for additional security procedures. The *Privacy Act* 2001 (Cwlth) states that a patient's personal health information includes a person's name, address, account details and any health information (including medical or personal opinions) about the person. Sometimes, details about a person's medical history or other contextual information can identify them, even if no name is attached to that information. This is still considered to be 'personal health information' (more information is available at www.privacy.gov.au).

It is likely that different health service staff members will have different levels of access to patient health information (administrative staff may not have access to patient health information, for example). The policy and procedures manual needs to document which staff are authorised to access patient health information.

The health service must also ensure that both active and inactive patient health information and records are kept and stored securely. An inactive patient health record is generally considered to be a record of a patient who is no longer detained in the immigration detention centre. It is recommended that inactive patient health records be retained by the health service indefinitely or as stipulated by the immigration legislation and contractual requirements with the Department of Immigration and Citizenship (DIAC).

Staff need to ensure the confidentiality and security of patient health information and other sensitive health service materials and equipment. The presence of an additional person in the health service (besides the medical or clinical staff member on duty) will increase security and safety for patients and staff, and reduces the risk of unauthorised access to patient health information (criterion 4.1.2).

When a health service uses computers to store patient health information, the health service needs to maintain regular back ups and have an information disaster recovery plan: a documented plan in the case of an emergency (eg. power failure) in order to protect and save the information stored on the health service's computers. The GPCG *Computer security self assessment guide and checklist for general practitioners* contains further information for health services about information disaster recovery plans.

Standard 4.2

Our service has an effective system for managing patient information.

Criterion 4.2.2 Information security (continued)

Indicators

- **A. Patient health information in our service is neither stored nor left visible in areas where non-health services staff have unrestricted access, or where constant staff supervision is not easily provided** (interview, direct observation).
- **B. Our facsimile machines, printers and other communication devices are only accessible to authorised staff** (direct observation).
- **C. Our staff can describe how they ensure security of patient health records** (interview).
- **D. If our service uses computers to store patient health information, our service ensures that:**
  - **our staff have personal passwords to authorise appropriate levels of access to health information**
  - **screensavers or other automated privacy protection devices are enabled**
  - **back ups of electronic information are performed at a frequency consistent with a documented information disaster recovery plan**
  - **back ups of electronic information are stored in a secure offsite environment**
  - **antivirus software is installed and updated**
  - **all internet connected computers have firewalls installed** (document review).
- **E. If our service uses computers to store personal health information, our service has developed, tested and documented an information disaster recovery plan** (document review).

CRITERION 4.2.3

Transfer of patient health information

On request by the patient, our service transfers a summary or a copy of the patient health record to the patient, another medical practitioner, health service provider or health service.

Explanation

Health services need to facilitate the transfer of patient information to another health care provider or service at the patient's request to assist that patient to access care.

When transmitting patient health information to a third party, health services need to have ways of ensuring that the patient has consented to the transfer. Consent may be given for the release of some information beyond an individual consultation.

Health services also need to have systems in place to ensure that patients share with the health service an understanding of the extent and boundaries of the use of personal information for administrative purposes.

The personal health information of patients is not the only information that people may wish to remain private. Staff working patterns may also be identified through data. Issues surrounding consent to disclosure of data that might identify staff members need to be considered prior to any transfer outside the health service.

Some continuing professional development (CPD) activities may involve the transfer of patient health information outside a health service (eg. National Prescribing Service activities) and these activities need to comply with relevant guidelines on CPD issued by an appropriate medical specialist college; they also need to be approved by that college. If the health service is transferring identifiable patient health information (any information that can identify the patient), then the health service needs to gain the consent of the patient to do so. If the health service is transferring deidentified patient information (information by which individual patients cannot be identified), then the health service needs to retain a copy of the CPD approval for that activity.

Patient health information that is transmitted electronically over a public network (eg. the internet) can pose significant privacy risks. It is technically possible for a third party to intercept and read emails, or for emails to be inadvertently sent to the wrong person. Encryption allows for the 'scrambling' of the message so that it can only be read by the intended person who verifies their identity using a unique identifying code. The General Practice Computing Group's (GPCG) *Computer security self assessment guide and checklist for general practitioners* provides further information about security procedures (including encryption such as public key infrastructure [PKI]) for practices (see resources). Some general practices and other health services have begun to use encryption to transfer patient health information. Health services should not transfer patient information via email unless it is encrypted.

For patients detained in immigration detention centres, it is important that the health service arranges the transfer of care to another health care practitioner when the patient is released from the immigration detention centre or transferred into another detention placement, eg. residential housing accommodation. This may be at the request of the patient, however, health services should be proactive in ensuring that the patient's health information is provided to the health professional who will carry on their care outside of the immigration detention centre. A comprehensive health

Criterion 4.2.3 Transfer of patient health information (continued)

summary needs to be provided (with patient consent) to the health professional who will coordinate the care for the patient outside the detention centre or to the patient (if no health professional has been identified). It is useful for this transfer of care to be managed by the person in the health service identified as leading the care for that individual patient (criterion 1.5.2).

Indicators

- **A. Our staff can describe the procedures for transferring patient health information to another service provider or health service** (interview).
- **B. We record the request by the patient to transfer patient health information on the file. This note includes details of where the information was sent and who authorised the transfer** (health records review).
- **C. When we collect identifiable patient health information for CPD activities, we only transfer it to a third party if the patient provides their consent** (document review).
- **D. When we collect deidentifiable patient health information for CPD activities, we only transfer it to a third party if we have approval to do so from a recognised medical college's CPD process** (document review).
- **E. Our electronic data transmission of patient health information over a public network is encrypted** (document review).

CRITERION 4.2.4

Retention of patient health information

Our service has a system for the retention of patient health information.

Explanation

The commonwealth *Privacy Act* 1988 requires personal health information to be destroyed or permanently de-identified once it is no longer needed for any authorised use or for disclosure under the legislation.

Health services need to be aware that there may be specific legislation in their state or territory requiring a minimum period of retention of health records. Such legislation normally recommends that individual patient health records be retained for a minimum of 7 years from the date of last contact, or until the patient has reached the age of 25 years, whichever is the longer.

In the case of patient health information collected for the purpose of providing medical advice or treatment, it may be appropriate to retain this information indefinitely so that it is available, if necessary, to assist with the patient's future diagnosis and treatment.

Additionally, staff need to be aware of the positions taken by medical defence organisations (and any other professional indemnity insurers) with respect to the retention, storage and destruction of patient health information.

The health service must also ensure that inactive patient health information/records are kept and stored securely. An inactive patient health record is a record of a patient who is no longer detained in an immigration detention centre.

The arrangements under which health care (including mental health care) is provided to people detained in immigration detention centres means that information about their treatment needs to be available to the DIAC within the requirements of the privacy principles.

The health service needs to be able to comply with the conditions of the contract with the DIAC for the provision of health services to people in detention. These conditions include compliance with obligations contained in the commonwealth *Privacy Act* 1988. Under the *Act*, the health service may not provide access to the health records to any third party other than the person the record relates to or to a person authorised by that person in writing to have access to the record. Following the expiration of the record retention period outlined in the contract with the DIAC, or the requirements in the relevant state or territory legislation concerning the minimum period for the retention of health records, whichever is the longer, the health service needs to be able to return all copies of the records to the commonwealth or otherwise destroy any copies as directed by the commonwealth.

Indicators

- A. **Our practice keeps individual patient health information until the patient has reached the age of 25 years or for a minimum of 7 years from the time of our last contact with the patient, whichever is the greater** (interview).
- B. **Our service has a process for identifying, storing and retrieving inactive patient health information** (interview, direct observation).
- C. **Our service has an appropriate method of destruction prior to disposal (eg. shredding) of any material containing patient health information** (interview, direct observation).

section five
PHYSICAL FACTORS

Standard 5.1 FACILITIES AND ACCESS

Our service provides a safe and effective working environment for our team and patients.

Standard 5.2 EQUIPMENT FOR COMPREHENSIVE CARE

Our service provides medical equipment and resources that are well maintained and appropriate for comprehensive patient care and resuscitation.

Standard 5.3 CLINICAL SUPPORT PROCESSES

Our service has processes in place that support safety and the quality of clinical care.

CRITERION 5.1.1

Health service facilities

Our service facilities are appropriate for a safe and effective working environment for patients and staff.

Explanation

Health service facilities need to be safe for staff and patients. Health and safety refers not just to requirements within consultation areas but also to other aspects of the health service.

While this criterion discusses consultation 'rooms', it is acknowledged that some health services may have 'areas' rather than rooms in which to treat patients. These consultation areas need to be appropriate for the health and safety of staff and patients. Consultation 'areas' refer to those areas used for medical, clinical or allied health care of patients.

To encourage a therapeutic environment, consultation rooms need to be clearly marked as space associated with the health service (eg. through the use of signage on the door). Consultation rooms should be for the exclusive use of the health service and should not be shared with non-health service parties (such as the Department of Immigration and Citizenship [DIAC] or the detention service provider).

Consultation room temperature needs to be such that a patient undressed for a clinical examination remains comfortable.

Visual privacy and dignity can be afforded to patients during clinical examinations by the use of a gown or sheet and an adequate curtain or screen positioned in such a way as to maximise the patient's privacy, particularly when a patient is required to undress for a clinical examination or procedure. This includes situations in which there is a door opening to an area to which staff of DIAC or the detention service provider have access, and also when patients are required to dress or undress in the presence of the medical or clinical staff member.

Toilets should be located within the health service. Toilets not within the health service itself need to be adjacent or within very close proximity. These need to be easily accessible and well signposted. Separate staff and patient toilets are desirable. Washbasins need to be situated in close proximity to the toilets to minimise the possible spread of contamination, and need to be easily accessible to staff and patients.

For occupational health and safety reasons, there should be no smoking on the health service premises and in the environs.

All environments should satisfy the relative state and federal occupational health and safety laws.

The health service needs to have an area that caters for the specific needs of patients who are at risk of self harm. This 'safe room' should be situated within or in close proximity to the health service to facilitate continual monitoring of the health (including mental health) of the patient inside and allow for immediate intervention if needed. The room should be designed with consideration of minimising potential for self harm (eg. no points from which patients could attempt to hang themselves).

Criterion 5.1.1 Health service facilities (continued)

Indicators

- **A. Our service has at least one dedicated consulting/examination room for the exclusive use of every medical and clinical staff member working in our service at any time** (interview, direct observation).
- **B. Each area or room used by our health service is clearly identified for the exclusive use by the health service** (direct observation).
- **C. Each of our consultation rooms (which may include an attached examination room/area):**
  - **is free from excessive extraneous noise**
  - **has adequate lighting**
  - **is maintained at a comfortable ambient temperature**
  - **has an examination couch (for medical or clinical consultations only)**
  - **has facilities to protect patient privacy when patients need to undress for a clinical examination (provision of an adequate curtain or screen, and gown or sheet)** (direct observation).
- **D. Our service has a waiting area sufficient to accommodate the usual number of patients and other people who would be waiting at any time** (direct observation).
- **E. Our service has an area that caters for the specific needs of patients who are at risk of self harm** (direct observation).
- **F. Our service has toilets and hand cleaning facilities readily available for use by patients and staff** (direct observation).
- **G. Where appropriate, our service has heating and/or air conditioning** (direct observation).
- **H. Our service has a telephone system with sufficient inward and outward call capacity** (staff interview, direct observation).
- **I. Our service has the capability for electronic communication by facsimile or email** (direct observation).
- **J. Prescription pads, letterhead, administrative records and other official documents stored in our service are accessible only to authorised persons** (direct observation).
- **K. Our service can demonstrate that we ensure there is no smoking in our service** (interview, document review, direct observation).

CRITERION 5.1.2

Physical conditions conducive to confidentiality and privacy

The physical conditions in our service encourage patient privacy and confidentiality.

Explanation

It is important that patients have confidence that their health information is being treated respectfully and with consideration to their privacy and confidentiality. Privacy and confidentiality of patient information needs to be considered at all times. The physical arrangements of the health service need to be considered in providing privacy and confidentiality to patients.

The layout of reception and waiting areas can also assist in encouraging patient privacy and confidentiality, especially when patients are discussing personal issues with staff.

Consultations need to be private and there should be no possibility of consultations being overheard. Auditory privacy within the health service can be enhanced by the use of background music to mask conversations between staff members and between staff and patients. The privacy of patients may also be ensured by the use of a curtain or screen, and gown or sheet when the patient needs to undress for a clinical examination or procedure (criterion 5.1.1).

Health services have a responsibility to protect the privacy and confidentiality of patients, and this may be achieved through the physical set up of the service and through processes that protect patients' health information (criteria 4.2.1 and 4.2.2).

Indicators

A. **The physical facilities of our service encourage patient confidentiality and privacy** (direct observation).

B. **Visual and auditory privacy of consultations is ensured** (direct observation).

CRITERION 5.1.3

Physical access

Our service provides appropriate physical access to our premises and services including access for people with disabilities.

Explanation

Good physical 'access' to the health service facilities and services is of high importance to patients. Health services need to make all reasonable efforts to facilitate physical access to their premises and services.

It is recommended that health services refer to the Australian standards regarding access to buildings for people with disabilities to help inform appropriate design for health services being built or undergoing renovations. These standards can be accessed through Standards Australia (www.standards.com.au).

Health services need to consider the needs of patients with a disability when considering what is 'reasonable'. The health service may take a range of steps to assist patients with a disability, such as having signage that is pictorial rather than textual (for patients with an intellectual disability), accessible pathways from the door to reception and to consultation rooms that are wide enough for patients in wheelchairs, and a unisex wheelchair accessible toilet for patients with disabilities. Staff need to consider the ways in which they can help facilitate access to the health service and its services for patients.

The Human Rights and Equal Opportunity Commission (HREOC) has expressed concern that health services may not be complying with the *Disability Discrimination Act* if they cannot provide effective access to people with disability with respect to height adjustable beds.

In response to the HREOC, the RACGP Council has endorsed a new (unflagged) indicator.

The *Standards* recommend visiting www.hreoc.gov.au for more information relating to the *Disability Discrimination Act* 1992 (Cwlth) and legislation regarding the right to access primary health care.

Indicators

A. **There is wheelchair access to our service and its facilities** (direct observation)

   OR

   if physical access is limited, our service provides visits to patient living quarters (interview).

B. **Our staff can describe how they facilitate access to our service for patients with disabilities** (interview).

C. **Our practice has a height adjustable bed.**

CRITERION 5.2.1

Health service equipment

Our service has access to medical equipment necessary to ensure comprehensive primary care and resuscitation.

Explanation

Health services in immigration detention centres need to have access to the necessary equipment to provide comprehensive primary care and resuscitation. To meet this criterion, such equipment must be present and in working order. It should be noted that there is a wide range of equipment that health services may require. Additional equipment to which a health service has access will depend on the nature of the health service, the interests and requirements of the medical, clinical and allied health staff, the procedures the health service undertakes and the nature of the patient population.

If a health service has access to spirometry within the health service, it is not essential to also have access to a peak flow meter (as outlined in Indicator A). Health services need to have timely access to spirometers and electrocardiographs. Some health services will have these diagnostic devices on their premises; other health services will have ready access to this equipment (eg. at a nearby facility) but may not own it themselves. Health services that do not have an electrocardiograph or spirometer on their premises need to be able to describe the arrangements for how they access this equipment when necessary on the day of the consultation. Similarly, if the health service does not provide dental care on its premises, access to a dental mirrors or the coordination of dental care by an external provider needs to be demonstrated.

Equipment that requires calibration or that is electrically or battery powered (eg. electrocardiographs, spirometers, autoclaves, vaccine fridges, scales, defibrillators) needs to be serviced on a regular basis to ensure that they are maintained in good working order.

There is evidence – both internationally and in Australia – to suggest that immediate defibrillation significantly improves the chance of survival after cardiac arrest. Although cardiac arrest in primary care situations is a very rare event, the difference in outcomes between early defibrillation and defibrillation performed a few minutes after the arrest is very significant (10% increase in mortality for each minute from the time of the arrest).[37] Patients detained in immigration detention centres have restricted access to mainstream emergency care compared to people within the community, and health services in immigration detention centres need to have access to equipment for emergency care and resuscitation (including an automated external defibrillator). As the health service is unlikely to be staffed 24 hours a day, it is recommended that the defibrillator is placed in an area where detention service provider staff and/or the Department of Immigration and Citizenship (DIAC) staff can access it in the case of an emergency (eg. outside the main door to the health service).

Standard 5.2

Our service provides medical equipment and resources that are well maintained and appropriate for comprehensive patient care and resuscitation.

Criterion 5.2.1 Health service equipment (continued)

Indicators

A. Equipment for comprehensive primary care and resuscitation is available within our service, including:

- **auriscope**
- **blood glucose monitoring equipment**
- **disposable syringes and needles**
- **equipment for resuscitation, equipment for maintaining an airway, equipment to assist ventilation (including bag and mask), IV access and emergency medicines**
- **examination light**
- **eye examination equipment (eg. fluorescein staining)**
- **gloves (sterile and non-sterile)**
- **height measurement device**
- **measuring tape**
- **monofilament for sensation testing**
- **ophthalmoscope**
- **oxygen (and the means to administer it)**
- **patella hammer**
- **peak flow meter or spirometer**
- **scales**
- **spacer for inhaler**
- **specimen collection equipment**
- **sphygmomanometer**
- **stethoscope**
- **thermometer**
- **torch**
- **tourniquet**
- **urine testing strips**
- **vaginal speculae**
- **visual acuity charts**
- **X-ray viewing facilities** (direct observation).

B. Our service has timely access to the following equipment:

- **spirometer**
- **electrocardiograph**
- **dental mirror** (direct observation, interview).

C. Our medical and clinical staff can list procedures commonly performed within our service and can demonstrate that available equipment is sufficient for these procedures (interview).

D. Our service has a schedule for the maintenance of our key clinical equipment (document review).

E. Our service has an automated external defibrillator (direct observation).

CRITERION 5.2.2

Doctor's bag

Our service ensures that our medical and clinical staff have access to a doctor's bag.

Explanation

Equipment need only be in the doctor's bag (or resuscitation bag) when it is being used. The health service is not required to maintain two sets of equipment, but rather the necessary items can be placed in the bag in an emergency or when the doctor is attending a consultation in a patient's living quarters. More than one doctor or nurse in the health service may share the use of a doctor's bag. It is acceptable for items of equipment to be kept in more than one bag so that they collectively include all the items listed in indicator B. Large health services need to consider whether more than one doctor's bag is needed to ensure that doctors or nurses have access to a doctor's bag when required.

It would be useful for health services to consider which medicines they use in their doctor's bags. Consideration needs to be given to the service location, the type of clinical conditions likely to be encountered, the shelf life (or date of expiry) and climatic vulnerability of the various medicines, and the cost and size of the doctor's bag.[38]

This criterion requires that the health service take sensible measures to keep the bag and its contents secure and that health services are aware of the security measures for the bag and its contents as outlined in state and territory regulations.

Indicators

A. **Our service has an accessible doctor's bag** (interview, direct observation).

B. **When in use, our doctor's bag(s) contains:**
- **auriscope**
- **disposable gloves**
- **equipment for maintaining an airway in adults**
- **in-date medicines for medical emergencies**
- **ophthalmoscope**
- **health service stationery (including prescription pads and letterhead)**
- **sharps container**
- **sphygmomanometer**
- **stethoscope**
- **syringes and needles in a range of sizes**
- **thermometer**
- **torch** (direct observation).

CRITERION 5.3.1

Medicines

Our service ensures that all medicines (including S4 and S8 medicines) are stored securely and are only accessed by authorised personnel.

Explanation

All sensible security measures need to be taken to prevent unauthorised access to medicines.

Health services are encouraged to be familiar with their state or territory legislation regarding the storage of Schedule 8 medicines. State and territory legislation generally requires that Schedule 8 medicines are stored in a locked cabinet or safe that is itself fixed to an immovable structure.

Furthermore, the use of Schedule 8 medicines must be correctly recorded in accordance with state and territory legislation and appropriate documentation is required in relation to the date of administration, patient details, quantity of incoming medicines, quantity of outgoing medicines, quantity of medicines still held, comments about prevailing conditions (eg. breakages) and signatures of the persons entering the data and administrating the medicine.

Some states and territories also have specific legislation relating to the storage, use and disposal of Schedule 4 medicines, and health services are encouraged to become familiar with these requirements.

Indicators

- **A. Schedule 4 and Schedule 8 medicines in our service are securely stored** (direct observation).
- **B. The acquisition, storage, use, transfer and disposal of Schedule 4 and Schedule 8 medicines in our service are appropriately documented** (document review).

CRITERION 5.3.2

Vaccine potency

Our service has appropriate processes that maintain the potency of vaccines.

Explanation

The success of any vaccination program depends on the potency of vaccines when they are administered. The essential reference for this criterion is the current published edition of the National Health and Medical Research Council (NHMRC) guidelines *The Australian immunisation handbook* (see resources) which outline exactly what a health service needs to do in relation to cold chain management. It is important that health services follow the current published edition of these guidelines in relation to cold chain management and monitoring during storage, use, transfer and disposal of vaccines.

The most common problems in maintaining the potency of vaccines are:

- daily monitoring of the maximum and minimum temperature of refrigerators in which vaccines are stored when the health service is open
- knowing what to do if the refrigerator temperature falls below or exceeds the acceptable range.

Vaccines may be safely stored in domestic refrigerators if appropriate safeguards are in place. Safeguards may include a combination of the following:

- a temperature probe placed in the vicinity of stored vaccines
- staff taking the correct action when out of range temperatures are recorded
- the use of trays in which to place stored vaccines.

Standards relating to cold chain management change from time to time and there are a number of bodies that make recommendations. The NHMRC recommendations, however, are seen as the authoritative advice on this health service process.

Indicators

A. **Our service can demonstrate how our cold chain management processes meet the current published edition of the NHMRC guidelines** (direct observation).

B. **Our staff can describe how the process used for cold chain management meets the current published edition of the NHMRC guidelines** (interview).

C. **Our service has a documented policy for cold chain management procedures in accordance with the current published edition of the NHMRC guidelines** (document review).

CRITERION 5.3.3

Perishable materials

Perishable materials held in our service (medicines, vaccines and other health care products) are not kept or used beyond their expiry dates.

Explanation

To promote the safe use of medicines, vaccines and other health care products, health services need to ensure that they do not keep perishable materials beyond their expiry dates. This is also relevant for perishable sample medicines or other health products that need to be stored, used and provided to patients before their expiry dates.

It is also important to ensure that medicines, vaccines and other health care products are stored (and secured) appropriately.

Indicators

- A. **Our service does not use or keep medicines, vaccines or medical consumables beyond their expiry date in our service or doctor's bag(s)** (direct observation).
- B. **Relevant health service staff can describe the procedure for checking expiry dates of perishable materials and for disposing of such materials where necessary** (interview).
- C. **Our service has a written procedure for checking expiry dates of perishable materials and for disposing of such materials where necessary** (document review).

CRITERION 5.3.4

Infection control

Our service manages the risk of cross infection in accordance with the current edition of the RACGP *Infection control standards for office based practices*.

Explanation

Infection control is concerned with the sterility of clinical equipment, the occupational health and safety of staff, and managing the risk of cross infection in the health service environment.

The health service needs to have a written policy on infection control processes within their service. This written policy needs to include:

- sharps injury management policy
- blood and body fluid spills management
- hand hygiene
- a regular cleaning schedule describing the frequency of cleaning, products and procedures in clinical and nonclinical areas of the health service
- the provision of sterile instruments whether by the use of disposables, or by onsite or offsite sterilisation of reuseable instruments
- procedures for all aspects of the sterilisation process if instruments are sterilised onsite or procedures covering the sterilisation and transport of instruments sterilised offsite. There should be procedures for validating or obtaining evidence of validation for all onsite and offsite aspects of sterilisation
- procedures for waste management including the safe storage and disposal of clinical waste (including sharps)
- the appropriate use of standard and additional precautions
- prevention of disease in the workplace by serology and immunisation.

The RACGP *Infection control standards for office based practices* (4th edition) (see resources) describe sterilisation as the preferred process for the reprocessing of all reusable instruments and equipment (noncritical, semicritical and critical) that can withstand this process regardless of their intended use. Disinfection can be achieved by thermal (hot water) systems and chemical disinfectants. Disinfecting is not a sterilising process; however, sterilisation is one form of disinfection.

Health services that sterilise onsite need to demonstrate that sterilising equipment is used and maintained correctly.

Where the health service uses offsite sterilisation facilities, the health service needs to be able to document the procedures for safe transport of instruments to and from the health service, and demonstrate that the offsite facility correctly performs the sterilisation and validates its processes. This may be demonstrated by providing evidence that the facility is accredited to the Australian Council on Healthcare Standards.

Health services that employ single use disposable instruments need to be able to demonstrate that the packaging of the instruments is not compromised and the instruments have remained sterile or disinfected appropriately until their use.

Criterion 5.3.4 Infection control (continued)

In relation to waste management within the health service, the 1999 NHMRC *National guidelines for waste management in the health care industry* define three categories of waste produced by health care industries and outline the appropriate disposal mechanism for each:

- clinical waste
  - includes discarded sharps, laboratory and associated waste directly involved in specimen processing, human tissues (but excluding hair, teeth, urine and faeces), materials or solutions containing free flowing or expressible blood and animal tissues or carcasses used in research
  - most clinical waste can be disposed of in a safely located yellow, leak proof container displaying a biohazard symbol
  - sharps can be disposed of in a safely located yellow, leak proof and puncture resistant container displaying a biohazard symbol (eg. mounted on a wall or on a bench) in all areas where sharps are generated
- related waste
  - includes cytotoxic waste, pharmaceutical waste, chemical waste and radioactive waste
- general waste
  - includes all waste materials produced that do not fall into the clinical or related waste categories. Gauze that has blood on it (but which cannot be expressed), used disposable vaginal spatulae, cervical spatulae and brushes, and tongue depressors are likely to be the most common items in this category
  - general waste contaminated with blood or body substances (though not to such an extent that it would be considered clinical waste, ie. not contaminated with 'expressible blood') may be disposed of in a small bin lined with plastic mounted on the wall or on a bench and then through the general waste processes of the health service
  - general waste not contaminated by blood or body fluids can be disposed of in the usual waste paper bin under the desk.[39]

Health services need to be aware of any local or state and territory regulations that may require alternative disposal of waste from health services.

Potential infection risks to staff need to be reduced. In this context, it is important for health services to ensure that all staff are familiar with infection control procedures within the health service (including standard and additional precautions, spills management, environmental cleaning), for the health service to be aware of the immunisation status of the staff, and for the health service to ensure that staff are offered appropriate immunisation for their roles.

Standard precautions apply to work practices that assume that all blood and body substances are potentially infectious. The NHMRC recommends the use of personal protective equipment including heavy duty protective gloves, gowns, plastic aprons, masks, eye protection or other protective barriers when cleaning, performing procedures, dealing with spills or handling waste (Indicator D).

Additional precautions apply to dealing with patients known or suspected to be infected with highly transmissible pathogens. In health services in immigration detention centres, this may be achieved by minimising the period of exposure to other patients and staff through the use of masks or by isolating the patient in a separate room or seeing that patient ahead of other patients (Indicator D).

It is important that health services remain alert to changes to guidelines for infection control, and be in a position to implement new guidelines accordingly. Health services should also have systems for monitoring and obtaining information about national and local infection outbreaks, and emerging risks of cross infection such as the advent of avian flu and SARS. This is particularly important for health services in immigration detention centres, as patients may be recent arrivals

in Australia from other countries. The health service may need to be alert to outbreaks in patients' countries of origin (eg. those who are detained for short periods for not having valid visas, and are subsequently deported).

Health care services in immigration detention centres need to be aware of the risk of infectious diseases from people recently arrived in Australia (eg. tuberculosis) and containment processes for the immigration detention centre as a whole. Staff need to be familiar with their responsibilities in relation to monitoring and reporting disease outbreaks to the relevant state or territory authorities and the detention service provider, and in responding with the implementation of appropriate precautions. Appropriate infection control measures need to be instituted to prevent the risk of diseases spreading to the population in the immigration detention centre. Furthermore, there needs to be a system in place that allows for the monitoring for threats of outbreaks (eg. varicella, measles, lyssavirus, hendravirus) and emerging disease (eg. SARS, avian influenza, community associated methicillin resistant *Staphylococcus aureus* [CAMRSA]).

For more information on infection control (including standard precautions, hand cleaning, staff immunisation, sharps injury, sharps and waste management), refer to the current edition of the RACGP *Infection control standards for office based practices* and the Commonwealth Department of Health and Ageing publication *Infection control guidelines for the prevention of transmission of infectious diseases in the health care setting* (see resources).

Indicators

- **A. Our staff can describe how our service ensures that, where necessary, sterile equipment is used in clinical procedures** (interview).
- **B. Our staff members with designated responsibility can describe in detail how the use of sterile equipment is assured, including where relevant:**
  - **provision of an adequate range of disposable equipment**
  - **procedures for having instruments sterilised offsite**
  - **procedures for onsite sterilisation of equipment**
  - **monitoring the integrity and validation of the whole sterilisation process and steriliser maintenance**
  - **procedures for safe storage and stock rotation, and**
  - **education and training of staff involved** (interview, direct observation).
- **C. Our staff can describe how risks of potential cross infection are managed within our service, including procedures for:**
  - **hand hygiene**
  - **managing a sharps injury**
  - **safe storage and disposal of clinical waste including sharps**
  - **managing blood and body fluid spills**
  - **monitoring ongoing adherence to these processes** (interview, direct observation).
- **D. Our staff can describe:**
  - **the routine used by our service for cleaning, disinfecting and decontaminating the clinical and nonclinical areas of our service**
  - **standard precautions**
  - **additional precautions** (interview).

Criterion 5.3.4 Infection control (continued)

- **E. Our service has a written policy that outlines our service's infection control procedures** (document review).
- **F. Subject to their informed consent, the immunisation status of our staff is known and staff members are offered immunisation appropriate to their duties** (document review, interview).
- **G. Our induction program ensures that staff who are new to our service are familiar with standard precautions against infection and other issues appropriate to their duties** (document review, interview).

The Royal Australian College of General Practitioners

section six

REFERENCES

RESOURCES

HISTORY OF STANDARDS DEVELOPMENT

GLOSSARY

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The RACGP *Standards for health services in immigration detention facilities* are based on published evidence about quality and safety.

Reference lists of published materials supporting these *Standards* are available on the RACGP website at www.racgp.org.au/standards.

RESOURCES

Publications and online resources

'10 tips for safer health care'
Australian Council for Safety and Quality in Healthcare
www.safetyandquality.org/internet/safety/publishing.nsf/Content/10-tips

ACCC info kit for the medical profession
Australian Competition and Consumer Commission
www.accc.gov.au/content/index.phtml/itemId/575092

The Australian immunisation handbook
National Health and Medical Research Council
www9.health.gov.au/immhandbook

Computer security self assessment guideline and checklist for general practitioners
General Practice Computing Group
www.gpcg.org.au/images/stories/pdfs/publications/docs/2004Phase1Proj/SecurityGuidelines.pdf

Consumer medicines information
Consumer Medicines Information
www.racgp.org.au/medicineinformation

Guide for general practitioners to the authorisation granted by the ACCC to The Royal Australian College of General Practitioners
Australian Competition and Consumer Commission
www.accc.gov.au/content/index.phtml/itemId/307373

Guidelines for preventive activities in general practice (6th edn)
The Royal Australian College of General Practitioners
www.racgp.org.au/guidelines/redbook

Handbook for the management of health information in private medical practice
The Royal Australian College of General Practitioners
www.racgp.org.au/privacy/handbook

Infection control guidelines for the prevention of transmission of infectious diseases in the health care setting
Australian Government Department of Health and Ageing
www.health.gov.au/internet/wcms/publishing.nsf/Content/Infection+Control+Guidelines-1

Infection control standards for office based practices
The Royal Australian College of General Practitioners
www.racgp.org.au/infectioncontrol

Medical care of older persons in residential aged care facilities (3rd edn)
The Royal Australian College of General Practitioners
www.racgp.org.au/guidelines/silverbook

National statement on ethical conduct in research involving humans
National Health and Medical Research Council
www.nhmrc.gov.au/publications/humans/contents.htm

'Points for using telephone interpreting'
Australian Government Department of Immigration and Citizenship
www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/english-speakers/doctors-priority-hints.htm

Putting prevention into practice (2nd edn)
The Royal Australian College of General Practitioners
www.racgp.org.au/guidelines/greenbook

The RACGP employment kit: tips on negotiating an employment contract in general practice
The Royal Australian College of General Practitioners
www.racgp.org.au/publications/tools#7

'Safety every time – our general practice checklist'
The Royal Australian College of General Practitioners
www.racgp.org.au/safety

'Safety for general practitioners and their practice teams'
The Royal Australian College of General Practitioners
www.racgp.org.au/gpissues/safety

Smoking, nutrition, alcohol and physical activity (SNAP): a population health guide to behavioural risk factors in general practice
The Royal Australian College of General Practitioners
www.racgp.org.au/guidelines/snap

Standards for general practices (3rd edn)
The Royal Australian College of General Practitioners
www.racgp.org.au/standards

Codes

'Code of conduct for corporations'
The Royal Australian College of General Practitioners
www.racgp.org.au/guidelines/codeofconduct

Code of ethics 2004
Australian Medical Association.
www.ama.com.au/web.nsf/tag/amacodeofethics

Position statements

Complementary medicine
Australian Medical Association
www.ama.com.au/web.nsf/doc/SHED-5FK4V5/$file/healths_gd_ps_compl%20medicine.doc

Health care of asylum seekers and refugees
Australian Medical Association
www.ama.com.au/web.nsf/doc/WEEN-6M95RZ

Joint position statement on complementary medicine
RACGP/Australian Integrative Medicine Association
www.racgp.org.au/Content/NavigationMenu/Advocacy/RACGPpositionstatements/2006compmedstatement.pdf

Position statement on personal safety and privacy for doctors
Australian Medical Association
www.ama.com.au/web.nsf/doc/WEEN-6JVUP9/$File/AMA_Position_Statement_Personal_Safety_and_Privacy_for_Doctors.pdf

Statement on complementary and alternative medicine
Medical Council of New Zealand
www.mcnz.org.nz/portals/0/guidance/comp_alternative.pdf

Services

National Auslan Interpreter Booking & Payment System
www.nabs.org.au

Translating and Interpreting Service (TIS) for non-English speakers
Department of Immigration and Citizenship
www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/non-english-speakers/index.htm

Other resources

Doctors health database
Australian Medical Association
www.ama.com.au/web.nsf/tag/doctors-health-database

HISTORY OF STANDARDS DEVELOPMENT

The RACGP has enjoyed a long history of developing standards for general practices on behalf of the profession. The college's standards reflect a commitment to develop standards that reflect the general practice profession's views on the high quality of care their practices provide. These *Standards for health services in immigration detention centres* are based on the RACGP *Standards for general practices* (3rd edition).

The RACGP *Standards for general practices* and the associated accreditation process were developed in the 1990s with the long term aim of engaging general practices in an ongoing process of quality improvement. In 1992, the RACGP established the Standards Reference Group with a grant from the Australian Government. The RACGP *Entry standards for general practices* were then developed to provide entry level standards for general practices to meet through a formal accreditation process.

The *Entry standards* and assessment processes were field tested by the RACGP in 1994 with financial assistance from the Australian Government. One hundred and ninety-nine randomly selected practices from urban, rural and remote areas of Australia participated. The field test of the *Entry standards* sought to test the acceptance and achievability of the standards through an accreditation process. The field test demonstrated high levels of validity, reliability, acceptance and achievability. The field test also sought to test the feasibility, reliability and validity of employing an assessment process through an accreditation system.[40,41] One of the major outcomes of the field test was the demonstration of significant levels of change undertaken or planned by the practices involved.

In 1994 and 1995 the (then) Commonwealth Department of Human Services and Health commissioned and financed divisions of general practice to undertake local demonstration trials of the *Entry standards* and the accreditation process. The trials were designed as an extension of – and were complementary to – the RACGP field test. The demonstration trials involved 500 general practices, either self selected or randomly chosen from metropolitan, rural and remote areas in all states and territories of Australia. The focus was on trialing the ways in which the *Entry standards* could be applied in a general practice accreditation setting.[42]

In 1996, the RACGP established a committee – now known as the National Expert Committee on Standards for General Practices (NECSGP) – to oversee the development and monitoring of the Standards and the accreditation process.

In 1998, the RACGP published the *Standards for medical deputising services* as an appendix to the *Entry standards*.

The *Entry standards* were revised in 1999 following further research and feedback from consultation with the profession. A second edition of the *Standards for general practices* was released in August 2000.

In 2003, the RACGP embarked on a review of the *Standards for general practices* (2nd edition). The review included an extensive consultation process with:

- individual GPs, practice staff and consultation organisations
- three expert working groups (Practice Management, Care Outside Normal Opening Hours and Information Management), which included representatives from the RACGP, Australian Association of Practice Managers, Australian Divisions of General Practice (ADGP), Australian Medical Association, Consumers' Health Forum and the Rural Doctors' Association of Australia
- analysis of questionnaires distributed at the ADGP Division of General Practice Network Forum conference in November 2003 and at the AGPAL conference in February 2004
- direct invitation for comments from 47 key stakeholder organisations including accreditation providers
- a fax survey of over 1000 rural RACGP members in March 2004
- receipt of 115 formal submissions between October 2003 and June 2004 from GPs, practice staff, and other stakeholders.

In July 2004, the draft of the revised *Standards for general practices* (3rd edition) was released for public comment and active feedback sought. As part of the consultation process the RACGP conducted a national field test of the revisions to the *Standards*. The field test was conducted in collaboration with both accreditation organisations, 200 general practices around Australia and 144 general practice accreditation surveyors. The field test generated qualitative and quantitative data and collected information about which indicators general practices were currently achieving, which indicators general practices found acceptable, and which indicators practices and surveyors found feasible to include in a new edition of the *Standards*. In addition, the field test tested the achievement, acceptance and feasibility of the revisions in the *Standards* in diverse general practices, exploring results in relation to the rurality of the practice, size of the practice, information management system used by the practice, whether the practice was undergoing accreditation or re-accreditation, and if the practice was an Aboriginal medical service.

The field test formed one component – albeit a significant component – of the process used by the RACGP to revise the draft *Standards*. Consideration was also given to a number of other aspects including:

- feedback from the consultation process between August 2004 and January 2005
- consideration of structure, process and outcome indicators
- the evidence base for the indicators
- the relevance of the indicators for Australian general practices
- the capacity for practices to alter processes to meet the indicators
- reliability of measurement of indicators
- capacity of indicators to be described unambiguously
- capacity for indicators to differentiate between high and low quality practices
- any duplication of indicators, and
- the number of indicators in the *Standards*.

In December 2006, the RACGP was advised that the *Standards for general practices* (3rd edition) were awarded accreditation by the International Society for Quality in Health Care (ISQua) This is important international recognition for the rigour of the RACGP's standards setting, and follows the RACGP's application for certification and review of its standards by an international expert panel.

In 2006, the Australian Government Department of Immigration and Citizenship (formerly the Department of Immigration and Multicultural Affairs) sought the assistance of the RACGP in developing standards for use in health services in immigration detention centres, and agreed that the RACGP should develop these standards. The RACGP considered that the *Standards for general practices* (3rd edition) could be customised in a way that would make them applicable to detention centre settings.

In the Palmer Report on the circumstances of the immigration detention of Cornelia Rau, Mr Mick Palmer made a number of recommendations relating to standards of health care. These recommendations include establishing a health advisory panel and developing national accreditation standards that all immigration detention service providers will be required to meet. Development of health care standards for use in immigration detention centres fell within the responsibility of the Detention Health Advisory Group (DeHAG).

In July 2006 DeHAG members agreed that DIAC should progress the development of health care standards based on the RACGP Standards of general practices. Members of the DeHAG have worked closely with the RACGP and the DIAC in the development of the RACGP *Standards for health services in Australian immigration detention centres*.

The development of the RACGP *Standards for health services in Australian immigration detention centres* in 2006 and 2007 included:

- consultation with DeHAG including nominees from the Australian Dental Association, Australian Medical Association, Australian Psychological Society, Commonwealth Ombudsman, Forum of Australian Services for Survivors of Torture and Trauma, Immigration Detention Advisory Group, Mental Health Council of Australia, Public Health Association of Australia, Royal Australian and New Zealand College of Psychiatrists, the RACGP, Royal College of Nursing, Australia and the Victorian Healthcare Association
- consultation visits to Villawood, Baxter, Maribyrnong, Perth and the Northern immigration detention centres
- consultation with general practice and allied health professionals with experience in detention centre health and/or refugee health
- a pilot test of draft proposals at the Maribyrnong Immigration Detention Centre
- a focus group discussion of draft proposals at the Maribyrnong Immigration Detention Centre.

These RACGP *Standards for health services in Australian immigration detention centres* were published in April 2007.

GLOSSARY

Access: The ability of patients to directly approach and obtain services from the health service

Active patient: A patient who is detained in an immigration detention centre

Active patient health record: Refers to records of patients who are detained in the immigration detention centre

Administrative staff: Staff employed by the health service who provide clerical or administrative services and who do not perform any clinical tasks with patients

Adverse event: An incident in which unintended harm was caused to a person receiving health care

Antivirus software: Software (computer program) that protects the computer or network from virus programs that can corrupt software and impede its functioning

Allied health staff: A nonmedical staff member who provides clinical care of the patient consistent with their professional training

Appointment system: The system a health service uses to assign consultations between patients and staff who provide clinical care

Asylum seeker: A person who is seeking to be recognised as a refugee

CALD: Refers to people from culturally and linguistically diverse backgrounds

Care outside normal opening hours: Clinical care that is provided to patients when the health service is normally closed. Each health service will have different opening and closing hours

CD-ROM: A compact disc for storing electronic information

Clinic based care: Care that is provided when patients attend the health service, as opposed to when they are visited in their living quarters

Clinical management area: Areas in the health service where clinical care is delivered

Clinical risk management system: A system or process the health service has put in place to management potential opportunities for error and adverse effects

Clinically significant: A judgment made by a clinician that something is clinically important for that particular patient in the context of that patient's health care. The judgment may be that something is abnormal and therefore clinically important for that particular patient, or it could be something that is normal but clinically important for that particular patient

Clinical staff: Nonmedical staff who provide clinical care to patients (including allied health staff who provide clinical care)

Complaint: An expression of dissatisfaction or concern with an aspect of the health service. Complaints may be expressed verbally or in writing and may be made through a formal complaints process, consumer surveys or focus groups

Confidentiality: The discretion used in keeping information secret

Consumer medicines information: Written information for the general public produced by pharmaceutical companies in relation to their medicines

Continuity of care: The degree to which a series of discrete health care events is experienced by the patient as coherent and connected and consistent with the patient's medical needs and personal context. Three aspects of continuity have been defined in the literature:

- informational continuity is the flow of information across health care events/consultations, particularly through documentation, hand over and review of notes from previous consultations
- management continuity is the consistency of care by the various people involved in a patient's care
- relational continuity is the sense of affiliation between the patient and their doctor

CPD (continuing professional development): Educational activities which lead to quality improvement in clinical care

Disability: Any type of impairment of body structure or function, activity limitation and/or restriction of participation in society

Disaster recovery plan: A documented plan of the actions the health service needs to take to retain and restore patient health information in the event of a 'disaster' (normally a power failure or other such event)

Discrimination: Providing differential treatment or consideration based on characteristics of the patient. Discrimination can be both positive (providing differential treatment to enhance care to the patient) and negative (providing differential treatment to the detriment of the patient's care)

Early detection and intervention: The detection of early stages of disease and the prompt and effective intervention to prevent disease progression

Electronic communication: The transfer of information (not necessarily patient health information) within or outside the health service through email, internet communications or facsimiles

Encryption: A process to convert text into cipher text (meaningless data) as a way to protect the contents of electronic communication and guarantee its authenticity

Error: A generic term to encompass all those occasions when a planned sequence of mental or physical activities fails to achieve its intended outcome, and when these failures cannot be attributed to the intervention of some chance agency

Fellowship of the RACGP (FRACGP): Fellowship of the RACGP is granted to those general practitioners who have demonstrated that they have reached the standard required for unsupervised general practice in Australia

Firewall: Any of a number of security schemes that prevent unauthorised users from gaining access to a computer network

Full back up: A copy of all files residing in a computer or server hard drive. The files are marked as having been 'backed up'

General practice: A health care setting that provides initial, continuing, comprehensive and coordinated medical care for individuals, families and communities and which integrates biomedical, psychological, social and environmental understandings of health

General practice registrar: A registered medical practitioner who is enrolled in a general practice training program approved by the RACGP to achieve Fellowship of the RACGP

General practitioner (GP): A registered medical practitioner who is qualified and competent for general practice anywhere in Australia, has the skills and experience to provide whole person comprehensive and coordinated and continuing medical care, and maintains professional competence for general practice

Hardware: The physical components of a computer (eg. monitor, hard drive)

Health promotion: Preventive health activities that reduce the likelihood of disease occurring

Human research ethics committee: A committee that reviews applications from people or investigators/institutions undertaking research projects. The committee needs to be constituted according to National Health and Medical Research Council requirements

Human resources: Relating to the field of personnel recruitment, training and management

Immigration detention centre: A secure facility for detaining people under Section 273 of the *Migration Act* 1958 (Cwlth)

Inactive patient health record: A record of a patient who is not longer detained in the immigration detention centre.

Induction program: A form of training provided to new staff members to introduce them to the health service's systems, processes and structures

Information sheet: A photocopied, typed or electronically generated information sheet which includes essential information for patients about services and methods of access to those services

Informed consent: Consent by a patient (either written or verbal) to proposed investigations, treatments or investigations or participation in research after achieving an understanding of the relevant purpose, importance, benefits, and associated risks

Interpreter service: A service that provides trained language translation either face-to-face or by telephone

Medical deputising services: Organisations that arrange for or facilitate the provision of medical services to patients of GPs (principals) by other medical practitioners (deputising doctors) during the absence of, and at the request of, the GPs

Medical staff: Staff who have current state or territory based medical registration

Near miss: An incident that could have caused harm (eg. to a patient) but did not result in harm

Need: Where these *Standards* use the phrase 'a health service needs...', the RACGP's position is that what 'needs' to be done in any situation is determined by what is reasonable in all the circumstances. In interpreting the *Standards*, care must be taken to be sensitive to the often highly variable circumstances of any particular situation

Network: A collection of connected computers used for information sharing and electronic communication

Normal opening hours: The normal consulting hours of the health service

Outcomes indicators: Indicators that relate to the effects of care on patients and communities

Outside normal opening hours: The hours not covered by the health service's normal opening hours

Patient health information: A patient's health information includes a person's name, address, account details and any health information (including opinion) about the person. Sometimes, details about a person's medical history or other contextual information can identify them, even if no name is attached to that information

Patient health record: The place (either computerised or hard copy) where an individual patient's personal health information is stored

Physical facilities: The building and equipment used to provide clinical care to patients

Policy and procedures manual: A resource document containing written information about the health service's policies and procedures

Position description: A document describing an employee's role, responsibilities and conditions of employment

Privacy of health information: The protection of personal and health information to prevent unauthorised access, use and dissemination

Psychologist: A mental health expert qualified and registered with the Psychologist Registration Board in their state or territory

Process indicators: Indicators that relate to what is done in giving and receiving care

Public key infrastructure (PKI): A secure method of transmitting information electronically to provide authentication and confidentiality. Public key infrastructure is used to transfer information between doctors and specialists, and hospitals, doctors and other health services.

Referral: To send on or direct a patient to another practitioner

Refugee: A person who has a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or opinion and who is unwilling or unable to return to their country of origin because of that fear

Relevant family history: Information about the patient's family history that the health care professional considers to be important for the purposes of providing clinical care to the patient

Relevant social history: Information about the patient's social history (including employment, accommodation, family structure) that the health care professional considers important for the purposes of providing clinical care to the patient

Risk management: The culture, processes and structures that are directed toward the effective management of potential opportunities for adverse events

Safe and reasonable: A decision that each health service needs to make in light of factors affecting their service (eg. location, patient population) in providing clinical care. What is safe and reasonable needs to be considered in light of what a health service's peers (or similar health services) would agree was safe and reasonable

Safety: The degree to which potential risk and unintended results are avoided or minimised

Screensaver: A software program that displays constantly changing images or dims the brightness of a display screen to protect the screen from having an image etched onto its surface, or being read

Self identified cultural background: Patients identifying as being of a particular ethnic or cultural background or heritage

Server: A computer in a network that provides services to the users connected to the network (eg. printing, accessing files)

Software: Computer programs that perform specific functions (eg. word processing or management of information)

Staff: All staff working within the health service

Staff involved in clinical care: Staff employed by the health service who perform any clinical tasks with patients

Structure indicators: Indicators that relate to material resources, facilities, equipment and the range of services provided at the health service

System: An organised and coordinated method or procedure

Team: Teams of staff who provide care within the health service (eg. doctors, receptionists, managers, psychologists or other mental health experts, nurses, allied health professionals)

Timely: An appropriate length of time

Urgent: A health need requiring immediate action or attention

Visits to patient living quarters: A consultation conducted in the patients' living quarters or rooms of the immigration detention centre.

The Royal Australian
College of
General Practitioners

FW: Annex 3 in separate word document, in case you need to send it to anyone

From: "Claire Harris (DHHS)" REDACTED REDACTED
To: "Annaliese Van Diemen (DHHS)" REDACTED
Date: Thu, 30 Apr 2020 13:09:46 +1000
Attachments: Annex 3 of draft Operation Soteria documents 29042020.docx (243.64 kB)

(saved in calendar meeting also-LL)

From: REDACTED
Sent: Wednesday, 29 April 2020 9:50 AM
To: Claire Harris (DHHS) REDACTED
Subject: Annex 3 in separate word document, in case you need to send it to anyone

Annex 3 – Health & Wellbeing

Standards for healthcare and welfare provision

Standard 1. Rights of people in mandatory quarantine

Criterion 1.1 Charter of Human Rights and Responsibilities

Operation Soteria must consider the Victorian Charter of Human Rights and Responsibilities when making decisions about people in mandatory quarantine.

The Victorian *Charter of Human Rights and Responsibilities Act 2006* (the Charter) contains twenty basic rights that promote and protect the values of freedom, respect, equality and dignity. The Charter requires the Victorian Government (state and local) to think about human rights when they makes decisions about people. While some of these rights may be restricted for quarantined people, consideration of these rights must underlie all decisions made by Operation Soteria staff in relation to people in mandatory detention.

Relevant Charter of Human Rights that must be considered by Operation Soteria staff when making decisions in relation to people in mandatory detention include:

- Right to life
- Right to protection from torture and cruel, inhumane or degrading treatment
- Freedom from forced work
- Right to freedom of movement
- Right to privacy and reputation
- Freedom of thought, conscience, religion and belief
- Freedom of expression
- Right to protection of families and children
- Cultural rights
- Property rights
- Right to liberty and security of the person
- Right to humane treatment when deprived of liberty

- Quarantined persons should be provided with a notice of detention, information on the terms and nature of the mandatory quarantine period and opportunity to seek exemption or review of the current detention order

Criterion 1.2 People with disabilities

Australia is a signatory to the United Nations Convention on the Rights of Persons with Disabilities, which sets out human rights for people with disabilities which include accessibility, personal mobility and access to healthcare

Quarantined persons should be screened on arrival to identify those with physical, sensory, psychosocial or intellectual disabilities.

Quarantined persons with a disability should be provided with the services and supports they require.

Criterion 1.3 Use of interpreters

Quarantined persons should be screened on arrival to identify those who require interpreters.

Interpreters must be used for quarantined persons where English is not their first language and translation would normally be required for interaction with the health or welfare systems.

Language requirements should be recorded in the quarantined person's record and hotel staff advised

Criterion 1.4 Feedback and complaints process

A feedback and complaints process can provide unique information about quarantined persons needs and the quality of care provided by Operation Soteria. Openly discussing feedback and concerns helps staff to understand strengths in their service, potential problems, and how to make improvements.

Processes for assessing satisfaction and receiving and addressing complaints should be established.

Indicators

Program delivery

Number of adverse events arising from failure to address the needs of a person with disability

Nature of adverse events (de-identified) arising from failure to address the needs of a person with disability

Number of adverse events arising from failure to use an interpreter

Nature of adverse events (de-identified) arising from failure to use an interpreter

Number of complaints related to health and welfare services

Nature of complaints (de-identified) related to health and welfare services

Outcomes

Outcomes of adverse events (de-identified) arising from failure to use an interpreter

Outcomes of adverse events (de-identified) arising from failure to address the needs of a person with disability

Resolution of complaints related to on-site staff, mandatory detention processes and health and welfare services

Reporting frequency

Significant adverse events: as soon as possible after occurrence

All other adverse events: daily

Complaints: weekly

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

As part of Operation Soteria's duty of care towards people in mandatory detention, it is essential that appropriately qualified staff screen quarantined individuals for health and welfare risk factors, so that appropriate services are made available to quarantined people who require them. At a minimum, health and welfare screening should take place on arrival and then at another point within the period of detention, so that existing and emerging health and welfare concerns can be risk assessed and addressed in a timely

Criterion 2.1 Health and welfare risk factors

- Returned travellers should be screened for risk factors related to the following:
  - current or potential infection with COVID-19 including
    - temperature
    - symptoms including fever, cough, shortness of breath, chills, body aches, sore throat, headache, runny nose, muscle pain or diarrhoea
  - potential complications or adverse events arising from
    - current or previous physical health conditions
    - current or previous mental health conditions
    - current or previous disabilities
  - allergies and food sensitivities, with particular note of anaphylaxis
  - need for ongoing medication, contact with usual treating health professionals, and other support services
  - family violence or child abuse
  - drug and alcohol use and/or dependence
  - current stressors or factors that will make quarantine particularly difficult, such as small children, bereavement, etc
  - needs or fears expressed by the quarantined person

Criterion 2.2 Schedule for screening

Returned travellers should be screened for COVID-19 at the following times:

On arrival at airport: screening to include temperature and symptoms of COVID-19

On day of arrival: screening to include all other risk factors

During detention: repeat screening to be conducted at least once during the detention period, preferably mid-way

Before release: voluntary screening around 24 hours before release

Returned travellers should be screened for other health and welfare issues at the following times:

- On day of arrival using the initial welfare survey
- Regularly throughout detention, during the welfare checks and checks by the nurses or other appropriate staff.

Criterion 2.3 Methods of screening

Screening tools (online or paper-based surveys, interview questions and prompts) that have been validated to assess health and welfare risk factors should be used.

If appropriate validated tools are unavailable, any tools created for this purpose should be developed by professionals with expertise in survey development.

Criterion 2.4 Staff undertaking screening

Staff undertaking screening should have appropriate qualifications to conduct the tasks they are allocated.

Assessment of current or potential infection with COVID-19 should be undertaken by medical or nursing staff.

Assessment of all other risk factors should be undertaken by staff who have:

- an understanding of the issues likely to be raised and their implications
- knowledge of the circumstances that would require escalation or referral to health or mental health professionals
- training and experience in handling conversations:
    - on sensitive topics, such as family violence
    - with disturbed or fearful people

It should be noted that health, education and other professional groups have mandatory requirements to report suspected child abuse.

Criterion 2.5 Risk assessment and follow up of persons 'at risk'

For example, quarantined persons could be triaged into three tiers of risk based on identified risk factors as per the example table below.

Risk Tier	**Risk factors**	**Follow up by appropriate health or welfare professionals**
Tier 1	Persons with suspected or confirmed COVID-19 Families with children < 18 years Persons aged > 65 years Aboriginal and Torres Strait Islander peoples Persons with underlying physical comorbidities (e.g. respiratory or cardiac conditions) Persons with a disability Persons with a history of mental illness Allergies and food sensitivities, with particular note of anaphylaxis History of family violence or child abuse Drug and alcohol use and/or dependence Current stressors or factors that will make quarantine particularly difficult, such as small children, bereavement, etc. Those with needs or fears expressed by the quarantined person Pregnant women	Phone call daily
Tier 2	Persons who indicate they require a phone call but do not have any other risk factors. Persons who are by themselves.	Phone call every second day
Tier 3	Persons with none of the factors above	Tailored contact

Plans for follow up of identified risks should be established

Protocols for communicating follow up plans to relevant health and welfare staff should be documented

At the discretion of the on-site clinical staff, quarantined persons with currently active physical or mental health issues should be

- managed on-site if within the capacity, capability and credentialing of attending medical and nursing staff
- referred to the appropriate health services (e.g. mental health services, specialist medical services, hospital, etc) or other support services as required

Indicators

Program delivery

Number of returning passengers arriving in Victoria

Number and percentage of returning passengers screened for COVID-19 at the airport

Reasons for COVID-19 screening not completed at the airport (e.g. passenger refused screening, insufficient staff, etc)

Number and percentage of quarantined persons receiving initial screen for risk factors on day of arrival

Reasons for initial screen not completed on day of arrival (passenger refused screening, insufficient staff, etc)

Number and percentage of quarantined persons receiving initial screen for risk factors after day of arrival (eg 20% on Day 2)

Number and percentage of quarantined persons receiving subsequent screen for risk factors during detention period (ie screening survey or interview, not follow up of identified risk factors)

Outcomes

Number and percentage of screened passengers with known COVID-19 based on documentary evidence

Number and percentage of screened passengers with known COVID-19 based on self-report

Number and percentage of screened passengers with suspected COVID-19 based on signs and symptoms

Number and percentage of quarantined persons referred to health or support services by service (e.g. 10 [2%] referred to on-site doctor, 5 [1%] referred to NorthWestern Mental Health Services)

Number and percentage of quarantined persons with identified risk factors at initial screen

Number and percentage of quarantined persons with identified risk factors at subsequent screen

Nature of risk factors (de-identified)

Number and percentage of quarantined persons with identified risk factors referred to external services

Reporting frequency

All: Daily

Standard 3. Provision of health and welfare services

The needs of quarantined individuals vary widely and Operation Soteria must have a flexible on-site system for the provision of health and welfare services that can accommodate urgent, non-urgent, complex, planned chronic care and preventive health needs.

Criterion 3.1 Meeting the needs of people in mandatory quarantine

The following principles should be followed in meeting the health and welfare needs of quarantined persons.

All reasonable requests for medical care from quarantined persons should be facilitated within an appropriate timeframe depending on the acuity of the issue or request

Provision of health or welfare services should not be deferred or delayed because a person is in quarantine.

Any request for medical review should be carefully considered to determine whether telemedicine or in-person consultation is the most appropriate approach. Telemedicine should not be used if an in-person review or physical examination is clinically indicated. However, if an in-person review is not required, telemedicine is appropriate to reduce risk of infection to health providers and quarantined persons.

Quarantined persons should be informed that they can access care through their usual general practitioner (GP), medical specialist or other health professional through telehealth arrangements. They should also be asked to request that the health professional consulted provides information regarding any ongoing health or welfare issues to the on-site clinical team if appropriate.

Criterion 3.2 Provision of on-site clinical services

Safeguarding of the health and welfare of quarantined persons is paramount.

Medical, nursing and other clinical services should be engaged at a ratio proportionate to the number of quarantined persons at each hotel/facility to enable ADEQUATE, APPROPRIATE and TIMELY delivery of acute clinical and support services. This should be determined by those commissioning/operating the health and welfare services. It should correspond to the workload and burden of illness/needs of the population in mandatory quarantine at any time.

Given the high risk of mental health issues for people in isolation, mental health primary care services should also be available at a ratio proportionate to the burden of disease emerging from the quarantined cohort

Medical, nursing and other clinical staff should practice within the requirements of their professional registrations, level of experience, codes of conduct and professional standards

Medical and nursing clinical practices, record-keeping and correspondence with other health professionals should meet the expectations and usual standards of high-quality primary care

Medical and nursing staff should have appropriate training, experience and credentials to

- identify physical and mental health emergencies
- deal with acute physical and mental health conditions by providing treatment or arranging appropriate referrals/ escalate care appropriately
- provide support to quarantined persons who are distressed

Clinical governance arrangements should be in place to ensure that

- staff have appropriate training, experience and credentials
- clinical practice is consistent with the best available evidence and follows applicable professional standards
- clear and consistent escalation pathways are clearly communicated to all clinical staff
- adequate, appropriate, well-maintained and calibrated clinical equipment is available to deliver primary care services
- suitable arrangements are in place to enable comprehensive and secure medical records

Provision should be made for both on-site in-person clinical consultations and telehealth consultations

On-site clinical staff should be provided with mobile phones to facilitate rapid access by quarantined persons, operational and administrative staff, and external healthcare providers

Processes for ensuring continuity of care through accurate and comprehensive medical record keeping and communication of medical information between providers engaged to provide on-site health care should be established.

It is the responsibility of the doctor who orders any test (COVID-19 or otherwise) to follow up on the result and notify the patient in a timely manner. If they are not able to do so, they must handover this task to the next doctor on-call, inform the nurse, and record this in the medical record.

Requests for medical care must be actioned in keeping with the acuity of the issue. Where staffing allows, the doctor may see patients before the nurse, particularly if the request is deemed urgent. An example of appropriate response times is included below.

Acuity of issue	**Time frame for response**
Emergency/life-threatening issue	Immediate – call 000 ASAP
Urgent physical health concerns	Nurse to review ASAP (within 30 minutes) Doctor to review within 1 hour
Urgent mental health issue	Doctor or nurse to review within 1 hour
Non-urgent issue requiring review and management	Nurse to review within 4 hours Doctor to review (if required) within 12 hours
Minor health issue, non-urgent	Phone review as soon as practicable Nurse to review within 8 hours Doctor to review (if required) within 24 hours
Urgent prescriptions of routine medication	Doctor to action within 8 hours
Non-urgent prescriptions of routine medication	Doctor to action within 24 hours

At the discretion of the on-site clinical staff, quarantined persons with currently active physical or mental health issues should be

managed on-site if within the capacity, capability and credentialing of attending medical and nursing staff

referred to the appropriate health services (e.g. mental health services, specialist medical services, hospital, etc) or other support services as required

In the case of a physical health emergency in a quarantined person (e.g. heart attack, stroke, anaphylaxis, etc) an ambulance should be called immediately by any person in attendance. There is no need to wait for referral to medical or nursing staff.

In the case of a mental health emergency in a quarantined person (e.g. acute suicidal ideation, thoughts of self-harm, psychosis, etc) the quarantined individual should be reviewed by the doctor on call as a matter of urgency and have a risk assessment completed within an hour. The general practitioner should then determine if transfer to hospital via ambulance is required for urgent psychiatric assessment or if psychiatric advice can be obtained over the phone. If the quarantined individual is deemed as needing urgent psychiatric review and is not willing to be transferred for assessment, the doctor on call will need to decide if enacting provisions within the Mental Health Act 2014 is required.

Documented protocols related to provision of on-site health services should include:

- Processes for follow up of physical and mental health risk factors identified through screening
- Clear instructions for:
  - quarantined persons on how to contact medical and nursing staff
  - clinical staff on responsibilities for first point of contact, triage, escalation and referral pathways
  - clinical staff on actions to be taken in response to acute physical and mental health emergencies
  - clinical staff on continuity of care and handover of outstanding tasks and concerns

- agreed method of documentation of outstanding tasks/ physical or mental health issues needing follow up

Documentation should also include contact numbers for

- Hotels and other facilities being used for quarantine
- Medical and nursing contacts at each facility
- Health service emergency departments, mental health services, liaison officers related to this operation
- Other resources including, but not limited to, local health and welfare services, psychiatric triage team (1300 TRIAGE), Crisis Assessment and Treatment Teams (CATT), DHHS Complex Assessment and Referral Team (CART), telephone advice lines, online services, etc
- Emergency operations and DHHS teams

Prescribing benzodiazepines

When considering initiating prescription of benzodiazepines for short term management of anxiety or other mental health issues (such as claustrophobia, panic attacks, PTSD etc) in mandatory detention, doctors should exercise a high degree of caution, and implement other strategies to manage these conditions where possible. Doctors initiating prescriptions for benzodiazepines, opioids, anxiolytics and antipsychotics should only do so after a careful history and risk assessment has been conducted. Psychiatric input should be sought where necessary. Care should be taken to ensure that benzodiazepines are not prescribed to individuals who are consuming alcohol, or who have other contraindications to these medications. Prescriptions should also be limited to small quantities of tablets at a time, with appropriate follow up review arranged to assess response and re-evaluate need for medication.

Initiation of sleeping tablets (including benzodiazepines, zolpidem, zopiclone etc.) in mandatory quarantine should only be considered after a thorough assessment by a healthcare profession. Those on sleeping tablets regularly should have their dose confirmed with their usual GP prior to prescriptions being provided in mandatory quarantine. Care should be taken to ensure sleeping tablets are not prescribed to individuals who are consuming alcohol, or who have other contraindications to these medications.

Criterion 3.3 Provision of welfare services

Safeguarding of the health and welfare of quarantined persons is paramount.

All quarantined persons should have access to communication services such as internet and wi-fi so that they can stay in regular contact with family and friends.

All quarantined persons should have access to entertainment and news services such as television and radio

Arrangements for quarantined persons to receive care packages of personal items from family and friends should be established

Appropriate professionals should be engaged at a ratio proportionate to the number of quarantined persons at each hotel/facility to enable ADEQUATE, APPROPRIATE and TIMELY delivery of welfare services. This should be determined by those commissioning/operating the health and welfare services. It should correspond to the workload and burden of illness/needs of the population in mandatory quarantine at any time.

Welfare professionals should practice within the requirements of their professional registrations, level of experience, codes of conduct and professional standards

Welfare practices, record-keeping and correspondence with other health and welfare professionals should meet the expectations of high-quality welfare services

Welfare staff should have appropriate training, experience and credentials to

identify and deal with significant welfare issues by providing advice or arranging appropriate referrals

provide support to quarantined persons who are distressed

Governance arrangements should be in place to ensure that welfare staff have appropriate training, experience and credentials

Provision should be made for both on-site in-person welfare consultations and telehealth consultations

Welfare staff should be provided with mobile phones to facilitate rapid access by quarantined persons, operational and administrative staff, and external healthcare providers

Regular welfare checks should be conducted, at a minimum, based on the three risk tiers noted above or more frequently to meet the needs of quarantined individuals as determined by clinical or welfare staff

Requests for welfare assistance from quarantined persons or clinical staff should be actioned in keeping with the urgency and significance of the issue (usually within 24 hours).

Processes for managing, escalating and referring incidents of family violence or child abuse should be established, including provision of safe accommodation and referral to Victoria Police where appropriate

Processes for assessing satisfaction and receiving and addressing complaints should be established

Documented protocols related to provision of welfare services should include, but not be limited to:

- Processes for follow up of risk factors related to welfare issues identified through screening
- Clear instructions for:
  - quarantined persons on how to contact welfare staff
  - quarantined persons on the arrangements for care packages
  - on-site clinical staff on how to contact welfare staff
  - welfare staff on responsibilities for first point of contact, triage, escalation and referral pathways
  - welfare staff on continuity of care and handover of outstanding tasks and concerns
  - welfare staff on management, escalation and referral of reports of family violence or child abuse

- Documentation should also include, but not be limited to contact numbers for
  - Welfare staff
  - Welfare agencies for referral
  - Family violence and child abuse services
  - Appropriate Victoria Police departments

Criterion 3.4 Provision of pharmacy and pathology services

Pharmacy services should be provided to allow for

prompt procurement of necessary medications (prescriptions or over-the-counter products) and equipment for quarantined persons

delivery to the relevant hotel/facility

prescriptions to be emailed to the pharmacy by the quarantined person's usual doctor or the on-site doctor

Processes for COVID-19 swabs should follow the 'Guidelines for managing COVID-19 in mandatory quarantine'. Each site should have a twice-daily pathology courier pickup, transporting swabs taken from that site to VIDRL.

Pathology tests required by the treating clinician (on-site doctor or person's own GP) should be undertaken by the on-site medical or nursing staff. Equipment for taking bloods should be available

at (or available to be transported to) the hotel/facility. These specimens should be labelled as per the protocol for labelling COVID-19 swabs (same requirement for identifiers).

Routine pathology tests should be deferred until after the quarantine period if possible.

Criterion 3.5 COVID-19 guidelines in mandatory quarantine

All staff should follow the ‘Guidelines for managing COVID-19 in mandatory quarantine’

Indicators

Program delivery

Number of quarantined persons followed up as per their risk screening follow up plan

Number of referrals to external health and welfare providers

Number of adverse events arising from absent or inadequate protocols for health and welfare or failure to follow relevant protocols

Nature of adverse events (de-identified) arising from absent or inadequate protocols for health and welfare or failure to follow relevant protocols

Number of serious physical or mental health incidents not related to protocols for health and welfare

Nature of serious physical or mental health incidents (de-identified) not related to protocols for health and welfare

Number of COVID-19 swabs

Number of calls related to family violence or child abuse

Number of emergencies requiring 000 calls

Number of emergency transfers to hospital

Number of non-emergency transfers to hospital

Nature of emergency and non-emergency transfers to hospital (de-identified)

Outcomes

Outcomes of adverse events (de-identified) arising from absent or inadequate protocols for health and welfare or failure to follow relevant protocols

Outcomes of serious physical or mental health incidents (de-identified) not related to protocols for health and welfare

Outcomes of emergency transfers to hospital

Outcomes of non-emergency transfers to hospital

Number of COVID-19 swabs with positive results

Action taken as a result of positive COVID-19 swab

Action taken as a result of response to calls related to family violence or child abuse

Reporting frequency

Adverse events, serious incidents and COVID-19 positive swabs: as soon as possible after occurrence

All others: daily

Standard 4. Health promotion and preventive care

While in mandatory quarantine, health promotion and preventative care should be made available to all quarantined individuals. This includes access to fresh air and promotion of exercise. Appropriately trained on-site clinical staff should be available to provide advice and management strategies in relation to smoking, alcohol and drugs, and referral to support services where needed.

Criterion 4.1 Smoking

Smoking is not permitted in most hotels

Quarantined persons who are smokers should be provided with information and actively encouraged to quit using validated methods such as:

- Nicotine Replacement Therapy
- Quitline telephone counselling (phone 13 78 48)
- Contacting their regular GP via telehealth

Criterion 4.2 Fresh air

Individuals in quarantine should have access to fresh air where possible.

If the room has a balcony or windows that open, quarantined persons should be advised to use them for fresh air and ventilation

If it is possible for quarantined persons to go outside to take some exercise for organised/supervised short periods of time, this should be facilitated. Physical distancing must be practised during this period. Only people who are well, and who are staying in the same room, should go outside to exercise at the same time.

Criterion 4.3 Exercise

Exercise is important for physical and mental health, particularly in the mandatory quarantine environment.

In-room exercises should be encouraged and resources to support this should be facilitated if possible

Criterion 4.4 Alcohol and drugs

Alcohol is permitted within hotels.

Excessive alcohol consumption should be discouraged.

Alcohol should not be provided to persons under 18 years of age (including in the hotel room minibar)

If there are concerns about potential alcohol or other substance abuse or withdrawal:

- Request nurse or medical review.
- Provide numbers for support services.

If there are concerns about acute alcohol withdrawal, confusion, deteriorating mental state, or mental illness:

- Escalate for urgent medical review
- Consider calling 000

Indicators

No reporting required

Standard 5. Infection control

Infection control procedures in the mandatory quarantine hotels are essential to both protect on-site staff and quarantined individuals from COVID-19 and other pathogens. The foundation of good infection control is to assume everyone is potentially infectious, and therefore proper procedures have to be followed at all times.

Criterion 5.1 Personal protective equipment (PPE)

Appropriate personal protective equipment (single-use face masks, P2/N95 masks, gowns and eye protection) should be available to all staff and quarantined individuals for use when indicated.

PPE stocks should be maintained at each hotel/facility, monitored through regular stocktake and a mechanism to rapidly obtain additional stock in place. Hotels should not run out of stock.

Biohazard bags for waste disposal, hand sanitizer, paper towels, and other necessities for hand hygiene stations should also be available in hotels.

PPE, hand hygiene stations, and waste disposal facilities should be situated at the donning/doffing areas in each hotel.

Appropriate PPE protocols (for droplet and contact precautions) should be available to all staff working in the hotels with clear instruction on what type of PPE to wear in what circumstances, how to don and doff it, and how to dispose of it (see the department's website for further information on PPE usage: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19#personal)

Additional training and educational resources should be made available to staff who require it.

Criterion 5.2 Cleaning and waste disposal

Quarantined individuals should have safe and clean rooms.

Housekeeping services should not be provided routinely in the interest of infection control.

Fresh linen, towels and additional amenities should be left outside rooms for quarantined individuals to collect.

Terminal cleaning is required on vacation of each room. This should follow the processes outlined in the DHHS document 'Cleaning and disinfecting to reduce COVID-19 transmission'.

Rooms that have been vacated should not be repurposed during the quarantine period.

Quarantined individuals may not be able to upkeep their rooms for various reasons, which may affect their physical and mental health. Efforts should be made to assist a quarantined person with cleaning their room if they are not capable of doing so themselves. Any persons for whom there is a concern about room hygiene and safety should be flagged to the team leader.

Criterion 5.3 Laundry

Quarantined individuals should place dirty linen in biohazard bags which are left outside rooms for collection.

Hotel staff should wear appropriate PPE when handling dirty laundry.

Handling of dirty linen should be minimised; it should be put straight into the washing machines if possible.

Laundry should be washed on the highest possible setting and thoroughly dried before use.

Staff should follow hand hygiene protocols after handling dirty linen.

Criterion 5.4 Isolation protocols

All staff should follow the 'Guidelines for managing COVID-19 in mandatory quarantine'

Suspected cases of COVID-19 should be separated/isolated from people they share a room with as soon as they become symptomatic.

If this has not already occurred, confirmed cases should be isolated from people they share a room with as soon as the positive result is known. Each hotel should have a COVID-19 positive floor or area (known as a "red zone"). Any person who is a confirmed case should be relocated to this area of the hotel when the test result is known. Appropriate signage, PPE and other consumables should be available at the entrance to this area of the hotel.

Where there are large numbers of confirmed cases arriving on a flight, a COVID-19 hotel is a more appropriate arrangement. Where the infrastructure allows, suspected cases should also be moved to an area of the hotel away from well individuals.

Indicators

Program delivery

Number of adverse events arising from absent or inadequate protocols for infection control or failure to follow relevant protocols

Nature of adverse events (de-identified) arising from absent or inadequate protocols for infection control or failure to follow relevant protocols

Outcomes

Outcomes of adverse events (de-identified) arising from absent or inadequate protocols for infection control or failure to follow relevant protocols

Reporting frequency

Significant adverse events: as soon as possible after occurrence

All others: daily

Standard 6. Allergies and dietary requirements

As part of Operation Soteria's duty of care towards people in mandatory detention, it is essential that appropriately qualified staff document and have processes for managing quarantined individuals' allergy and dietary requirements, as failure to do this can have life-threatening consequences.

Information on allergies should be collected from all quarantined individuals.

- Allergen (e.g. name of medication, type of food, etc)
- Allergic reaction (e.g. rash, gastrointestinal disturbance, etc)
- History of severe allergic reactions or anaphylaxis
- Use of antihistamines, corticosteroids or EpiPens

Clinical staff should ensure that quarantined persons have adequate supplies of allergy medications. If required, urgent prescriptions should be filled and delivered to the hotel/facility

Mechanisms should be put in place to avoid/limit quarantined individual's contact with allergens

Dietary requirements should be collected from all quarantined individuals

- Food allergy (as above, e.g. cow's milk allergy)
- Food intolerance (e.g. lactose intolerance)
- Clinical diet (e.g. low salt diet for kidney disease)

Screening tools that have been validated to collect details of allergies and dietary requirements should be used. If appropriate validated tools are unavailable, any tools created for this purpose should be developed by professionals with methodological expertise in survey development and content knowledge of allergy and dietary requirements.

Clinical staff should ensure that details are provided to catering providers.

- An ambulance should be called for anyone who develops a severe allergy whilst in mandatory quarantine, without needing approval from clinical staff, authorised officers or hotel staff etc
- On arrival, paramedics should be given clear access to the person for whom the ambulance was called

Documented protocols related to provision of appropriate services to meet allergy and dietary requirements should include, but not be limited to:

- Processes for dealing with food allergies, intolerances and other requirements
- Clear instructions for:
    - clinical staff on how to communicate allergy and dietary requirements to catering providers
    - catering providers on how to address allergy and dietary requirements
    - quarantined persons on how their allergy and dietary requirements will be met

Documentation should also include, but not be limited to contact numbers for next of kin of the person with an allergy

- As a safeguard, some form of door marking or sign should be used to indicate that a person in the hotel room has a significant allergy or specific dietary requirements.

Indicators

Program delivery

Number of adverse events arising from absent or inadequate protocols for allergies and dietary requirements or failure to follow relevant protocols

Nature of adverse events (de-identified) arising from absent or inadequate protocols for allergies and dietary requirements or failure to follow relevant protocols

Outcomes

Outcomes of adverse events (de-identified) arising from absent or inadequate protocols for allergies and dietary requirements or failure to follow relevant protocols

Reporting frequency

Significant adverse events: as soon as possible after occurrence

All others: daily

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

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

Operation Soteria has a systematic approach to maintaining the confidentiality and privacy of a quarantined person’s personal and health information.

The *Privacy Act 2001 (Cth)* states that a patient's personal health information includes a person's name, address, account details and any health information (including medical or personal opinion) about the person.

Medical, nursing, clinical and allied heath staff have requirements relating to confidentiality in their professional registration and codes of conduct.

Quarantined persons should be informed that their health information will be treated as private and confidential and will only be released to third parties with their consent or in compelling circumstances (eg. concern for the patient's safety or the safety of others) as required by law.

Mechanisms should be in place to ensure that information is shared between on-site staff when necessary but within the bounds of the law. Any transfer of information to a third party without the consent of the quarantined person needs to be documented in their medical record.

Patient information in hotels/facilities should not be stored or left visible in areas where non-health services staff have unrestricted access, or where constant staff supervision is not easily provided.

Devices used to access the information management systems are only accessible to authorised clinical staff

Screensavers or other automated privacy protection devices are enabled

Documented protocols related to the confidentiality and privacy of personal and health information of quarantined persons should include, but not be limited to:

- Informing newly quarantined people about the information collected about them, the use of that information, the range of people (e.g. doctors, nurses, psychologists) who may have access to their medical records and the scope of that access, privacy arrangements and how they can gain access to their personal and health information
- Gaining consent from quarantined people before disclosing personal and health information to third parties
- Providing health information to another health professional if requested by the quarantined person
- Maintaining the security of information held at the hotel/facility, on private external servers or on government servers
- Retaining medical records as required by law

Documentation should also include, but not be limited to:

- the type of personal health information that may need to be relayed to DHHS when assessing special needs of a quarantined person
- how confidentiality can be maximised if a third party is present in the consultation without the consent of on-site clinical staff or patient

Criterion 7.2 Information security

It is paramount that the security of confidential data on quarantined persons is maintained.

The security of patient information (including medical records) in electronic or paper formats should be maintained through the use of secure-access information management systems.

A minimum number of secure databases should be used to prevent fragmentation of records management and reduce the risk of critical information not being available to DHHS, health or welfare staff providing for the health and welfare needs of quarantined persons.

Different staff members should have different levels of access to quarantined person's information (for example, administrative staff should not have access to the patient's medical records). In relation to medical records, the principles of patient confidentiality should be maintained unless required by law.

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

On-site staff have personal passwords to authorise appropriate levels of access to health or other personal information

If medical notes are recorded on paper, these should be stored securely and uploaded to the information management system as soon as is practicable and within 72 hours at most.

If an on-site doctor completes an assessment, they must provide a written record of this to the on-site nursing staff, either on paper or via email, if an electronic medical record system is not available. This must be securely stored as soon as possible.

Inactive records must also be also be kept and stored securely. An inactive record is generally considered to be a record of a person who is no longer detained in mandatory detention.

An information disaster recovery plan for use in an emergency such as device failure or power failure should be established.

- Back-ups of electronic information are performed at an appropriate frequency
- Back-ups of electronic information are stored in a secure offsite environment
- Antivirus software is installed and updated

All internet connected devices have firewalls installed

Documented protocols related to information security should include, but not be limited to processes for:

- Collection, storage and transfer to electronic storage
- Back-up and recovery of digital information

Documentation should also include, but not be limited to:

- Record of which staff are authorised to access different levels of information about a quarantined person (e.g. Personal details, contact details, medical record, COVID-19 status, etc)

Criterion 7.3 Transfer of personal information (including medical records)

On request from a quarantined individual, in an emergency, or to support a referral for health or welfare reasons, a summary or a copy of personal information (including the patient health record) may be transferred to the patient, another medical practitioner, health service provider or health service.

Transfer of patient information in these situations should be facilitated.

Consent of the quarantined person should be obtained before transferring information, except in an emergency when they are unable to give consent and failure to transfer the information will prevent optimal care. Consent may be given for the release of some information beyond an individual consultation.

On-site staff record any requests by quarantined individuals or other reasons for transfer of health information in the medical record. This note should include details of where the information was sent and who authorised the transfer.

Any electronic data transmission of patient information over a public network must be encrypted

Criterion 7.4 Retention of personal information (including medical records)

The *Privacy Act 1988 (Cth)* requires personal health information to be destroyed or permanently de-identified once it is no longer needed for any authorised use or for disclosure under the legislation.

The *Health Records Act 2001 (Vic)* recommends that individual patient health records be retained for a minimum of 7 years from the date of last contact, or until the patient has reached the age of 25 years, whichever is the longer. In the case of patient health information collected for the purpose of providing medical advice or treatment, it may be appropriate to retain this information indefinitely so that it is available, if necessary, to assist with the patient's future diagnosis and treatment.

1. A protocol for the retention and destruction of personal health information for people in mandatory quarantine consistent with the *Privacy Act 1988 (Cth)* and *Health Records Act 2001 (Vic)* should be established and communicated to all relevant staff

Indicators

Program delivery

Incidents of breach of privacy related to medical information

Incidents related to failure to maintain adequate medical records

Outcomes

Adverse events arising from breach of privacy or failure to maintain adequate medical records

Reporting frequency

Significant adverse events: as soon as possible after occurrence

All others: daily

Standard 8. Health and welfare reporting to Public Health Commander

A daily health and welfare report should be provided to the Deputy Public Health Commander for Physical Distancing by the Deputy Commander Welfare. This is to ensure oversight and accountability for the mandatory quarantine process. This report should include but is not limited to the following:

Total number of people in mandatory detention

Total number of confirmed COVID-19 cases (cumulative and new)

Total number requesting exemptions to leave mandatory quarantine (temporary and permanent)

The number of persons in mandatory detention receiving:

- A nurse review
- A mental health assessment
- A GP review
- Referral to hospital
- A 000 call

The number of persons awaiting:

- A mental health assessment

- A GP review

The number of persons in the following groups:

- Significant psychiatric history - mild/moderate/severe mental health issues (as per the risk stratification)
- Serious/life-threatening medical conditions (e.g. anaphylaxis, stage 4 cancer)
- Age < 16 years or > 70 years
- Pregnant women

The number of calls from the hotels to:

- 000
- VicPol
- Other DHHS phone lines

The number of risk incidents logged in the database.

Other major concerns flagged.

Audit

Healthcare audit

Medical care provided by doctors and nurses contracted by DHHS will be audited regularly. This should be reported to the EOC Commander and Deputy Public Health Commander. The audit process may consist of, but is not limited to, the following:

Assessing waiting times for delivery of care;

Record-keeping and review of medical records;

Medical care satisfaction surveys;

Number of repeat requests for medical care/escalation;

Number of risks reported;

Feedback from authorised officers and other organisations involved/staff.

Welfare audit

Audit of welfare procedures should be performed by the Welfare Lead at the EOC on a regular basis. The audit process may consist of:

Review of weekly satisfaction surveys;

Feedback from staff;

Audit of welfare check calls (review of a sample of recorded calls).

Number of returning passengers arriving in Victoria

Number and percentage of returning passengers screened for COVID-19 at the airport

Reasons for COVID-19 screening not completed at the airport

- passenger refused screening
- insufficient staff
- other

Number and percentage of quarantined persons receiving initial screen for risk factors on day of arrival

Reasons for initial screen not completed on day of arrival

- passenger refused screening
- insufficient staff
- other

Number and percentage of quarantined persons receiving initial screen for risk factors after day of arrival (e.g. 20% on Day 2)

Number and percentage of quarantined persons receiving subsequent screen for risk factors during detention period (i.e. screening survey or interview, not follow up of identified risk factors)

Number of adverse events arising from

- failure to address the needs of a person with disability
- failure to use an interpreter
- absent or inadequate protocols for health and welfare or failure to follow relevant protocols
- other

Nature of adverse events (de-identified) arising from

- failure to address the needs of a person with disability
- failure to use an interpreter
- absent or inadequate protocols for health and welfare or failure to follow relevant protocols
- other

Outcomes of adverse events (de-identified) arising from

- failure to address the needs of a person with disability
- failure to use an interpreter
- absent or inadequate protocols for health and welfare or failure to follow relevant protocols
- other

Number of complaints related to health and welfare services

Nature of complaints (de-identified) related to health and welfare services

Resolution of complaints related to health and welfare services

Number and percentage of screened passengers with known COVID-19

- based on documentary evidence
- based on self-report

Number and percentage of screened passengers with suspected COVID-19 based on signs and symptoms

Number and percentage of quarantined persons referred to health or support services by service (e.g. 10 [2%] referred to on-site GP, 5 [1%] referred to NorthWestern Mental Health Services)

- On-site doctor
- On-site MH nurse
- Quarantined person’s usual GP
- MH service
- Hospital
- Other

Number and percentage of quarantined persons with identified risk factors at initial screen

Number and percentage of quarantined persons with identified risk factors at subsequent screen

Nature of risk factors (de-identified)

Number and percentage of quarantined persons with identified risk factors referred to external services

Number of quarantined persons followed up as per their risk screening follow up plan

Number of referrals to external health and welfare providers

Number of adverse events arising from absent or inadequate protocols for health and welfare or failure to follow relevant protocols

Nature of adverse events (de-identified) arising from absent or inadequate protocols for health and welfare or failure to follow relevant protocols

Number of serious physical or mental health incidents not related to protocols for health and welfare

Nature of serious physical or mental health incidents (de-identified) not related to protocols for health and welfare

Number of COVID-19 swabs

Number of calls related to family violence or child abuse

Number of emergencies requiring 000 calls

Number of emergency transfers to hospital

Number of non-emergency transfers to hospital

Nature of emergency and non-emergency transfers to hospital (de-identified)

Outcomes

Outcomes of adverse events (de-identified) arising from absent or inadequate protocols for health and welfare or failure to follow relevant protocols

Outcomes of serious physical or mental health incidents (de-identified) not related to protocols for health and welfare

Outcomes of emergency transfers to hospital

Outcomes of non-emergency transfers to hospital

Number of COVID-19 swabs with positive results

Action taken as a result of positive COVID-19 swab

Action taken as a result of response to calls related to family violence or child abuse

Standard	Indicator	Frequency
Rights of people in mandatory quarantine	**Program delivery** Number of adverse events arising from failure to address the needs of a person with disability Nature of adverse events (de-identified) arising from failure to address the needs of a person with disability Number of adverse events arising from failure to use an interpreter Nature of adverse events (de-identified) arising from failure to use an interpreter Number of complaints related to health and welfare services Nature of complaints (de-identified) related to health and welfare services **Outcomes** Outcomes of adverse events (de-identified) arising from failure to use an interpreter Outcomes of adverse events (de-identified) arising from failure to address the needs of a person with disability Resolution of complaints related to health and welfare services	**ASAP after occurrence** Significant adverse events **Daily** All other adverse events **Weekly** Complaints
Screening and follow up of health and welfare risk	**Program delivery** Number of returning passengers arriving in Victoria Number and percentage of returning passengers screened for	**Daily** All

factors	COVID-19 at the airport Reasons for COVID-19 screening not completed at the airport (e.g. passenger refused screening, insufficient staff, etc) Number and percentage of quarantined persons receiving initial screen for risk factors on day of arrival Reasons for initial screen not completed on day of arrival (passenger refused screening, insufficient staff, etc) Number and percentage of quarantined persons receiving initial screen for risk factors after day of arrival (e.g. 20% on Day 2) Number and percentage of quarantined persons receiving subsequent screen for risk factors during detention period (i.e. screening survey or interview, not follow up of identified risk factors) **Outcomes** Number and percentage of screened passengers with known COVID-19 based on documentary evidence Number and percentage of screened passengers with known COVID-19 based on self-report Number and percentage of screened passengers with suspected COVID-19 based on signs and symptoms Number and percentage of quarantined persons referred to health or support services by service (e.g. 10 [2%] referred to on-site GP, 5 [1%] referred to NorthWestern Mental Health Services) Number and percentage of quarantined persons with identified risk factors at initial screen Number and percentage of quarantined persons with identified risk factors at subsequent screen Nature of risk factors (de-identified) Number and percentage of quarantined persons with identified risk factors referred to external services	
Provision of health and welfare services	**Program delivery** Number of quarantined persons followed up as per their risk screening follow up plan Number of referrals to external health and welfare providers Number of adverse events arising from absent or inadequate protocols for health and welfare or failure to follow relevant protocols Nature of adverse events (de-identified) arising from absent or inadequate protocols for health and welfare or failure to follow relevant protocols Number of serious physical or mental health incidents not related to protocols for health and welfare Nature of serious physical or mental health incidents (de-identified) not related to protocols for health and welfare Number of COVID-19 swabs	**ASAP after occurrence** Significant adverse events, serious incidents and COVID-19 positive swabs **Daily** All other adverse events

	Number of calls related to family violence or child abuse Number of emergencies requiring 000 calls Number of emergency transfers to hospital Number of non-emergency transfers to hospital Nature of emergency and non-emergency transfers to hospital (de-identified) **Outcomes** Outcomes of adverse events (de-identified) arising from absent or inadequate protocols for health and welfare or failure to follow relevant protocols Outcomes of serious physical or mental health incidents (de-identified) not related to protocols for health and welfare Outcomes of emergency transfers to hospital Outcomes of non-emergency transfers to hospital Number of COVID-19 swabs with positive results Action taken as a result of positive COVID-19 swab Action taken as a result of response to calls related to family violence or child abuse	
Infection control	**Program delivery** Number of adverse events arising from absent or inadequate protocols for infection control or failure to follow relevant protocols Nature of adverse events (de-identified) arising from absent or inadequate protocols for infection control or failure to follow relevant protocols **Outcomes** Outcomes of adverse events (de-identified) arising from absent or inadequate protocols for infection control or failure to follow relevant protocols	**ASAP after occurrence** Significant adverse events **Daily** All other events
Allergies and dietary requirements	**Program delivery** Number of adverse events arising from absent or inadequate protocols for allergies and dietary requirements or failure to follow relevant protocols Nature of adverse events (de-identified) arising from absent or inadequate protocols for allergies and dietary requirements or failure to follow relevant protocols **Outcomes** Outcomes of adverse events (de-identified) arising from absent or inadequate protocols for allergies and dietary requirements or failure to follow relevant protocols	**ASAP after occurrence** Significant adverse events **Daily** All other events
Information and data management (including medical	**Program delivery** Incidents of breach of privacy related to medical information Incidents related to failure to maintain adequate medical records	**ASAP after occurrence** Significant adverse

records)	**Outcomes** Adverse events arising from breach of privacy or failure to maintain adequate medical records	events **Daily** All other events

Guidelines for managing COVID-19 in mandatory quarantine Introduction

Purpose

The purpose of this document is:

To provide stepwise guidance to identify and manage suspected and confirmed cases of COVID-19 at each stage of the mandatory quarantine process.

To consolidate the public health principles for managing COVID-19 in this context into one source.

Scope

This document addresses the public health policy and operational requirements for managing suspected and confirmed cases of COVID-19, as well as close contacts, in mandatory quarantine.

Audience

This document is intended for use by DHHS staff, health care workers and other people involved in the care of individuals in mandatory quarantine (detention).

Abbreviations

AO	Authorised Officer
AV	Ambulance Victoria
COVID-19	Coronavirus Disease 2019
DAWE	Department of Agriculture, Water and the Environment
DHHS	Department of Health and Human Services (the department)
EOC	Emergency Operations Centre (for Operation Soteria)
HBO	Human Biosecurity Officer
NEPT	Non-Emergent Patient Transport
PH Ops	Public Health Operations team

At the airport

Airport health screening

At the airport, DHHS nurses and Department of Agriculture, Water and the Environment (DAWE) biosecurity officers will screen all passengers arriving from overseas for symptoms of COVID-19. This symptom check includes questions about cough, sore throat, breathing difficulties, headaches and other symptoms of unwellness (as per the health screening protocol for Melbourne airport). Nurses

will perform a temperature check on each passenger. If a person screens positive on the symptom check, or on the temperature check (temperature >37.8 ˚**C)**, the Human Biosecurity Officer (HBO) will be contacted by the DAWE biosecurity officer to arrange for testing (process outlined below).

Management of an unwell person at the airport

The lead for this situation is the HBO on behalf of the Deputy Chief Health Officer (Communicable Diseases). Any passengers who screen positive on the airport health check will trigger the DAWE biosecurity officer to contact the HBO on-call for the department via 1300 651 160. After discussion with the HBO, if it is determined that the person meets the criteria for a suspected case of COVID-19, the following actions should be taken:

The HBO should organise an ambulance transfer to the Royal Melbourne Hospital (or Royal Children's Hospital) for testing and assessment.

The DHHS authorised officer (AO) at the airport should:

- Issue the person their detention notice.
- Log the person as requiring mandatory quarantine at a specified hotel.
- Provide an information sheet to travel with the person to provide to the hospital advising that the person is being detained in mandatory quarantine. This should list a phone number for the hospital to call when the person is ready for discharge so that transport can be organised by the hotel team leader (patient transfer/ambulance/maxi taxi etc.) to return the person to the hotel.
- Provide a permission to enable the person to be transported to the hospital and, following medical release, be transported back to the hotel.
- Follow-up with the hospital to update on the person's situation.

The person must remain at the hospital until the result of their COVID-19 test is known.

After the test result is known, if they are well enough to be discharged from the hospital, transfer (by patient transfer/ambulance/maxi taxi etc.) can be organised to bring the person to the assigned hotel.

- If the person has a positive test result (i.e. they are a confirmed case), they should be situated on a COVID-19 floor/area of the hotel (the 'RED ZONE').
- If the person has a negative test result, they can be situated in a general part of the hotel.
- The AO must ensure the room number is included on the detention notice.

If the person is unwell and requires admission to hospital, the Compliance/AO Lead should be informed and the EOC.

Refusal of testing

At the airport

If a person refuses to be transported from the airport to hospital for COVID-19 testing, and they are only mildly symptomatic (as per assessment made by the DHHS nurse and the HBO):

They should be transported to the hotel.

They should be treated as a suspected case of COVID-19 and offered testing again at the hotel.

If they refuse testing at the hotel they should be treated as if they are COVID-19 positive – they must be situated on the COVID floor of the hotel ('RED ZONE') and the necessary precautions taken.

They should be encouraged to comply with testing, but they cannot be forcibly tested.

At the hotel

If a person refuses testing for COVID-19 at a hospital and they are well enough to return to the hotel:

Every effort should be made to encourage them to get tested before leaving hospital to allow for the most appropriate quarantine location at the hotel (COVID floor or 'RED ZONE'). However, they cannot be forcibly tested.

If they continue to refuse testing, they should be transported back to the hotel and treated as if they are COVID-19 positive - they must be situated on the COVID floor of the hotel ('RED ZONE') and the necessary precautions taken.

If a person refuses testing and treatment at a hospital and is too unwell to be released from hospital, a Human Biosecurity Control Order (HBCO) may need to be considered.

At the hotel

Quarantine and isolation arrangements

Accommodation options to promote effective quarantine

There are a number of accommodation options for people – such a couple or family – to promote effective quarantine. When a person within a party or group is identified as positive for COVID-19, other family members who have been cohabiting with that person will need to commence a further 14 days of quarantine from the date of last contact with the infectious person (explained further below). Therefore, there should be an option to separate people – if they consent – at various points in the quarantine journey.

Option 1 – Parties stay together

A couple or family stay together and share a suite or room. If a person becomes positive, an extension of quarantine will be required on a tailored basis for the other persons.

Option 2 – Parties separate from arrival at the hotel

A couple or family are separated from the outset. If a person becomes positive, the other parties do not need to recommence 14 days of quarantine.

Option 3 – Parties are separated once one person becomes positive

A couple or family separate into different rooms (with no contact thereafter) after a person becomes positive for COVID-19. The non-infected persons then start a new 14-day quarantine period, which is served at home once they complete the mandatory 14-day period in the hotel.

Option 4 – Parties stay together after one person becomes positive

The parties stay together. At the end of the 14-day period, they both leave to home isolation, and the non-infected persons commence a further 14-day quarantine period, as long as they separate in the house to which they go.

Communication of these options to people in mandatory quarantine

The DHHS Team Leader should communicate these options to people at booking, with the default option being that parties stay together unless they indicate a preference to separate from the outset.

Room sharing

Well persons

In instances where two or more well people (who are not suspected or confirmed cases of COVID-19) wish to share a room in advance of check-in at the hotel, this should be facilitated. However, they should be informed that sharing a room may have implications for the amount of time they are

required to quarantine (although not their mandatory detention period) should their roommate become a confirmed case.

If a request to share a room is made after an initial period in separate rooms, the persons involved should be informed that this may increase their risk of infection with COVID-19 if the other person is incubating the infection, and that COVID-19 infection may result in serious illness and death in some cases. They should also be informed, as above, that such an arrangement may have implications for the amount of time they are required to be in quarantine if their roommate goes on to develop infection. If the persons still insist, then it must be documented in the Dynamic CRM Database that the risks have been discussed with them (e.g. by a nurse), before facilitating this request.

COVID discordant couples

In instances where one person in a room share situation is identified as a confirmed case and the other person is asymptomatic or has a negative COVID-19 test, the confirmed case should self-isolate in a separate room away from the person who does not have COVID-19. The 14-day quarantine period (but not the mandatory detention period) for the COVID-negative person starts from their last contact with the confirmed case during the confirmed case's infectious period. This may mean that they need to self-quarantine for an additional number of days after the mandatory detention period ends, but they may do this in their own home or in alternative accommodation, not in detention. The self-isolation arrangements for the confirmed case are outlined in the section below ("Exit arrangements for confirmed COVID-19 cases"). If the COVID discordant couple/group still insist on sharing a room for the duration of the detention period, then it must be documented in the Dynamic CRM Database that the risks have been discussed with them (e.g. by a nurse).

COVID floors and hotels

Each hotel should have a COVID-19 positive floor or area (known as the 'RED ZONE'). Any person who is a confirmed case should be relocated to this area of the hotel when the test result is known. Appropriate signage, PPE and other consumables should be available at the entrance to this area of the hotel.

Where there are large numbers of confirmed cases arriving on a flight, a COVID hotel may be considered. Where the infrastructure allows, suspected cases may also be moved to an area of the hotel away from well individuals.

Confirmed cases entering detention

Current infectious cases

In the situation that an arriving passenger is a current infectious case of COVID-19:

They will still be handed the detention notice and will be placed in mandatory quarantine.

They will be given a single use face mask to wear and will be kept separate from the other passengers where possible.

At the hotel, they will be asked to provide confirmation of their diagnosis.

If there is any doubt surrounding the certainty of the diagnosis of COVID-19, they will be offered additional testing.

Recovered cases

In the situation that an individual reports they are a confirmed case of COVID-19 and have recovered from the infection:

They will still be handed the detention notice and placed in mandatory quarantine.

The onus is on the individual to provide the evidence that they have a confirmed case of COVID-19 and the required amount of time has passed such that they are no longer considered infectious.

The department will decide on a case-by-case basis whether evidence from other sources (from testing done overseas) can be considered sufficient proof to inform clinical and public health decision-making.

If they meet the criteria for release from isolation (see below) and the testing and medical reports provided are considered sufficient by the department, they may be considered for release from detention.

They will still be handed the detention notice until this can be verified, and the request has been approved.

Note – there are no automatic exemptions for persons who are recovered cases. These requests need to be assessed on a case-by-case situation.

Throughout detention

Clinical assessment and testing for COVID-19

Timing of testing

Individuals in mandatory quarantine should be tested for COVID-19 if:

They screen positive on the health screen (temperature and symptom check) at the airport.

They report symptoms during a nurse check or welfare check.

A doctor recommends testing.

They screen positive on the voluntary exit health screen 24-48 hours before release.

The had a positive test overseas and the overseas laboratory result does not meet the required reporting standards.

Pathology arrangements

Swabs

Each site should have a twice-daily pathology courier pickup, transporting swabs taken from that site to the specified laboratory.

Currently, the delivery of swabs to each hotel and the arrangement of couriers is being undertaken by REDACTED

The marking requirements for each swab in order to ensure appropriate delivery of results and prioritisation of testing are as follows:

The pathology request slip must be clearly marked as a hotel quarantine swab – this should include the clinical details section or at the top of the form (e.g. “Swab for a person in mandatory quarantine in hotel Crown Metropol, room 1234”);

There must be three identifiers on every swab and pathology request (name, DOB, address);

The address must be listed as the hotel where the person is being quarantined, not their usual home address;

A phone number must be provided for every patient being swabbed;

The name and phone number of the testing clinician **and** the responsible team leader for the hotel should be included.

Provision of testing information to the EOC

Details of quarantined individuals who have COVID-19 testing performed should be sent to the EOC inbox that day, as well as the PH Ops inbox.

- Publichealth.operations@dhhs.vic.gov.au
- DHHSOpSoteriaEOC@dhhs.vic.gov.au

Communication of results

It is the responsibility of the medical practitioner who ordered the test to follow-up the result of the test and ensure arrangements are in place to advise the patient of the result, whether negative or positive. If they are not able to do so, they must handover this task to the next doctor on-call, inform the nurse, and record this in the medical record. If the result is positive, the requesting medical practitioner must notify the department on **1300 651 160**.

Case management

Management of suspected cases

The following actions should be taken once a quarantined individual is a suspected case:

Suspected cases should be isolated in a separate room away from other quarantined individuals if feasible.

If this is not possible and they are sharing a room with another person or persons, they should be given a single use face mask and advised to physically distance themselves (> 1.5m) from other persons in the room, practise hand hygiene and cough and sneeze etiquette, open a window, and clean/sanitise surfaces and common areas.

If they have been isolated in a separate room, when the result of the test is known they can either return to their original room, sharing with other quarantined individuals (if negative), or relocated to the 'red zone' of the hotel (if positive).

Management of confirmed cases

The following actions should be taken once a quarantined individual is a confirmed case:

They should be accommodated / cohorted in a separate section or floor of the hotel, away from the non-COVID-19 infected passengers → the 'RED ZONE' of the hotel.

The medical practitioner who requests the COVID-19 test is responsible for notifying the department of a positive result and notifying the patient (or handing this over to the doctor on call)

A case and contact officer (CCO) from the department will then contact the case and perform a case interview.

The case's room mates will be listed as close contacts and will also be contacted and monitored by the department. They will be given the opportunity to isolate in separate rooms for the remainder of their time at the hotel.

The CCO will have daily contact with the case until they are ready to be released from isolation (and therefore detention).

Appropriate PPE (droplet and contact precautions) should be worn by all persons having contact with the confirmed case.

Hospital transfer plan

The current hotels in operation are in the catchment of four major hospitals:

The Alfred

Royal Melbourne Hospital (RMH)

St Vincent's Hospital

Royal Children's Hospital (RCH)

For any planned or unplanned transfers of suspected or confirmed cases:

All parties (Ambulance Victoria, other transport providers, the receiving hospital) must be informed of the person's COVID status and that they are in mandatory quarantine, so that necessary precautions can be taken.

The quarantined individual should be given a single use face mask to wear in transit, if tolerated.

The transport provider determines PPE requirements for their staff and advises hospital of the patient's COVID and quarantine status.

An information sheet should be sent with the patient to hospital with mandatory quarantine and hotel contact details.

Transfer from hospital to hotel

Discharge from hospital should be at the behest of the treating team.

Refer to the current 'Guidelines for health services and general practitioners' (see https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19).

Transfers from hospital back to the hotel are arranged by the hospital in liaison with the DHHS Team Leader. When the patient is ready for discharge:

The hospital informs the AO that the patient is being discharged.

If within the 14-day mandatory quarantine period:

- The hospital arranges for patient transport back to hotel (including determining necessary PPE requirements).
- The AO checks the patient back into hotel.

If 14-day period has expired:

- Hospital discharges patient and they are free to return home.
- The AO arranges for patient to access hotel to collect their belongings if needed.

Exiting detention

Release from isolation

Criteria for release from isolation

Confirmed cases of COVID-19 will be considered for release from mandatory quarantine, once they meet the department's criteria for release from isolation of a confirmed case:

the person has been afebrile for the previous 72 hours, and

at least **ten days** have elapsed after the onset of the acute illness, and

there has been a noted improvement in symptoms, and

a risk assessment has been conducted by the department and deemed no further criteria are needed

Clearance testing is not required for release from isolation, either in the home or in mandatory quarantine.

Process for release from isolation

As per the DHHS guidelines for health services and general practitioners (see https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19),

the department will determine when a confirmed case no longer requires to be isolated in mandatory quarantine, hospital or in their own home.

Every confirmed case that is diagnosed in Victoria is notified to the department and assigned a case and contact officer (CCO), regardless of whether they are diagnosed in detention or outside of detention. Every confirmed case receives daily contact from the case and contact team.

The CCO will advise when it is appropriate for consideration for release from isolation, and will issue a clearance certificate (via email) to COVID.quarantine@dhhs.vic.gov.au for the case when they meet the criteria for release from isolation.

Nurses looking after confirmed cases in detention should temperature check and review symptoms of confirmed cases daily. The date of acute illness onset should be clearly documented in their records.

Release from detention of a confirmed case

If a confirmed case is due for release from mandatory quarantine but does not yet meet the department's criteria for release from isolation:

They will not be detained longer than the 14-day quarantine period.

They will be released from detention at the agreed time, but will be subject to the Isolation (Diagnosis) Direction

They should be assisted to self-isolate at home or in another suitable premises in Victoria until they meet the required criteria.

A premises is considered suitable if it has a facility/room where the person can be isolated so as not to cause undue a risk for another householder (i.e. not a hostel or dormitory accommodation).

They will be given a single-use face mask to wear when checking-out from the hotel and in transit to their next destination.

They will be provided with a 'confirmed case' information sheet.

Exit arrangements

The following table documents the exit management plans for quarantined individuals in different scenarios.

Scenario	Exit plan
Well person who has served 14 days of quarantine	**Can leave** Receives end of detention notice (universal version). Transport is arranged as part of the standard exit arrangements
Confirmed case of COVID-19 who has met criteria for release from isolation (i.e. is declared no longer infectious as per release from isolation), even if they have not completed their 14-day detention period	**Can leave** Must not be prevented from leaving if the AO is aware they are cleared and the person demands to leave. They are non-infectious and therefore not a public health risk • End of isolation letter provided by Public Health Operations (PH Ops) to COVID Quarantine Inbox and Emergency Operations Centre (EOC) inbox • Release from isolation by Case Manager following Health and Welfare checks • Transport should be arranged as part of the standard exit arrangements • Release outcome provided to EOC, PH Operations and Compliance Team via Case

	Manager
Confirmed case of COVID-19 who is still potentially infectious and has been in detention less than 14 days	**Must stay in detention.**
Confirmed case of COVID-19 who is still potentially infectious but has reached the end of their 14-day detention period	**Can leave** Detention but is now subject to the Isolation (Diagnosis) Direction If Victorian Resident • Accommodation needs to be identified by PH Operations and EOC informed of needs prior to end of detention period – either home isolation with transport or continued hotel voluntary isolation • Safe travel to be arranged by EOC to place of isolation in Victoria (mask, stay separate, go straight to home; but preferred travel by non-emergency patient transport with PPE'd ambulance officers) • Case continued to be monitored by PH Operations If Interstate Resident • Not permitted to travel interstate / not permitted to fly domestically but no detention order needed to prevent – they must proceed immediately to a place of isolation. • Accommodation identified by PH Operations and EOC informed of needs prior to end of detention period – continued hotel voluntary isolation (noting that interstate travel is not allowed)
Close contact of a confirmed case of COVID-19 who has reached the end of their 14-day detention period	Close contact's end date of quarantine may be past that of 14-day detention period Case and Contact Sector must do an assessment, assign a new 14-day period (from date of last contact with infectious case) and issue a requirement to quarantine until that 14 days ends – give factsheet, lodge new date in PHESS, reverting person to effective close contact status. No detention order required, and no legal order preventing flying, but must be advised by case and contact management sector not to fly and that they need to quarantine If Victorian Resident Need for accommodation to be identified by PH Operations and EOC informed of needs prior to end of detention period – either home isolation with transport or continued hotel voluntary isolation Safe travel to be arranged by EOC to place of

	isolation in Victoria (mask, stay separate, go straight to home; but preferred travel by non-emergency patient transport with PPE'd ambulance officers) Contact continued to be monitored by PH Operations If Interstate Resident Should be advised not to travel to interstate jurisdiction – do not currently have powers to prevent travel Accommodation needs to be identified by PH Operations and EOC informed of needs prior to end of detention period – either interstate transport or continued hotel voluntary isolation Appropriate hygiene precautions must be taken if travelling by air (i.e. face masks) and people must return straight home. The home jurisdiction must be informed so they can be followed up as close contacts by their home jurisdiction
Hotel detainees who have symptoms and are awaiting test results at the end of the 14-day detention period.	Individuals with symptoms cannot be detained and are not under an isolation direction but are asked to self-isolate while awaiting results. Hotel Nurse should inform EOC and PH Operations of test being undertaken. EOC should have discharge plan in place for individuals awaiting test results. Allowed to leave detention safely (mask, separate; ideally NEPT transport to home isolation). EOC should follow-up result to convey result (as DHHS oversaw this testing so is obliged to follow-through). If Victoria resident Safe travel to be arranged by EOC to place of isolation in Victoria until results are known If Interstate Resident Accommodation should be arranged by EOC until test results are known. If individual is positive – case will be managed by PH Operations

Suspected cases

Any suspected case of COVID-19 who is in mandatory quarantine who has reached 14 days from the start of their mandatory quarantine period (midnight) may leave and should be assisted to safely isolate in an appropriate environment until COVID-19 is excluded.

Any suspected case of COVID-19 who is in mandatory quarantine who has NOT reached 14 days from the start of their mandatory quarantine period (midnight) needs to remain in mandatory quarantine.

Confirmed cases

Confirmed cases who leave detention but have not yet met the department's criteria for release from isolation are now subject to the Isolation (Diagnosis) Direction.

Non-emergency ambulance transport

When a confirmed case of COVID-19 who is considered still infectious (but is stable) is assessed as appropriate for transition to isolation in their home and is nearing the end of the 14-day quarantine period, Ambulance Victoria (AV) will be requested by the DHHS Team Leader to provide non-emergency patient transport (NEPT) for that person to a destination in Victoria that is the assessed appropriate home isolation location.

If there are multiple persons to be transitioned to home isolation on the same day, subject to compliance-related logistics and any privacy considerations being met, it is permissible for two or more potentially infectious confirmed cases of COVID-19 to be transported together in one NEPT, i.e. to cohort confirmed cases.

Quarantine domestic travel checklist

The following is a checklist of what is required for a person to travel domestically whilst they should still be in quarantine (i.e. if they have been released from mandatory quarantine (detention)):

The requirements for onward travel (e.g. funeral, sick relative).

Reassessment that the person remains well (afebrile, asymptomatic).

Person has a supply of single use face masks and hand sanitiser.

The two rows around the person on the flight are kept empty.

Care after release from mandatory quarantine

It is important that when a quarantined person has health concerns that need ongoing medical care, transfer of care to another healthcare practitioner, including appropriate documentation and/or copy of the medical record, is arranged when the person is released from mandatory detention.

Operational guidance for mandatory quarantine

Process for mandatory hotel quarantine

*Note: 14-day mandatory quarantine period refers to the hotel detention directive.

Overseas travellers are assessed at the airport and transported for testing if symptomatic.

When they arrive at the hotel, people must be informed that if someone becomes a confirmed case and they are sharing a hotel room, the quarantine period will be extended.

If someone becomes a confirmed case, people will be given the option to separate. This is to reduce the likelihood of the close contact becoming infected.

A close contact's quarantine period (14 days) begins from the last contact with a confirmed case during their infectious period. If people choose not to separate, the quarantine period cannot begin until the confirmed case meets the release from isolation criteria.

Quarantined individuals in hotels who are not cases or contacts are managed by the staff (e.g. DHHS team leaders, Authorised Officers, nurses and doctors) located on-site.

If a quarantined individual develops symptoms, they should be offered testing by the hotel nurses. They should inform the Case and Contact Management team.

Once a quarantined individual becomes a confirmed case or contact, they should be managed by Public Health Operations (PH Ops).

PHOps is to inform the EOC of all confirmed cases and identified contacts.

Quarantined individual becomes a confirmed case

If a hotel detainee becomes a confirmed case, they are followed up by the New Cases team.

An interview is conducted to identify possible acquisition and close contacts. The difference between the 14-day mandatory hotel quarantine period and the isolation requirements during their infectious period are explicitly explained. The case will have been told this information on arrival.

The EOC is informed via email of the confirmed case. If it is identified that people wish to separate, an additional room is requested in the email.

A confirmed case is contacted daily by the Existing Cases team for a risk assessment of symptoms.

If a confirmed case meets the release from isolation criteria within the 14-day mandatory quarantine period, the PH Ops emails COVID quarantine and the EOC and provides a standardised letter informing the case they have met their release from isolation criteria.

The case is informed of the release process, and to expect contact by the Hotel Team Leader.

If a confirmed case meets the release from isolation criteria after the 14-day mandatory quarantine period is completed and is not a Victorian resident or is a Victorian resident and cannot return to an appropriate location, PH Ops emails the EOC and requests extended accommodation to be arranged. The outcome must be provided back to PH Ops.

If a confirmed case meets the release from isolation criteria after the 14-day mandatory quarantine period is completed and is a Victorian resident that can continue to quarantine within their home, the PH Ops emails the EOC to request arrangement of transport. The outcome must be provided back to PH Ops.

Quarantined individual becomes a close contact

Close contacts are followed up by the New Close Contact team.

The difference between 14-day mandatory hotel quarantine period and the 14-day quarantine period from last contact with a confirmed case is explicitly explained. If currently sharing a room, they are advised that their quarantine period will be extended and are advised to separate.

If they wish to separate, the PH Ops emails EOC and request an additional room be organised for the close contact.

A close contact is contacted daily by the Existing Contacts team to assess if they have developed symptoms and assess if they are still sharing a room. If still sharing, the Existing Contacts team again recommend separating and explicitly explain that their 14-day quarantine period will be extended. If it is identified that people wish to separate, the PH Ops will email the EOC and request an additional room be organised.

If a close contact develops symptoms and requires testing, the Existing Contacts team emails the EOC to arrange testing.

If a close contact (Victorian resident) has completed their 14-day mandatory quarantine period but is still within their 14-day quarantine period, the PH Ops emails EOC to request transport be arranged for them to return home for the remainder of their quarantine period. The outcome must be provided back to PH Ops.

If a close contact (non-Victorian resident or Victorian resident that cannot return to an appropriate location) has completed their 14-day mandatory quarantine period but is still within their 14-day

quarantine period, the PH Ops emails EOC and requests extended accommodation to be arranged. The outcome must be provided back to PH Ops.

If an interstate resident wishes to return to their home state for the remainder of their quarantine period, this may be considered on a case by case basis.

Appropriate hygiene precautions must be taken if travelling by air (i.e. face masks) and people must return straight home. The home jurisdiction must be informed so they can be followed up as close contacts by their home jurisdiction.

Other measures

To ensure all parties are kept informed of current residents and cases/contacts:

Accommodation team to provide daily updates of all residents arriving in detention to PH Ops.

PH Ops to provide daily updates of all cases and contacts currently in detention.

This process will be reviewed as the operation progresses.

Infection control and hygiene

Cleaning

Please refer to the department document ‘Cleaning and disinfecting to reduce COVID-19 transmission.’

Biohazard bags can be left for residents to place dirty linen in and to leave outside their rooms for collection. Terminal cleaning (cleaning and disinfection) is required on vacation of each room.

Laundry

Staff may wear PPE when handling dirty laundry. Laundry should be washed on the highest possible setting and thoroughly dried before use. Staff should not overly handle the linen – it should be put straight into the washing machines. Staff should follow hand hygiene procedures after handling dirty linen.

Personal protective equipment

A supply of P2/N95 masks and gowns should be maintained, in addition to single-use face masks and gowns. PPE stocks should be checked regularly by the DHHS Team Leader, and urgently requested if needed. Regular stocktake should be undertaken to pre-empt additional orders.

Hotels should have allocated PPE donning and doffing areas. Biohazard bags for waste disposal, and hand hygiene stations, should be available at the doffing section of the hotel.

PPE protocols should be available to all staff working in the hotels, so that there is clear instruction on what type of PPE to wear and in what circumstances, how to don and doff it, and how to dispose of it. The PPE protocols must be in line with DHHS recommendations for PPE use for COVID-19 (droplet and contact precautions).

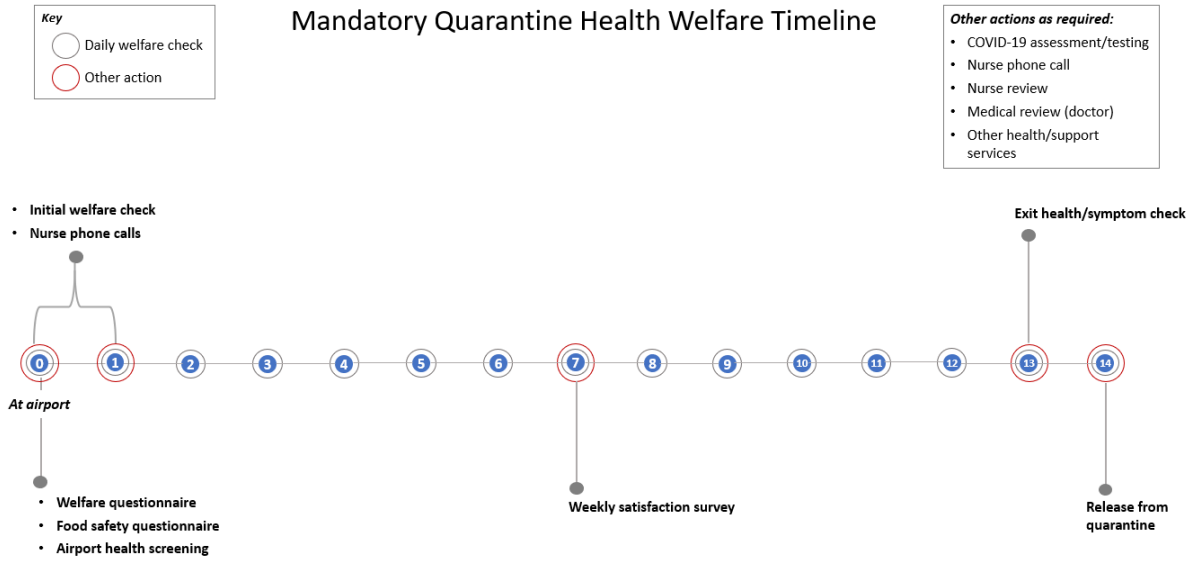
Note: P2 or N95 masks are only recommended for use when aerosol generating procedures are being undertaken or will occur. In all other instances don a surgical face mask for direct case contact.

Health and welfare assessments (arrival, during detention, preparation for discharge)

Healthcare and welfare timeline

The following table consists of an overview of the recommended healthcare and welfare checks and activities carried out throughout the 14-day mandatory quarantine period:

Timing	Process/activity
At the airport	- Airport health screening by contracted nurses (escalation to Health Biosecurity Officer) - Welfare questionnaire - Food safety questionnaire
At the hotel (within first 24 hours)	- Initial welfare phone-call - Nurse phone-call
Daily throughout the quarantine period	- Welfare check (phone or text) - Nurse check (as required)
Weekly	- Satisfaction survey
24-48 hours before exiting	- Exit health/symptom check
As required	- COVID-19 assessment/testing - Nurse phone-call - Nurse review - Doctor review - Other health/support services



Assessment at the airport

At the airport, DHHS contracted nurses and Department of Agriculture, Water and the Environment (DAWE) biosecurity officers will screen all passengers arriving from overseas for symptoms of COVID-19. Nurses will perform a temperature check on each passenger. Any passengers that have a fever or COVID 19 may refer to the Health Biosecurity Officer for escalation/review.

Assessment at the hotel

All quarantined individuals will be given a welfare questionnaire and a food safety questionnaire to complete on the way to or at the hotel. These questionnaires include questions about past medical history, mental health history, allergies, medications, next of kin/emergency contact details, dietary requirements, and other important health and welfare needs. A doctor and nurse will be available on site to urgently review anyone who reports illness or an urgent medical need on arrival at the hotel. Nurses will review the questionnaires and contact all individuals who are identified as having significant health needs, as soon as is practicable. After initial phone contact is made, further assessment/management can be organised as needed.

Assessment during detention

Medical care should be available 24 hours a day to individuals in mandatory quarantine.

The need for medical care can be identified through the following channels:

Via the daily welfare check (See Appendix 6- Welfare Survey)

By the person contacting the concierge or nurse directly

Nurse phone call to the individual

The 1800 government services number (DJPR), the physical distancing hotline, the COVID hotline, or any other DHHS phone line

Family members directly contacting the hotel/team/COVID quarantine inbox

Individuals in mandatory quarantine should be supported to contact their regular health care provider by phone or telemedicine if appropriate. In these instances, the healthcare provider should be provided with the contact details of the hotel nurse or GP so that the outcome of the assessment or management plan can be communicated to the medical team on site.

Assessment in preparation for exit

Approximately 24-48 hours before the mandatory quarantine detention period is complete, each quarantined individual should be offered a health check. This will be carried out by the nurse and consists of a review for symptoms and a temperature check. This health screen is voluntary, and the outcome will not affect the duration of the detention period, but may influence further clinical management.

If a person screens positive on the health check:

They will not be detained longer than the 14 day mandatory quarantine period.

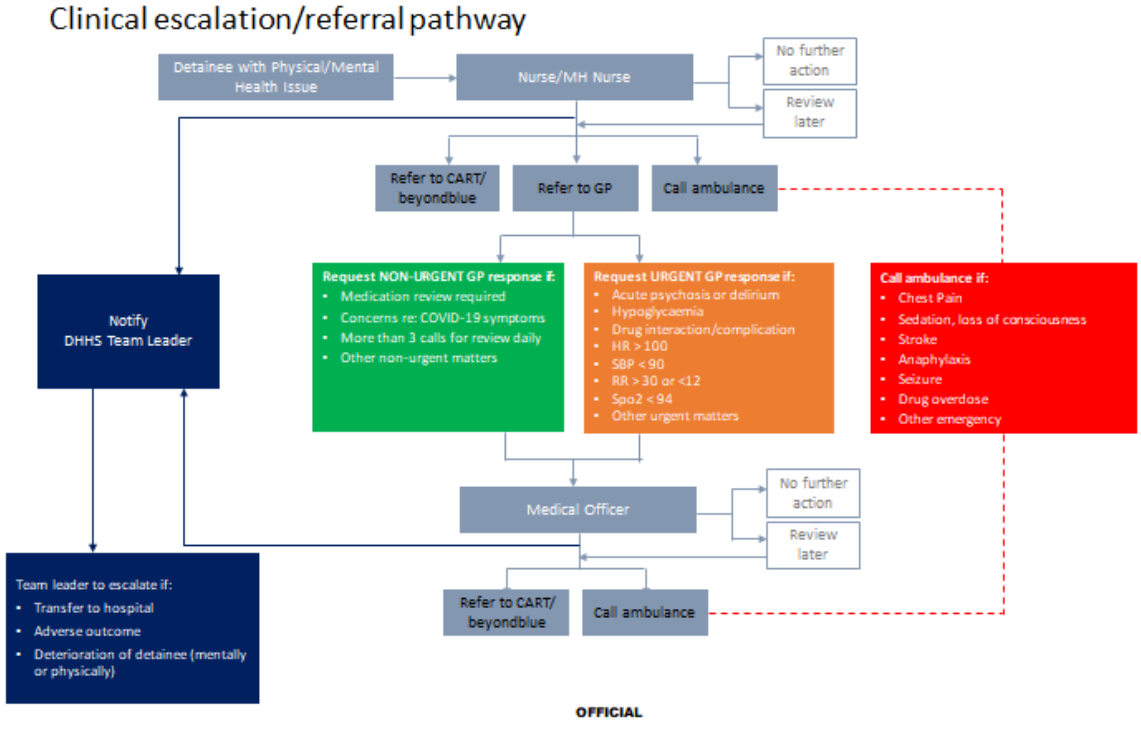
A swab will be sent and they will be informed that they need to self-isolate after exiting, until the result of the swab is known

If they do not have appropriate accommodation to self-isolate after release, they will be assisted to find such accommodation

If a person screens negative on the health check, no further action is required.

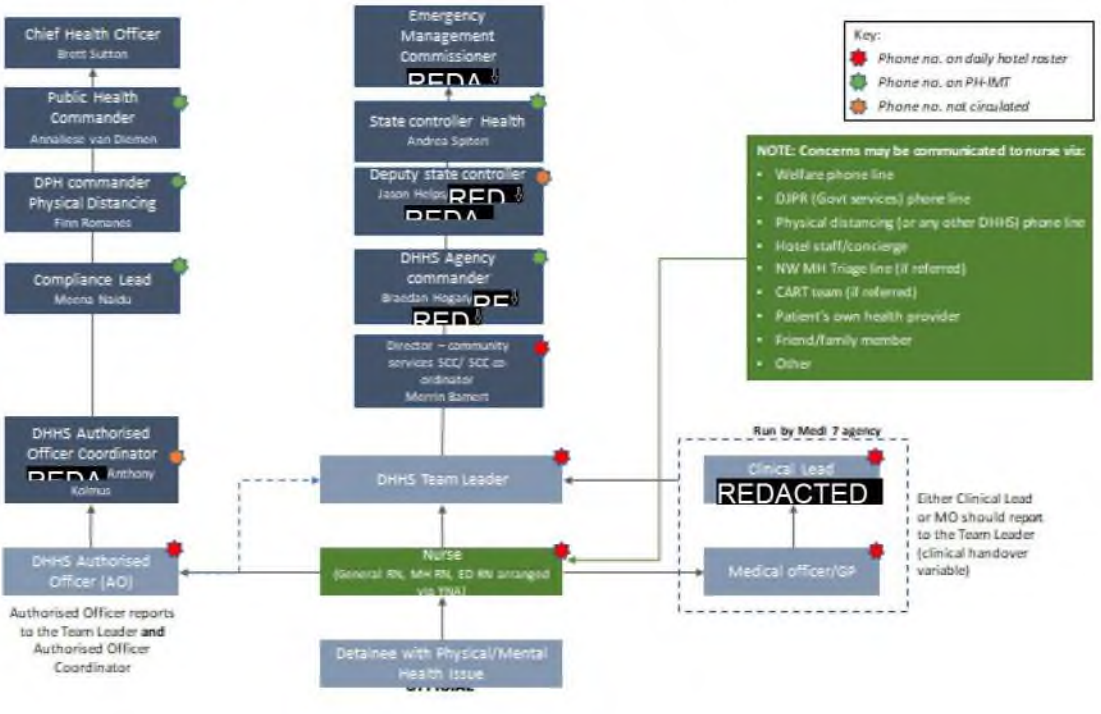
Escalation process flowchart

Example Clinical Escalation/Referral Pathway



Chain of command for detainee identified as having physical/mental health issue

Chain of command re: Detainee Physical/Mental Health Issues



Infection prevention & control/PPE cell

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

To: [redacted] "Katherine Ong (DHHS)" [redacted]

Cc: Allen Cheng [redacted]

Date: Fri, 27 Mar 2020 21:39:43 +1100

Dear all,

As discussed with most of you, it has become evident that expert guidance in infection prevention and control/PPE policy needs to be a bit more coordinated and systematised.

I am proposing that we implement a cell, primarily with [redacted] (apologies I don't have her email address) to coordinate and consolidate any pieces of work around infection prevention and control and PPE usage throughout the COVID19 response.

Katherine Ong will be the executive lead for this for the moment as she is transitioning back into the Public Health response side, given the ongoing links into the hospitals and primary care world.

Medical team, Allen has agreed on your collective behalves for the team to seek guidance as required from all of you, especially given it sounds like a lot of things have been developed already for your services. I thought it would be good to share the load- we wont call all of you all of the time!

The overall structure of the departmental response may change somewhat next week, so we can see where this group might fit generally, but it is really just a virtual grouping of all the people who need to be involved in the decision making around this, to be coordinated by Katherine. I will find a spot for this to report through to into the IMT next week once things are a bit more settled.

A major initial piece of work which needs to be done as soon as possible is assisting Jackie Kearney with PPE and aged care, which I believe has a meeting already booked next week. Quick dot points over this are:

- Commonwealth have said they will reimburse states for PPE provided to Aged Care in outbreaks
- Takes too long to get it from Canberra so we need a supply here, ready to go.
- Cannot preposition in facilities as people are stealing it
- Need a quick plan covering:
    - Basic stocktake and needs assessment of what a facility should have to get them through first 24 hours of an outbreak
    - Idea of how much we should have in stock if a number of facilities report outbreaks over a weekend
    - Put in place a process for those who are managing outbreaks to also get PPE to facilities asap – should be done via the regular outbreak processes not in a separate manner
    - Aged care sector in general could also do with some staff training and or modules (possibly with help from RICPRAC) from recent reports

There will be many further pieces of work as models of care, cohorting, streaming, new products etc come up so no shortage.

Thanks all, have a good weekend .

Annaliese

Dr Annaliese van Diemen MBBS BMedSc MPH FRACGP FAFPHM
Public Health Commander- COVID-19 Department Incident Management Team
Deputy Chief Health Officer (Communicable Disease)
Regulation, Health Protection & Emergency Management
Department of Health & Human Services | 14 / 50 Lonsdale St
REDACTED
health.vic.gov.au/public-health

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

RE: FOR APPROVAL: Infection control training - HOTELS

From: "Annaliese Van Diemen (DHHS)" REDACTED
REDACTED
To: "Katherine Ong (DHHS)" REDACTED
Cc: REDACTED
Date: Wed, 10 Jun 2020 10:35:26 +1000

Thanks Katherine,

Approved by me.

Cheers

Annaliese

Dr Annaliese van Diemen MBBS BMedSc MPH FRACGP FAFPHM
Public Health Commander- COVID-19 Department Incident Management Team
Deputy Chief Health Officer (Communicable Disease)
Regulation, Health Protection & Emergency Management
Department of Health & Human Services | 14 / 50 Lonsdale St
REDACTED
health.vic.gov.au/public-health

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

From: Katherine Ong (DHHS) REDACTED
Sent: Wednesday, 10 June 2020 9:00 AM
To: Annaliese Van Diemen (DHHS) REDACTED
Cc: REDACTED
Subject: FOR APPROVAL: Infection control training - HOTELS

Hi Annaliese,

Just seeking your in principle approval to arrange IPC training for security staff at hotels as detailed below. We have a provider who have used to train the outreach nurses, and this would cost $4250 (5 days at $850 per day), and there is already $20K signed off on the contract by RE.

Just wanted to check you're comfortable with this approach, as I'm not across the hotel arrangements and whether it's within our remit to provide IPC training to the security staff.

Thanks,
Katherine

Dr Katherine Ong
Deputy Public Health Commander, Pathology and Infection Prevention & Control
COVID-19 Public Health Incident Management Team
Department of Health & Human Services | 50 Lonsdale Street, Melbourne, Victoria, 3000
REDACTED

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

From: REDACTED
Sent: Tuesday, 9 June 2020 5:00 PM
To: Katherine Ong (DHHS) REDACTED
Cc: REDACTED
REDACTED
Subject: Fw: Infection control training - HOTELS

Hi Katherine,
I had a discussion with REDACTED last week about the need for training of security guards involved in the Rydges COVID Hotel (and potential for ongoing breaches) and RE raised some concerns about consistency in training and, the outreach teams abaility to deliver training to Security guards.

The following email trail highlights my proposed next steps. I have spoken with RED and RED indicated REDA has up to $20,000 value in RE contract, some of which may be available to run 1.5-2 hr sessions f-f with the securtiy guards. This of course would need to be agreed to by the Security companies contracting services to the COVID hotels but it is likely that the potential pool is 100-200 - RE wasnt quite sure how many but though it was around this number as they service 4 hotels in 3 shifts on several floors!

In summary:

- I estiamte 15pax in each session @1.5 hours (4 sessions per day total of 6 hours) run over 5 days = 30 hours
- content would be developed by the IPC cell and at a minimum cover basic COVID info, PPE and likely scenarios plus a practical don/doff session
- REDA available when approvals granted

If you approve in principal I can progress if RE is happy with my suggested way forward?

Kind regards,
REDACTED

From: REDACTED
Sent: Tuesday, 9 June 2020 16:42
To: REDACTED
Cc: REDACTED
REDAC
Subject: Re: Infection control training

Hello RED
I am just updating you on a couple of issues regarding hotel security training we discussed late last week.

I have spoken with another education consultant approved for use by the Department, REDAC REDACT and RE has the capacity and willingness to train the security guards and, there is also provision within his existing DHHS contract to do this as his scope included other high risk non-health settings. We dicussed this in the IPC cell and given that security guards may be non-EAFL and as we know adult learners in this type of occupational group learn best through practical demonstration that hands on training would be best.

I am proposing 2 hours (max time) to train security guards in groups of 10-15 with REDA at the

Hotel location. In order to scope out the next steps are you able to provide the names of the 2 security guard companies and I will contact them to find out numbers and seek their approvals to progress? Are you happy with this approach? If not would you mind contacting them in the first instance, making the introduction, setting the background and I'll facilitate next steps toward training?

The IPC cell will provide the high level advice and expertise to REDACTED which will ensure RE works to a minimum set of competencies and, that the delivery and content is standardised and aligns with the hotel nurse IPC/PPE training provided to date.

The IPC cell is also reviewing the videos put forward to see where the inconsistency may have occurred around key PPE steps between the training initially provided by REDACTED and the WHO video, and other training you mentioned in your email on Friday. I particularly like your suggestion of considering utilising REDACTED if RE has capacity to assist with independent reviews as a quality assurance activity?

Once I have had the 'green light" from you regarding the proposed way forward I will seek final approval from Katherine Ong to progress this work.

Please let me know if any clarification required RED
Kind regards,
REDACTED

From: REDACTED
Sent: Friday, 5 June 2020 19:28
To REDACTED
Subject: Infection control training

H REDACTED

Attached are the endorsed documents currently available to support the quarantine hotels

The following links have also been provided for consideration

Hand hygiene

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

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

Further Education

Although the security group may not fit exactly in the 'who it's for' training description, the security sector now finds itself providing in the hotel group used for quarantining and isolating those with Covid19. There are some who may find it useful. Just a thought…

Covid 19 Infection Control Training 30 minute video – put out by the Australian Govt.
https://www.health.gov.au/resources/apps-and-tools/covid-19-infection-control-training

As mentioned I am keen to establish a consistent approach across all the hotels in the education offered relating to infection control measures. Included in this will be a clarity around the resourcing available through the IPC and the Outbreak team and understanding how best we can use the expertise of REDACTED I wonder if it is good to consider utilising RED to assist with independent reviews as an assurance activity?

I have attached the EOC roster so you have an overview of the structure within the EOC and command structure. We are currently located at the Fitzroy office but arrangements are underway for us to relocate to 50 Lonsdale in the next few weeks.
REDACTED, is my counterpart and we alternate on the Health Coordination roster

Have a lovely weekend

Cheers
RED

REDACTED

Incident Action Plan

Novel Coronavirus 2019/20

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

Priorities (2 February 2020)

As of 1700 on 1 February 2020,

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

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

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

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

Other relevant positions

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

Governance

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

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

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

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

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

Administration

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

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

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

Safety

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

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

Ready access to Employee Assistance Program services for staff.

Risk assessment

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

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

As of 1 February 2020,

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

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

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

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

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

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

1. Confirmed case

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

2. Suspected case

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

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

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

Risk management

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

Case management

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

Laboratory management

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

Contact management

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

Infection prevention and control

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

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

Risk communication

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

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

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

Attachments

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

FOR OFFICIAL USE ONLY

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

Situation overview

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

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

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

Epidemiology Summary	

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

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

State Response and Control Measures	

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

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

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

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

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

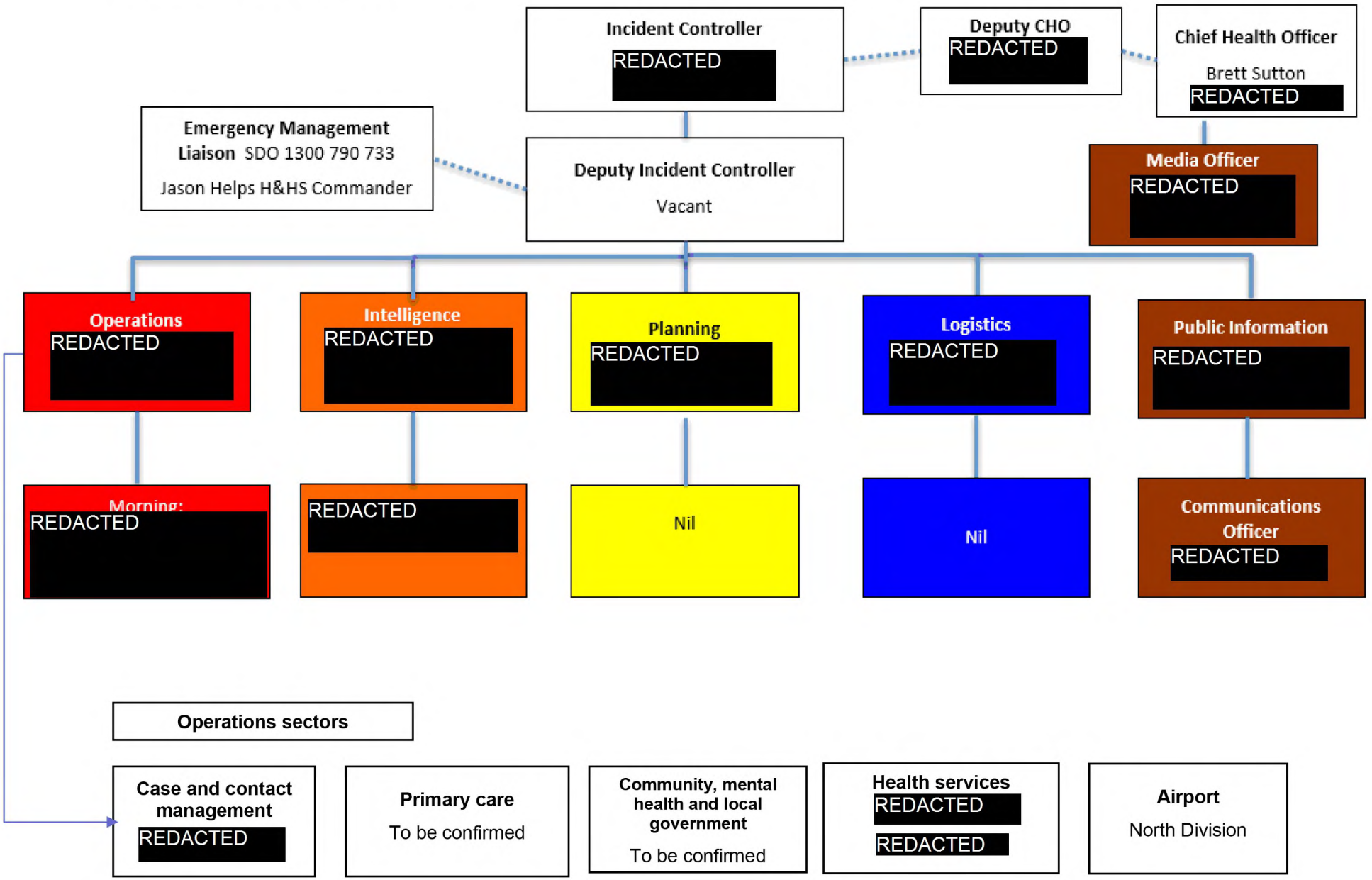
Appendix B: Action list (2 February 2020)

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

Appendix C: Log of significant policy changes

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

Appendix D: Incident Management Team



Appendix E: Communication lists

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

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

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

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

'VIP' distribution list
To be confirmed

Cleaning and disinfecting to reduce COVID-19 transmission

Tips for non-healthcare settings
20 March 2020

Purpose

The current outbreak of coronavirus disease 2019 (COVID-19) has been declared a pandemic. The Victorian government is working with health services, agencies and businesses to keep the Victorian community safe.

As more people are diagnosed with COVID-19, practicing good personal hygiene will be critical to help prevent the spread of this disease. It will also be important to clean and disinfect premises, including non-healthcare settings, where cases worked or studied.

This guide aims to provide advice on cleaning and disinfecting to reduce the risk of COVID-19 transmission in all non-healthcare settings in Victoria. The principles in this guide apply equally to domestic settings, office buildings, small retail businesses, social venues and all other non-healthcare settings.

How COVID-19 is transmitted

- COVID-19 spreads through close contact with an infected person and is typically transmitted via respiratory droplets (produced when an infected person coughs or sneezes). It may also be possible for a person to acquire the disease by touching a surface or object that has the virus on it and then touching their own mouth, nose or eyes, but this is not thought to be the main way that the virus is spreading in this pandemic.
- Current evidence suggests the virus causing COVID-19 may remain viable on surfaces for many hours and potentially for some days. The length of time that COVID-19 survives on inanimate surfaces will vary depending on factors such as the amount of contaminated body fluid (e.g. respiratory droplets) present, and environmental temperature and humidity. In general, coronaviruses are unlikely to survive for long once droplets produced by coughing or sneezing dry out.

Cleaning and disinfection

- **Cleaning** means physically removing germs, dirt and organic matter from surfaces. Cleaning alone does not kill germs, but by reducing the numbers of germs on surfaces, cleaning helps to reduce the risk of spreading infection.
- **Disinfection** means using chemicals to kill germs on surfaces. This process does not necessarily clean dirty surfaces or remove germs, but by killing germs that remain on surfaces after cleaning, disinfection further reduces the risk of spreading infection. Cleaning before disinfection is very important as organic matter and dirt can reduce the ability of disinfectants to kill germs.
- Transmission or spread of coronavirus occurs much more commonly through direct contact with respiratory droplets than through contaminated objects and surfaces. The risk of catching coronavirus when cleaning is substantially lower than any risk from being face-to-face without appropriate personal protective equipment with a confirmed case of COVID-19 who may be coughing or sneezing.

Importance of cleaning your hands regularly

- Soap and water should be used for hand hygiene when hands are visibly soiled. Use an alcohol-based hand rub at other times (for example, when hands have been contaminated from contact with environmental surfaces).
- Cleaning hands also helps to reduce contamination of surfaces and objects that may be touched by other people.
- Avoid touching your face, especially their mouth, nose, and eyes when cleaning.

- Always wash your hands with soap and water or use alcohol-based hand rub before putting on and after removing gloves used for cleaning.

Cleaning and disinfection

Routine cleaning and disinfection

Households, workplaces and schools should routinely (at least daily) clean frequently touched surfaces (for example, tabletops, door handles, light switches, desks, toilets, taps, TV remotes, kitchen surfaces and cupboard handles). Also, clean surfaces and fittings when visibly soiled and immediately after any spillage. Where available, a disinfectant may be used following thorough cleaning. See below for choice, preparation and use of disinfectants.

What to clean and disinfect and when

Clean and disinfect all areas (for example, offices, bathrooms and common areas) that were used by the suspected or confirmed case of COVID-19. Close off the affected area before cleaning and disinfection. Open outside doors and windows to increase air circulation and then commence cleaning and disinfection.

In situations where a suspected or confirmed case remains in a facility that houses people overnight (for example, a boarding house or hotel), focus on cleaning and disinfection of common areas. To minimise any risk of exposure to staff, only clean or disinfect bedrooms/bathrooms used exclusively by suspected or confirmed case as needed.

In household settings where there is an suspected or confirmed case, dedicate a bedroom (and bathroom if possible) for their exclusive use. Clean or disinfect the ill person's bedroom/bathroom as needed (at least daily). If a separate bathroom is not available, the bathroom should be cleaned and disinfected after each use by the ill person.

How to clean and disinfect

1. Wear gloves when cleaning and disinfecting. Gloves should be discarded after each clean. If it is necessary to use reusable gloves, gloves should only be used for COVID-19 related cleaning and disinfection and should not be used for other purposes. Wash reusable gloves with soap and water after use and leave to dry. Clean hands immediately after removing gloves.
2. Thoroughly clean surfaces using detergent (soap) and water.
3. Apply disinfectant to surfaces using disposable paper towel or a disposable cloth. If non-disposable cloths are used, ensure they are laundered and dried before reusing.
4. Ensure surfaces remain wet for the period of time required to kill the virus (contact time) as specified by the manufacturer. If no time is specified, leave for 10 minutes.

A one-step detergent/disinfectant product may be used as long as the manufacturer's instructions are followed regarding dilution, use and contact times for disinfection (that is, how long the product must remain on the surface to ensure disinfection takes place).

Cleaning and disinfection of items that cannot withstand bleach

Soft furnishings or fabric covered items (for example, fabric covered chairs or car seats) that cannot withstand the use of bleach or other disinfectants or be washed in a washing machine, should be cleaned with warm water and detergent to remove any soil or dirt then steam cleaned. Use steam cleaners that release steam under pressure to ensure appropriate disinfection.

Use of personal protective equipment (PPE) when cleaning

Gloves are recommended when cleaning and disinfecting. Use of eye protection, masks and gowns is not required when undertaking routine cleaning.

Always follow the manufacturer's advice regarding use of PPE when using disinfectants.

For cleaning and disinfection for suspected and confirmed cases, when available, a surgical mask and eye protection may provide a barrier against inadvertently touching your face with contaminated hands and fingers, whether gloved or not.

For cleaning and disinfection for suspected and confirmed cases, wear a full-length disposable gown in addition to the surgical mask, eye protection and gloves if there is visible contamination with respiratory secretions or other body fluid. Get advice from your work health and safety consultants on correct procedures for wearing PPE.

Choice, preparation and use of disinfectants

- Where possible, use a disinfectant for which the manufacturer claims antiviral activity (meaning it can kill viruses). Chlorine-based (bleach) disinfectants are one product that is commonly used. Other options include common household disinfectants or alcohol solutions with at least 70% alcohol (for example, methylated spirits).
- Follow the manufacturer's instructions for appropriate dilution and use. Table 1 below provides dilution instructions when using bleach solutions.

Chlorine dilutions calculator

Household bleach comes in a variety of strengths. The concentration of active ingredient — hypochlorous acid — can be found on the product label.

Table 1. Recipes to achieve a 1000 ppm (0.1%) bleach solution

Original strength of bleach		Disinfectant recipe		Volume in standard 10L bucket
%	Parts per million	Parts of bleach	Parts of water	
1	10,000	1	9	1000 mL
2	20,000	1	19	500 mL
3	30,000	1	29	333 mL
4	40,000	1	39	250 mL
5	50,000	1	49	200 mL

For other concentrations of chlorine-based sanitisers not listed in the table above, a dilutions calculator can be found on the department's website <https://www2.health.vic.gov.au/public-health/infectious-diseases/infection-control-guidelines/chlorine-dilutions-calculator>.

Management of linen, crockery and cutlery

If items can be laundered, lauder them in accordance with the manufacturer's instructions using the warmest setting possible. Dry items completely. Do not shake dirty laundry as this may disperse the virus through the air.

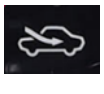
Wash crockery and cutlery in a dishwasher on the highest setting possible. If a dishwasher is not available, hand wash in hot soapy water.

Reducing the risk of transmission in social contact settings

Social contact settings or environments include (but are not limited to), transport vehicles, shopping centres and private businesses.

To reduce the risk of spreading COVID-19 in these settings:

- Promote cough etiquette and respiratory hygiene.
- Routinely clean frequently touched hard surfaces with detergent/disinfectant solution/wipe.
- Provide adequate alcohol-based hand rub for staff and consumers to use. Alcohol-based hand rub stations should be available, especially in areas where food is on display and frequent touching of produce occurs.
- Train staff on use of alcohol-based hand rub.
- Consider signs to ask shoppers to only touch what they intend to purchase.

Vehicle air-conditioning should be set to fresh air ☒  ☑ 

Cleaning and disinfection

From: "Sarah McGuinness (DHHS)" REDACTED

To: REDACTED REDACTED

Cc: "Merrin Bamert (DHHS)" REDACTED "Pam Williams (DHHS)" REDACTED

Date: Fri, 29 May 2020 15:38:26 +1000

Attachments: Cleaning and disinfecting to reduce COVID-19 transmission Building and construction sites- 4 April (1).docx (64.65 kB)

Hi REDA

As discussed, we are concerned that **environmental transmission** may be happening at the Rydges hotel.

In consultation with our IPC team, I am recommending that we implement **at least once daily** cleaning + disinfection (using a disinfectant for which the manufacturer claims **antiviral activity**) of all common areas at the Rydges hotel frequently by staff including all high touch surfaces AND lifts.

Attached are the current DHHS guidelines for cleaning and disinfection. A commercial cleaning company should be able to provide this level of cleaning.

Thanks and kind regards,
Sarah

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

Cleaning and disinfecting to reduce COVID-19 transmission

Building and construction sites

4 April 2020

Purpose

The current outbreak of coronavirus (COVID-19) has been declared a pandemic. The Victorian government is working with health services, agencies and businesses to keep the Victorian community safe.

As more people are diagnosed with coronavirus (COVID-19), practicing good personal hygiene will be critical to help prevent the spread of this disease. It will also be important to clean and disinfect premises, including non-healthcare settings, where cases worked or studied.

This guide aims to provide advice on cleaning and disinfecting to reduce the risk of coronavirus (COVID-19) transmission in building and construction sites. Note that this advice applies to all non-healthcare settings in Victoria. The principles in this guide apply equally to domestic settings, office buildings, small retail businesses, social venues and all other non-healthcare settings.

How coronavirus (COVID-19) is transmitted

- Coronavirus (COVID-19) spreads through close contact with an infected person and is typically transmitted via respiratory droplets (produced when an infected person coughs or sneezes). It may also be possible for a person to acquire the disease by touching a surface or object that has the virus on it and then touching their own mouth, nose or eyes, but this is not thought to be the main way that the virus is spreading in this pandemic.
- Current evidence suggests the virus causing coronavirus (COVID-19) may remain viable on surfaces for many hours and potentially for some days. The length of time that coronavirus (COVID-19) survives on inanimate surfaces will vary depending on factors such as the amount of contaminated body fluid (e.g. respiratory droplets) present, and environmental temperature and humidity. In general, coronaviruses are unlikely to survive for long once droplets produced by coughing or sneezing dry out.

Cleaning and disinfection

- **Cleaning** means physically removing germs, dirt and organic matter from surfaces. Cleaning alone does not kill germs, but by reducing the numbers of germs on surfaces, cleaning helps to reduce the risk of spreading infection.
- **Disinfection** means using chemicals to kill germs on surfaces. This process does not necessarily clean dirty surfaces or remove germs, but by killing germs that remain on surfaces after cleaning, disinfection further reduces the risk of spreading infection. Cleaning before disinfection is very important as organic matter and dirt can reduce the ability of disinfectants to kill germs.
- Transmission or spread of coronavirus occurs much more commonly through direct contact with respiratory droplets than through contaminated objects and surfaces. The risk of catching coronavirus when cleaning is substantially lower than any risk from being face-to-face without appropriate personal protective equipment with a confirmed case of coronavirus (COVID-19) who may be coughing or sneezing.

Importance of cleaning your hands regularly

- Soap and water should be used for hand hygiene when hands are visibly soiled. Use an alcohol-based hand rub at other times (for example, when hands have been contaminated from contact with environmental surfaces).
- Cleaning hands also helps to reduce contamination of surfaces and objects that may be touched by other people.
- Avoid touching your face, especially their mouth, nose, and eyes when cleaning.

VICTORIA State Government | Health and Human Services

- Always wash your hands with soap and water or use alcohol-based hand rub before putting on and after removing gloves used for cleaning.

Cleaning and disinfection

Routine cleaning and disinfection

Workplaces should routinely (at least daily) clean frequently touched surfaces (for example, tabletops, door handles, light switches, desks, toilets, taps, TV remotes, kitchen surfaces, cupboard handles and other equipment and materials relevant to construction and building sites). Also, clean surfaces and fittings when visibly soiled and immediately after any spillage. Where available, a disinfectant may be used following thorough cleaning. See below for choice, preparation and use of disinfectants.

What to clean and disinfect and when

Clean and disinfect all areas (for example, offices, bathrooms and common areas) that were used by the suspected or confirmed case of coronavirus (COVID-19). Close off the affected area before cleaning and disinfection. Open outside doors and windows to increase air circulation and then commence cleaning and disinfection.

The department will notify employers when a worker has been diagnosed with coronavirus (COVID-19) and has been infectious while on a building and construction site. The department will advise if cleaning and disinfection is required. It is the responsibility of employers to apply the principles in this document to conduct relevant cleaning and disinfection.

How to clean and disinfect

1. Wear gloves when cleaning and disinfecting. Gloves should be discarded after each clean. If it is necessary to use reusable gloves, gloves should only be used for coronavirus (COVID-19) related cleaning and disinfection and should not be used for other purposes. Wash reusable gloves with soap and water after use and leave to dry. Clean hands immediately after removing gloves.
2. Thoroughly clean surfaces using detergent (soap) and water.
3. Apply disinfectant to surfaces using disposable paper towel or a disposable cloth. If non-disposable cloths are used, ensure they are laundered and dried before reusing.
4. Ensure surfaces remain wet for the period of time required to kill the virus (contact time) as specified by the manufacturer. If no time is specified, leave for 10 minutes.

A one-step detergent/disinfectant product may be used as long as the manufacturer’s instructions are followed regarding dilution, use and contact times for disinfection (that is, how long the product must remain on the surface to ensure disinfection takes place).

Cleaning and disinfection of items that cannot withstand bleach

Soft furnishings or fabric covered items (for example, fabric covered chairs or car seats) that cannot withstand the use of bleach or other disinfectants or be washed in a washing machine, should be cleaned with warm water and detergent to remove any soil or dirt then steam cleaned. Use steam cleaners that release steam under pressure to ensure appropriate disinfection.

Use of personal protective equipment (PPE) when cleaning

Gloves are recommended when cleaning and disinfecting. Use of eye protection, masks and gowns is not required when undertaking routine cleaning.

Always follow the manufacturer’s advice regarding use of PPE when using disinfectants.

For cleaning and disinfection for suspected and confirmed cases, when available, a surgical mask and eye protection may provide a barrier against inadvertently touching your face with contaminated hands and fingers, whether gloved or not.

For cleaning and disinfection for suspected and confirmed cases, wear a full-length disposable gown in addition to the surgical mask, eye protection and gloves if there is visible contamination with respiratory secretions or other body fluid. Get advice from your work health and safety consultants on correct procedures for wearing PPE.

Choice, preparation and use of disinfectants

- Where possible, use a disinfectant for which the manufacturer claims antiviral activity (meaning it can kill viruses). Chlorine-based (bleach) disinfectants are one product that is commonly used. Other options include common household disinfectants or alcohol solutions with at least 70% alcohol (for example, methylated spirits).
- Follow the manufacturer's instructions for appropriate dilution and use. Table 1 below provides dilution instructions when using bleach solutions.

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Wash crockery and cutlery in a dishwasher on the highest setting possible. If a dishwasher is not available, hand wash in hot soapy water.

Reducing the risk of transmission in social contact settings

Social contact settings or environments include (but are not limited to), transport vehicles, shopping centres and private businesses.

To reduce the risk of spreading coronavirus (COVID-19) in these settings:

- Promote cough etiquette and respiratory hygiene.
- Routinely clean frequently touched hard surfaces with detergent/disinfectant solution/wipe.

- Provide adequate alcohol-based hand rub for staff and consumers to use. Alcohol-based hand rub stations should be available, especially in areas where food is on display and frequent touching of produce occurs.
- Train staff on use of alcohol-based hand rub.
- Consider signs to ask shoppers to only touch what they intend to purchase.

Vehicle air-conditioning should be set to fresh air ☒  ☑ 

Coronavirus disease 2019 (COVID-19)

Case and contact management guidelines for health services and general practitioners

25 April 2020

Version 20

VICTORIA State Government | Health and Human Services

Contents

Background

Coronavirus disease 2019 (COVID-19) was first identified in Wuhan City, Hubei Province, China in December 2019. Updated epidemiological information is available from the World Health Organization (WHO) and other sources. Current information on COVID-19 is summarised in a section at the end of this guideline entitled 'The disease'.

These guidelines and a range of other resources for health services and general practitioners can be found at the department's Coronavirus disease (COVID-19) website <https://www.dhhs.vic.gov.au/novelcoronavirus>.

A hotline is available for the general public who have questions or concerns – 1800 675 398.

Public health response objectives

This situation is evolving rapidly with new clinical and epidemiological information. Following the declaration of a State of Emergency in Victoria on Monday 16th March and subsequent Directions, the Department of Health and Human Services' (the department) public health response has now transitioned from the Initial Containment stage (which encompassed an inclusive approach to identifying cases and a precautionary approach to the management of cases and contacts), to the Targeted Action stage, with implementation of physical distancing measures and shutdowns of non-essential services to slow disease transmission, prioritisation of diagnostic testing to critical risk groups, and adoption of sustainable strategies and models of care.

The overall objectives of the public health response are to:

1. Reduce the morbidity and mortality associated with COVID-19 infection through an organised response that focuses on containment of infection.
2. Rapidly identify, isolate and treat cases, to reduce transmission to contacts, including health care, household and community contacts.
3. Characterise the clinical and epidemiological features of cases in order to adjust required control measures in a proportionate manner.
4. Minimise risk of transmission in healthcare and residential aged care environments, including minimising transmission to healthcare and residential aged care workers.

Checklist for general practitioners

The following actions should be undertaken when a patient presents to a general practice or community health service who may be a case of COVID-19:

1. Provide a single-use surgical mask for the patient to put on.
2. Isolate the patient in a single room with the door closed.
3. Any person entering the room should don droplet and contact precautions personal protective equipment (single-use surgical mask, eye protection, gown and gloves).
4. Conduct a medical assessment, and focus on:
   a) the date of onset of illness and especially whether there are symptoms or signs of pneumonia
   b) contact with confirmed cases of COVID-19
   c) precise travel history and occupation
   d) history of contact with sick travellers or other people or overseas health care facilities
   e) work or residence in a moderate or high risk setting for transmission
   f) residence in a geographically localised area with elevated risk of community transmission, as defined by the department.
5. Determine:
   (a) Does the patient need testing for COVID-19? Refer to *Who should be tested for COVID-19*
   (b) Does the patient require further assessment in an emergency department? Where there is suspicion of pneumonia or the patient is quite unwell, a suspected case of COVID-19 should be tested and managed in hospital.
   (c) If further assessment is required, how will the patient be transferred?

   The department no longer needs to be notified about suspected cases (only confirmed cases).

   If the patient is not tested – advise them to stay at home until their symptoms have resolved, 72 hours have elapsed since the last fever and they feel well.
6. If a suspected case of COVID-19 is unwell enough to require ambulance transfer to hospital, call Triple Zero (000) in the normal manner but advise that the patient may have suspected COVID-19 infection. Ambulance transfers do not need to be approved by the department. Where there is no clinical need for ambulance transfer, alternative means of transport should be used including private car driven by the case or an existing close contact (not bus, taxi or Uber).
7. Remember to provide a surgical face mask for the patient and driver if being transferred to an emergency department by any means.
8. If a patient is tested in the community by a general practitioner, the general practitioner should **undertake testing** as indicated in this guide. Ensure arrangements are in place for contacting the patient with the test result – this is the responsibility of the general practitioner.
9. **Advise a suspected case they must self-isolate at home**, and provide a factsheet for suspected cases from the department's COVID-19 webpage.
10. Undertake **cleaning and disinfection** of the room as detailed in this guide.
11. When the test result is available:
    a) **If the test is negative** for COVID-19 provide the negative result from the laboratory to the patient and manage any other cause of illness you have assessed as requiring treatment. Consider advising the patient in the normal manner that admission to hospital and further testing may be required if they deteriorate.

b) **If the test is positive** for COVID-19, call the department on 1300 651 160 to confirm that the department is aware of the result and agree on next steps for management of the patient.

Checklist for health services

The following actions should be undertaken when a patient presents to an emergency department or urgent care centre who may be a suspected case of COVID-19:

1. Staff at triage points should wear personal protective equipment for droplet and contact precautions (single-use surgical mask, eye protection, gown and gloves).
2. Triage high risk patients to a separate isolated waiting area away from low risk patients, staff and general public.
3. Provide a single-use surgical mask for the patient to put on.
4. Isolate the patient in a single room with the door closed.
5. Any person entering the room should don droplet and contact precautions personal protective equipment (single-use surgical mask, eye protection, gown and gloves).
6. Conduct a medical assessment, and focus on:
   (a) the date of onset of illness and especially whether there are symptoms or signs of pneumonia
   (b) contact with confirmed cases of COVID-19
   (c) precise travel history and occupation
   (d) history of contact with sick travellers or other people or overseas health care facilities
   (e) work or residence in a moderate or high risk setting for transmission
   (f) residence in a geographically localised area with elevated risk of community transmission, as defined by the department.
7. Determine whether the patient fits the current criteria for testing. Refer to *Who should be tested for COVID-19*
8. If admission is not required and the patient can return to the community:
   a) for patients that do **not** fit the current criteria for testing for COVID-19 – advise the patient to stay at home until their symptoms have resolved and they feel well. Those with fever should stay at home until at least 72 hours (3 days) after the last fever.
   b) for patients that fit the current criteria for testing - the notifying clinician should **advise the patient to self-isolate at home** (if not already) and minimise contact with other people. Provide a factsheet for suspected cases from the department's coronavirus disease (COVID-19) website <https://www.dhhs.vic.gov.au/information-health-services-and-general-practitioners-novel-coronavirus>
   c) consider advising the patient in the normal manner that admission to hospital and further testing may be required if they deteriorate
   d) ensure **arrangements are in place for the patient to be contacted with the test result** – this is the responsibility of the testing clinician and health service.
9. If admission is required:
   a) maintain infection control precautions and actively consider taking multiple samples for testing including from lower respiratory tract specimens.
10. When the test result is available:
    a) **if the test is positive** for COVID-19, provide the result to the patient. The health service infectious diseases lead, or senior clinician should call the department on 1300 651 160 to

confirm that the department is aware of the result and to provide any additional clinical information.

b) **if the test is negative** for COVID-19, provide the negative result to the patient and manage any other cause of illness you have assessed as requiring treatment.

c) consider advising the patient in the normal manner that admission to hospital and further testing may be required if they deteriorate and no other cause is found.

Who should be tested for COVID-19?

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

Patients who meet the following clinical criteria should be tested:

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

OR

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

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

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

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

Only confirmed cases need to be notified to the department. Notify the department of confirmed cases as soon as practicable by calling 1300 651 160, 24 hours a day.

General comments:

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

Definition of close contact

For the purposes of testing, the department advises a precautionary understanding of close contact. In keeping with definitions of close contact developed in other jurisdictions, close contact means greater than 15 minutes face-to-face, cumulative, or the sharing of a closed space for more than two hours, with a confirmed case without recommended personal protective equipment (PPE). Recommended PPE includes droplet and contact precautions.

Contact needs to have occurred during the period of 48 hours prior to onset of symptoms in the confirmed case until the confirmed case is no longer considered infectious to be deemed close contact.

Examples of close contact include:

- living in the same household or household-like setting (for example, a boarding school or hostel)
- direct contact with the body fluids or laboratory specimens of a confirmed case without recommended PPE (droplet and contact precautions)
- a person who spent two hours or longer in the same room (such as a GP clinic or ED waiting room, a school classroom; an aged care facility)
- a person in the same hospital room when an aerosol generating procedure (AGP) is undertaken on the case, without recommended PPE for an AGP (airborne and contact precautions)
- Aircraft passengers who were seated in the same row as the case, or in the two rows in front or two rows behind a confirmed COVID-19 case.
- For aircraft crew exposed to a confirmed case, a case-by-case risk assessment should be conducted by the airline to identify which crew member(s) should be managed as close contacts. This will include:
  - Proximity of crew to confirmed case
  - Duration of exposure to confirmed case
  - Size of the compartment in which the crew member and confirmed case interacted
  - Precautions taken, including PPE worn, when in close proximity to the confirmed case
  - If an aircraft crew member is the COVID-19 case, contact tracing efforts should concentrate on passengers seated in the area where the crew member was working during the flight and all of the other members of the crew.
- Close contacts on cruise ships can be difficult to identify, and a case-by-case risk assessment should be conducted to identify which passengers and crew should be managed as close contacts.
- Face-to-face contact for more than 15 minutes with the case in any other setting not listed above.

Healthcare workers (HCWs) and other contacts who have taken recommended infection control precautions, including the use of recommended PPE (droplet and contact precautions for the purposes of this contact definition), while caring for a suspected or confirmed case of COVID-19 are **not** considered to be close contacts.

Triaging and managing high risk patients on arrival to hospital

A patient is considered high-risk for COVID-19 if:

- presenting with acute respiratory tract infection
- presenting with fever (≥38 degrees), without another immediately apparent cause (e.g. UTI or cellulitis)
- they have travelled overseas and have onset of symptoms within 14 days of return
- they have been in close contact with a confirmed coronavirus (COVID-19) case with onset of symptoms within 14 days
- they are a confirmed coronavirus (COVID-19) case (this includes healthcare workers who are known confirmed cases and are attending for clearance testing to determine when they can return to work).

Patient transfer and destination health service

The following is advice on where patients should be managed:

- patients should be assessed and managed by the health service they present to
- transport of patients to other facilities should be avoided unless medically necessary
- ambulance transfer should be reserved for cases where there is clinical need; alternative means of transport should be used for other cases including a private car driven by the case or an existing close contact (not bus, taxi or Uber).
- suspected or confirmed cases in the community who require assessment or admission at a hospital should be seen and assessed at the nearest emergency department

Arrival to hospital and triage

Upon arrival to the emergency department, patients assessed as high-risk should be triaged to a separate isolated section of the waiting area, away from the general public and provided with a surgical mask. Assessment centres can support the management of high-risk patients if they are in place at the health service. All staff at triage points and assessment centres should be wearing PPE required for suspected or confirmed cases of coronavirus (COVID-19).

Ambulance triage

Patients assessed as high-risk and arriving by ambulance should be triaged to an isolated section of the waiting area away from the general public and be provided with a surgical mask as appropriate. For patients who cannot go to the waiting area (for example, stretcher, ongoing clinical care), they should remain in the ambulance vehicle until their triage and cubicle allocation is completed. Once allocated, the patient should move directly from the ambulance to the cubicle, and not stop in the corridors.

Emergency department admissions

A dedicated floor plan should be established that clearly designates areas assigned for high-risk patients within the emergency department. If able, rostering of staff to these areas to support the separation and resourceful use of PPEs should be considered. For staff working directly in the area of suspected or confirmed cases of coronavirus (COVID-19), PPE should be worn accordingly. Designated areas for donning and removing PPE should be in place.

Patient transfers

Should high-risk patients need to be moved outside of the initial isolation section, they should be transferred using a route that minimises contact with the general hospital population including clinicians (for example, dedicated lift service, external path). Staff involved in patient transfer should wear PPE required for suspected or confirmed cases of coronavirus (COVID-19). Physical distancing rules apply during all stages of the transfer.

Case management

Assessment and management of patients for COVID-19 testing

A checklist above indicates key actions for the assessment of patients for testing.

Victorian health services and general practitioners are only required to notify the department of **confirmed** cases.

The medical assessment of the patient should focus on the following:

- the date of onset of illness and especially whether there are symptoms or signs of pneumonia.
- contact with confirmed cases of COVID-19
- precise travel history and occupation
- history of contact with sick travellers or other people or overseas health care facilities.
- work or residence in a high risk setting for transmission.

People awaiting results of tests for COVID-19 should be isolated until COVID-19 is excluded.

People meeting testing criteria who are not tested for COVID-19 or any other infectious disease should self-isolate until the acute symptoms have resolved and it has been 72 hours since the last fever.

Further information is available for healthcare services managing healthcare workers with suspected or confirmed COVID-19 in the "Interim guide for healthcare services managing healthcare workers with suspected or confirmed COVID-19" on the department website < https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>.

Exclusion of COVID-19

For patients with fever or respiratory tract infection who are not hospitalised, a single negative nasopharyngeal/oropharyngeal swab (plus sputum if possible) is sufficient to exclude COVID-19 infection.

Repeat testing (especially of lower respiratory tract specimens) in clinically compatible cases should be performed if initial results are negative and there remains a high index of suspicion of infection.

There is no strong evidence to support a required time interval between exclusion swabs or the need for multiple practitioners performing the swab. Health services should apply discretion and consider the need for this on a case by case basis.

A patient who developed symptoms while in self-quarantine, for example because of recent overseas travel or contact with a confirmed case, who has then tested negative for COVID-19 should continue their quarantine period but be considered for a second test if they deteriorate and require hospitalisation.

Clinical management of confirmed cases

This is at the discretion of the treating team and at the present time is supportive care only.

Admission to hospital should occur when medically necessary or when directed by the department in order to reduce the risk of transmission or facilitate testing for clearance, such as if the case resides in a communal environment. Emerging information suggests COVID-19 may be associated with a delayed deterioration in clinical status in some cases.

Interim clinical guidelines for the management of patients with COVID-19 have been released by the following peak professional bodies:

- The Australasian Society for Infectious Diseases (ASID)
- The Australian and New Zealand Intensive Care Society (ANZICS)

Persons not requiring hospitalisation who have confirmed COVID-19 can be managed at home. The United States Centers for Disease Control and Prevention (USCDC) has developed principles for such home care management at https://www.cdc.gov/coronavirus/COVID-19/guidance-home-care.html.

Criteria for inpatient discharge

A confirmed case may be discharged if the following criteria are met:

- a senior member of the treating team (or appropriate consulting team) has determined the patient is clinically improved and well enough to be managed in the community, and
- appropriate infection control measures can be implemented in the community or household setting to ensure risk to other household members can be managed, and
- the department is notified about the pending discharge

If a patient is returning to a high-risk setting, consideration should be given for the requirement to be PCR negative on at least two consecutive respiratory specimens collected at least 24 hours apart at least 7 days after symptom onset, prior to going into the higher risk setting. This can be discussed with the department on a case-by-case basis if required.

A confirmed case in the home must remain in isolation until criteria for release from isolation are met.

Release from isolation of a confirmed case

The department will determine when a confirmed case no longer requires to be isolated in their own home.

Release from isolation will be actively considered when all of the following criteria are met:

- the person has been afebrile for the previous 72 hours, and
- at least **ten days** have elapsed after the onset of the acute illness, and
- there has been a noted improvement in symptoms, and
- a risk assessment has been conducted by the department and deemed no further criteria are needed

In the event that a confirmed case meets the above criteria during an inpatient hospital stay, the department will consult with the patient's treating clinician (and if applicable the infectious diseases or infection prevention and control team) to determine whether release from isolation is appropriate. For patients with severe disease, requiring hospital admission, consideration will be given to the need for testing prior to release from isolation or a longer period of isolation.

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

Return-to-work criteria for health care workers and workers in aged care facilities who are confirmed cases

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

- PCR negative on at least two consecutive respiratory specimens collected at least 24 hours apart after the acute illness has resolved.

Testing for return-to-work clearance can commence once the acute illness has resolved, provided this is at least **7 days** after the onset of illness. Testing should be arranged by the healthcare worker's employer, the healthcare or aged care worker's treating doctor, or at a coronavirus assessment centre if testing by the treating doctor is not feasible. The patient should inform the department of where they intend to be tested. The department will follow up test results and provide a letter indicating that the patient can return to work once the return-to-work criteria are met.

In the event that a healthcare worker or aged care worker returns a positive PCR result on either of their first two consecutive clearance tests (performed at least 24 hours apart), wait 3 days before performing another "round" of two tests, at least 24 hours apart. If a positive PCR result is returned in this "second round" of testing, a third round of testing should be undertaken after a further 5-7 days. In the event that respiratory specimens remain persistently PCR positive, a decision on suitability to return to work should be deferred until 21 days post symptom onset. At this time, a decision should be made on a case-by-case basis after consultation between the person's treating doctor, the testing laboratory and the department.

The following criteria should be considered in this discussion:

- the person has met the criteria for release from isolation, AND
- the person's symptoms have completely resolved, AND
- at least 21 days have passed since onset of the acute illness, AND
- consideration should be given to mitigating circumstances such as the characteristics of the patients/residents which the person would care for at work (e.g. elderly or immunocompromised patients/residents) and whether the healthcare worker is immunosuppressed. In certain high-risk settings (such as oncology wards), it may be appropriate for the HCW not to return to this setting until they have returned two negative swabs at least 24 hours apart. The timing of repeat swabs should be discussed with the treating doctor and the department.

The following procedures should be followed when performing return-to-work clearance testing:

- all HCWs should seek medical care from a medical practitioner. They should not be their own testing or treating clinician.
- all HCWs presenting for testing must wear a single use face mask and comply with infection control standards applicable to a confirmed case of COVID-19 until the department determines that release from isolation criteria are met
- specimens should be collected using droplet and contact precautions
- pathology requests must be clearly labelled with the following content under 'clinical information' – **'URGENT: HCW CLEARANCE TESTING, please notify result to DHHS**' and results should be copied to the department's COVID-19 Response team and the HCW's treating physician
- HCWs attending for return-to-work testing should be triaged as priority patients for testing.

The department will follow up the results of return-to-work testing and will contact healthcare and aged care workers regarding next steps. Once the return-to-work criteria are met, the department will provide healthcare and aged care workers with a letter confirming that they can return to work.

Checklist of key actions for the department for confirmed cases

- Confirm the diagnosis with testing laboratory.
- Contact the treating team/GP to confirm that the confirmed case is isolated and agree the management of the patient.
- Contact the confirmed case +/- parent/guardian (for cases under 18 years) to collect relevant social, clinical and epidemiological information.
- Identify close contacts and recommend immediate quarantining of any close contacts.
- Identify any potential exposure sites and assess whether any further action is required.
- Undertake all public health response activities including risk communication and sharing of relevant resources.

Checklist of key actions for the clinical team for confirmed cases

- If a patient is in the community at the time of diagnosis and if clinically necessary, the department will organise with the nearest appropriate health service to admit the patient, in order for care to be provided in hospital or via Hospital in the Home.
- For patients who do not require admission to hospital or Hospital in the Home, clinical teams only need to provide patients with the initial feedback of their results, information and counselling and usual advice to seek medical attention if their condition deteriorates. Clinical teams do not need to routinely contact cases unless clinically appropriate.
- Notify the department on 1300 651 160 as soon as possible (within 24 hours) if a patient becomes critically unwell, in the case of intensive care admission, or death.
- Commence list of all HCWs and visitors who enter the case's room. (If the case is at home and being visited by Hospital in the Home only a list of HCWs required.)
- Advise HCWs who provide care for the case (even with appropriate use of PPE) to self-monitor for symptoms of COVID-19 for 14 days after their last contact with the case.

Signage and triage of people presenting to health and other services

Diagnosis and management of COVID-19 must be undertaken by medical practitioners in accordance with the current guidelines from the Victorian Department of Health and Human Services. This will occur primarily in general practice and hospitals.

However, to reduce risks to service providers and detect people with COVID-19 risk factors, rapid pre-assessment is indicated by a broader range of service providers prior to the provision of a service. This pre-assessment may include enquiring about recent travel history and relevant symptoms. Only health-care services who manage unwell patients (such as general practice, hospitals and ambulance services) are expected to assess for symptoms.

For examples of posters that can be used, see the department's website <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>

Contact management

The department will conduct contact tracing for confirmed cases in the community and will seek assistance from a health service in relation to any contact tracing required for health service staff.

Close contacts

Self-quarantine

The following groups are now required to self-quarantine:

- close contacts of confirmed cases until 14 days after last close contact with the confirmed case.
- As of midnight, 28 March 2020, all travellers arriving into Melbourne from overseas will be quarantined for two weeks in hotel rooms and other accommodation facilities after submitting an Isolation Declaration Card. Interstate travellers can return to their home states after fulfilling the mandatory quarantine requirements.

Self-quarantine means remaining at home except in cases of medical emergency. This means a person recommended to self-quarantine:

- must not visit public settings or mass gatherings.
- must not use public transport.
- must not attend settings like health services, residential aged care facilities or educational settings.

This requirement for people who are in quarantine not to attend health services, includes a requirement that they do not attend a family member who is a confirmed case in a Victorian health service.

Health services and GPs are not required to provide a certificate of medical clearance to those who have completed the required 14 days self-quarantine.

Close contacts should not travel within Australia or internationally within the 14 days after last contact with the infectious case.

Symptomatic close contacts

Testing for COVID-19 is not indicated unless symptoms develop.

The approach to a symptomatic close contact requires an assessment by a treating clinician. The next steps depend on whether a treating clinician has identified the patient as having a non-infectious cause, a likely non-respiratory infectious cause, or an acute respiratory illness.

For a symptomatic close contact during the 14-day quarantine period, the department will:

- Advise the close contact to attend a suitable general practice, emergency department or coronavirus assessment centre for evaluation with a single-use face mask on and to identify themselves immediately on arrival.

Where a close contact has an illness during the 14-day period of quarantine after the step above, the treating clinician will:

- use a single room and appropriate PPE as for a suspected case
- test for COVID-19 and manage the person as a suspected case.
- If the test is positive, the person will be managed as a confirmed case. Notify the department.

Where the illness is diagnosed as acute respiratory illness:

- If testing for COVID-19 is negative and the treating clinician has diagnosed an acute respiratory illness or an illness that is highly compatible with COVID-19, the close contact may then require a subsequent test at a short period thereafter.

Where the illness is diagnosed as likely to be some other form of infection or is not an infection:

- If testing for COVID-19 is negative and the treating clinician has diagnosed some other infection or a non-infectious cause, then the treating team should consider, in conjunction with an infectious disease specialist, whether testing of relevant specimens such as urine and faeces for COVID-19 might be of value or whether evidence is now clear for an alternative cause, including legionellosis.
- The close contact can be advised to continue to self-quarantine until a full 14 days have expired from date of last close contact with confirmed case.

Checklist of key actions for the department for close contacts

For all close contacts the department will:

- Advise self-quarantine including restriction on travel until 14 days from the last contact with confirmed case.
- Counsel close contacts about risk and awareness of potential symptoms.
- Provide a close contact fact sheet
- Make regular contact with the close contact to monitor for any symptoms, either through SMS, email or telephone call.
- If after 14 days of quarantine (from the last contact with a confirmed case), the contact remains asymptomatic, the individual is cleared and may cease quarantine.
- If a school or employer requests confirmation from the department that the quarantine period has been met, the department will provide evidence with the consent of the individual.

Healthcare workers

HCWs and other contacts who have taken recommended infection control precautions, including the use of recommended PPE, while caring for a confirmed case of COVID-19 are not considered to be close contacts. However, they should be advised to self-monitor and if they develop symptoms consistent with COVID-19 infection they should isolate themselves. See also Infection prevention and control.

Any healthcare workers who is unwell with a compatible illness should not attend work and should seek appropriate medical care. All healthcare workers with fever or symptoms of acute respiratory infection should be tested for COVID-19, as per the testing criteria.

Hospital workers currently must not enter or remain at a hospital in Victoria if:

- the person has been diagnosed with COVID-19, and has not yet met the criteria for discharge from isolation OR
- if the person has travelled/arrived in Australia from any country in the past 14 days OR
- has had known contact with a person who is a confirmed COVID 19 case in the previous 14 days OR
- has a fever or symptoms of acute respiratory infection.

The current Directions and accompanying frequently asked questions can be viewed on the department's website at <https://www.dhhs.vic.gov.au/coronavirus>

Further criteria apply to healthcare workers who become confirmed cases before they can return to work in healthcare settings – see Return-to-work criteria for health care workers and workers in aged care facilities who are confirmed cases.

Infection prevention and control

Background

Infection prevention and control recommendations are based on the *Communicable Diseases Network Australia Series of National Guidelines – Coronavirus Disease 2019 (COVID-19) guideline*, and WHO guideline *Infection prevention and control during health care when novel coronavirus (nCoV) infection is suspected: Interim guidance January 2020* <https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-(ncov)-infection-is-suspected>.

Nationally consistent advice regarding the management of COVID-19 suspected and confirmed cases has evolved as further information regarding the specific risks of transmission associated with this infection have become known. As it becomes available, this advice has been incorporated into this guideline.

To reduce transmission of COVID-19, there are now general restrictions on who can visit or work at a Victorian hospital and how long visits can last. Screening procedures to prevent unwell visitors entering hospitals are also being implemented. The current restrictions are available on the department's website <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>.

Healthcare workers

Healthcare workers are required to self-quarantine for 14 days after overseas travel and self-quarantine for 14 days after close contact of a confirmed case of COVID-19 (see Healthcare workers in Contact management section). If a healthcare worker is identified as a confirmed case of COVID-19, they must not return to work until they are advised by the department that they meet return to work criteria (see section 'Return-to-work criteria for health care workers and workers in aged care facilities who are confirmed cases').

Healthcare workers should only attend work if they are well. Prior to going to work each day, healthcare workers should consider whether or not they feel unwell and should take their own temperature.

Those working in a Victorian public health services are required to report to their manager if they have the following symptoms prior to starting work or at any time while at work:

- temperature higher than 37.5 degrees Celsius
- symptoms of acute respiratory infection, such as shortness of breath, cough, sore throat or nasal congestion.

Some health services may require you to be screened (temperature and/or symptom check) on site prior to starting work.

Looking after yourself when wearing PPE

It is important that healthcare workers look after themselves during this time of increased use of PPE. Upon removal of PPE, healthcare workers should remember to hydrate themselves, practice hand hygiene and avoid touching their faces. Regular application of hand cream should be considered. Healthcare workers who are sensitive to latex should ensure that they wear non-latex gloves.

Using mobile phones in healthcare settings

People touch their phones as frequently as their faces. Mobile phones may be dirty, so please:

- ensure mobile phones are cleaned regularly with disinfectant wipes
- ensure hands are cleaned before and after using mobile phone
- do not answer mobile phones when you are wearing PPE
- consider placing your mobile phone in a clear sealed bag at the commencement of each shift and discarding the bag prior to going home as an additional precaution.

Physical distancing measures in healthcare settings

Physical distancing is to be practiced within clinics and wards, between staff and patients, and between staff and staff. This includes:

- waiting room chairs separated by at least 1.5 metres
- direct interactions between staff conducted at a distance
- staff and patients to remain at least 1.5 metres apart with the exception of clinical examinations and procedures
- hospital cafeterias may only provide takeaways.

Transmission-based precautions

For the purposes of PPE, healthcare workers are people in close contact with patients or the patient space. For example, doctors and nurses and cleaners who enter the patient's room or cubicle are included as healthcare workers. Staff who work in non-clinical areas who do not enter patient rooms are not included as healthcare workers for this purpose.

Patient placement

The following patient placement options should be used in the following order, according to facility resources:

1. Single room with en suite facilities, negative pressure air handling, with or without a dedicated anteroom
2. Single room with en suite facilities without negative pressure air handling
3. Single room without en suite facilities and without negative pressure air handling
4. Cohorted room

A dedicated toilet / commode should be used where possible, ensuring lid is closed when flushed to reduce any risk of aerosolization.

Suspected cases of COVID-19 infection may be cohorted together where single rooms are not available.

Maintain a record of all persons entering the patient's room including all staff and visitors.

PPE and routine patient care, during the COVID-19 emergency

During the COVID-19 emergency, **all healthcare workers** in Victorian public health services in **high-risk** areas – intensive care units (ICU), emergency departments (ED), Coronavirus (COVID-19) wards, and acute respiratory assessment clinics – are to wear **surgical masks** for **all patient interactions, unless the situations below apply**.

This is in addition to hand hygiene in accordance with the WHO five moments of hand hygiene. Unless damp or soiled, a surgical mask may be worn for the duration of a clinic or shift of up to four hours. Masks must be removed and disposed of for breaks and then replaced.

The risk in birthing suites is unknown, however the use of a surgical face mask and eye protection may be prudent where there is a risk of splashes from body fluids.

Lung function testing should only be performed if it is deemed clinically essential by a respiratory physician, and staff performing testing should followed droplet and contact precautions as outlined in the document Healthcare worker personal protective equipment (PPE) guidance for performing clinical procedures <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>.

For all other areas within Victorian public health services, standard precautions apply.

Caring for suspected and confirmed cases

In line with advice from the WHO and the Communicable Disease Network Australia (CDNA), the department recommends **droplet and contact precautions** for HCWs providing routine care of suspected and confirmed cases of COVID-19 infection, including during initial triaging.

This means that in addition to standard precautions, **all individuals, including family members, visitors and HCWs** should apply droplet and contact precautions. This includes use of the following PPE:

- single-use surgical mask
- eye protection (for example, safety glasses/goggles or face shield. Note that prescription glasses are not sufficient protection.)
- long-sleeved gown
- gloves (non-sterile).

If the gown is disposable and soiled, take it off and dispose of it with clinical waste. If the gown is reusable (non-disposable), take it off and have it reprocessed. Posters showing the order of putting on and taking off PPE (donning and doffing) can be found on the department's website <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>.

Masks, gloves and gowns are not to be worn outside of patient rooms (for example, between wards, break room, reception area) and are to be removed before proceeding to care for patients that are not isolated for COVID-19.

For hand hygiene, use an alcohol-based hand rub with over 60 per cent alcohol if hands are visibly clean, soap and water when hands are visibly soiled.

Visiting confirmed cases of COVID-19 is discouraged due to the high likelihood of contamination of the environment of the room of an infectious confirmed case. If a visitor attends a confirmed case in hospital, the visitor must wear PPE as described above. Staff should educate visitors on appropriate use of PPE, for example, when and where they should apply PPE. Visitors should be helped to carefully don and doff PPE by a person experienced in infection prevention and control requirements.

Airborne and contact precautions

Airborne and contact precautions are now recommended in **specific circumstances** when undertaking aerosol generating procedures (AGPs).

Airborne and contact precautions are:

- P2/N95 respirator (mask) – fit-check with each use
- eye protection (for example, safety glasses/goggles or face shield)
- long-sleeved gown
- gloves (non-sterile)

Total head covering is not required as part of airborne and contact precautions.

P2/N95 respirators (mask) should be used only when required. Unless used correctly, that is with fit checking, they are unlikely to protect against airborne pathogen spread. A poorly fitted P2/N95 respirator/mask should not be used, and the procedure either delayed, or performed by a clinician whom can fit their respirator/mask correctly.

Aerosol generating procedures (AGPs)

For further information regarding which procedures are AGPs see the document Healthcare worker personal protective equipment (PPE) guidance for performing clinical procedures <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>.

Appropriate cleaning and disinfection should be undertaken following an AGP. See Environmental cleaning and disinfection for further information.

Fit checking

Healthcare workers must perform fit checks every time they put on a P2/N95 respirator to ensure a facial seal is achieved. No clinical activity should be undertaken until a satisfactory fit has been achieved. Fit checks ensure the respirator is sealed over the bridge of the nose and mouth and that there are no gaps between the respirator and face. Healthcare workers must be informed about how to perform a fit check.

The procedure for fit checking includes:

- placement of the respirator on the face so the top rests on your nose and the bottom is secured under your chin
- placement of the top strap or ties over the head and position it high on the back of the head. Pull the bottom strap over your head and position it around your neck and below your ears.
- place fingertips from both hands at the top of the nosepiece. Using two hands, mould the nose area to the shape of your nose by pushing inward while moving your fingertips down both sides of the nosepiece.
- checking the negative pressure seal of the respirator by covering the filter with both hands or a non-permeable substance (for example, plastic bag) and inhaling sharply. If the respirator is not drawn in towards the face, or air leaks around the face seal, readjust the respirator and repeat process, or check for defects in the respirator.

Always refer to the manufacturer's instructions for fit checking of individual brands and types of P2/N95 respirators/masks.

Healthcare workers who have facial hair (including a 1–2 day stubble) must be aware that an adequate seal cannot be achieved between the P2/N95 respirator/mask and the wearer's face. The wearer must either shave or seek an alternative protection.

When to discard P2/N95 respirators (masks)

P2/N95 respirators (masks) should be:

- **Discarded** and **replaced** if contaminated with blood or bodily fluids
- **Replaced** if it becomes hard to breathe through or if the mask no longer conforms to the face or loses its shape
- **Removed** outside of patient care areas (for example, between wards, break room, reception area) and are to be removed before proceeding to care for patients that are not isolated for COVID-19.

Undertaking diagnostic testing for COVID-19

For information on the appropriate specimens for testing see the section on Laboratory testing for COVID-19 below.

There is no requirement for airborne precautions when taking a nose and throat swab.

A patient with clinical evidence of pneumonia who requires testing for COVID-19 should be managed in a hospital setting. Management of patients with pneumonia in the hospital setting will also facilitate lower respiratory tract specimen collection.

Table 3: When airborne precautions are recommended for specimen collection

Specimen type	Airborne precautions required?
Nasopharyngeal swab	No
Oropharyngeal swab	No
Sputum (not induced)	No
Nasal wash/aspirate	No
Bronchoalveolar lavage	Yes
Induced sputum	Yes

Ref: Infection Control Advisory Group – 2019-nCoV, *Interim recommendations for the use of PPE during clinical care of people with possible nCoV infection*. CDNA

While patient's faecal samples may be tested under some circumstances where there is capacity to do so, faecal sampling is not recommended as a standard test.

Prioritising PPE for health care workers

To ensure that single-use surgical masks are available to protect health workers and for patients presenting with suspected coronavirus (COVID-19) the following strategies are recommended:

Single-use surgical masks

- Prioritise use to frontline staff (ICU, ED, coronavirus (COVID-19) wards, acute respiratory assessment clinics, theatre and birthing suites).
- Surgical mask supplies are to be stored in secure areas or supervised by a staff member and not accessible to patients

- Unless damp or soiled, a surgical mask may be worn for the duration of a clinic or shift of up to four hours.

General PPE:

- Substitutions that may be considered include:
  - plastic apron instead of a long-sleeved disposable gown where appropriate
  - full-face shield instead of a surgical mask for situations that are appropriate.

PPE training should use expired PPE stock only (if available).

Care of critically ill patients in ICU

- Patients who require admission to ICU with severe COVID-19 infection are likely to have a high viral load, particularly in the lower respiratory tract.
- Contact and airborne precautions (as above) are required for patient care and are adequate for most AGPs. The risk of aerosol transmission is reduced once the patient is intubated with a closed ventilator circuit. There is a potential, but unknown, risk of transmission from other body fluids such as diarrhoeal stool or vomitus or inadvertent circuit disconnection.

ICU staff caring for patients with COVID-19 (or any other potentially serious infectious disease) should be trained in the correct use of PPE, including by an infection control professional.

Case movement and transfers

Where possible, all procedures and investigations should be carried out in the case's room, with exception of AGPs which should be performed in a negative pressure room whenever possible, or a single room with the door closed.

Transfers to other healthcare facilities should be avoided unless it is necessary for medical care. Inter hospital transfers should use routine providers.

Environmental management

Signage

Clear signage should be visible to alert HCWs of required precautions before entering the room, see Australian Commission on Safety and Quality in Health Care <https://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/infection-control-signage>.

Management of equipment

Preferably, all equipment should be either single-use or single-patient-use disposable. Reusable equipment should be dedicated for the use of the case until the end of their admission. If this is not possible, equipment must be cleaned and disinfected (see Environmental cleaning and disinfection below) prior to use on another patient.

Disposable crockery and cutlery may be useful in the patient's room to minimise the number of contaminated items that need to be removed. Otherwise, crockery and cutlery can be reprocessed as per standard precautions.

Environmental cleaning and disinfection

Required agents for cleaning and disinfection

Cleaning of a patient consultation room or inpatient room should be performed using a neutral detergent. Disinfection should then be undertaken using a chlorine-based disinfectant (for example, sodium

hypochlorite) at a minimum strength of 1000ppm, or any hospital-grade, TGA-listed disinfectant with claims against coronaviruses or norovirus, following manufacturer's instructions.

A one-step detergent/chlorine-based product may also be used. Ensure manufacturer's instructions are followed for dilution and use of products, particularly contact times for disinfection.

Wearing PPE whilst undertaking cleaning and disinfection

Droplet and contact precautions should be used during any cleaning and disinfection of a room where there has not been an AGP or if more than 30 minutes has elapsed since the AGP was done.

Airborne and contact precautions should be used during any cleaning and disinfection of a room where there has been an AGP performed within the previous 30 minutes.

Steps for disinfection and cleaning of a patient consultation room or inpatient room

The patient consultation room should be cleaned at least once daily and following any AGPs or other potential contamination.

There is no need to leave a room to enable the air to clear after a patient has left the room unless there was an AGP performed. Nose and throat swabs are not considered AGPs unless performed on a patient who has pneumonia. If an AGP was performed, leave the room to clear for 30 minutes.

The patient consultation room (or inpatient room after discharge of the suspected case) should now be cleaned and disinfected using the agents listed above. In most cases this will mean a wipe down with a one-step detergent disinfectant as listed above. There is no requirement to wait before the next patient is seen. The room is now suitable for consultation for the next patient.

Waste management

Dispose of all waste as clinical waste. Clinical waste may be disposed of in the usual manner.

Linen

Bag linen inside the patient room. Ensure wet linen is double bagged and will not leak.

Reprocess linen as per standard precautions.

Environmental cleaning and disinfection in an outpatient or community setting (for example, a general practice)

Cleaning and disinfection methods as below:

- Clean surfaces with a neutral detergent and water first.
- Disinfect surfaces using either a chlorine-based product at 1000ppm or other disinfectant that makes claims against coronavirus. Follow the manufacturer's instructions for dilution and use.
- A one-step detergent/disinfectant product may be used as long as the manufacturer's instructions are followed re dilution, use and contact times for disinfection (that is, how long the product must remain on the surface to ensure disinfection takes place).

Follow the manufacturer's safety instructions for products used regarding precautions and use of safety equipment such as gloves or aprons.

All linen should be washed on the hottest setting items can withstand.

Wash crockery and cutlery in a dishwasher on the hottest setting possible.

Care of the deceased if COVID-19 is suspected or confirmed

Deaths in healthcare settings

Please refer to the guidance "Handling the body of a deceased person with suspected or confirmed COVID-19" on the department website < https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19> for more details regarding care of the deceased.

Any person having contact with the body of a person with suspected or confirmed COVID-19 must ensure hand hygiene before and after interacting with the body and the environment and wear personal protective equipment (PPE) appropriate for droplet and contact precautions. This includes a gown, disposable gloves, a surgical mask and appropriate eye protection.

Additional precautions may be required, for example airborne and contact precautions, if conducting an autopsy. This will be dependent upon the risk of generation of aerosols.

Deaths in the community

In the event that an unexpected death of a person with suspected or confirmed COVID-19 occurs at home, family members should be advised that:

- they may view the body but must continue the same precautions as when they were living with the person. Family members should not touch or kiss the body.
- relevant authorities should not touch the body unless equipped with appropriate PPE upon arrival at the place of death
- they must leave the room (or vicinity) or maintain a distance greater than 1.5 metres when handling or transferring the body for transportation
- the area of death must be cleaned and disinfected using standard household bleach. Further information can be found in the document: Cleaning and disinfecting tips for non-healthcare settings found here < https://www.dhhs.vic.gov.au/business-sector-coronavirus-disease-covid-19 >

If there is a suspicion that the deceased may have had undiagnosed COVID-19, or on request of paramedics or other first responders, the medical practitioner certifying a death in the community should take a nasopharyngeal AND/OR oropharyngeal swab for PCR testing of the deceased for COVID-19 and advise first responders and the family of the test results. Positive test results must be notified to the department on **1300 651 160**, 24 hours a day, to allow contact tracing to occur.

Advice for funeral workers

Advice for funeral industry workers may be found in the document "Handling the body of a deceased person with suspected or confirmed COVID-19" on the department website < https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>.

Laboratory testing for COVID-19

Prioritisation of testing

A number of Victorian laboratories are undertaking testing for COVID-19 in Victorian patients. There is significant pressure on supply of swabs and reagent kits for COVID-19 testing. It is **critical** that clinicians use the current testing criteria to guide patient investigation and use **only one swab** when testing. Please provide **clinical details** on request slips so high-risk patients and healthcare workers, aged care workers or disability workers can be prioritised where resources allow. Specimens taken from health care workers should be marked URGENT- Health Care Worker (or in the case of testing for return-to-work criteria for healthcare and aged care workers, mark with **'URGENT: HCW CLEARANCE TESTING, please notify result to DHHS**'. Results should be copied to the DHHS COVID-19 Response and the HCW's treating physician.

Specimens for testing

For initial diagnostic testing for COVID-19, DHHS recommends collection of the following samples:

1. upper respiratory tract specimens.
2. lower respiratory tract specimens (if possible).
3. serum, where possible (to be stored for later analysis).

Label each specimen container with the patient's ID number (for example, medical record number), specimen type (for example, serum) and the date the sample was collected.

Respiratory specimens

Collection of upper respiratory (nasopharyngeal AND/OR oropharyngeal swabs), and lower respiratory (sputum, if possible) is recommended for patients with a productive cough.

1. Upper respiratory tract
    a) Nasopharyngeal swab: Insert a swab into nostril parallel to the palate. Leave the swab in place for a few seconds to absorb secretions. Swab both nostrils (nasopharyngeal areas) with the same swab.

    AND/OR

    b) Oropharyngeal swab (that is, a throat swab): Swab the tonsillar beds, avoiding the tongue.

    c) **To conserve swabs** the same swab that has been used to sample the oropharynx should be utilised for nasopharynx sampling

    d) If testing for other respiratory viruses is indicated, contact your testing laboratory to find out if testing (for example, multiplex PCR) can be undertaken on the same specimen, or if an additional specimen needs to be collected.

    Note. Swab specimens should be collected only on swabs with a synthetic tip (such as polyester, Dacron® or Rayon, flocked preferred) with aluminium or plastic shafts. Do not use calcium alginate swabs or swabs with wooden shafts, as they may contain substances that inactivate some viruses and inhibit PCR testing. For transporting samples, recommended options include viral transport medium (VTM) containing antifungal and antibiotic supplements, or Liquid Amies medium which is commonly available. Avoid repeated freezing and thawing of specimens.

2. Lower Respiratory tract (if possible)

a) Sputum: Have the patient rinse the mouth with water and then expectorate deep cough sputum directly into a sterile, leak-proof, screw-cap sputum collection cup or sterile dry container. Refrigerate specimen at 2-8°C. If sending to Victorian Infectious Diseases Reference Laboratory (VIDRL), send on an ice pack.

b) Bronchoalveolar lavage, tracheal aspirate: Collect 2-3 mL into a sterile, leak-proof, screw-cap sputum collection cup or sterile dry container. Refrigerate specimen at 2-8°C - if sending to VIDRL, use ice pack.

Lower respiratory tract specimens are likely to contain the highest virus loads based on experience with SARS and MERS coronaviruses.

Other specimens:

3. Blood (serum) for storage for serology at a later date:

    a) Children and adults: Collect 1 tube (5-10mL) of whole blood in a serum separator tube.

    b) Infant: A minimum of 1ml of whole blood is needed for testing paediatric patients. If possible, collect 1mL in a serum separator tube.

At the current time there is no serological test for COVID-19 and blood when received at VIDRL will be stored for future testing, when testing is available and if the case is confirmed as COVID-19 infection.

The department is continuously reviewing whether there is a requirement for other specimens such as stool or urine to be sent to VIDRL. At the current time this is not routinely recommended in cases of respiratory illness. A stool specimen may be recommended by the department to provide additional reassurance before a confirmed case is released from isolation.

Specimen collection and transport

See also Undertaking diagnostic testing for PPE recommendations.

Specimen collection process

For most patients with mild illness in the community, collection of upper respiratory specimens (that is, nasopharyngeal or oropharyngeal swabs) is a low risk procedure and can be performed using **droplet and contact** precautions.

- Perform hand hygiene before donning gown, gloves, eye protection and single-use surgical mask. See How to put on your PPE poster on the department's website <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>.
- When collecting throat or nasopharyngeal swabs stand slightly to one side of the patient to avoid exposure to respiratory secretions should the patient cough or sneeze.
- At the completion of the specimen collection process, remove all PPE and perform hand hygiene after removing gloves and when all PPE has been removed. See How to take off your PPE poster on the department's website <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>.

Note that, for droplet and contact precautions, the room does not need to be left empty after sample collection. Droplet and contact precautions PPE must be worn when cleaning the room. See Environmental cleaning and disinfection for further information.

If the patient has severe symptoms suggestive of pneumonia, for example, fever and breathing difficulty, or frequent, severe or productive coughing episodes then **airborne and contact precautions** should be observed. This means that a P2 respirator must be used instead of a single-use surgical mask.

Patients with symptoms suggestive of pneumonia should be managed in hospital, and sample collection conducted in a negative pressure room, if available. If referral to hospital for specimen collection is not possible, specimens should be collected in a single room. The door should be closed during specimen collection and the room left vacant for at least 30 minutes afterwards (cleaning can be performed during this time by a person wearing PPE for airborne and contact precautions).

There are no special requirements for transport of samples. They can be transported as routine diagnostic samples for testing (that is, Biological substance, Category B).

Handling of specimens within diagnostic laboratories

All diagnostic laboratories should follow appropriate biosafety practices, and testing on clinical specimens, including for other respiratory viruses, should only be performed by adequately trained scientific staff.

Current advice from the WHO is that respiratory samples for molecular testing should be handled at Biosafety Level 2 (BSL2), with the USCDC recommending that the following procedures involving manipulation of potentially infected specimens are performed at BSL2 within a class II biosafety cabinet:

- aliquoting and/or diluting specimens
- inoculating bacterial or mycological culture media
- performing diagnostic tests that do not involve propagation of viral agents in vitro or in vivo
- nucleic acid extraction procedures involving potentially infected specimens
- preparation and chemical- or heat-fixing of smears for microscopic analysis.

Information on testing for coronavirus at VIDRL

VIDRL has moved to utilising Real-Time specific COVID-19 PCR assays as the primary diagnostic tool for COVID-19 detection.

Real-time COVID-19 PCR assay

- The test takes approximately 2–3 hours to perform.
- Results reported as positive or negative for COVID-19, for example, *COVID-19 not detected*.

The current VIDRL testing algorithm is as follows:

- All suspected cases will be tested by a real-time assay as above.
  - This test will be performed twice a day at the current time (morning and afternoon), with results released through routine pathways.
- All negative results will be reported and finalised.
- Any positive results will be confirmed by a second specific Real-Time COVID-19 PCR assay targeting a different RNA sequence.
  - This second Real-Time assay will be run for any presumptive positive results, immediately following completion of the first Real-Time assay.
  - Samples positive in both Real-Time assays will thus be reported on the same day as initial testing and will be telephoned through to the referring pathology service as well as the department.
  - Discordant results between the two different Real-Time assays are not anticipated and will be managed on a case by case basis with further molecular testing (for example, Pan-coronavirus PCR assay).
- Urgent specimens can be tested outside of these periods in consultation with the department.
- Viral culture will be attempted from any positive sample under high containment, but such testing is not a diagnostic modality.
- Serum samples will be stored.

As experience with testing develops this algorithm may change further. VIDRL has the intention to register the Real-Time assays with NATA in the near future once sufficient data is available.

Indeterminate test results

Indeterminate test results have been reported from a number of Victorian laboratories. These are usually samples that have had one gene detected in the assay but not both genes.

Indeterminate results may be referred to VIDRL for further testing, although **these samples should be considered as positive**. Confirmatory testing may not be possible as the sample may already be low titre and degradation due to processing may mean that VIDRL's PCR may not be sufficiently sensitive to offset loss of titre in the sample.

Cases with indeterminant results should be managed as confirmed cases. If the treating clinician feels that the pre-test probability for COVID-19 is low, another sample may be collected for further testing. If the second sample tests negative, the department will discuss the case with the treating doctor and the testing laboratory to determine whether the case should continue to be managed as a confirmed case.

Governance

International response

The WHO declared COVID-19 a Public Health Emergency of International Concern (PHEIC) under the *International Health Regulations 2005* and on 30 January 2020. A pandemic has now been declared.

A State of Emergency was declared in Victoria on 16 March 2020.

Public Health Incident Management Team

The Department of Health and Human Services (the department, DHHS) has formed a Public Health Incident Management Team, chaired by a Public Health Commander, to coordinate the public health and sector response. A Class 2 Emergency, or public health emergency, was declared on 1 February 2020.

The Infection Clinical Network of Safer Care Victoria will be a network that is requested to provide comment and advice to the department, alongside national committees including the Communicable Diseases Network Australia (CDNA).

Communications and media

The department will coordinate communications and media in relation to suspected and confirmed cases of COVID-19. In some instances, the department may – in collaboration with a Victorian health service – request a service to provide media responses in relation to one of more cases associated with that service. A health service should contact the department's Media Unit with any queries.

Role of Ambulance Victoria

Where clinically appropriate, Ambulance Victoria can be used to transport any suspected cases of COVID-19 from a port of entry or unwell suspected cases from general practice or other settings to an emergency department. Triple 000 should be called in the normal manner but advise that the patient may have suspected COVID-19 infection.

Prevention

- From midnight, 28 March 2020, all travellers arriving into Melbourne from overseas will be quarantined for two weeks in hotel rooms and other accommodation facilities
- Follow physical distancing advice
- Follow advice on influenza vaccination.
- Ensure adherence to good hand and respiratory hygiene practices.
- Adhere to good food safety practices.
- Consider avoiding live animal markets.
- At the present time, travel within Australia is not recommended, and a ban on overseas travel is currently in place. Check for overseas travel advice or restrictions at Smartraveller <https://www.smartraveller.gov.au>.
- Advice on physical distancing and other transmission reduction measures is available on the department's website <https://www.dhhs.vic.gov.au/coronavirus-covid-19-transmission-reduction-measures>.

Risk management at ports of entry

Infection with COVID-19 was designated a Listed Human Disease (LHD) under the *Biosecurity Act 2015* on 21 January 2020.

As of 18th March, the Australian Government advises all Australians not to travel overseas to any country at this time.

Currently all passengers from every arriving international aircraft are health screened. The department's healthcare workers are also conducting health checks on passengers from any international flight if required by the biosecurity officer. Single-use facemasks are provided to arriving passengers who have been identified as unwell. As of midnight, 28 March 2020, all travellers arriving into Melbourne from overseas will be quarantined for two weeks in hotel rooms and other accommodation facilities after submitting an Isolation Declaration Card. Interstate travellers can return to their home states after fulfilling the mandatory quarantine requirements.

The disease

Infectious agent

Severe Acute Respiratory Syndrome coronavirus 2 (SARS-CoV-2) has been confirmed as the causative agent. Coronaviruses are a large and diverse family of viruses that include viruses that are known to cause illness of variable severity in humans, including the common cold, severe acute respiratory syndrome (SARS-CoV), and Middle East Respiratory Syndrome (MERS-CoV). They are also found in animals such as camels and bats.

First termed 2019 novel coronavirus (2019-nCoV), the virus was officially named Severe Acute Respiratory Syndrome coronavirus 2 (SARS-CoV-2) 11 February 2020. The disease it causes is now called coronavirus disease 2019 (COVID-19).

Reservoir

The reservoir is essentially unknown, but probably zoonotic, meaning they are likely transmitted between animals and people; however, an animal reservoir has not yet been identified for COVID-19.

Initial cases were business operators at the Hua Nan Seafood Wholesale Market, which sold live animals such as poultry, bats, marmots, and wildlife parts. The source of the outbreak is still under investigation in Wuhan. Preliminary investigations have identified environmental samples positive for COVID-19 in Hua Nan Seafood Wholesale Market in Wuhan City, however some laboratory-confirmed patients did not report visiting this market.

Mode of transmission

The mode or modes of transmission of COVID-19 are not yet fully understood, although based on the nature of other coronavirus infections, transmission is likely through droplet and contact. There were cases with a strong history of exposure to the Hua Nan Seafood Wholesale Market in Wuhan City, China where live animals are sold. However, the mechanism by which transmission occurred in these cases, whether through respiratory secretions after coughing or sneezing, or direct physical contact with the patient or via fomites after contamination of the environment by the patient, is unknown.

Person to person transmission has now occurred worldwide and the WHO declared a pandemic on 11 March 2020. As a result, droplet and contact precautions are recommended.

Incubation period

The incubation period is not yet known. However, the interim view on the incubation period is that it is 4 to 14 days, based on the nature of previous coronavirus infections.

Infectious period

Evidence on the duration of infectivity for COVID-19 infection is evolving. Epidemiological data suggests that the majority of transmission occurs from symptomatic cases, however there is some evidence to support the occurrence of pre-symptomatic transmission. As a precautionary approach, cases are considered to be infectious from 48 hours prior to onset of symptoms until they meet the criteria for release from isolation.. Infection control precautions should be applied throughout any admission and until the department has declared the confirmed case to be released from isolation.

Given that little information is currently available on viral shedding and the potential for transmission of COVID-19, testing to detect the virus may be necessary to inform decision-making on infectiousness. Patient information (for example age, immune status and medication) should also be considered. Criteria for release from isolation are described in this guideline.

Clinical presentation

Common signs of infection include respiratory symptoms, fever, cough, shortness of breath and breathing difficulties. Sore throat, coryzal symptoms, headache and fatigue have been reported.

In more severe cases, it appears that infection can cause pneumonia, severe acute respiratory syndrome and multi-organ failure (including renal failure). In summary the clinical spectrum varies from mild cases, through to severe acute respiratory infection (SARI) cases.

Illness is more likely in the middle-aged and elderly.

The case fatality rate is unknown but appears to be lower than for SARS and higher than the common cold. The case fatality rate may be higher in elderly, people with immune compromise or who have co-morbidities. The case fatality rate also appears to be higher in countries where the rate of infection has overwhelmed the ability of the relevant health system to care for unwell patients. Current estimates are that the case fatality rate may be as high as two to four per cent.

Information resources

The department will place resources for health professionals on the department's Coronavirus website <https://www.dhhs.vic.gov.au/novelcoronavirus>.

It is important that health professionals consult this website regularly, as case definitions and content of this guideline change regularly during the response to this outbreak.

Hotel Quarantine Response

Advice for cleaning requirements for hotels who are accommodating quarantined, close contacts and confirmed COVID-19 guests

Last updated: 16 June 2020

Background

Operation Soteria manages the mandatory quarantine of international arrivals, diagnosed persons and close contacts who are self-isolating at a hotel to reduce the potential spread of coronavirus (COVID-19). To reduce the risks of transmission of COVID-19, guests confirmed as COVID-19 positive will be moved from their allocated quarantine hotel and accommodated in quarantine 'red hotels'.

COVID-19 spreads through respiratory droplets produced when an infected person coughs or sneezes. A person can acquire the virus by touching a surface or object that has the virus on it and then touching their own mouth, nose or eyes.

To protect all staff, contractors and guests in Operation Soteria program from the risk of exposure to COVID-19, appropriate cleaning and disinfection measures are required. A combination of cleaning and disinfection is most effective in removing the COVID-19 virus. To meet these requirements:

(a) Daily cleaning – common areas in quarantine and quarantine red hotels will have their frequently touch surfaces cleaned twice daily and all floor surfaces will be cleaned once a day.

(b) Exit deep clean – clean and disinfection of hotel rooms that have accommodated COVID-19 positive guest(s), quarantined guest(s), close contact guest(s) or transiting guest(s) will be performed when the guest(s) has physically left the hotel room.

(c) Exit hotel quarantine program – at the completion of the hotel quarantine program, in addition to meeting the daily cleaning requirements all floor surfaces and soft furnishings in common areas will be cleaned and disinfected.

Cleaning and disinfection

Cleaning means physically removing germs, dirt and organic matter from surfaces. Cleaning alone does not kill germs, but by reducing the numbers of germs on surfaces, cleaning helps to reduce the risk of spreading infection.

Disinfection means using chemicals to kill germs on surfaces. This process does not necessarily clean dirty surfaces or remove germs, but by killing germs that remain on surfaces after cleaning, disinfection further reduces the risk of spreading infection. Cleaning before disinfection is very important as organic matter and dirt can reduce the ability of disinfectants to kill germs.

Recommended cleaning and disinfection products

Cleaning of surfaces must be undertaken first with a neutral detergent and water prior to disinfection of surfaces unless a one-step detergent/disinfectant product is used.

Disinfection with a chlorine-based product following the manufacturer's instructions or made using the chlorine dilutions calculator (see Table 1) to achieve a 1000ppm dilution should be used. Note that prediluted bleach solutions lose potency over time and on exposure to sunlight and as such needs to be made up fresh daily.

Household bleach comes in a variety of strengths. The concentration of active ingredient – hypochlorous acid – can be found on the product label.

After cleaning surfaces with a neutral detergent, apply the bleach solution using disposable paper towels or a disposable cloth. Ensure surfaces remain wet for the specified contact time. Wipe the disinfectant off surfaces to prevent damage.

Dispose of personal protective equipment (PPE) and single use cleaning wipes in a leak proof plastic bag, tied up and disposed in the general waste.

Wash hands well using soap and water and dry with disposable paper or single-use cloth towel. If water is unavailable, clean hands with alcohol-based hand rub.

Table 1: Chlorine dilutions calculator to achieve a 1000 ppm (0.1%) bleach solution

Original strength of bleach		Disinfectant recipe		Volume in standard 10L bucket
%	Parts per million	Parts of bleach	Parts of water	
1	10,000	1	9	1000 mL
2	20,000	1	19	500 mL
3	30,000	1	29	333 mL
4	40,000	1	39	250 mL
5	50,000	1	49	200 mL

For other concentrations of chlorine-based sanitisers not listed in the table above, a dilutions calculator can be found on the https://www2.health.vic.gov.au/public-health/infectious-diseases/infection-control-guidelines/chlorine-dilutions-calculator.

Regardless of the product used, it is vital that sufficient contact time is allowed. Refer to the manufacturer's instruction for such information. If no time is specified, leave for 10 minutes.

Surfaces that are unable to be cleaned with a chlorine-based product should follow the guidance in Table 2.

Table 2: Recommended cleaning procedure by surface type (adapted from SafeWork Australia – COVID 19 - Recommended cleaning: Supplementary information, 26 May 2020).

Any Surface	Method
Soft plastics	Detergent + Disinfectant
Hard plastics	Detergent + Disinfectant
Metal surfaces (stainless steel, uncoated steel, zinc coated steel, aluminium)	Detergent + Disinfectant* *uncoated steel is more susceptible to rust when disinfected with bleach. After contact time is complete, there is a need to wipe off the disinfected metal surface with water.
Painted metal surfaces	Detergent + Disinfectant
Wood	Detergent + Disinfectant
Laminate	Detergent + Disinfectant
Glass	Detergent + Disinfectant
Concrete (polished)	Detergent + Disinfectant
Concrete (rough)	Detergent + Disinfectant
Leather	Clean and disinfect according to manufacturer's recommendations

Fabric (for confirmed COVID-19 cases and transiting passenger hotel rooms – mattresses, carpet, window and room furnishings)	Remove dirt or soil with warm water and detergent then steam clean If launderable, wash on warmest possible setting according to manufacturer's recommendations with laundry detergent
Fabric – common areas[1] (e.g. for confirmed cases access to exercise, medical treatment, evacuation, rooms and includes carpet, window and chairs in hallways, lifts, common areas and PPE change rooms)	Vacuum with a vacuum cleaner that contains a HEPA filter Damp dust + Detergent

How to clean and disinfect

Cleaning contractors are responsible for training staff on how to use products and how to appropriately clean and disinfect surfaces.

(d) Wear appropriate personal protective equipment as outlined in the Personal Protective Equipment (PPE) section below.

(e) Thoroughly clean surfaces using detergent (soap) and water.

(f) Apply disinfectant to surfaces using disposable paper towel or a disposable cloth. If non-disposable cloths are used, ensure they are laundered and dried before reusing.

(g) Ensure surfaces remain wet for the period of time required to kill the virus (contact time) as specified by the manufacturer. If no time is specified, leave for 10 minutes.

(h) Wipe disinfectant off surfaces to prevent damage.

(i) Remove and discard PPE after each clean into a leak proof plastic bag. For example, after an exit deep clean, after cleaning between communal areas such as bathroom, kitchen and shared lounge area.

(j) Wash hands with soap and water and dry or use and alcohol-based hand rub immediately after removing gloves.

Personal Protective Equipment (PPE)

Cleaning contractors are responsible for the provision of PPE for their staff and ensuring staff are trained on how to wear PPE in accordance with DHHS PPE donning and doffing protocols.

Always follow the manufacturer's advice regarding use of PPE when using disinfectants.

Disposable gloves should be worn for cleaning and disposed if they become damaged, soiled or when cleaning is completed.

Exit deep clean of guest rooms, wear a full-length disposable gown, surgical mask, eye protection and gloves.

Daily cleaning of communal areas, gloves only are recommended. Guests are only allowed to leave their rooms for scheduled exercise and staff should maintain 1.5 meters between themselves and a guest.

Other PPE is only required if specified by the manufacturer's instructions or may be used to protect clothing from splash if using bleach.

Avoid touching the face with gloved or unwashed hands.

Cleaning equipment

Where possible disposable cleaning equipment should be used, such as cleaning cloths, mops and gloves. A fresh cloth and mop used for each exit deep clean and for communal area, for example, kitchen, bathroom, lounge.

All disposable cleaning equipment should be placed into a tied, leak proof plastic bag and disposed of in the general waste stream.

If other cloths and mops are used, they should be laundered in a hot water wash before re-use and allocated to only be used at the quarantine or quarantine red hotel.

Re-useable equipment such as vacuum cleaners, buckets, steam cleaners should be cleaned and disinfected after each use and stored at the hotel site separate from other cleaning equipment.

Ensuring workplace safety

When cleaning on or around electrical equipment/fittings, isolate electrical equipment and turn off power source if possible before cleaning with liquids.

Read the label for the detergent or disinfectant and follow the manufacturer's recommendations.

Obtain a copy of the Safety Data Sheet (SDS) for the detergent or disinfectant and become familiar with the contents.

Wear the appropriate PPE that is identified on the label and the SDS.

Cleaning requirements for quarantine and quarantine red hotels

The following cleaning schedules should be followed for hotel floors that are accommodating quarantined, close contact and confirmed COVID-19 guests.

Daily cleaning of communal areas in quarantine and quarantine red hotels

The following actions should generally be taken every day.

- It is recommended that all hotels should remove all soft furnishings (chairs, desks, tables, lamps) in hallways to allow guests to access for exercise, medical treatment, evacuation and place these in storage.
- Carpets in common areas of red hotels are to be vacuumed with a vacuum cleaner that contains a HEPA filter.
- Laminate, concrete and/or tile flooring in common areas of red hotels are to be mopped with a detergent and disinfectant solution daily.
- Clean and disinfect all frequently touched surfaces in all common areas twice daily (see Table 3).
- Visibly dirty surfaces may require additional cleaning.

Exit deep clean of guest room

All rooms that have accommodated a quarantined, close contact or confirmed COVID-19 guest should have an exit deep clean performed.

All frequently touched surfaces outlined in Table 3 should be cleaned and disinfected.

Soft furnishings or fabric covered items (for example, fabric covered chairs, mattresses or window furnishings) that cannot withstand the use of bleach or other disinfectants or be washed in a washing machine, should be cleaned with warm water and detergent to remove any soil or dirt then steam cleaned. Use steam cleaners that release steam under pressure to ensure appropriate disinfection.

Window furnishing may be laundered in accordance with the manufacturer's instructions on the warmest setting possible. The window furnishing should be dried completely before rehanging. Do not shake dirty window furnishings as this may disperse the virus through the air.

At the conclusion of the hotel quarantine program an exit clean and disinfection of all floor surfaces and soft furnishings in common areas in red hotels will be also be performed.

Management of linen, crockery and cutlery and waste

If items can be laundered, launder them in accordance with the manufacturer's instructions using the warmest setting possible. Dry items completely. Do not shake dirty laundry as this may disperse the virus through the air.

Wash crockery and cutlery in a dishwasher on the highest setting possible. If a dishwasher is not available, hand wash in hot soapy water.

Waste can be disposed of in the general waste stream.

Table 3: General cleaning recommendations for frequently touched surfaces (adapted from SafeWork Australia, COVID 19 - Recommended cleaning: Supplementary information, 26 May 2020).

Item[1]	Communal area Twice daily cleaning	Exit deep clean
Alcohol-based hand sanitiser dispenser	Twice daily	Yes
Bath	-	Yes
Call bell / doorbell	Twice daily	Yes
Carpet (Soft floor)	Daily (unless visibly soiled)	Yes
Ceiling	Spot cleaned	Spot cleaned
Chairs - non-upholstered (e.g. plastic chairs, wooden chairs, other non-padded chairs)	Twice daily – hard surfaces Soft furnishings – spot cleaned	Yes
Chairs - upholstered (e.g. fabric padded chairs, sofas, office chairs)	Twice daily – hard surfaces Soft furnishings – spot cleaned	Yes
Cleaning Equipment	Yes – after use	Yes
Clipboard / Folders	Twice daily	Yes
Computer, Keyboard, Mouse Headsets	Twice daily	Yes
Curtains and Blinds	Spot clean	Yes
Door frames	Daily	Yes
Doorknob / handles	Twice daily	Yes
Drinking Fountains	Twice daily	Yes
Elevator buttons	Twice daily	Yes
Floor (non-slip vinyl)	Daily	Yes
Floor (polished concrete)	Daily	Yes
Fridges	Daily	Yes
Handrails, stair rails	Twice daily	Yes
Keys and locks and padlocks	Twice daily	Yes
Kitchen appliances (toasters, kettles, sandwich presses, jaffle makers, ovens)	Daily	Yes
Light and power point switches	Twice daily	Yes
Lights/lighting	Twice daily	Yes
Microwave	Daily	Yes
Push/pull doors (with and without a push plate)	Twice daily	Yes
Remote controls	Twice daily	Yes
Shelves (and items on shelves)	Daily	Yes
Shower	Daily	Yes
Sink (hand washing & kitchen)	Twice daily	Yes
Tables / desks	Twice daily	Yes
Telephone	Twice daily	Yes
Toilet	Twice daily	Yes
Toilet doors and locks	Twice daily	Yes
TV	Daily	Yes
Vending Machines	Daily	Yes
Walls	Spot clean	Yes
Windows / ledges	Weekly	Yes
Window frames (sliding servery window types)	Twice daily	Yes

[1]Other frequency touched surfaces may be identified during an initial walk through that will need to be added to this list.

References

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- Coronavirus (COVID-19) – Infection control guidelines <https://www.dhhs.vic.gov.au/covid19-infection-control-guidelines>
- Directions issued by Victoria's Chief Health Officer <https://www.dhhs.vic.gov.au/victorias-restriction-levels-covid-19>
- Environmental cleaning and disinfection principles for health and residential care facilities, Version 3, 13 May 2020. <https://www.health.gov.au/sites/default/files/documents/2020/05/coronavirus-covid-19-environmental-cleaning-and-disinfection-principles-for-health-and-residential-care-facilities.pdf>
- Guidance on how to clean and disinfect your workplace - COVID-19 – Recommended cleaning: Supplementary information, 26 May 2020 <www.swa.gov.au>
- How to put on and take off your PPE <https://www.dhhs.vic.gov.au/how-put-and-take-your-ppe>

Rational use of personal protective equipment for coronavirus disease 2019 (COVID-19)

Interim guidance
27 February 2020

World Health Organization

Coronavirus disease 2019 (COVID-19), caused by the COVID-19 virus, was first detected in Wuhan, China, in December 2019. On 30 January 2020, the WHO Director-General declared that the current outbreak constituted a public health emergency of international concern.

This document summarizes WHO's recommendations for the rational use of personal protective equipment (PPE) in healthcare and community settings, as well as during the handling of cargo; in this context, PPE includes gloves, medical masks, goggles or a face shield, and gowns, as well as for specific procedures, respirators (i.e., N95 or FFP2 standard or equivalent) and aprons. This document is intended for those who are involved in distributing and managing PPE, as well as public health authorities and individuals in healthcare and community settings, and it aims to provide information about when PPE use is most appropriate.

WHO will continue to update these recommendations as new information becomes available.

Preventive measures for COVID-19 disease

Based on the available evidence, the COVID-19 virus is transmitted between people through close contact and droplets, not by airborne transmission. The people most at risk of infection are those who are in close contact with a COVID-19 patient or who care for COVID-19 patients.

Preventive and mitigation measures are key in both healthcare and community settings. The most effective preventive measures in the community include:

- performing hand hygiene frequently with an alcohol-based hand rub if your hands are not visibly dirty or with soap and water if hands are dirty;
- avoiding touching your eyes, nose and mouth;
- practicing respiratory hygiene by coughing or sneezing into a bent elbow or tissue and then immediately disposing of the tissue;
- wearing a medical mask if you have respiratory symptoms and performing hand hygiene after disposing of the mask;
- maintaining social distance (a minimum of 1 m) from individuals with respiratory symptoms.

Additional precautions are required by healthcare workers to protect themselves and prevent transmission in the healthcare setting. Precautions to be implemented by healthcare workers caring for patients with COVID-19 disease include using PPE appropriately; this involves selecting the proper PPE and being trained in how to put on, remove and dispose of it.

PPE is only one effective measure within a package that comprises administrative and environmental and engineering controls, as described in WHO's *Infection prevention and control of epidemic- and pandemic-prone acute respiratory infections in health care* (*1*). These controls are summarized here.

- **Administrative controls** include ensuring the availability of resources for infection prevention and control measures, such as appropriate infrastructure, the development of clear infection prevention and control policies, facilitated access to laboratory testing, appropriate triage and placement of patients, adequate staff-to-patient ratios and training of staff.
- **Environmental and engineering controls** aim at reducing the spread of pathogens and reducing the contamination of surfaces and inanimate objects. They include providing adequate space to allow social distance of at least 1 m to be maintained between patients and between patients and healthcare workers and ensuring the availability of well-ventilated isolation rooms for patients with suspected or confirmed COVID-19 disease.

COVID-19 is a respiratory disease that is different from Ebola virus disease, which is transmitted through infected bodily fluids. Due to these differences in transmission, the PPE requirements for COVID-19 are different from those required for Ebola virus disease. Specifically, coveralls (sometimes called Ebola PPE) are not required when managing COVID-19 patients.

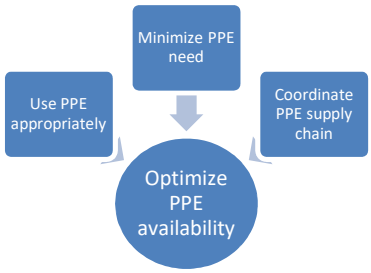
Disruptions in the global supply chain of PPE

The current global stockpile of PPE is insufficient, particularly for medical masks and respirators; the supply of gowns and goggles is soon expected to be insufficient also. Surging global demand − driven not only by the number of COVID-19 cases but also by misinformation, panic buying and stockpiling − will result in further shortages of PPE globally. The capacity to expand PPE production is limited, and the current demand for respirators and masks cannot be met, especially if the widespread, inappropriate use of PPE continues.

Recommendations for optimizing the availability of PPE.

In view of the global PPE shortage, the following strategies can facilitate optimal PPE availability (Fig. 1).

Fig. 1. Strategies to optimize the availability of personal protective equipment (PPE)



(1) Minimize the need for PPE

The following interventions can minimize the need for PPE while protecting healthcare workers and other individuals from exposure to the COVID-19 virus in healthcare settings.

- Consider using telemedicine to evaluate suspected cases of COVID-19 disease (*2*), thus minimizing the need for these individuals to go to healthcare facilities for evaluation.
- Use physical barriers to reduce exposure to the COVID-19 virus, such as glass or plastic windows. This approach can be implemented in areas of the healthcare setting where patients will first present, such as triage areas, the registration desk at the emergency department or at the pharmacy window where medication is collected.
- Restrict healthcare workers from entering the rooms of COVID-19 patients if they are not involved in direct care. Consider bundling activities to minimize the number of times a room is entered (e.g., check vital signs during medication administration or have food delivered by healthcare workers while they are performing other care) and plan which activities will be performed at the bedside.

Ideally, visitors will not be allowed but if this is not possible, restrict the number of visitors to areas where COVID-19 patients are being isolated; restrict the amount of time visitors are allowed to spend in the area; and provide clear instructions about how to put on and remove PPE and perform hand hygiene to ensure visitors avoid self-contamination (see https://www.who.int/csr/resources/publications/putontakeoffPPE/en/).

(2) Ensure PPE use is rationalized and appropriate

PPE should be used based on the risk of exposure (e.g., type of activity) and the transmission dynamics of the pathogen (e.g., contact, droplet or aerosol). The overuse of PPE will have a further impact on supply shortages. Observing the following recommendations will ensure that the use of PPE rationalized.

- The type of PPE used when caring for COVID-19 patients will vary according to the setting and type of personnel and activity (Table 1).
- Healthcare workers involved in the direct care of patients should use the following PPE: gowns, gloves, medical mask and eye protection (goggles or face shield).
- Specifically, for aerosol-generating procedures (e.g., tracheal intubation, non-invasive ventilation, tracheostomy, cardiopulmonary resuscitation, manual ventilation before intubation, bronchoscopy) healthcare workers should use respirators, eye protection, gloves and gowns; aprons should also be used if gowns are not fluid resistant (*1*).
- Respirators (e.g., N95, FFP2 or equivalent standard) have been used for an extended time during previous public health emergencies involving acute respiratory illness when PPE was in short supply (*3*). This refers to wearing the same respirator while caring for multiple patients who have the same diagnosis without removing it, and evidence indicates that respirators maintain their protection when used for extended periods. However, using one respirator for longer than 4 hours can lead to discomfort and should be avoided (*4–6*).
- Among the general public, persons with respiratory symptoms or those caring for COVID-19 patients at home should receive medical masks. For additional information, see *Home care for patients with suspected novel coronavirus (COVID-19) infection presenting with mild symptoms, and management of their contacts* (*7*).
- For asymptomatic individuals, wearing a mask of any type is not recommended. Wearing medical masks when they are not indicated may cause unnecessary cost and a procurement burden and create a false sense of security that can lead to the neglect of other essential preventive measures. For additional information, see *Advice on the use of masks in the community, during home care and in healthcare settings in the context of the novel coronavirus (2019-nCoV) outbreak* (*8*).

(3) Coordinate PPE supply chain management mechanisms.

The management of PPE should be coordinated through essential national and international supply chain management mechanisms that include but are not restricted to:

- using PPE forecasts that are based on rational quantification models to ensure the rationalization of requested supplies;
- monitoring and controlling PPE requests from countries and large responders;
- promoting the use of a centralized request management approach to avoid duplication of stock and ensuring strict adherence to essential stock management rules to limit wastage, overstock and stock ruptures;
- monitoring the end-to-end distribution of PPE;
- monitoring and controlling the distribution of PPE from medical facilities stores.

Handling cargo from affected countries

The rationalized use and distribution of PPE when handling cargo from and to countries affected by the COVID-19 outbreak includes following these recommendations.

- Wearing a mask of any type is not recommended when handling cargo from an affected country.
- Gloves are not required unless they are used for protection against mechanical hazards, such as may occur when manipulating rough surfaces.
- Importantly, the use of gloves does not replace the need for appropriate hand hygiene, which should be performed frequently, as described above.
- When disinfecting supplies or pallets, no additional PPE is required beyond what is routinely recommended. To date, there is no epidemiological information to suggest that contact with goods or products shipped from countries affected by the COVID-19 outbreak have been the source of COVID-19 disease in humans. WHO will continue to closely monitor the evolution of the COVID-19 outbreak and will update recommendations as needed.

Table 1. Recommended type of personal protective equipment (PPE) to be used in the context of COVID-19 disease, according to the setting, personnel and type of activity[a]

Setting	Target personnel or patients	Activity	Type of PPE or procedure
Healthcare facilities			
Inpatient facilities			
Patient room	Healthcare workers	Providing direct care to COVID-19 patients.	Medical mask Gown Gloves Eye protection (goggles or face shield).
		Aerosol-generating procedures performed on COVID-19 patients.	Respirator N95 or FFP2 standard, or equivalent. Gown Gloves Eye protection Apron
	Cleaners	Entering the room of COVID-19 patients.	Medical mask Gown Heavy duty gloves Eye protection (if risk of splash from organic material or chemicals). Boots or closed work shoes
	Visitors[b]	Entering the room of a COVID-19 patient	Medical mask Gown Gloves
Other areas of patient transit (e.g., wards, corridors).	All staff, including healthcare workers.	Any activity that does not involve contact with COVID-19 patients.	No PPE required
Triage	Healthcare workers	Preliminary screening not involving direct contact[c].	Maintain spatial distance of at least 1 m. No PPE required
	Patients with respiratory symptoms.	Any	Maintain spatial distance of at least 1 m. Provide medical mask if tolerated by patient.
	Patients without respiratory symptoms.	Any	No PPE required
Laboratory	Lab technician	Manipulation of respiratory samples.	Medical mask Gown Gloves Eye protection (if risk of splash)
Administrative areas	All staff, including healthcare workers.	Administrative tasks that do not involve contact with COVID-19 patients.	No PPE required

Outpatient facilities			
Consultation room	Healthcare workers	Physical examination of patient with respiratory symptoms.	Medical mask Gown Gloves Eye protection
	Healthcare workers	Physical examination of patients without respiratory symptoms.	PPE according to standard precautions and risk assessment.
	Patients with respiratory symptoms.	Any	Provide medical mask if tolerated.
	Patients without respiratory symptoms.	Any	No PPE required
	Cleaners	After and between consultations with patients with respiratory symptoms.	Medical mask Gown Heavy duty gloves Eye protection (if risk of splash from organic material or chemicals). Boots or closed work shoes
Waiting room	Patients with respiratory symptoms.	Any	Provide medical mask if tolerated. Immediately move the patient to an isolation room or separate area away from others; if this is not feasible, ensure spatial distance of at least 1 m from other patients.
	Patients without respiratory symptoms.	Any	No PPE required
Administrative areas	All staff, including healthcare workers.	Administrative tasks	No PPE required
Triage	Healthcare workers	Preliminary screening not involving direct contact[c.]	Maintain spatial distance of at least 1 m. No PPE required
	Patients with respiratory symptoms.	Any	Maintain spatial distance of at least 1 m. Provide medical mask if tolerated.
	Patients without respiratory symptoms.	Any	No PPE required
Community			
Home	Patients with respiratory symptoms.	Any	Maintain spatial distance of at least 1 m. Provide medical mask if tolerated, except when sleeping.
	Caregiver	Entering the patient's room, but not providing direct care or assistance.	Medical mask
	Caregiver	Providing direct care or when handling stool, urine or waste from COVID-19 patient being cared for at home.	Gloves Medical mask Apron (if risk of splash)
	Healthcare workers	Providing direct care or assistance to a COVID-19 patient at home	Medical mask Gown Gloves Eye protection
Public areas (e.g., schools, shopping malls, train stations).	Individuals without respiratory symptoms	Any	No PPE required

Points of entry			
Administrative areas	All staff	Any	No PPE required
Screening area	Staff	First screening (temperature measurement) not involving direct contact[c.]	Maintain spatial distance of at least 1 m. No PPE required
	Staff	Second screening (i.e., interviewing passengers with fever for clinical symptoms suggestive of COVID-19 disease and travel history).	Medical mask Gloves
	Cleaners	Cleaning the area where passengers with fever are being screened.	Medical mask Gown Heavy duty gloves Eye protection (if risk of splash from organic material or chemicals). Boots or closed work shoes
Temporary isolation area	Staff	Entering the isolation area, but not providing direct assistance.	Maintain spatial distance of at least 1 m. Medical mask Gloves
	Staff, healthcare workers	Assisting passenger being transported to a healthcare facility.	Medical mask Gown Gloves Eye protection
	Cleaners	Cleaning isolation area	Medical mask Gown Heavy duty gloves Eye protection (if risk of splash from organic material or chemicals). Boots or closed work shoes
Ambulance or transfer vehicle	Healthcare workers	Transporting suspected COVID-19 patients to the referral healthcare facility.	Medical mask Gowns Gloves Eye protection
	Driver	Involved only in driving the patient with suspected COVID-19 disease and the driver's compartment is separated from the COVID-19 patient.	Maintain spatial distance of at least 1 m. No PPE required
		Assisting with loading or unloading patient with suspected COVID-19 disease.	Medical mask Gowns Gloves Eye protection
		No direct contact with patient with suspected COVID-19, but no separation between driver's and patient's compartments.	Medical mask
	Patient with suspected COVID-19 disease.	Transport to the referral healthcare facility.	Medical mask if tolerated
	Cleaners	Cleaning after and between transport of patients with suspected COVID-19 disease to the referral healthcare facility.	Medical mask Gown Heavy duty gloves Eye protection (if risk of splash from organic material or chemicals). Boots or closed work shoes

Special considerations for rapid response teams assisting with public health investigations[d]			
Community			
Anywhere	Rapid response team investigators.	Interview suspected or confirmed COVID-19 patients or their contacts.	No PPE if done remotely (e.g., by telephone or video conference). Remote interview is the preferred method.
		In-person interview of suspected or confirmed COVID-19 patients without direct contact.	Medical mask Maintain spatial distance of at least 1 m. The interview should be conducted outside the house or outdoors, and confirmed or suspected COVID-19 patients should wear a medical mask if tolerated.
		In-person interview with asymptomatic contacts of COVID-19 patients.	Maintain spatial distance of at least 1 m. No PPE required The interview should be performed outside the house or outdoors. If it is necessary to enter the household environment, use a thermal imaging camera to confirm that the individual does not have a fever, maintain spatial distance of at least 1 m and do not touch anything in the household environment.

[a] In addition to using the appropriate PPE, frequent hand hygiene and respiratory hygiene should always be performed. PPE should be discarded in an appropriate waste container after use, and hand hygiene should be performed before putting on and after taking off PPE.

[b] The number of visitors should be restricted. If visitors must enter a COVID-19 patient's room, they should be provided with clear instructions about how to put on and remove PPE and about performing hand hygiene before putting on and after removing PPE; this should be supervised by a healthcare worker.

[c] This category includes the use of no-touch thermometers, thermal imaging cameras, and limited observation and questioning, all while maintaining a spatial distance of at least 1 m.

[d] All rapid response team members must be trained in performing hand hygiene and how to put on and remove PPE to avoid self-contamination.

For PPE specifications, refer to WHO's novel coronavirus (COVID-19) disease commodity packages at https://www.who.int/emergencies/what-we-do/prevention-readiness/disease-commodity-packages/dcp-ncov.pdf?ua=1.

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WHO reference number: WHO/2019-nCov/IPC PPE_use/2020.1

RE: Greg Mortimer passengers - closing the loop

From: "Melissa Skilbeck (DHHS)" REDACTED
REDACTED
To: "Andrea Spiteri (DHHS)" REDACTED "Braedan Hogan (DHHS)"
REDACTED , "Annaliese Van Diemen (DHHS)"
Date: Thu, 09 Apr 2020 19:44:29 +1000

Any changes – anyone pre8pm?
Thank you
Point 1-2 are fine
Point 3 – Terry has advised RMH and Alfred are best to deal with worst-case numbers and potential complexity – even if we were to have small numbers it is best to have two to maximise flow of patients into Emergency
Point 4 - We have one contracted hotel who is ready willing and able to accept COVID-positive guests – Rydges Swanton Street
At this late stage of planning it would be risky to seek to convince another hotel to contract to take such guests.
Regards,
Melissa

Melissa Skilbeck
Deputy Secretary | Regulation, Health Protection and Emergency Management
REDACTED

From: Kym Peake (DHHS) REDACTED
Sent: Thursday, 9 April 2020 7:01 PM
To: Annaliese Van Diemen (DHHS) REDACTED Brett Sutton (DHHS) REDACTED ; Melissa Skilbeck (DHHS) REDACTED Terry Symonds (DHHS) REDACTED ; Andrea Spiteri (DHHS) REDACTED Jacinda de Witts (DHHS) REDACTED Finn Romanes (DHHS) REDACTED
Subject: RE: Greg Mortimer passengers - closing the loop
Further steer
Flight will be proceeding.
Annaliese – I think now is the time to reflect your suggestion of two flights to separate people who have not tested positive.
Premier has also requested that we use a hotel that is close to the airport, not in the CBD. If possible could we say tonight which hotel that would be? If not, we can confirm with everyone as soon as possible
Please let me know if there are any concerns/adjustments to the following points that I will provide to REDA to share centrally
Actions in train:

1. Email from SCC to NIR/Commonwealth outlining significant concerns with the safety of transporting such a large number of confirmed cases of a listed human disease on a long haul flight and seeking assurance that medical coverage and equipment on the flight is increased to appropriate levels. Also determining whether separate flights could be chartered to reduce the risk of further infection – so that people who have not tested positive are kept separate from confirmed cases for the flight home.
2. Planning for landing including FEMO attendance at the airport, field tent to be set up, ambulances on site, further ambulances ready to go. Consistent with arrival protocols, all returned travellers will be assessed and transported airside (they won't come through the terminal)
3. Consultation with RMH, Western, Alfred and Monash on arrangements to receive
    a. anyone known to be COVID positive who is seriously unwell, plus
    b. anyone who has not tested positive but is displaying symptoms on arrival, for assessment and testing

4. Remainder of passengers to be transferred to a dedicated hotel close to the airport (not in the CBD)

Kym

Kym Peake
Secretary
Department of Health and Human Services
Level 1, 50 Lonsdale Street, Melbourne 3000
REDACTED

From: Annaliese Van Diemen (DHHS) REDACTED
Sent: Thursday, 9 April 2020 6:09 PM
To: Brett Sutton (DHHS) REDACTED; Kym Peake (DHHS) REDACTED; Melissa Skilbeck (DHHS) REDACTED Terry Symonds (DHHS) REDACTED; Andrea Spiteri (DHHS) REDACTED Jacinda de Witts (DHHS) REDACTED; Finn Romanes (DHHS) REDACTED
Subject: Greg Mortimer passengers - closing the loop

Dear all,

Huge amount of rapid work on this today, just closing the loop on next steps in this process and ensuring we are covered/ready to go regardless of what decisions are made at Commonwealth level re; flight leaving:

1. Email from myself to NIR/Commonwealth outlining significant concerns with the safety of transporting such a large number of confirmed cases of a listed human disease on a long haul flight and requesting that confirmed cases are managed in country until they are non-infectious – **ANNALIESE**
2. Request that if the Uruguayan government send the passengers regardless, that the medical coverage on the flight is increased to appropriate levels as per discussions with REDACT – **ANNALIESE**
3. If the flight takes off regardless, put in place plan at the airport for landing including FEMO attendance at the airport, field tent to be set up, ambulances on site, further ambulances ready to go – **FINN** with assistance from Braedan Hogan and REDACTED, (to be overseen by Human Biosecurity Officer on Sunday morning – Annaliese as Acting CHO)
4. Ensure there is adequate hospital capacity to take a potentially large number of cases when the flight lands **– TERRY** – RMH/Western +/- Alfred and Monash
5. Remainder of passengers to be transferred to hotels as per existing logistics plan for mandatory hospital detention – **As per roster for weekend**

I will check back in with this group as soon as we have any further updates from NIR regarding planned take off of the flight or otherwise. Please let me know if there is anything I have missed or more information has come to light since an hour ago.

Kind Regards

Annaliese

Dr Annaliese van Diemen MBBS BMedSc MPH FRACGP FAFPHM
Public Health Commander- COVID-19 Department Incident Management Team
Deputy Chief Health Officer (Communicable Disease)
Regulation, Health Protection & Emergency Management
Department of Health & Human Services | 14 / 50 Lonsdale St
REDACTED

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

Outbreak squad /hotels today

From: REDACTED

To: "Merrin Bamert (DHHS)" REDACTED "Pam Williams (DHHS)"

Cc: "Simon Crouch (DHHS)" REDACTED "Annaliese Van Diemen (DHHS)"

Date: Wed, 17 Jun 2020 07:40:29 +1000

Hi all, I am sending 2x teams this morning:

REDACTED to Brady's to complete security hand hygiene training

REDACTED to Stamford they will bring with them extra swans (100) that we have, gowns, masks, gloves, bins, eyewear etc.and signage.. they will be in PPE...

Both teams should be at the sites by 0800 to help...

Call me directly if you need any further assistance.

REDACTED

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