# Curriculum Vitae - Jacinda de Witts

**Current role**

- Deputy Secretary, Legal and Executive Services Division and General Counsel, January 2019 to present*

  *From 8 April to 8 August 2020, I was seconded to the role of Deputy Secretary, Public Health Emergency Operations and Coordination/COVID-19 Public Health Division

**Prior roles**

- General Counsel and Chief Legal Officer, Department of Health and Human Services (June 2018-January 2019)
- Acting General Counsel and Chief Legal Officer, Department of Health and Human Services (January 2017-June 2018) (secondment)
- Director, The Royal Children's Hospital (2013-2018)
- Director, Cancer Council Victoria (2015-2018)
- Member, Quality and Safety Committee, The Royal Children's Hospital (2013-2018)
- Member, Audit and Risk Committee, The Royal Children's Hospital (2013-2018)
- Chair, Finance, Risk and Audit Board Committee, Cancer Council Victoria (2017-2018)
- Member, Executive Committee, Cancer Council Victoria (2017-2018)
- Founding principal, Hive Legal (2014–2018)
- Partner, Minter Ellison (2007-2014)
- Senior Associate, Minter Ellison (2002–2007)
- Senior Associate, Baker & McKenzie (2000–2002)
- Lawyer, Baker & McKenzie (1999–2000)
- Associate to Justice Munro, Senior Deputy President, Australian Industrial Relations Commission (1996–1997)
- Graduate, Commonwealth Department of Industrial Relations (1995-1996)
- Research Assistant, Faculty of Law, University of Sydney (1994–1997)
- Research Officer, Australian Institute of Company Directors (1994)

**Industry Awards**

- Best Lawyers in Australia, 2014, 2015, 2016, 2017 and 2018 - Government Practice
- Best Lawyers in Australia, 2014, 2015, 2016, 2017 and 2018 – Regulatory Practice
- Best Lawyers in Australia, 2017 and 2018 – Retirement Villages and Senior Living Law
- Best Lawyers in Australia, 2015, 2016, 2017 and 2018 - Energy
- The Legal 500 Australia (2017)
- Finalist Lawyers Weekly Partner of the Year (Health), 2016
- APL 500 recommended for Corporate and M&A, 2016

**Qualifications**

- Graduate Diploma of Corporate and Securities Law, University of Melbourne, 2004
- College of Law (NSW), 1996
- LLB (Hons I), University of Sydney, 1995 (Second place, Final Year)
- B Ec, University of Sydney, 1990

**Admission to practice**

- New South Wales (1997)
- High Court of Australia (1998)
- Victoria (2000)

# Interim changes to RHPEM structure and establishment of COVID-19 Public Health Division

Frequently asked questions

## Background

### Why are we making these changes now?

These interim structures are being put in place to stabilise the structures that were rapidly developed to respond to the coronavirus (COVID-19) pandemic. It is important that we more formally establish an emergency management and public health response to COVID-19 and enable non-COVID emergency management and health protection functions to focus on other priorities.

### Are we still in a state of emergency?

Yes. The Declaration of State of Emergency has been extended through to 11.59pm 21 June 2020 and can be continued up to a period of six months.

## Staff impacts

### What does the term 'assign' mean?

The *Public Administration Act 2005* provides for a public service body head, such as the Secretary, to be able to 'assign' employees to duties consistent with their employment classification, skills and capabilities, subject to the exercise of this power in a reasonable manner. In the context of the pandemic it is reasonable to assign employees to roles and functions where the department, as the lead response agency, requires employees with the requisite skills to manage and lead the government's response activities.

### Who will decide who is assigned and on what basis will this occur?

Jacinda de Witts and Melissa Skilbeck will engage with their respective teams to identify the staff and teams needed to be assigned to critical functions.

### Will my skills and experience be considered when I am assigned?

Work undertaken by staff in these structures should be consistent with their current work value and capability. Sourcing arrangements will be consistent with the department's recruitment policy and the government's industrial relations framework.

### If I am assigned, what will happen to my substantive position?

Employees' substantive positions and structures are not affected by these interim structures through this emergency response. Changes relating to substantive roles and structures would be subject to formal change processes and consultation with staff and the Community and Public Sector Union (CPSU). This includes any existing clause 10s that are underway, but currently paused due to the current COVID-19 response.

## How long will I be required to be assigned?

It is important that staff are provided with as much clarity as possible about the time frame of their assignment. Staff may be assigned to roles for different periods of time based on the need for their skillset and work they perform, within the context of the COVID-19 response. Given the dynamic nature of the emergency response, it is anticipated that the situation will continue to change and evolve and any initial assignment periods – or changes to this – will be communicated with staff.

## Why is the COVID-19 Public Health Division being established for 12 months?

While the specific response activities and skillsets required may change over time, emergency response activity for COVID-19 will continue for the next 12 months.

## Do I have a choice about where I am assigned?

Where employees do not agree with where they have been assigned, then those individual concerns can be managed in the usual way through discussions with their line manager or designated executive.

## What if I disagree with the role I am assigned to?

In the context of the pandemic, it is reasonable to assign employees to roles and functions where the department, as the lead response agency, requires employees with the requisite skills to manage and lead the government's response activities. Employees who have concerns about the temporary role that they have been assigned to will be able to discuss their concerns with their line manager or relevant executive.

## What if my manager won't release me?

Your Deputy Secretaries and executive will negotiate assignments to ensure critical functions have the necessary resources to deliver their work.

The department's policy for Recruitment and flexible deployment during the COVID-19 pandemic sets out the expectation that managers should release staff for temporary assignments to COVID-19 response teams. In the first instance, discussion between the substantive manager, the assigned manager, and the staff member is encouraged to explore options that will enable the assignment to take place around existing work commitments. If these discussions are not able to resolve the matter, it should be escalated to the relevant executive to resolve.

If you have any feedback or questions please feel free to email PHEOC@dhhs.vic.gov.au or depsec.rhpem@dhhs.vic.gov.au or you may wish to speak to our People & Culture contact

## If I am assigned to a particular role, will my reporting line change?

Yes, reporting lines may alter as a result of moving to these interim structures. It is important that employees have clear oversight and management structures in place to support them whilst undertaking the COVID-19 response activities.

## Will my hours of work change, and will I be required to work shifts?

A combination of temporary shift work arrangements with applicable penalties and allowances and ordinary working arrangements (non-shift) and overtime arrangements will support the response activities. Staff will be supported, particularly through rosters, to ensure their wellbeing and to meet the department's OHS obligations. Appropriate arrangements will be in place to support fatigue management and to ensure consistent industrial practices.

Discussions will occur on an individual basis to ensure employees understand what is being proposed for them.

### Can I be assigned at a higher level to my substantive position?

Employees from within the department will be assigned from their substantive area at their current classification level. Any staff currently acting in higher duties roles will be assessed on a case-by-case basis, with a view of continuing to honour those arrangements wherever possible.

### Will there be the opportunity to get ongoing promotions?

There is no opportunity to obtain ongoing promotions through this process, although there may be opportunities for certain higher duty activities, where appropriate.

### Will vacant roles be advertised?

The leadership team will identify individuals and teams to be assigned to the COVID-19 Public Health Division to ensure we continue to support COVID-19 response activities, as well as restore capacity to critical emergency management, regulatory and health protection functions in RHPEM and operational divisions. Recruitment will be undertaken to fill vacant roles consistent with the department's policy for Recruitment and Flexible deployment during the COVID-19 pandemic.

### Who else can I talk to and where can I direct any feedback or questions I have?

Please talk to your line manager if you are concerned about the interim structures and assignment.

Please also remember that the Employee wellbeing and support program is a free, confidential service to support you (and your immediate family) with issues that may be affecting your wellbeing at work or at home.  Here is the link: https://intranet.dhhs.vic.gov.au/employee-wellbeing-and-support-program-formerly-eap-more-counselling

If you have any feedback or questions please feel free to email PHEOC@dhhs.vic.gov.au or depsec.rhpem@dhhs.vic.gov.au for RHPEM.

## Structural and functional impacts

### What is the role of the COVID-19 Public Health Division?

The COVID-19 public health response functions will continue to operate as part of a new division for the next 12 months. The division will be responsible for managing the response to the critical public health risks from COVID-19, including providing public health advice to Government and other government agencies, infection prevention and control, case contact and outbreak management, physical distancing, public information and intelligence.

### What are the roles of the Chief Health Officer in the RHPEM and COVID-19 Public Health Divisions?

Professor Brett Sutton, Chief Health Officer, will continue to have statutory responsibility for all public health functions. As he is doing now, Brett will continue to provide the expert public health advice to government and provide oversight of both the public health response functions in the COVID-19 Public Health Division as well as the Health Protection Branch in RHPEM.

### What is the role of State Control?

The State Control Centre (SCC) is Victoria's primary control centre for the management of emergencies. The State Controller is currently activated to oversee and coordinate the Whole of Victorian Government response to control the spread of coronavirus (COVID-19) and mitigate and address any state-level consequences of the pandemic.

### What is the role of the COVID-19 Emergency Accommodation Operations and Enforcement and Compliance teams?

These teams manage the 14-day quarantine of all people arriving from overseas into Victoria, and support enforcement of wider public health restrictions.

## Staff engagement and consultation

### Why is this not a 'Clause 10' consultation?

In the context of a pandemic, it is reasonable to assign employees to roles and functions where the department, as the lead response agency, requires employees with the requisite skills to manage and lead the government's response activities. The department will of course still engage with impacted employees and the CPSU about the proposed changes.

### Why are we creating a separate Division and not managing the COVID-19 response out of RHPEM?

The COVID-19 emergency is one of many communicable diseases that are managed in Victoria. The new COVID-19 Public Health Division will provide a dedicated response to COVID-19 activities, including management of the expanded workforce and whole of Victorian Government COVID-19 response coordination. While the scale and dynamic nature of the COVID-19 response requires a dedicated focus for a period of time, it is important that the two Divisions continue to work closely on public health matters overall.

### Does the establishment of a temporary COVID-19 Public Health division mean that the idea of an integrated public health function, as proposed in the paused RHPEM Clause 10, is no longer being considered?

No. The RHPEM clause 10 is paused, and these temporary arrangements do not change what was proposed. These arrangements are to formalise the dedicated focus on COVID-19 needed for the response, while restoring necessary effort to non-COVID-19 public health threats.

### What will happen to the existing RHPEM clause 10?

Employees' substantive positions and structures are not affected by these interim structures through this emergency response. Changes relating to substantive roles and structures would be subject to formal change processes and consultation with staff and the CPSU. This includes any existing clause 10s that are underway, but currently paused due to the current COVID-19 response.

VICTORIA State Government | Health and Human Services

| | |
|---|---|
| **To:** | Dr Annaliese van Diemen, Deputy Chief Health Officer (Communicable Disease) |
| **From:** | Jacinda de Witts, General Counsel |

**Decision to sign notices to be issued to persons arriving in Victoria from outside Australia requiring them to self-quarantine in designated premises for 14 days and to revoke previous directions**

**Action required by:** 11pm on 28 March 2020

| | |
|---|---|
| 1. **Note** the department has prepared draft notices to be issued to persons arriving in Victoria from outside Australia (whether by plane or sea), requiring them to self-quarantine in a designated premises for 14 days (**Attachment B**) (the **Isolation (International Arrivals) Detention Notices**). | ☑ Noted / ☐ Please discuss |
| 2. **Note** the department has prepared the **Airport and Cruise Ships Revocation** to revoke the Airport Arrivals Directions and Cruise Ship Docking Directions (**Attachment C**). | ☑ Noted / ☐ Please discuss |
| 3. **Note** the assessment of the Legal Services Branch that the Isolation (International Arrivals) Detention Notices are compatible with the *Charter of Human Rights and Responsibilities Act 2006* (**Attachment D**). | ☑ Noted / ☐ Please discuss |
| 4. **Note** the relevant considerations under PHW Act as set out in this brief. | ☑ Noted / ☐ Please discuss |
| 5. **Agree,** subject to proper consideration of the matters set out in this brief and the legal advice contained in **Attachment D**, to sign the Isolation (International Arrivals) Detention Notices and the Airport and Cruise Ships Revocation. | ☑ Agreed / ☐ Not agreed |

**Comments**

REDACTED

**Dr Annaliese van Diemen**
Deputy Chief Health Officer

Date: 28/ 3 /2020

**Key issues**

1. We note you are considering signing:
   (a) the Isolation (International Arrivals) Detention Notices, to be issued to persons arriving in Victoria from outside Australia (whether by plane or sea), requiring them to self-quarantine in a designated premises for 14 days in order to address the public health emergency posed by nCoV-19; and
   (b) the Airport and Cruise Ships Revocation.

2. The Isolation (International Arrivals) Detention Notices are at **Attachment B** of this brief. The Airport and Cruise Ships Revocation is at **Attachment C** of this brief. The corresponding legal advice with respect to the Charter is at **Attachment D** of this brief.
3. In deciding to sign the Isolation (International Arrivals) Detention Notices to persons arriving in Victoria from outside Australia, you must:

   (a) give proper consideration to any relevant human rights;
   (b) act in a way that is compatible with human rights; and
   (c) comply with the requirements of the PHW Act.

**PART A - Authorisation**

4. I note you are an authorised officer appointed by the Secretary under the PHW Act.
5. As the Minister for Health has issued a state of emergency under section 198 of the PHW Act, section 199(2) is operable. Section 199(2) provides that the Chief Health Officer may, for the purpose of eliminating or reducing the serious risk to public health, authorise you (or any other authorised officer appointed by the Secretary under the PHW Act) to exercise any of the public health risk powers and emergency powers.
6. The Chief Health Officer has authorised you to exercise the public health risk powers and emergency powers (**Attachment A**).
7. This authorisation enables you to sign the Isolation (International Arrivals) Detention Notices and the Airport and Cruise Ships Revocation.

**PART B - Charter assessment**

*Human rights considerations*

8. Under section 38 of the Charter, public authorities are required to give proper consideration to relevant human rights when making decisions and to act compatibly with those rights.
9. The department considers that your decision to sign the Isolation (International Arrivals) Detention Notices will be compatible with the Charter.
10. The department has identified the following rights that may be impacted by the Isolation (International Arrivals) Detention Notices:

    (a) Section 21 - right to liberty
    (b) Section 12 - freedom of movement
    (c) Section 14 - freedom of religion
    (d) Section 19 - cultural rights
    (e) Section 16 - freedom of peaceful assembly and association
    (f) Section 13 - rights to privacy, family and home
    (g) Section 17 - protection of families and children
    (h) Section 22 - right to humane treatment when deprived of liberty

11. The right to protection from cruel, inhuman and degrading treatment under section 10 may also be engaged by the decision, but is unlikely to be limited.
12. Based on all of the available information, the department considers that the Isolation (International Arrivals) Detention Notices are compatible with the human rights in the Charter.
13. A detailed account of this assessment is at **Attachment D**.

**PART C - PHW Act**

14. Section 199 of the PHW Act empowers you to authorise the exercise of any emergency powers in section 200 of the PHW Act if:

    (a) a state of emergency exists; and

(b) you believe that it is necessary to eliminate or reduce a serious risk to public health.

15. A state of emergency was declared on 16 March 2020. The below discussion sets out the considerations that you must take into account in determining if the Isolation (International Arrivals) Detention Notices are necessary to eliminate or reduce a serious risk to public health.

16. We note that the PHW Act provides that emergency powers are exercised by authorised officers. The Chief Health Officer has authorised you under s 199 to exercise the emergency powers in s 200(1).

*Mandatory considerations*

17. Serious risk to public health is defined in s 3 of the PHW Act to mean a material risk that substantial injury or prejudice to the health of human beings has or may occur having regard to:

(a) the number of persons likely to be affected;
(b) the location, immediacy and seriousness of the threat to the health of persons;
(c) the nature, scale and effects of the harm, illness or injury that may develop; and
(d) the availability and effectiveness of any precaution, safeguard, treatment or other measure to eliminate or reduce the risk to the health of human beings.

18. Section 4(3) of the PHW Act provides that it is Parliament's intention that regard should be given to the guiding principles set out in ss 5 to 11A in the administration of the PHW Act, which includes all decisions made under the PHW Act. Those principles relevantly include:

(a) the principle of evidence based decision-making (s 5);
(b) the precautionary principle (s 6);
(c) the principle of primacy of prevention (s 7);
(d) the principle of accountability (s 8);
(e) the principle of proportionality (s 9); and
(f) the principle of collaboration (s 10).

19. As the above principles are likely to be mandatory relevant considerations with respect to all decisions under the PHW Act, you must take these matters into account and give weight to them as fundamental elements in your decision.[1]

20. We have reviewed the Chief Health Officer's advice to the Minister outlining the reasons for the recommendation that a state of emergency be declared in Victoria which allows for the exercise of additional powers. That recommendation indicates that:

(a) available relevant and reliable evidence is being considered, consistent with the principle in s 5 (evidence based decision-making);
(b) because nCoV-19 poses a serious threat, the lack of full scientific certainty about that threat is not being used as a reason for postponing measures to prevent or control it, consistent with the principle in s 6 (the precautionary principle);
(c) preventative measures to stop the spread of nCoV-19, are being preferred over remedial measures, consistent with the principle in s 7 (primacy of prevention);
(d) the reasons for decisions are being transparently and systematically provided, consistent with the principle in s 8 (accountability);
(e) the reasons why additional powers are needed to minimise the spread of nCoV-19 have been carefully considered and explained and it appears from the description of the public health risk that is sought to be prevented, minimised or controlled, that those additional powers are a proportionate response to that threat (accepting that they

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[1] *R v Hunt; Ex Parte Sean Investments Pty Ltd* (1979) 52 ALJR 552, 554 (Mason J, Gibbs J agreeing).

compel a person arriving in Victoria from outside Australia to self-quarantine in designated premises for 14 days) and this careful consideration also indicates that decisions have not been taken in an arbitrary manner, consistent with the principle in s 9 (proportionality);

(f) finally, the action recommended supports compliance with the new Commonwealth guideline regarding isolation of patients diagnosed with nCoV-19 throughout Australia, consistent with the principle in s 10 (collaboration).

21. The contents of the above recommendation, in which the Chief Health Officer sought a declaration that would allow the exercise of the powers that you are now considering exercising, indicates that in the lead up to this current decision real weight has been given to the relevant principles as a matter of substance.

22. If, after considering these principles and giving them real weight, you now believe that it is necessary to issue the Isolation (International Arrivals) Detention Notices to require persons arriving in Victoria from outside Australia (whether by plane or sea) to self-quarantine in designated premises for 14 days in order to eliminate or reduce a serious risk to public health, it is open to you to sign the Notices.

**CONSULTATION**

23. This brief was prepared in consultation with the Victorian Government Solicitor's Office and Counsel.

Prepared by: Ed Byrden, Acting Director, Legal Services

Approved by: Jacinda de Witts, Deputy Secretary and General Counsel, Legal and Executive Services, 9096 1557/0400 399 136 ...../...../2020

# RE: [For consideration] Suggestions on statutory reporting requirements relating to individual detainment

**From:** REDACTED

**To:** REDACTED, "Meena Naidu (DHHS)" REDACTED

**Cc:** "Ed Byrden (DHHS)" REDACTED "Merrin Bamert (DHHS)" REDACTED "Jacqueline Goodall (DHHS)" REDACTED

**Date:** Sun, 29 Mar 2020 12:03:18 +0000

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Thank you REDA
I am preparing the document that you sent prior (the spreadsheet) based on the room lists that we have received through from Crown resorts. This is just to begin the documentation in preparation for tomorrow morning, when we are likely to obtain more information, as well as more arrivals.
I will ensure that the document is located securely with adequate access/version controlling around it.
Will touch base tomorrow, again, thank you very much for your assistance thus far; it is much appreciated ☺
Have a good night,

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 | 50 Lonsdale Street, Melbourne, VIC 3000
REDACTED | www.dhhs.vic.gov.au


We respectfully acknowledge the Traditional Owners of country throughout Victoria and pay respect to the ongoing living cultures of Aboriginal people.

**From:** REDACTED
**Sent:** Sunday, 29 March 2020 8:41 PM
**To:** Meena Naidu (DHHS) REDACTED
REDACTED
**Cc:** Ed Byrden (DHHS) REDACTED Merrin Bamert (DHHS)
REDACTED Jacqueline Goodall (DHHS) REDACTED
REDACTED
**Subject:** RE: [For consideration] Suggestions on statutory reporting requirements relating to individual detainment
Hi Meena, REDA
As per our discussions, I just wanted to set out the arrangements we think could see Authorised Offices complying with the twenty-four hour review requirement in relation to the exercise of emergency detainment powers under the *Public Health and Wellbeing Act 2008* (PHWA):

- **An Authorised Office could meet this requirement through a paper based review of all the relevant detainment arrangements each twenty four hour period.** I understand this would significantly reduce the burden on Authorised Officers, especially if a central database of these arrangements is kept with all the critical information (see below).

- **To do this review, the relevant Authorised Officer would need to ask themselves: "is the continued detention of this person reasonably necessary to eliminate or reduce a serious risk to public health?"** In these circumstances, the relevant Authorised Officer would need to have two critical pieces of information in front of them to make this decision:

    - a note that the person is a returned overseas traveller who is subject to a notice that

they must comply with the exercise of the detainment power

- the date that person entered the country and when the notice was given (these should be the same date)

- **NB It is possible to do the review using this analysis because the expert medical advice is that travellers returning from overseas pose a significant health risk due to the possibility they could spread COVID-19. This means an Authorised Officer could complete the assessment with just these two pieces of critical information in most cases.** However, as I have noted below, if an Authorised Officer becomes aware of any other relevant information they should note it because it could alter the outcome of the review (and require escalation to the Chief Health Officer and Minister for Health).
- **The records should also include the outcome of each review as each twenty four hour period progresses for each detained person** – this is because one of the key aspects of each Authorised Officer's subsequent review is that the continuing detention of a person is required for up to fourteen days from when they arrive to Australia. Each assessment supports the next officers assessment that the detainment is required (and avoids the risk of a person being detained for too long).
- **If possible, any other information about that person's health and wellbeing noted by an Authorised Officer should be included in the record** – for example, whether that person has displayed any symptoms on arrival, has a medical record of being previously infected with COVID-19 and cleared, has recently been tested in Australia for COVID-19 and cleared, has any other physical or mental health well-being issues that have come to light, has left the place they were required to quarantine at etc. These individual circumstances may alter the basis for the direction based on the Authorised Office's assessment of the risk to public health.
- **It is also important that any issues identified during spot checks or welfare checks, compliance breaches and any other material self-reported issues by people subject to quarantine directions be recorded, where possible –** This is important because these records will be used to discharged the reporting requirements under sub-sections 200(7) and (9) of the PHWA to report to the Chief Health Office and the Minister for Health the name of each person who is subject to individual detention requirements and the reasons why. Without this information, the reviews may give the impression that there are no issues with the detention when material risks are present (e.g. a person is not compliant, sick, at risk of self-harm, suffering mental health issues etc). Any solutions to these issues taken to-date by the Authorised Officers and the department should be included. These could be high-level notes.

The spreadsheet we have provided attempts to set this minimum requirements out (I've re-attached the spreadsheet to assist). I have noted to Meena and RED that version control and data integrity is a critical part of successfully completing this exercise. I'm also completing a template brief to help assist with discharging the reporting requirement.

Please do not hesitate to give me a ring if there are any issues.

REDAC
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REDACTED
**Principal Adviser to Jacinda de Witts, Deputy Secretary and General Counsel**
**Legal and Executive Services**
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Department of Health and Human Services | 50 Lonsdale St, Melbourne VIC 3000
**We Care | We Connect | We Innovate**

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**From:** Jacqueline Goodall (DHHS) <REDACTED
**Sent:** Sunday, 29 March 2020 6:44 PM
**To:** Meena Naidu (DHHS) REDACTED
REDACTED
REDACTED
**Cc:** Ed Byrden (DHHS) REDACTED Merrin Bamert (DHHS)
REDACTED
**Subject:** Re: [For consideration] Suggestions on statutory reporting requirements relating to individual detainment

Hi Meena
I'll respond to this. We will get this advice to you as soon as possible. It does raise serious issues, as it is a requirement under the Act to review every person on a detention notice to review 24 hours.
Jacqui
Get Outlook for

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**From:** Meena Naidu (DHHS) REDACTED
**Sent:** Sunday, March 29, 2020 6:40:23 PM
**To:** REDACTED
REDACTED
**Cc:** Jacqueline Goodall (DHHS REDACTED Ed Byrden (DHHS)
REDACTED ; Merrin Bamert (DHHS) REDACTED
**Subject:** RE: [For consideration] Suggestions on statutory reporting requirements relating to individual detainment

Hi REDA
Thanks for this.
We are somewhat concerned about our ability to keep up with the 24 hour checks. The requirement for AOs to do the 24 hour reviews and the numbers of people arriving in the country make the task challenging to do every 24 hours at the same time as the other activity requiring AOs ie attending the hotels 24/7, being at the airport issuing the direction, undertaking the other compliance work with VicPol (mass gatherings, confirmed case checks etc). While we have new AOs coming on board, we are not sure we will have enough if we have to check everyone detained every 24 hours. We will have seven AOs in place for tomorrow to do the reviews but we expect the number will likely rise very quickly depending on arrival numbers.
Your email suggests that we may not have to check every person but could possibly do spot checks. Is that correct? We would also like to explore whether we can use Whipr as a way to reduce the load. Would this meet the requirements of the direction?
Look forward to receiving the guidelines to finalise the scripts.
Kind regards
REDACT

REDACTED **Director, Health and Human Services Regulation and Reform**
Regulation, Health Protection and Emergency Management Division
Department of Health and Human Services | 50 Lonsdale Street Melbourne Victoria 3000
REDACTED
w. www.health.vic.gov.au

Executive Assistant:
REDACTED

VICTORIA State Government | Health and Human Services

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**From:** REDACTED >
**Sent:** Sunday, 29 March 2020 6:03 PM
**To:** Meena Naidu (DHHS) REDACTED
REDACTED
**Cc:** Jacqueline Goodall (DHHS) REDACTED ; Ed Byrden (DHHS)
REDACTED
**Subject:** [For consideration] Suggestions on statutory reporting requirements relating to individual detainment

Hi Meena, REDACTE
As discussed, I've set out some key points to consider in relation to ensuring we complete the legislative requirements when individually detaining returned overseas travellers under section 200(1)(a) of the *Public Health and Wellbeing Act 2008* (PHWA):

- **A number of steps must be completed to ensure the exercise of power to detain a person under section 200(1)(a) of the PHWA is made effectively.** This includes:

- an Authorised Officer giving notice to the Chief Health Officer that a person has been detained, including that person's name and why that person has been detained or continues to be detained
- an Authorised Officer giving notice to the Chief Health Officer that (after a review) a person's detainment continues every 24 hours after the initial notice is given they are subject to the detainment power
- the Chief Health Officer reporting to the Minister for Health that he has received notice the Authorised Officer's notice a person has been detained or, after a review, a person's detainment continues.

- **There is a risk that without these steps being taken the exercise of power to detain a person may not have occurred properly. Each step must be completed as soon as reasonably practicable.**
- **We have attached a spreadsheet that we suggest an Authorised Officer could complete in a centralised way to provide this reporting to the Chief Health Officer and to the Minister for Health (Attachment A – EXAMPLE Master Sheet of people subject to detainment).**
- **We suggest that it would be prudent to record the information for today's intake today or early tomorrow so that their reviews can easily be conducted while incorporating the next intake (and so on).** This is to minimise the risk that a person who is subject to detainment is missed from the reporting and review requirements under the PHWA. This would also facilitate RHPEM preparing a briefing to the Chief Health Officer and Minister for Health on the returning traveller intake for today and Monday – this would fulfil the timing requirements for Authorised Officers to report to the Chief Health Officer and the Minister for Health.
- **While it would be prudent to perform the reviews based on welfare checks we understand this may be difficult to implement for every detained person.** We note it would be important to ensure there is a level of welfare and compliance work underpinning the review outcomes (i.e. that a person's detainment must continue), even if it is passive monitoring or spot checks, to ensure the outcomes are consistent with the actual arrangements of that person (i.e. the person remains in detainment rather than having absconded or moved to another location for medical care etc). I understand Ed Byrden has undertaken work with VGSO for the Chief Health Officer on guidelines for Authorised Officers to ensure the physical and mental wellbeing of travellers in individual detention. This should follow shortly.
- We also note that for completeness of the process it would be preferable to issue the notice at the point of entry rather than at the site designated for quarantines to occur – i.e. the direction should be given at the airport or port rather than at the hotel.
- Finally, we should note the importance of making sure this information is stored securely as it may contain personal information or information relating to a person's health.

We are also preparing a template brief to help facilitate this reporting.

I hope this assists.

REDACTED

**Principal Adviser to Jacinda de Witts, Deputy Secretary and General Counsel**
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**Master List - Returned Travellers subject to a Detainment Direction under section 200 of the Public Health and Wellbeing Act 2009**

**Last updated:** XX

**Updated by:** XX

**After reviewing this person's detention arrangements in the last twenty four hours, is it necessary to continue this person's detention arrangements for a further twenty-four hour period as a result of their recent return from overseas travels to eliminate or reduce the serious risk to public health posed by COVID-19?**

| Date Notice Given | Name of person detained | Has this person returned from overseas travel? | Where did this person arrive from? | Is this person being detained to eliminate or reduce the serious risk of public health posed by COVID-19 because they have returned from overseas travel? | Contact details of detained person | Authorised Officer | Location Direction Given | Area Directed to Quarantine | Further details of direction locations and specifications | (+) Day 1 from Date Notice Given | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 | Day 8 | Day 9 | Day 10 | Day 11 | Day 12 | Day 13 | Day 14 | Discharged from Quarantine? |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| XX/xx/2020 | Joe Bloggs | Yes | USA | Yes | XXXXXX | Mr Public Health | Melbourne Airport | Crown Casino | Room location being finalised | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | |
| XX/xx/2020 | Jane Bloggs | Yes | UK | Yes | XXXXXX | Ms Public Health | Melbourne Airport | Crown Casino | Isolated to Room 255, Crown Casino | Yes | Yes | Yes | X has fallen ill - Isolation Directions now apply | | | | | | | | | | | |

# 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<br>Families with children < 18 years<br>Passengers aged > 65 years<br>Aboriginal and Torres Strait Islander peoples<br>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.<br>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**

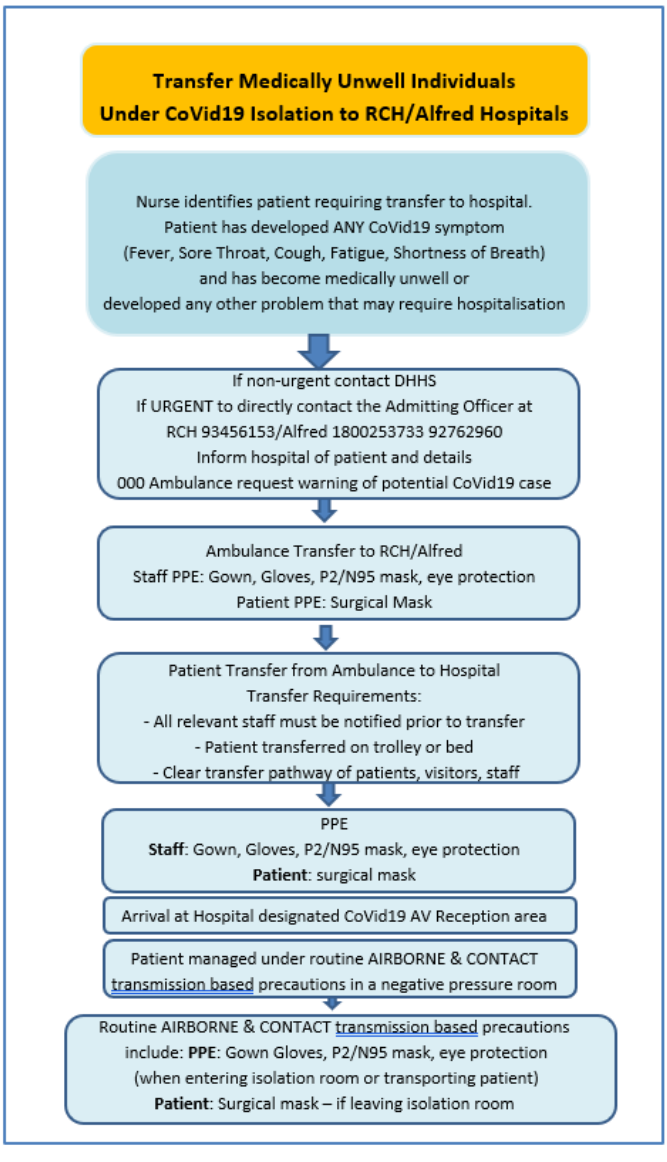
The following are the actions to enact this:

- 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.

## References

1. Li Q, Guan X, Wu P, Wang X, Zhou L, Tong Y, et al. Early Transmission Dynamics in Wuhan, China, of Novel Coronavirus–Infected Pneumonia. New England Journal of Medicine. 2020 Jan 29;
2. Lai A, Bergna A, Acciarri C, Galli M, Zehender G. Early phylogenetic estimate of the effective reproduction number of SARS-CoV-2. Journal of Medical Virology [Internet]. 2020 Mar 3 [cited 2020 Mar 27];jmv.25723. Available from: https://onlinelibrary.wiley.com/doi/abs/10.1002/jmv.25723
3. Choi SC, Ki M. Estimating the reproductive number and the outbreak size of Novel Coronavirus disease (COVID-19) using mathematical model in Republic of Korea. Epidemiology and Health [Internet]. 2020 Mar 12 [cited 2020 Mar 27];e2020011. Available from: http://www.ncbi.nlm.nih.gov/pubmed/32164053
4. Imai N, Cori A, Dorigatti I, Baguelin M, Donnelly CA, Riley S, et al. Report 3: Transmissibility of 2019-nCoV. [cited 2020 Mar 23]; Available from: https://doi.org/10.25561/77148

5. Wu JT, Leung K, Leung GM. Nowcasting and forecasting the potential domestic and international spread of the 2019-nCoV outbreak originating in Wuhan, China: a modelling study. The Lancet. 2020 Feb;395(10225):689–97.
6. Jung S, Akhmetzhanov AR, Hayashi K, Linton NM, Yang Y, Yuan B, et al. Real-Time Estimation of the Risk of Death from Novel Coronavirus (COVID-19) Infection: Inference Using Exported Cases. Journal of Clinical Medicine [Internet]. 2020 Feb 14 [cited 2020 Mar 27];9(2):523. Available from: https://www.mdpi.com/2077-0383/9/2/523
7. Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19). 2020.
8. Wu Y, Guo C, Tang L, Hong Z, Zhou J, Dong X, et al. Prolonged presence of SARS-CoV-2 viral RNA in faecal samples. The Lancet Gastroenterology & Hepatology [Internet]. 2020 [cited 2020 Mar 27];0(0). Available from: https://doi.org/10.1016/S2468-1253(20)30083-2
9. van Doremalen N, Bushmaker T, Morris D, Holbrook M, Gamble A, Williamson B, et al. Aerosol and surface stability of HCoV-19 (SARS-CoV-2) compared to SARS-CoV-1. medRxiv. 2020 Mar;2020.03.09.20033217.
10. Cai J, Sun W, Huang J, Gamber M, Wu J, He G. Indirect Virus Transmission in Cluster of COVID-19 Cases, Wenzhou, China, 2020. Emerging Infectious Diseases [Internet]. 2020 Jun;26(6). Available from: http://wwwnc.cdc.gov/eid/article/26/6/20-0412_article.htm
11. Seah I, Agrawal R. Can the Coronavirus Disease 2019 (COVID-19) Affect the Eyes? A Review of Coronaviruses and Ocular Implications in Humans and Animals. Ocular immunology and inflammation [Internet]. 2020 Mar 16 [cited 2020 Mar 27];1–5. Available from: http://www.ncbi.nlm.nih.gov/pubmed/32175797
12. Zhou F, Yu T, Du R, Fan G, Liu Y, Liu Z, et al. Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study. The Lancet. 2020 Mar 28;395(10229):1054–62.
13. Luo S-H, Liu W, Liu Z-J, Zheng X-Y, Hong C-X, Liu Z-R, et al. A confirmed asymptomatic carrier of 2019 novel coronavirus (SARS-CoV-2). Chinese Medical Journal [Internet]. 2020 Mar;1. Available from: http://journals.lww.com/10.1097/CM9.0000000000000798
14. Bai Y, Yao L, Wei T, Tian F, Jin DY, Chen L, et al. Presumed Asymptomatic Carrier Transmission of COVID-19. JAMA - Journal of the American Medical Association. American Medical Association; 2020.
15. Yu P, Zhu J, Zhang Z, Han Y, Huang L. A familial cluster of infection associated with the 2019 novel coronavirus indicating potential person-to-person transmission during the incubation period. The Journal of infectious diseases [Internet]. 2020 Feb 18 [cited 2020 Mar 27]; Available from: http://www.ncbi.nlm.nih.gov/pubmed/32067043
16. Nishiura H, Kobayashi T, Suzuki A, Jung S-M, Hayashi K, Kinoshita R, et al. Estimation of the asymptomatic ratio of novel coronavirus infections (COVID-19). International Journal of Infectious Diseases [Internet]. 2020 Mar;0(0). Available from: https://linkinghub.elsevier.com/retrieve/pii/S1201971220301399
17. Zhao S, Cao P, Chong MKC, Gao D, Lou Y, Ran J, et al. The time-varying serial interval of the coronavirus disease (COVID-19) and its gender-specific difference: A data-driven analysis using public surveillance data in Hong Kong and Shenzhen, China from January 10 to February 15, 2020. Infection Control & Hospital Epidemiology [Internet]. 2020 Mar;1–8. Available from: https://www.cambridge.org/core/product/identifier/S0899823X20000641/type/journal_article
18. He X, Lau EHY, Wu P, Deng X, Wang J, Hao X, et al. Temporal dynamics in viral shedding and transmissibility of COVID-19. medRxiv. 2020 Mar 18;2020.03.15.20036707.
19. Li R, Pei S, Chen B, Song Y, Zhang T, Yang W, et al. Substantial undocumented infection facilitates the rapid dissemination of novel coronavirus (SARS-CoV2). Science [Internet]. 2020 Mar;eabb3221. Available from: https://www.sciencemag.org/lookup/doi/10.1126/science.abb3221
20. Lauer SA, Grantz KH, Bi Q, Jones FK, Zheng Q, Meredith HR, et al. The Incubation Period of Coronavirus Disease 2019 (COVID-19) From Publicly Reported Confirmed Cases: Estimation and Application. Annals of internal medicine [Internet]. 2020 Mar; Available from: http://www.ncbi.nlm.nih.gov/pubmed/32150748
21. Yang X, Yu Y, Xu J, Shu H, Xia J, Liu H, et al. Clinical course and outcomes of critically ill patients with SARS-CoV-2 pneumonia in Wuhan, China: a single-centered, retrospective, observational study. The Lancet Respiratory Medicine. 2020;0(0).

22. Wu Z, McGoogan JM. Characteristics of and Important Lessons From the Coronavirus Disease 2019 (COVID-19) Outbreak in China: Summary of a Report of 72 314 Cases From the Chinese Center for Disease Control and Prevention. JAMA [Internet]. 2020 Feb; Available from: http://www.ncbi.nlm.nih.gov/pubmed/32091533
23. Cao Q, Chen YC, Chen CL, Chiu CH. SARS-CoV-2 infection in children: Transmission dynamics and clinical characteristics [Internet]. Vol. 119, Journal of the Formosan Medical Association. Elsevier B.V.; 2020. p. 670–3. Available from: http://www.ncbi.nlm.nih.gov/pubmed/32139299
24. Bi Q, Wu Y, Mei S, Ye C, Zou X, Zhang Z, et al. Epidemiology and Transmission of COVID-19 in Shenzhen China: Analysis of 391 cases and 1,286 of their close contacts. medRxiv. 2020 Mar;2020.03.03.20028423.
25. Cao Q, Chen YC, Chen CL, Chiu CH. SARS-CoV-2 infection in children: Transmission dynamics and clinical characteristics [Internet]. Vol. 119, Journal of the Formosan Medical Association. Elsevier B.V.; 2020. p. 670–3. Available from: http://www.ncbi.nlm.nih.gov/pubmed/32139299
26. Ferguson NM, Laydon D, Nedjati-Gilani G, Imai N, Ainslie K, Baguelin M, et al. Impact of non-pharmaceutical interventions (NPIs) to reduce COVID-19 mortality and healthcare demand. Available from: https://doi.org/10.25561/77482
27. Chang SL, Harding N, Zachreson C, Cliff OM, Prokopenko M. Modelling transmission and control of the COVID-19 pandemic in Australia. 2020.
28. Lauro F di, Kiss IZ, Miller JC. The timing of one-shot interventions for epidemic control. 2020; Available from: https://doi.org/10.1101/2020.03.02.20030007
29. Kucharski AJ, Russell TW, Diamond C, Liu Y, Edmunds J, Funk S, et al. Early dynamics of transmission and control of COVID-19: a mathematical modelling study. The Lancet Infectious Diseases [Internet]. 2020 Mar;0(0). Available from: https://linkinghub.elsevier.com/retrieve/pii/S1473309920301444
30. Lai S, Ruktanonchai NW, Zhou L, Prosper O, Luo W, Floyd JR, et al. Effect of non-pharmaceutical interventions for containing the COVID-19 outbreak in China. medRxiv. 2020 Mar;2020.03.03.20029843.
31. Prem K, Liu Y, Russell T, Kucharski AJ, Eggo RM, Davies N, et al. The effect of control strategies that reduce social mixing on outcomes of the COVID-19 epidemic in Wuhan, China. medRxiv. 2020 Mar;2020.03.09.20033050.
32. Hellewell J, Abbott S, Gimma A, Bosse NI, Jarvis CI, Russell TW, et al. Feasibility of controlling COVID-19 outbreaks by isolation of cases and contacts. The Lancet Global Health. 2020 Feb 1;8(4):e488–96.
33. Kretzschmar M, Rozhnova G, van Boven M. Effectiveness of Isolation and Contact Tracing for Containment and Slowing Down a COVID-19 Epidemic: A Modelling Study. SSRN Electronic Journal [Internet]. 2020 Mar 6 [cited 2020 Mar 26]; Available from: https://www.ssrn.com/abstract=3551343
34. Domenico L di, Pullano G, Coletti P, Hens N, Colizza V. Expected impact of school closure and telework to mitigate COVID-19 epidemic in France [Internet]. [cited 2020 Mar 27]. Available from: www.epicx-lab.com/covid-19.html]
35. World Health Organization. Coronavirus disease 2019 (COVID-19) Situation Report-46. 2020.
36. Fong MW, Gao H, Wong JY, Xiao J, Shiu EYC, Ryu S, et al. Nonpharmaceutical Measures for Pandemic Influenza in Nonhealthcare Settings—Social Distancing Measures. Emerging Infectious Diseases. 2020 May;26(5).
37. Bootsma MCJ, Ferguson NM. The effect of public health measures on the 1918 influenza pandemic in U.S. cities. Proceedings of the National Academy of Sciences of the United States of America [Internet]. 2007 May;104(18):7588–93. Available from: http://www.ncbi.nlm.nih.gov/pubmed/17416677
38. Wu JT, Cowling BJ, Lau EHY, Ip DKM, Ho LM, Tsang T, et al. School closure and mitigation of pandemic (H1N1) 2009, Hong Kong. Emerging Infectious Diseases [Internet]. 2010 Mar;16(3):538–41. Available from: http://www.ncbi.nlm.nih.gov/pubmed/20202441
39. Cowling BJ, Lau MSY, Ho LM, Chuang SK, Tsang T, Liu SH, et al. The effective reproduction number of pandemic influenza: Prospective estimation. Epidemiology [Internet]. 2010 Nov;21(6):842–6. Available from: http://www.ncbi.nlm.nih.gov/pubmed/20805752

40. Kawano S, Kakehashi M. Substantial impact of school closure on the transmission dynamics during the pandemic Flu H1N1-2009 in Oita, Japan. PLoS ONE [Internet]. 2015 Dec;10(12):e0144839. Available from: http://www.ncbi.nlm.nih.gov/pubmed/26669757
41. Sato T, Akita T, Tanaka J. Evaluation of strategies for control and prevention of pandemic influenza (H1N1pdm) in Japanese children attending school in a rural town. Simulation using mathematical models. [Nihon kōshū eisei zasshi] Japanese journal of public health [Internet]. 2013;60(4):204–11. Available from: http://www.ncbi.nlm.nih.gov/pubmed/23909187
42. Chen T, Huang Y, Liu R, Xie Z, Chen S, Hu G. Evaluating the effects of common control measures for influenza A (H1N1) outbreak at school in China: A modeling study. PLoS ONE [Internet]. 2017 May;12(5):e0177672. Available from: http://www.ncbi.nlm.nih.gov/pubmed/28542360
43. Chen T, Zhao B, Liu R, Zhang X, Xie Z, Chen S. Simulation of key interventions for seasonal influenza outbreak control at school in Changsha, China. The Journal of international medical research [Internet]. 2020 Jan;48(1):300060518764268. Available from: http://www.ncbi.nlm.nih.gov/pubmed/29569977
44. Ahmed F, Zviedrite N, Uzicanin A. Effectiveness of workplace social distancing measures in reducing influenza transmission: A systematic review [Internet]. Vol. 18, BMC Public Health. BioMed Central Ltd.; 2018. p. 518. Available from: http://www.ncbi.nlm.nih.gov/pubmed/29669545
45. Asfaw A, Rosa R, Pana-Cryan R. Potential Economic Benefits of Paid Sick Leave in Reducing Absenteeism Related to the Spread of Influenza-Like Illness. Journal of Occupational and Environmental Medicine [Internet]. 2017 Sep;59(9):822–9. Available from: http://www.ncbi.nlm.nih.gov/pubmed/28692009
46. Piper K, Youk A, James AE, Kumar S. Paid sick days and stay-At-home behavior for influenza. PLoS ONE [Internet]. 2017 Feb;12(2):e0170698. Available from: http://www.ncbi.nlm.nih.gov/pubmed/28151940

## 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:<br><br>Alerts: Alcohol & Other Drugs Y/N<br>Disability Y/N<br>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:<br>Room number: |
| location (room number): | |
| Confirm passenger name: | |
| Passenger DOB: | |
| Contact number: | Mobile:<br>Room: |
| Interpreter required: | Yes/no<br>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.

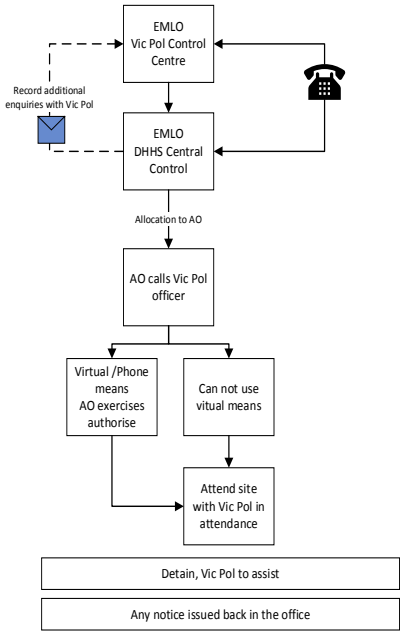
Officers and managers both have a shared responsibility for occupational health and safety. All employees have a responsibility to report and discuss hazards or perceived hazards, by bringing this to the managers attention.

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<br><br>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 |

# *PPE advice for hotel-based healthcare worker (HCW) for contact with COVID-19 quarantine clients*

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 | Activity | Health care worker PPE required | Client PPE required |
|---|---|---|---|
| **Hotel quarantine floor**<br><br>Not entering the client/s room or having direct contact with client/s. | Telephone or online triage to check for recent change in condition or development of symptoms.<br>No direct client contact e.g. walking room hallways. | • No PPE | • No PPE |
| **Doorway indirect contact by HCW**<br>Clients **without** symptoms suggestive of COVID-19<br>(e.g. cough, fever, shortness of breath)<br><br>**Perform hand hygiene before and after every client contact** | Any doorway visit:<br>• Able to maintain physical distance of at least 1.5 metres<br>(e.g. second HCW accompanying primary HCW) | • Surgical mask<br>• Hand hygiene | • No PPE |
| | Any doorway visit:<br>• 1.5 metre physical distance is **not feasible** | • Surgical mask<br>• Hand hygiene | • Client to wear surgical face mask if tolerated<br>• Hand hygiene |
| **Doorway indirect contact by HCW**<br>Clients **with** symptoms suggestive of COVID-19<br>(e.g. cough, fever, shortness of breath)<br><br>**Perform hand hygiene before and after every client contact** | Any doorway indirect contact by HCW | • Surgical mask<br>• Gown<br>• Gloves<br>• Protective eyewear | • Client to wear surgical face mask if tolerated<br>• Hand hygiene |

| Setting | Activity | Health care worker PPE required | Client PPE required |
|---|---|---|---|
| **Entering the client/s room**<br>Clients **with or without** symptoms suggestive of COVID-19<br>(e.g. cough, fever, shortness of breath)<br><br>**Perform hand hygiene before and after every client contact** | Providing direct care or any close contact in the **absence** of aerosol generating procedures (AGP)<br><br>NOTE Naso pharyngeal swab is not classified as an AGP. | • Surgical mask<br>• Gown<br>• Gloves<br>• Protective eyewear | • Client to wear surgical face mask if tolerated and appropriate to procedure (e.g. not for naso-pharyngeal swab)<br>• Hand hygiene |
| | Providing direct care or any close contact in the **presence** of aerosol generating procedures<br><br>*Examples of aerosol generating procedures include:*<br>• *Cardiopulmonary resuscitation*<br>• *Nebulisation of medication*<br>• *Intubation*<br>• *Suctioning airways* | • Respirator N95/P2 standard<br>• Gown<br>• Gloves<br>• Protective eyewear | • Surgical mask not appropriate for clients undergoing these procedures |

***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).*

# Guidelines for managing COVID-19 in mandatory quarantine

23 April 2020

## 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.

## 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 claims 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 Email REDACTED or phone 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**<br>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**<br>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<br>• End of isolation letter provided by Public Health Operations (PH Ops) to COVID Quarantine Inbox and Emergency Operations Centre (EOC) inbox<br>• Release from isolation by Case Manager following Health and Welfare checks<br>• Transport should be arranged as part of the standard exit arrangements<br>• 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**<br>Detention but is now subject to the Isolation (Diagnosis) Direction<br><br>If Victorian Resident<br>• 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<br>• 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)<br>• Case continued to be monitored by PH Operations<br><br>If Interstate Resident<br>• 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.<br>• 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<br><br>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.<br><br>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<br><br>If Victorian Resident<br>• 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<br>• 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)<br>• Contact continued to be monitored by PH Operations<br><br>If Interstate Resident<br>• Should be advised not to travel to interstate jurisdiction – do not currently have powers to prevent travel<br>• 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<br><br>• Appropriate hygiene precautions must be taken if travelling by air (i.e. face masks) and people must return straight home.<br><br>• 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.<br><br>Hotel Nurse should inform EOC and PH Operations of test being undertaken.<br>EOC should have discharge plan in place for individuals awaiting test results.<br><br>Allowed to leave detention safely (mask, separate; ideally NEPT transport to home isolation).<br>EOC should follow-up result to convey result (as |

| | |
|---|---|
| | DHHS oversaw this testing so is obliged to follow-through).<br><br>If Victoria resident<br>• Safe travel to be arranged by EOC to place of isolation in Victoria until results are known<br><br>If Interstate Resident<br>• Accommodation should be arranged by EOC until test results are known.<br>• 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.

**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.

# Coronavirus disease 2019 (COVID-19)

## Case and Contact Management Guide

Version 11

29 April 2020

VICTORIA State Government | Health and Human Services

## Version control

| Version number | Comment | Date of approval |
|---|---|---|
| v 2 | Updated countries with risk | 11 February 2020 |
| v 3 | Updated with new case definition and biosecurity screening | 20 February 2020 |
| v 4 | Updated case definition; updates to countries with risk, travel restrictions and quarantine requirements | 6 March 2020 |
| v 5 | Updated case definition | 10 March 2020 |
| v 6 | Updated case definition | 14 March 2020 |
| v 7 | Changes to checklists and overall structure of document | 23 March 2020 |
| v 8 | Changes to structure and inclusion of procedures for notifications, case interviews and onboarding | 26 March 2020 |
| v 9 | Updated case definition | 01 April 2020 |
| v 10 | Updated case definition | 05 April 2020 |
| v 11 | Complete overhaul | 28 April 2020 |

Last updated: 10 May 2020

This document is available at:

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# Table of Contents

# 1 Background

Coronavirus disease 2019 (COVID-19) was first identified in December 2019. It has since spread globally and has been declared a pandemic by the WHO.

## 1.1 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 2020 and subsequent Directions, the public health response of the Department of Health and Human Services (the department) has now transitioned from the Initial Containment stage (which encompassed an inclusive approach to identifying cases and a precautionary approach to the management of cases and contacts), to the Targeted Action stage, with implementation of social distancing measures and shutdowns of non-essential services to slow disease transmission, prioritisation of diagnostic testing to critical risk groups, and adoption of sustainable strategies and models of care.

The overall objectives of the public health response are to:

1. Reduce the morbidity and mortality associated with COVID-19 infection through an organised response that focuses on containment of infection.
2. Rapidly identify, isolate and treat cases, to reduce transmission to contacts, including health care, household and community contacts.
3. Characterise the clinical and epidemiological features of cases in order to adjust required control measures in a proportionate manner.
4. Minimise risk of transmission in healthcare and residential aged care environments, including minimising transmission to healthcare and residential aged care workers.

## 1.2 Staying up to date with advice

Definitions, criteria and guidance around optimal public health management for COVID-19 is constantly changing, as understanding of the virus progresses. Guidelines developed by the Department of Health and Human Services will be regularly updated, however constant vigilance is required for all people involved in COVID-19 operations.

To ensure you are aware of the most recent advice, it is recommended you access and review online definitions and guidelines daily on the department's website (https://www.dhhs.vic.gov.au/coronavirus).

### 1.2.1 Daily update

The Chief Health Officers daily update, including developments in the outbreak and updated advice for clinicians can be accessed at https://www.dhhs.vic.gov.au/coronavirus-covid-19-daily-update

### 1.2.2 Testing criteria

The current case testing criteria for Victoria can be accessed at https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

### 1.2.3 Who is required to self-quarantine?

Requirements for self-quarantine in Victoria can be accessed at https://www.dhhs.vic.gov.au/victorian-public-coronavirus-disease-covid-19

## 1.3 Information technology and documentation

Before team members commence working they need to have access to and competence with the following IT processes:

- DHHS computer access (to access completable electronic forms). This includes access to the following databases and systems
  - PHESS
  - TRIM
  - Microsoft Office/Sharepoint
  - Teams
- Genesys PureCloud (to make and receive phone calls)

Formal requests, escalations and decisions should be clearly documented by email to the relevant lead position. Most other communications can be performed through the 'chat' and 'posts' functions on Teams.

### 1.3.1 Guidelines

- Coronavirus disease 2019 (COVID-19) Case and Contact Management Guidelines (this document)
- Coronavirus disease 2019 (COVID-19) Guidelines for Health Services and General Practitioners – Available from:
- PHESS Quick Entry Guide

### 1.3.2 Factsheets

- Confirmed case – Available from: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19
- Close Contact – Available from: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19
- Telephone Interpreter Service – see the SOP for accessing the Translating and Interpreting Service (TIS)
- Location of coronavirus testing centres (Acute Respiratory Assessment Clinics and GP respiratory clinics) – list available on the department's webpage under "Where can I get tested for coronavirus?": https://www.dhhs.vic.gov.au/victorian-public-coronavirus-disease-covid-19

### 1.3.3 Completable Forms

- Notification of COVID-19 (novel coronavirus) by Medical Practitioners (paper form)
- Notification of COVID-19 electronic form: https://forms.business.gov.au/smartforms/servlet/SmartForm.html?formCode=internalnovelcoronav&tmFormVersion=0.1.2
- Communicable Disease Call Log Sheet (paper form)
- Communicable Disease Call Log -electronic form
- Call log sheet (used in the triage team to record calls received) accessed at https://forms.office.com/Pages/ResponsePage.aspx?id=H2DgwKwPnESciKEExOufKBgNxs0yxExHhPbFAW8y1dBUQ1JMMkRFSEVGMzdDOENQR0hTTDRGT0RWVyQlQCN0PWcu (I hope this link works)
- Case questionnaire COVID-19 (Novel Coronavirus) Part A and Part B (paper form)

# 2 Testing criteria, case and contact definitions

## 2.1 Testing criteria

The latest testing criteria can be accessed under 'Current Victorian coronavirus disease (COVID-19) case definition and testing criteria' at: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

## 2.2 Case definition

The confirmed case definition is also available in the Coronavirus disease 2019 (COVID-19) General Practice quick reference guide: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

### 2.2.1 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.

### 2.2.2 Probable case

Victoria does not currently employ a probable case definition

## 2.3 Close contact definition

The close contact definition is also available on the Coronavirus disease 2019 (COVID-19) – Guidelines for health services and general practitioners: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

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) which is 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.

### 2.3.1 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 followed 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.

# 3 Triage and Notification

DHHS operates a 24-hour communicable diseases hotline (1300 651 160). This number receives urgent communicable disease notifications from clinicians, including notifications for COVID-19. Some health services have instituted processes to send notifications via text message or email. As case numbers evolve, different models of notification are being explored.

In addition to receiving notifications, DHHS receives a large number of calls through the 24-hour communicable disease hotline, including:

- Queries from confirmed cases or close contacts of confirmed cases.
- Queries from members of the public on testing criteria, symptoms of concern and other risks.
- Queries from institutions regarding processes and risks relating to suspected or actual cases.
- Offers of assistance to the department in providing services or equipment.

The objectives of the Triage and Notification team are to:

- Ensure 24-hour coverage of the COVID-19 hotline through the 1300 number
- Record notifications of confirmed cases of COVID-19
- Manage enquiries from confirmed cases, close contacts and other stakeholders relating to case and contact management
- Manage other miscellaneous enquiries and where relevant, triage to the correct part of the response

## 3.1 Processes and workflow

### 3.1.1 Receiving a new notification of COVID-19

When receiving a new notification of COVID-19, the team member needs to access the form “Notification of COVID-19 (novel coronavirus) by Medical Practitioners”. This form may be completed in hardcopy (paper) form OR electronic form (do not complete both).

### 3.1.2 Managing other non-notification enquiries

Non-notification enquiries can be segmented into case and contact related enquiries and other.

Any enquiries relating to a new case, new close contact, existing confirmed case, or existing close contact should be recorded in the call log and where relevant, escalated to the appropriate team leader.

All phone calls to the 1300 number should be related to case and contact management. Other enquiries may need to be re-directed to the appropriate number or contact address. There are several generic inboxes that have been created for managing other parts of the response. Discuss with your team leader if you are not sure of where to direct an enquiry.

### 3.1.3 Escalation and workflow

Team members may escalate any concerns to the Assistant Team Leader. This includes enquiries about the correct interpretation and completion of the “Notification of COVID-19 (novel coronavirus) by Medical Practitioners).

Any notifications that require an urgent public health response or that are received from a sensitive setting must be escalated to the Team Leader. This includes the following situations:

- The case is a health care or aged care worker
- The case lives in a residential aged care facility or other care facility

- The case works in or attends a school or childcare centre
- The case is in an intensive care unit
- The case has died
- The case is part of a known outbreak or cluster

Complete notifications are sent for data entry before the “New Cases” team will contact cases to begin the case and contact management process.

## 3.2 Troubleshooting common issues

### 3.2.1 Misdirected phone call

All incoming calls to the 1300 number should be related to case and contact management. Any other enquiries should be re-directed, if required, to one of the below hotlines.

| Number/email | Title | Functions |
|---|---|---|
| 1800 675 398 | Victorian Coronavirus hotline | 1: Health information or symptom assessment or health professional<br>2: Information on social distancing measure (business or individual)<br>3: Self isolating and have urgent relief needs (e.g. food, personal care, wellbeing)<br>4: Alleged breach of Chief Health Officer directions |
| 1800 020 080 | National Coronavirus hotline | 1: Health information or symptom assessment<br>2: For health professionals |
| 1800 960 944 | DJPR ‘concierge support’ for those in hotel quarantine | Relief, accommodation and other requests from people in mandatory hotel quarantine |
| 1800 825 955 | Homelessness support team | For Hospitals/clinicals to provide advice on accommodation for homeless people (for example a homeless COVID-19 patient in hospital who is medically fit for discharge) |

### 3.2.2 Incomplete notification form

An incomplete form should be discussed with the Assistant Team Leader, to discuss whether sufficient information has been provided. As a guide the following information must be provided:

- The name (first and last name) of the case
- A contact phone number for the case
- The name and contact phone number of the notifying clinician
- Occupation of the case (where available)

If it is determined that sufficient information to complete the public health response is provided, then notification can be finalised in the usual manner.

If insufficient information to complete the public health response has been provided, a solution should be discussed with the Assistant Team Leader or Team Leader that does not breach confidentiality of the case. For example, if a notification has been provided by a laboratory, the requesting clinician may be contacted for further information.

If no solution can be found to complete the necessary information, escalate to the Team Leader who will finalise the notification.

### 3.2.3 Indeterminant/Suspected/Low positive test results

Current testing for the SARS-CoV-2 virus (the virus that causes COVID-19) is undertaken by laboratories using a method called Nucleic Acid Amplification Test (NAAT), also called Polymerase Chain Reaction (PCR). Due to the rapid rollout of laboratory testing for SARS-CoV-2, the methods of laboratory testing have not undergone the same, intense, validation that occurs with more established tests. Some test results may not be clearly positive or clearly negative. Depending on the laboratory, these may be reported as “suspected”, “indeterminant” or “low positive”.

For the purpose of the public health response, cases with laboratory tests results that are not negative (i.e. “suspected”, “indeterminant” or “low positive”) should be managed as confirmed cases, and should undergo the same isolation and contact tracing procedures as all cases with a “positive” test result.

If the treating clinician or testing laboratory calls the department to discuss an indeterminant/low positive test result, the call should be escalated to the Operations Lead (and/or the Strategy, Policy and Planning Lead). In select cases, such as where the treating clinician feels that the pre-test probability for COVID-19 is low, it may be appropriate for the patient to be re-tested for COVID-19. If the second sample tests negative, the Operations/Strategy, Policy and Planning Lead (or someone they delegate) should discuss the case with the treating clinician and testing laboratory to determine whether it is appropriate to continue to manage the case as a confirmed case. Approval should be sought from the deputy Public Health Commander: Case, Contact and Outbreak Management before a decision is made to reject a case.

This information is subject to change as the pandemic progresses and team members should ensure they are aware of the most up to date guidance.

### 3.2.4 Patient has not been notified of their positive test result

It is preferable that patients are contacted by the requesting clinician and informed of their positive test result before the DHHS case and contact management begins. This allows the clinician to review the medical requirements of the patient and answer any questions that the patient may have.

When receiving a notification from a clinician who has not informed the case of their positive test result, you should request the clinician contact the patient ASAP to discuss their result and follow usual processes. Document on the notification form your request to the clinician to contact the case and the clinician’s response. The DHHS response will proceed as usual (DHHS will not confirm the case has been contacted or wait for the clinician to contact the case before beginning the usual follow-up).

# 4 New Case and Contact Management

The New Case and Contact (NCAC) Team are the first point of contact between the DHHS and a confirmed case of COVID-19.

The objectives of the NCAC team are to:

- Identify the likely source of exposure of a case, including if they are part of an outbreak or cluster
- Identify if a case is from a sensitive setting (e.g. a healthcare worker)
- Provide a case with clear instructions about their public health requirements (e.g. their period of isolation)
- Identify close contacts of a case of COVID-19
- Inform close contacts of confirmed cases of COVID-19 of their isolation requirements
- Complete appropriate documentation in case questionnaire and PHESS

## 4.1 Processes and workflow

### 4.1.1 New Case

Following receipt of a confirmed COVID-19 notification from either a laboratory or a clinician, a PHESS event is created by the data entry team. New cases appear on the 'Confirmed cases, actions pending' workflow. After checking to ensure the case is not a duplicate entry or a case being managed in another jurisdiction, the case is allocated for interview by the New Cases team leader.

The NCAC Team Leader will distribute cases for interview to team members. The following cases should be prioritised for urgent interview:

- Case is a healthcare worker
- Case lives in or works in a sensitive setting (e.g. correctional facility, aged care facility, childcare centre)
- Case is related to a known cluster or outbreak
- Case presents significant public health risk

Team members should review the notification form and data in PHESS prior to contacting the case.

### 4.1.2 Taking the history

The "case questionnaire COVID-19 (Novel Coronavirus) Part A and Part B" for provides the structure to taking a targeted public health history from a confirmed case of COVID-19. All sections of the form should be completed.

The incubation period for COVID-19 is up to 14 days. This is the time between exposed to the SARS-CoV-2 virus and the development of symptoms.

The infectious period for COVID-19 is currently unknown. However, for the purposes of isolation and contact tracing, cases are considered to be infectious (able to transmit the virus to others) from 48 hours before onset of symptoms until they meet the criteria for release from isolation.

The incubation period and infectious period are used to determine specific timelines used in the case questionnaire. For example:

- Considering case exposures (including travel) in the 14 days before symptom onset (incubation period)
- Identifying close contacts of the case from **48** hours prior to the onset of symptoms (infectious period)

The incubation period and the infectious period are subject to change as understanding of the SARS-CoV-2 virus progresses. The most up-to-date guidelines should be reviewed to ensure accurate definitions of incubation period and infectious period are being applied.

### 4.1.3 Initial management of cases

Confirmed cases should be informed that a member of the DHHS Existing Cases team will contact the case every day. Verbal information must be followed up with written information – send the case the Factsheet – confirmed case via email. The fact sheet provides the 24-hour communicable diseases phone number should the case need to speak with DHHS.

The Isolation (Diagnosis) Direction that is currently in effect (see: https://www.dhhs.vic.gov.au/state-emergency) makes it **compulsory** for anyone with a confirmed diagnosis of COVID-19 to go into isolation for a minimum period, and to meet other compulsory conditions before being able to resume normal activities. Penalties apply to those who refuse or fail to comply with this direction.

Cases must isolate themselves at home until they are advised otherwise by a Public Health Officer:

- They must not leave their house or accommodation except to seek medical attention or limited other permitted reasons, such as an emergency or if required by law
- They should stay in a different room to other people as much as possible. Sleep in a separate bedroom and use a separate bathroom if available.
- They should wear a surgical face mask when they are in the same room as another person and when seeking medical care.
- They should not go to work, school, university, or attend public places or events. Do not use public transport or taxi services.
- Where possible, they should get others such as friends or family who are not required to be isolated to get food or other necessities for them.

If they have difficulties getting food or necessities, call 1800 675 398 for support.

The above isolation requirements are outlined on the Factsheet – confirmed cases, available from: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

It is important to reiterate to the case the implications of not maintaining appropriate self-isolation and the risks that this can pose to other people including close contacts located in their household. If they do not sufficiently isolate themselves 5n

- The period of time for which household contacts will be required to self-quarantine will be extended. This is because household contacts will be required to self-quarantine from the time that they are identified as a close contact of a case until 14 days have elapsed since the date they last had close contact with the case while they were infectious (i.e. their total quarantine period may be >14 days).

### 4.1.4 Close Contacts

It is desirable, but not essential, that the case contacts people they have identified as close contacts themselves and advises them that they (the case) have been diagnosed with COVID-19. Regardless of whether they have been contacted by the case, all close contacts must be contacted by the New Case and Contact Team to explain their requirement to quarantine at home and provide instructions on testing should they develop symptoms. If any close contact requires medical advice, they need to seek this from their usual sources (e.g. their GP).

Close contacts should be informed that a member of the department's close contact team will contact them. Verbal information must be followed up with written information, send the Factsheet – close contacts via email. The fact sheet provides the 24-hour communicable diseases phone number should they need to speak with DHHS.

Close contacts should quarantine themselves at home (or in other appropriate accommodation) until 14 days after they were last exposed to the infectious person.

- They should not leave their house except to seek medical attention.
- They should stay in a different room to other people as much as possible. Sleep in a separate bedroom and use a separate bathroom if available.
- They should not go to work, school, university, or attend public places or events. Do not use public transport or taxi services.
- Where possible, they should get others such as friends or family who are not required to be quarantined to get food or other necessities for them.
- If they have difficulties getting food or necessities, call 1800 675 398 for support.

The above isolation requirements for close contacts are outlined on the Factsheet – close contacts: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

#### 4.1.4.1 Interstate/overseas cases and close contacts

An interstate resident who is isolating in Victoria should be followed up and managed by the department (i.e. the Department of Health and Human Services, Victoria).

If interstate or overseas close contacts of a confirmed Victorian case of COVID-19 are identified, collect their details and email these to the relevant jurisdiction. Provide as much information as has been obtained, for example:

- Name
- Date of birth
- Phone number
- Date of exposure
- Any other relevant information obtained.

The team leader has access to the appropriate email address for each jurisdiction. For international close contacts email publichealth.intelligence@dhhs.vic.gov.au

### 4.1.5 Households

When multiple cases within a single household are interviewed together, it is appropriate to assess their close contacts together and determine the close contacts' last date of exposure to the case(s) at this time.

If the interviews of the household members occur separately, the last exposure date to any of the confirmed cases must be identified for each close contact. The close contact's quarantine period must be updated to reflect a 14-day period from last exposure to any confirmed case. This must be communicated to the close contact at the time of interview.

### 4.1.6 Hotel Detention

International arrivals into Australia are subject to a 14-day mandatory quarantine period in designated hotels. For couples and families, there are a number of room sharing options. The team leader at the hotel must communicate these options in advance of hotel check-in and inform people of the consequences of their choice. These consequences include an increased risk of infection, and a prolonged quarantine period should their roommate become a confirmed case of COVID-19.

When a person who is a current confirmed case of COVID-19 arrives in Australia, they will be placed in mandatory quarantine and asked to provide confirmation of their diagnosis. If there is doubt surrounding the certainty of the diagnosis, they will be offered additional testing at the hotel.

If an individual arriving in Australia states that they are a recovered (confirmed) COVID-19 case, they will initially be placed in mandatory quarantine, and asked to provide evidence of their diagnosis and that 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 is sufficient.

Further information relating to hotel detention can be found in sections 5.1.4 and 6.1.4.

### 4.1.7 Escalation and workflow

Team members may escalate any concerns to the Assistant Team Leader. This includes enquiries about the correct interpretation and completion of the "Case Questionnaire COVID-19 (Novel Coronavirus)" or any issues contacting confirmed cases.

Any notifications that require an urgent public health response or are received from a sensitive setting must be escalated to the Team Leader. This includes the following situations:

- The case is a healthcare worker
- The case works in or lives in a residential aged care facility
- The case works in or attends a school or childcare centre
- The case is in an intensive care unit
- The case has died
- The case is part of (or suspected to be part of) a known outbreak or cluster
- The case may trigger a large response (i.e. a large number of close contacts have been identified or if the case has been at work while infectious)
- The case is from a cruise ship
- The case is likely to generate media interest (for example if they are a celebrity or politician)
- The case appears resistant or reluctant to isolate
- The case appears resistant or reluctant to identify close contacts

Complete notifications are sent for data entry to complete the data entry requirements.

## 4.2 Troubleshooting common issues

### 4.2.1 Aeroplane flights taken by the case

For flights that were taken by the case, while infectious, obtain:

- flight number
- ports of departure and arrival
- date of arrival
- seat number

Currently, there is no contact tracing requirements for international flights or domestic flights < 2 hours duration. Contact tracing is required on domestic flights of > 2 hours duration. For the purposes of airline crew follow up, inform the National Incident Room by emailing publichealth.intelligence@dhhs.vic.gov.au regarding any flights that had an infectious case on board.

### 4.2.2 Outbreaks and sensitive settings

Outbreaks (sometimes called clusters) may occur in any setting but are of particular concern when they occur in sensitive settings, such as healthcare settings or residential aged care facilities.

The definition of an outbreak varies according to context. Outbreak definitions usually have elements of person, place and time. In Residential Aged Care Facilities, a confirmed outbreak is defined as "two or more cases of fever or acute respiratory infection in residents or staff within 3 days (72 hours) AND at least one case of COVID-19 confirmed by laboratory testing".

Established outbreak definitions do not currently exist for other sensitive settings. However, an outbreak should be suspected if two or more cases of suspected or confirmed COVID-19 (linked by time and place) occur within a sensitive setting.

When an outbreak is suspected, the details of the outbreak (for example the setting) should be recorded by the Team Leader. The Team Leader should also inform the Operations Lead, who will decide if escalation to the Deputy Public Health Commanders/Public Health Commanders is required. The Operations Lead will also arrange for the outbreak to be investigated by the "outbreak" team within the NCAC team. If extra support is required, the Team Leader can request input from the Strategy, Policy and Planning Operations Liaison and/or the Strategy, Policy and Planning

Lead.

In some cases, a single confirmed case of COVID-19 in a sensitive setting may warrant investigation. Team Leaders should inform the Operations Lead of cases in sensitive settings, to determine if escalation or further investigation is warranted.

### 4.2.3 Contacts who are healthcare workers

The same definition of close contact applies to healthcare workers (HCW) as other members of the community and should be managed in the same way. If a HCW is determined to be a close contact of a confirmed case, they must be isolated for a period of 14 days following their last contact with the case. A HCW who is a close contact of a confirmed case should not be swabbed for SARS-CoV-2 unless they develop symptoms (unless direction to do so is provided by a Deputy Public Health Commander/Public Health Commander).

A HCW who has had contact with a confirmed case of COVID-19 but does not satisfy the criteria as a close contact does not require isolation but should isolate immediately if they become unwell and seek testing for COVID-19.

#### 4.2.3.1 Emergency Accommodation

The Victorian Government's COVID-19 Healthcare worker Emergency Accommodation (CHEA) Program (also known as the "Hotels for Heroes" program) provides access to free accommodation for hospital workers and paramedics who need to self-quarantine or self-isolate because of COVID-19 (i.e. as confirmed cases or close contacts) and who do not have a suitable home environment to do so. Examples of unsuitable home environments include HCWs who live with a member of an at-risk population group (e.g. people aged >65, or people who are immunosuppressed or have an underlying chronic condition), those who live in share houses, and those who live with other HCWs. If a contact wishes to access emergency accommodation, they should be advised to contact their employing health service, who will complete a request form on their behalf and send it to the email address covid19.hcwaccom@dhhs.vic.gov.au

### 4.2.4 Healthcare workers and PPE

HCWs who wear adequate PPE when caring for confirmed cases of COVID-19 are not considered to be close contacts, as is outlined in the close contact definition.

For routine care of confirmed COVID-19 cases (during their infectious period), adequate PPE consists of:

- surgical mask
- long sleeved gown
- face shield or goggles
- gloves

For aerosol generating procedures (AGPs), adequate PPE consists of:

- N95 mask / P2 respirator
- long sleeved gown
- face shield or goggles
- gloves

Further details, including a list of what constitutes an AGP can be found in the document "Coronavirus disease 2019 (COVID-19) Healthcare worker personal protective equipment (PPE) guidance for performing clinical procedures" which is available under the "Guidelines for health services and general practitioners" tab on the following webpage: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

If a HCW works in a setting that has an infection control unit (such as a hospital), an assessment of the adequacy of PPE should be undertaken in consultation with the facility's infection control unit.

Healthcare workers who are assessed as wearing inadequate PPE (e.g. incomplete/inappropriately applied PPE or where a PPE breach occurred) and who meet the definition of a close contact should be considered close contacts and managed accordingly. For example, if a nurse spends 30 minutes directly caring for a patient, wearing a surgical mask, gloves and long sleeve gown, but no eye protection, they are not wearing adequate PPE and should therefore be considered a close contact.

Judgement may be applied in some circumstances for HCWs who are wearing most of the required PPE and have had a low risk contact. In these situations, the department has recommended that a case not attend work for 14 days, but do not need to be in isolation. This can only be recommended after discussion with a Cell Lead.

### 4.2.5 Close contacts unable to isolate from confirmed cases

Every effort should be made for close contacts with ongoing contact to a confirmed case to isolate from that case. For example, a husband and wife couple should make every attempt isolate. Ideally this would mean having access to alternative accommodation. If this is not possible then every attempt to live

separately within their house including, not sleeping together, not eating or preparing meals together, using separate bathrooms, cleaning appropriately between use of common areas, kitchen and bathrooms (where alternative is not available). Isolating from each other protects the contact from an ongoing risk of infection with COVID-19, and reduces the period that they will be required to remain in isolation. If DHHS is not satisfied that a contact living in the same house as a case is isolated, the contacts period of quarantine will extend for 14 days after the last infectious period of the case (i.e for 14 days after the case is cleared).

If the close contact were to become unwell and test positive for COVID-19, the couple should continue to attempt to isolate from each other. If this is not possible, the original case can still be “cleared” by the Existing Cases Team when they meet the appropriate clearance criteria. No further quarantine is required for the exposure to their spouse or housemate. The Existing Close Contact and Existing Cases team will need to work together to identify cases and contacts requiring changes to their management based on inadequate isolation.

# 5 Existing Cases Team

The Existing Cases Team maintain contact with cases following their initial interview (conducted by the NCAC team). The Existing Cases Team make daily contact with confirmed cases of COVID-19, to monitor the isolation, health of the case, and to escalate any concerns as necessary. The Existing Cases Team also assess and provide clearance to cases who have met the end of isolation criteria.

The objectives of the existing cases team is

- Reduce the morbidity experienced by cases by:
  - Providing daily contact with cases and ensuring they have access to necessary medical support
  - Ensuring minimal impact of isolation requirements by releasing cases from isolation when they meet the appropriate criteria.
- Reduce transmission of COVID-19 by:
  - Ensure cases are aware of their isolation requirement through reinforcement of the message provided at first contact, and as a portal to answer questions cases may have.
  - Provide support and encouragement to cases to maintain their isolation requirements through daily contact with cases.
- Minimise the risk of transmission in healthcare settings by:
  - Applying the appropriate return to work criteria to healthcare workers
  - Advising confirmed cases on how to safely access medical care during their infectious period.

## 5.1 Processes and workflow

Confirmed cases of COVID-19 are entered into PHESS following receipt of the notification. Case interviews must be completed before the existing confirmed team takes over management.

Existing cases team generate a workflow from PHESS that is populated into an excel spreadsheet that outlines the required actions.

The Existing Cases Team Leader distributes the actions to the Team Members.

For the purpose of the public health management, confirmed cases are categorised into one of three groups, general community, healthcare workers, hospitalised patients and hotel detention.

### 5.1.1 Hospitalised patients

Together with the Intelligence team, the Existing Cases team collect information on hospitalised patients to ensure up-to-date statistics are available for decision makers. This includes understanding the number of COVID-19 patients in Victoria who are hospital inpatients, patients in an Intensive Care Unit (ICU) and those ventilated in ICU.

Up to date clinical data about COVID-19 patients who are currently in hospital is obtained via VICNISS (VICCNISS Healthcare Associated Infection Surveillance Coordinating Centre) and updated in PHESS by the Intelligence team. The Existing Cases team do not regularly contact cases while they are in hospital.

In the 'Guidelines for health services and general practitioners', the department recommends that 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

A confirmed case in the home must remain in isolation until criteria for release from isolation are met.

### 5.1.2 Healthcare workers

Healthcare workers who are in home isolation are contacted daily during their isolation by the Existing Cases Team.

When the case is eligible to meet end of **isolation** criteria (see below) they are called by an Existing Case team member to confirm criteria is met. An email of a standardised letter is provided. When the case is eligible to meet **return to work** criteria (see below) they are called by an Existing Case team member to confirm criteria are met. An email of a standardised letter is provided.

### 5.1.3 General community members

A person in isolation at home, who is not a healthcare worker, is contacted daily during their isolation by the Existing Cases Team. This contact, particularly for those deemed to be low risk, may be made through text message (via Soprano).

The team member provides a daily check on the cases condition. When the case is eligible to be "cleared" from isolation (see clearance criteria below) this is provided by the team member and confirmed by emailing the standardised letter.

### 5.1.4 Hotel detention

Confirmed cases of COVID-19 that are in hotel detention are managed, as per all cases, by the Existing Cases team.

When the confirmed case in hotel detention meets the criteria for release from isolation, the clearance certificate is provide (via email) to COVID.quarantine@dhhs.vic.gov.au.

Confirmed cases that meet the criteria for release from isolation, will also be eligible to be released from hotel detention.

A confirmed case that requires ongoing isolation, will not be detained longer than the 14 day quarantine period and appropriate conditions for them to maintain their isolation need to be arranged. The following table summarises situations provided in the *Guidelines for managing COVID-19 in mandatory quarantine*.

**Excerpt from *Guidelines for managing COVID-19 in mandatory quarantine***

| Scenario | Exit plan |
|---|---|
| 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**<br>Must not be prevented from leaving if the AO is aware they are cleared and the person demands to leave<br>They are non-infectious and therefore not a public health risk<br>• End of isolation letter provided by PH Operations to COVID Quarantine Inbox and EOC inbox<br>• Release from isolation by Case Manager following Health and Welfare checks<br>• Transport should be arranged as part of the standard exit arrangements<br>• 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**<br>Detention but is now subject to the Isolation (Diagnosis) Direction<br><br>If Victorian Resident<br>• Accommodation needs to be identified and EOC informed of needs prior to end of detention period – either home isolation with transport or continued hotel voluntary isolation<br>• 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)<br><br>If Interstate Resident<br>• Not permitted to travel interstate / not permitted to fly domestically but no detention order needed to prevent<br>• Accommodation needs identified and EOC informed of needs prior to end of detention period – continued hotel voluntary isolation (noting that interstate travel is not allowed) |

## 5.2 Troubleshooting common issues

### 5.2.1 Confirmed case suspected of not isolating or putting others at risk

In the event that DHHS would like police attendance, either due to non-compliance with self-isolation or concern about a person's welfare (including when an officer is unable to reach case via phone after multiple attempts) - call 000 and ask for **welfare check** (the terminology is important). Explain that you are calling from DHHS about a confirmed case of COVID-19 and the nature of your concerns.

### 5.2.2 A close contact of a confirmed case, living in the same residence, becomes a confirmed case

Where a confirmed case lives in the same residence as a close contact, the opportunity for the confirmed case to isolate within their own house needs to be explored. If the close contact becomes a confirmed case, attempts for the two cases to remain isolated separately within their own house should be maintained. It is not yet known how likely reinfection is for recovered cases, although it is currently believed to be low.

When one of the confirmed cases in the residence is provided with "clearance from isolation" before the other, attempts at ongoing isolation within the residence should be maintained.

While attempts to isolate should be maintained, the confirmed case who has been provided clearance from isolation does not require isolation as a "close contact" of the confirmed case who is continuing isolation even if the attempts at isolation appear unsatisfactory.

### 5.2.3 Subsequent exposure of a confirmed case

If a confirmed case who has been "cleared" from isolation is subject to a second exposure (i.e is identified as a close contact of a confirmed case of COVID-19 after they have completed their isolation as a confirmed case), they will not need to undergo a period of isolation as a close contact

### 5.2.4 End of isolation criteria

A confirmed case who is isolating at home, no longer requires to be isolated in their own home, 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

### 5.2.5 Healthcare worker, return to work

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 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 from either of their first two consecutive clearance tests, wait 3 days before performing another “round” of 2 tests, 24 hours apart. If a positive PCR result is returned in this “second round” of testing, a third round of 2 tests, taken 24 hours apart 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). 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.

# 6 Existing close contacts

The Existing Close Contacts Team maintain contact with close contacts following an initial contact (conducted by the NCAC team). The Existing Close Contact Team make regular contact with known close contacts of confirmed COVID-19 cases to monitor their isolation, health, and escalate any concerns as necessary.

The objectives of the Existing Close Contact Team are to:

- Reduce the morbidity experienced by close contacts by:
  - Providing support and encouragement through daily contact with close contacts. Including ensuring they have accessto necessary medical support including COVID-19 testing if they develop symptoms.
- Reduce transmission of COVID-19 by:

- Ensure close contacts are aware of their isolation requirement (including known how long they must isolate for) through reinforcement of the message provided at first contact, and as a portal to answer questions cases may have.

## 6.1 Processes and workflow

Close contacts of confirmed cases of COVID-19 are entered into PHESS following their identification and primary consultation by the New Cases and Contact Team.

Existing Close Contact Team generate a workflow from PHESS that is populated into an excel spreadsheet that is used as a reference form for contact and outsourced to a third party (HelloWorld).

The third party (HelloWorld) records their interaction with close contacts on the spreadsheet, which is sent to the Existing Close Contact Team leader via Sharepoint twice daily; at 11:30am and end of day. The returned spreadsheet includes details of interactions with close contacts that requires further action – principally for one of three reasons:

1. The close contact has become unwell
2. The close contact is not isolating
3. The close contact requires that their last date of isolation be clarified

### 6.1.1 Close contacts who become unwell

Close contacts of confirmed cases of COVID-19, are at a higher risk of  becoming infected themselves. It is therefore important for close contacts of confirmed cases of COVID-19, with appropriate symptoms, to undergo laboratory testing for COVID-19, to confirm the diagnosis and ensure appropriate clinical and public health management.

Close contacts of confirmed cases of COVID-19 who become unwell should present to the medical facility that is most equipped to manage the significance of their symptoms.

After being tested for COVID-19, close contacts must remain in isolation while awaiting their test result. If the test result is negative they must continue to isolate as a close contact until their 14 day isolation period has been completed. If their test result is positive, they begin a new period of isolation as a confirmed case. They will be informed of these requirements by the New Case and Contact Team, after the notification is received by DHHS (via the Notification and Triage Team).

### 6.1.2 Close contacts who are not isolating

Close contacts of confirmed cases of COVID-19 are informed of their isolation requirements when they are contacted by the New Cases and Contacts Team. This includes being emailed or posted the “Factsheet – close contact” that provides the details of isolation requirements in writing.

The factsheet may be re-provided to a close contact who has not received it (they should also check the SPAM or Junk folders of their email if they have not received it).

If the close contact indicates they will not comply with the home isolation requirements, they should be advised non-compliance will be escalated to police. If the close contact continues to indicate they will not comply with the isolation requirements, the Existing Close Contact Team Member contacts the Police Hotline on 131-444 to advise that this person has indicated non-compliance with the isolation requirement.

### 6.1.3 Close contact who requires their last date of isolation to be clarified

A dispute about the last day of isolation may be a result of misunderstanding, a change in the date that has not been conveyed to the close contact or incorrect recording in PHESS.

The last date of isolation may change if the close contact has had further (or ongoing) contact with the confirmed case, or if they have been identified as a close contact of more then one confirmed case (for example, a second person in the same house has been identified as a confirmed case.)

If there has misunderstanding or change in the date of last contact with a confirmed case the following process should be undertaken to confirm the date:

- Review PHESS notes of the contact and confirmed case
- Review original questionnaire (available on TRIM)

Once the date is confirmed, the contact must be advised of the correct end of isolation date. This must be updated and recorded in PHESS, and resent in writing, via email, to the close contact.

### 6.1.4 Hotel Detention

See the “guidelines for managing COVID-19 in mandatory quarantine” for further information.

- Close contacts of confirmed cases of COVID-19 that are in hotel detention are managed, as per all close contacts, by the Close Contacts Team.
- Close contact’s end date of quarantine may be past that of 14-day detention period, if they are exposed to a confirmed case during their period of hotel detention.
- 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 is to be identified 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)
- Continued management by the Close Contacts Team.

If **Interstate** Resident

- Should be advised not to travel to interstate jurisdiction, but there are no legislative powers to prevent travel
- Accommodation needs to be identified 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

## 6.2 Troubleshooting common issues

### 6.2.1 A close contact who becomes unwell and refuses testing

A close contact of a confirmed case of COVID-19 who develops any symptoms consistent with COVID-19 should be requested to undergo testing. For the purposes of this guide, symptoms consistent with COVID-19 are:

- Fever or chills
- Cough
- Sore throat

- Shortness of breath
- Headache
- Myalgia
- Runny or stuffy nose
- Anosmia
- Nausea
- Vomiting
- Diarrhoea

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.

### 6.2.2 A close contact who needs to seek medical attention during their isolation period

Seeking medical attention is an acceptable reason for a close contact of a confirmed case of COVID-19 to leave isolation.

If an ambulance is required (for emergency treatment), when speaking to the 000 operator, the close contact should inform them that they are a close contact of a confirmed case of COVID-19 and are currently in home quarantine.

When seeking other medical attention, the close contact should call ahead and inform the staff at the facility they are attending that they are a close contact of a confirmed case of COVID-19.

If required to be driven by another person or utilise a taxi they should be informed to sit in the back seat (if possible), wear a mask if available and minimise time spent together in vehicle.

After receiving the required medical care, a close contact of a confirmed case of COVID-19 should ensure they are provided with a medical certificate that can be provided to VicPol if required, as proof of the legitimacy to leave their isolation requirements.

### 6.2.3 Request for documentation of quarantine end date

A contact may request an ‘end of isolation letter’. This can be emailed providing that the contact is not symptomatic, awaiting results and/or has not breached isolation guidelines if isolating with a confirmed case.

# 7 Management of asymptomatic cases and their contacts

Asymptomatic testing is currently being performed in Victoria in two different contexts:

1) Testing is being offered to asymptomatic individuals belonging to specific occupational groups and individuals at higher risk of severe illness as part of a 'testing blitz'. These people have a lower pre-test probability for COVID-19.
2) Testing of asymptomatic individuals is also occurring in selected high-risk outbreak settings (e.g. aged care facilities) as part of an 'active case finding' approach. These people have a higher pre-test probability for COVID-19.

## 7.1 Testing blitz

The current Victorian coronavirus testing blitz includes testing of asymptomatic individuals belonging to certain occupational groups. The aim of this testing is to gain information on the degree of community transmission that is occurring. Asymptomatic testing will be made available to various groups throughout the blitz. This testing is not compulsory.

Testing of asymptomatic individuals belonging to specific occupational groups may only be conducted at designated testing sites including:

- Respiratory Assessment Centres at Victorian public health services
- Respiratory Assessment Centres at community health centres
- Designated mobile drive-through testing clinics (located in retail settings)

Asymptomatic testing is being offered to those that cannot easily move their work to the home environment. This includes workers in the following industries:

- Construction
- Supermarkets
- Healthcare
- Police force
- Emergency services

Asymptomatic testing is also focusing on those who are at a higher risk of developing severe illness from infections with SARS-CoV-2. This includes members of the following groups:

- People living with chronic illness
- Aboriginal and Torres Strait Islanders

## 7.2 Testing protocol

Asymptomatic person offered testing as part of 'testing blitz'

Eligible populations may present for testing (SARS-CoV-2 PCR) on a voluntary basis in the absence of symptoms. There is no requirement for asymptomatic individuals to self-isolate whilst awaiting the result of a PCR test. However, asymptomatic individuals who have been identified by the department as close contacts of a case should self-quarantine until advised otherwise by the department (including whilst awaiting test results).

Samples from asymptomatic patients should be labelled as “asymptomatic testing” when sent to the laboratory.

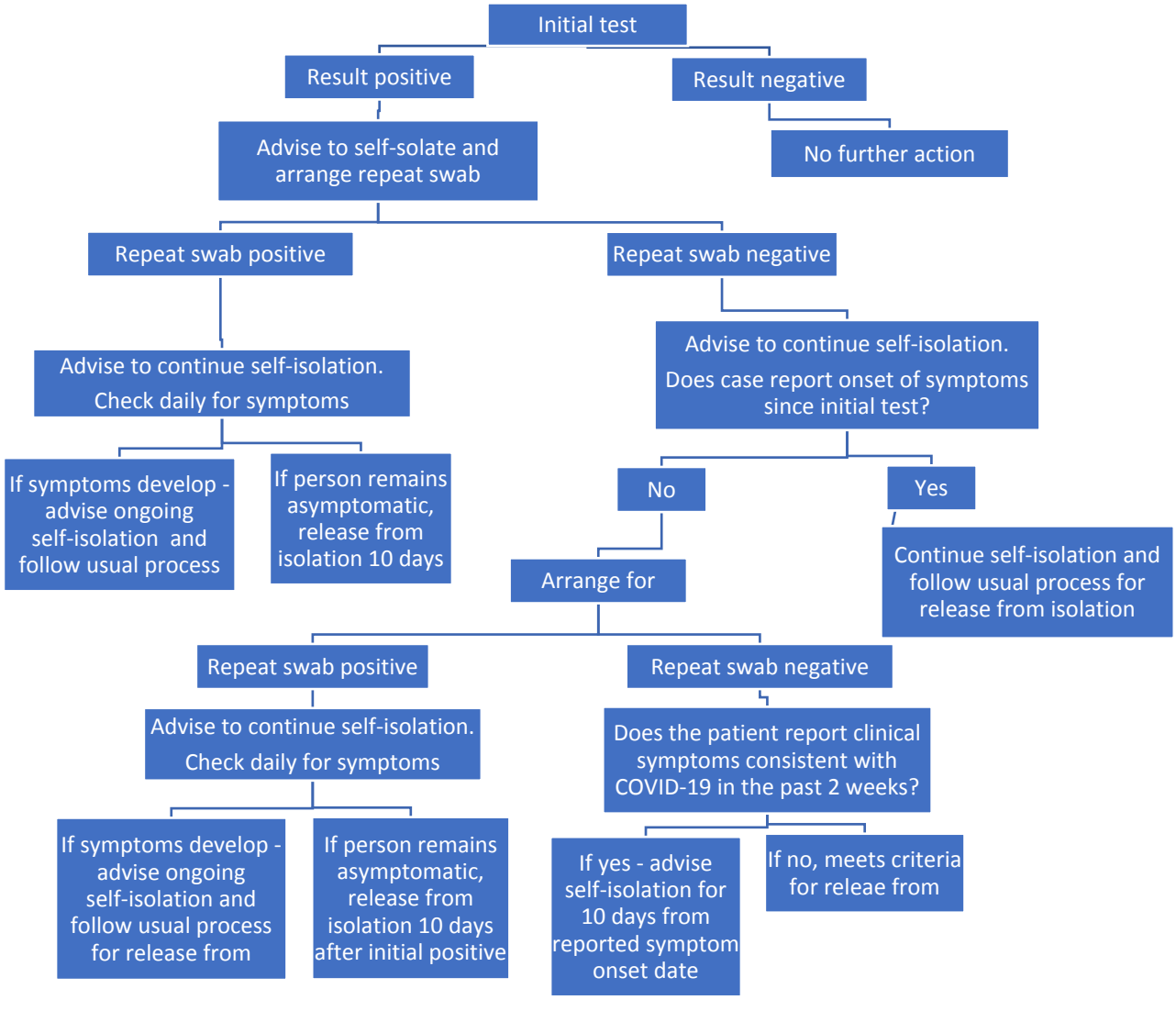
Individuals should be notified directly of the positive or negative result of the test. The current arrangement for notification of results for people who attend mobile testing centres is that those with a positive test will receive a phone call from a doctor advising them of the positive result, and those with a negative result will receive a text message from the testing laboratory.

It is the responsibility of the requesting clinician or health service to notify the department in the event of a positive result. The person will be treated as a confirmed case and a case interview and contact tracing will commence.

The requesting clinician or health service should contact the case to advise them of their positive result and request that they present for a second test. If possible, the second sample should be sent unprocessed the Victorian Infectious Diseases Reference Laboratory (VIDRL). Please ensure that the following information is provided on the pathology request form: “Repeat testing of asymptomatic positive”.

Any asymptomatic person with a positive test should be regarded as a confirmed case and should be advised to isolate. However, further testing should be undertaken as per the following algorithm:

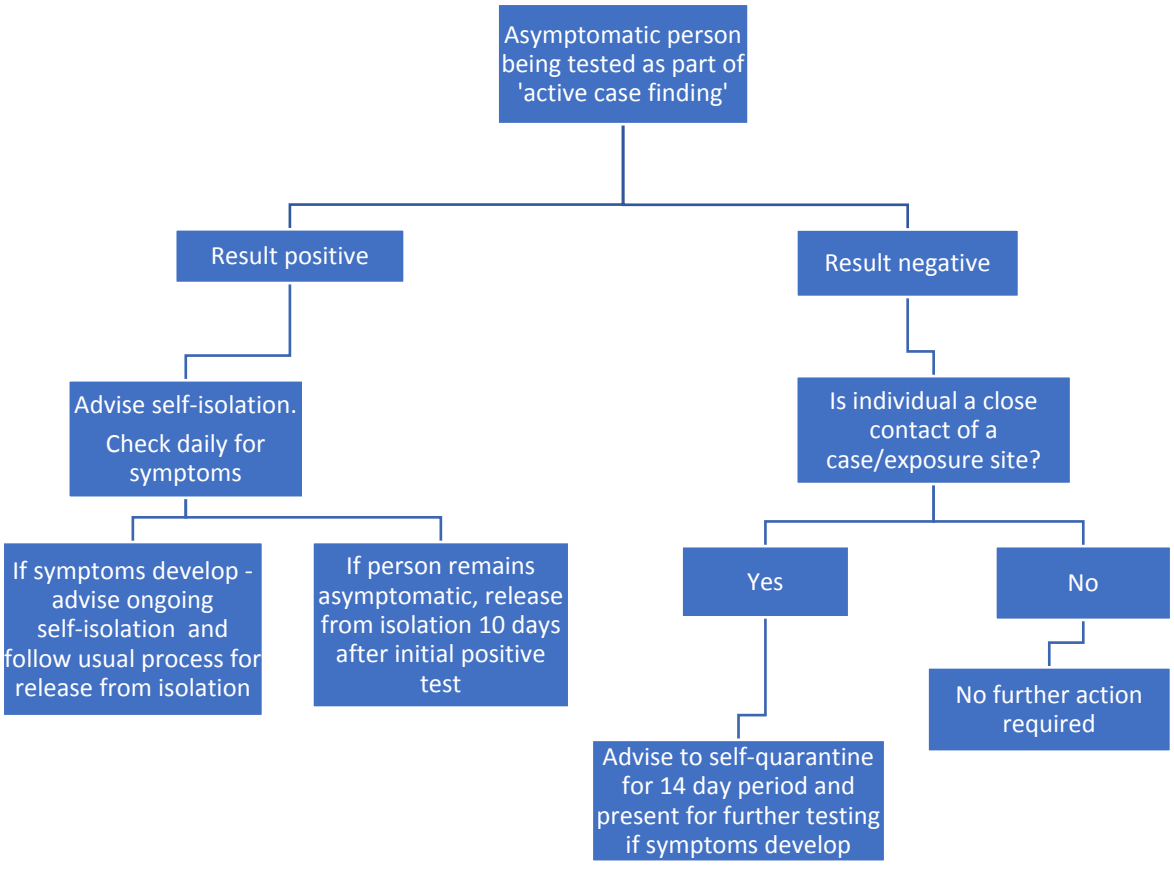
***Algorithm 1: Asymptomatic person offered testing as part of testing blitz***



Asymptomatic person tested as part of active case finding

In selected high-risk outbreak settings (e.g. aged care facilities), asymptomatic individuals may be offered testing as part of an 'active case finding' approach. Test results should be managed as per the following algorithm.

***Algorithm 2: Asymptomatic person offered testing as part of testing blitz***




## 7.3 Confirmed Cases

In the case of a positive result, the New Cases Team will contact the individual to conduct a case interview in the usual way. The interview will aim to establish whether the individual reports having had any recent symptoms consistent with COVID-19 preceding the positive screening test.

- If symptoms are identified, the date of onset of these symptoms should be recorded as the symptom onset date.
- If no symptoms are identified, the date of the initial positive test should be recorded as the symptom onset date

In either case, for the purposes of contact tracing the infectious period will be taken as beginning at least 48 hours prior to the recorded symptom onset date. Further investigation may extend this period.

## 7.4 Management of close contacts of asymptomatic cases

Close contacts of asymptomatic cases should isolate for 14 days since last contact with the case during their infectious period.

If the case is an asymptomatic person who was offered testing as part of the 'testing blitz' and has had 2 subsequent negative tests after their positive test, the close contacts may come out of isolation at the same time as the case (i.e. after the second negative test result). This is based on the following rationale:

- The pre-test probability is very low which increases the likelihood that the result is a false positive.
- It takes around seven days to return all three test results (sometimes longer).
- The case is likely at the very end of their period of infection and their infectivity is likely to be minimal in the days leading up to the initial test.

# 8 Glossary – Key terms

| | |
|---|---|
| **Confirmed case** | A person who has the disease and meets the case definition. For COVID- |

| | |
|---|---|
| | 19, the case definition is a person who tests positive to a validated SARS-CoV-2 nucleic acid test or has the virus identified by electron microscopy or viral culture. |
| **Contact** | A person who has been in contact with a confirmed case during their infectious period. Contacts are typically defined as either close contacts or casual contacts |
| ***Close contact*** | A person who has had greater than 15 minutes face-to-face contact (cumulative) or who has shared a closed space for more than two hours with a confirmed case during their infectious period without recommended personal protective equipment (PPE). See section 2.3. |
| ***Casual contact*** | A person who has been in contact with a confirmed case during their infectious period but who does not meet the definition of a close contact. |
| **Contact tracing** | The process of identifying people who are close contacts of a case, and ensuring they are quarantined for the maximum incubation period (14 days) after last close contact with the case. |
| **COVID-19** | Coronavirus disease 2019 (the name of the disease).<br>COVID-19 was initially referred to as “novel coronavirus” (2019-nCoV) and is sometimes referred to as just “coronavirus” |
| **Incubation period** | The period of time between exposure to the disease and the onset of symptoms. For COVID-19 this is not yet known, but the interim view is up to 14 days (mean incubation period ~5-6 days) |
| **Infectious agent** | An infectious microorganism that causes disease – including viruses, bacteria, protozoa and fungi. The infectious agent that causes COVID-19 is the virus SARS-CoV-2. |
| **Infectious period** | Also known as the “communicable period,” this is the period during which an infected person can transmit an infectious agent to a susceptible person. The duration of the infectious period for COVID-19 is unknown. However, for the purposes of isolation and contact tracing, cases are considered to be infectious from 48 hours prior to the onset of symptoms, until they meet criteria for release from isolation. |
| **Isolation** | Isolation refers to the physical separation of ill people with a communicable disease (e.g. COVID-19) from those who are healthy |
| **PPE** | Personal protective equipment. This is clothing or equipment designed to be worn by someone to protect them from the risk of illness. For COVID-19, this usually means a mask, eye protection, gown and gloves. |
| **Quarantine** | Quarantine refers to the physical separation of people who are well but who may have been exposed with a communicable disease (e.g. contacts of a COVID-19 case) and are potentially infectious to see if they become ill. |
| **SARS-CoV-2** | Severe acute respiratory syndrome coronavirus 2 (the virus that causes COVID-19) |
| **Sensitive settings** | Settings at high risk for rapid transmission of infectious diseases and/or that have vulnerable people at high risk of serious illness or death. Sensitive settings include:<br>• Healthcare settings<br>• Aged care and residential care facilities<br>• Prison / justice settings (correctional facilities, detention centres)<br>• Aboriginal rural and remote communities |

| | |
|---|---|
| | • Boarding schools<br>• Military operational settings<br>• Educational settings where students are present (e.g. schools)<br>• Childcare centres<br>• Settings where COVID-19 outbreaks have previously occurred (e.g. cruise ships)<br>Cases in these settings are likely to attract media attention. |
| **Transmission** | The spread of an infectious agent from one host (person or animal) to another is called transmission. COVID-19 is primarily transmitted through direct or indirect contact with respiratory droplets containing the virus, typically produced when and infectious person coughs or sneezes. |

# 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.

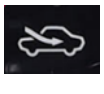
Wash crockery and cutlery in a dishwasher on the highest setting possible. If a dishwasher is not available, hand wash in hot soapy water.

# 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 ☒  ☑ 

# Fwd: Cleaning COVID positive rooms in hotels

**From:** REDACTED (DHHS)" <REDACTED

**To:** REDACTED, "Merrin Bamert (DHHS)" REDACTED, DHHSOpSoteriaEOC <dhhsopsoteriaeoc@dhhs.vic.gov.au>

**Date:** Mon, 27 Apr 2020 18:11:47 +1000

---

Further advice on cleaning below
Get Outlook for iOS

---

**From:** REDACTED (DHHS) <REDACTED>
**Sent:** Monday, April 27, 2020 5:14:47 PM
**To:** Simon Crouch (DHHS) REDACTED
**Cc:** Pam Williams (DHHS) REDACTED
REDACTED
**Subject:** RE: Cleaning COVID positive rooms in hotels

Hi Simon,

Answer to the two points in the email below:

- Yes the cleaning and disinfection advice in the document you sent them before is equally applicable to the hotel setting. They were also provided advice a week or so ago via Katherine Ong that rooms of those ending quarantine without developing symptoms could have a standard clean (i.e. however they would normally clean the room after any hotel guests leaves). It is only the rooms of people who became positive that a full clean and disinfection of the room is required.
- There is no period of 'settling' required unless an aerosol generating procedure (e.g. nebuliser on a confirmed case) was undertaken which is highly unlikely to have occurred in a hotel room. Otherwise, cleaning can take place immediately after they have vacated the room.

Regards,
REDACTED

REDACTED
**Infection Control Consultant | Communicable Disease Prevention and Control**
Health Protection Branch | Regulation Health Protection and Emergency Management
REDACTED
eREDACTED w. www.dhhs.vic.gov.au



---

**From:** DJPR COVID Accom-Lead (DJPR) <DJPRcovidaccom-lead@ecodev.vic.gov.au>
**Sent:** Monday, April 27, 2020 4:24:24 PM
**To:** Pam Williams (DHHS) REDACTED, DJPR COVID Accom-Lead (DJPR) <DJPRcovidaccom-lead@ecodev.vic.gov.au>
**Cc:** DHHSOpSoteriaEOC <DHHSOpSoteriaEOC@dhhs.vic.gov.au>; DJPR COVID Accom-Support (DJPR) <DJPRcovidaccom-support@ecodev.vic.gov.au>
**Subject:** Cleaning COVID positive rooms in hotels

Thanks, Pam.

Yes this was previously provided, but our discussion with Braedan and Jason a few weeks ago was that this information relates to workplaces and domestic settings. We were awaiting a response

on two matters:

- Does this protocol apply equally to hotel rooms
- Is any period of 'settling' required for COVID positive rooms prior to cleaning.

Thanks

REDACTED

**Operations Soteria (COVID-19)**
**DJPR Hotel Quarantine Agency Commander**
djprcovidaccom-lead@ecodev.vic.gov.au

A / Executive Director Emergency Coordination and Resilience
**Department of Jobs, Precincts and Regions**
402 Mair Street Ballarat, Victoria Australia 3350
REDACTED
REDACTED

**djpr.vic.gov.au**

---

**From:** Pam Williams (DHHS) <REDACTED>
**Sent:** Monday, 27 April 2020 4:05 PM
**To:** DJPR COVID Accom-Lead (DJPR) <DJPRcovidaccom-lead@ecodev.vic.gov.au>
**Cc:** DHHSOpSoteriaEOC <DHHSOpSoteriaEOC@dhhs.vic.gov.au>
**Subject:** FW: Cleaning in hotels

FYI

**Pam Williams**
**COVID19 Accommodation Commander**
Department of Health and Human Services
REDACTED
**www.dhhs.vic.gov.au**

*Soteria (Ancient Greek : Σωτηρία) was the goddess or spirit (daimon) of safety and salvation, deliverance, and preservation from harm.*

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**From:** Simon Crouch (DHHS) <REDACTED>
**Sent:** Monday, 27 April 2020 3:23 PM
**To:** Pam Williams (DHHS) <REDACTED
REDACTED
**Cc** REDACTED
REDACTED
**Subject:** Cleaning in hotels

Dear Pam and RED

I have been advised that we have previously recommended following the cleaning guidance for non-healthcare settings which are available here: https://www.dhhs.vic.gov.au/business-sector-coronavirus-disease-covid-19.

Please direct the relevant cleaning contractors to this document.

Thanks
Simon

**Dr Simon Crouch** BA MBBS MA MPH PhD FAFPHM
COVID-19 Deputy Public Health Commander (Case, Contact and Outbreak Management)
Health Protection Branch | Regulation, Health Protection and Emergency Management
Department of Health and Human Services | 50 Lonsdale Street, Melbourne, Victoria 3000

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w. www.dhhs.vic.gov.au | he/him

# OPERATION SOTERIA
# PPE Advice for Hotel-Based Security Staff & AOs in Contact with Quarantined Clients

Approved

Date: 5 May 2020 By: M Bamert (Dir EM)

## Recommended PPE

Recommended PPE use according to type of activity

| Setting | Activity | Security Staff | Client PPE required |
|---|---|---|---|
| **Hotel Lobby**<br><br>(accepting deliveries and checking/greeting people)<br><br>**Perform hand hygiene before and after every client contact** | • Able to maintain physical distance of at least 1.5 metres | • No PPE<br>• Hand hygiene | • Not applicable |
| **Hotel Lobby**<br><br>**When new guests are arriving for the commencement of their quarantine**<br><br>**Perform hand hygiene before and after every client contact** | • Able to maintain physical distance of at least 1.5 metres | • No PPE<br>• Hand hygiene | • Client to wear surgical face mask if tolerated<br>• Hand hygiene<br>• Advised not to touch anything on the way in/up |
| | • 1.5 metre physical distance is **not feasible** | • Surgical mask<br>• Hand hygiene | |
| **Hotel quarantine floor**<br><br>Not entering the client/s room or having direct contact with client/s.<br>**Perform hand hygiene before and after every client contact** | No direct client contacts e.g. walking room hallways or stationed in room corridors | • No PPE<br>• Hand hygiene | • No PPE / Not applicable |
| **Doorway indirect contact by security**<br><br>**Perform hand hygiene before and after every client contact** | Any doorway visit:<br>• Able to maintain physical distance of at least 1.5 metres | • No PPE<br>• Hand hygiene | • No PPE |
| | Any doorway visit:<br>• 1.5 metre physical distance is **not feasible** | • Surgical mask<br>• Hand hygiene | • Client to wear surgical face mask if tolerated<br>• Hand hygiene |

| Setting | Activity | Security Staff | Client PPE required |
|---|---|---|---|
| **Accompanying clients for fresh air/exercise breaks from room to outside**<br>**Perform hand hygiene before and after every client contact** | • Able to maintain 1.5 metres physical distance | • No PPE<br>• Hand hygiene | • Client to wear surgical face mask if tolerated<br>• Hand hygiene<br>• Advised not to touch anything on the way out/down |
| | • 1.5 metre physical distance is **not feasible** | • Surgical mask<br>• Hand hygiene | |

# Hand Hygiene

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

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

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

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

ALWAYS AVOID TOUCHING YOUR FACE.

Hand sanitiser is NEVER applied to gloved hands.

# Mask usage

PROCEDURE FOR PUTTING ON MASK

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

PROCEDURE FOR TAKING OFF MASK

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

**Note**: Hand hygiene should be performed when you feel that you may have contaminated your hands from touching the mask (if wearing one), or your face.

# OPERATION SOTERIA

# PPE Advice for Hotel Security Staff and AO's in Contact with Quarantined Individuals

Approved
Date: 08 Jun 20 By: REDACTED DEP CMDR HLTH

Version 2.2

## Recommended PPE use According to Type of Activity

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

## Hand Hygiene

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

Hands should be washed with soap and water if they are visibly soiled, otherwise alcohol-based hand rub can be used continuously.

Hand hygiene should be frequently performed, including

- Before and after contact with client
- After touching a client's items or surroundings
- Before putting on and after taking off personal protective equipment (e.g. surgical mask).
- Before and after eating
- After going to the toilet

Gloves are NOT a substitute for hand hygiene and gloves are NOT recommended for **any security staff or AO staff member at any time**

**Alcohol-based hand rub is NEVER applied to gloved hands.**

(Separate advice is available for those involved with care of clients or cleaning practices)

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

**ALWAYS AVOID TOUCHING YOUR FACE**

## Correct use of PPE (Mask only)

### PROCEDURE FOR PUTTING ON A MASK

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

### PROCEDURE FOR TAKING OFF MASK

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

## NOTES

- Hand hygiene should be performed when you feel that you may have contaminated your hands from touching the mask if wearing one or your face
- Single-use masks should not be reused, but discarded appropriately immediately after use
- Masks must not be pulled down or removed to consume food or drink. Masks should be removed using above procedure and replaced with a fresh mask.
- Masks will be less effective if they become damp or damaged

# Hotel Quarantine Response

Advice for cleaning requirements for hotels who are accommodating quarantined, close contacts and confirmed COVID-19 guests

## Last updated: 19 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 and disinfection – clean and disinfection of hotel rooms that have accommodated COVID-19 positive guest(s), will be performed when the guest(s) has physically left the hotel room.

(c) Exit deep clean – cleaning of hotel rooms that have accommodated a close contact and/or quarantined guest(s) who were never confirmed as having COVID-19 by DHHS with a detergent solution will be performed when the guest(s) has physically left the hotel.

(d) Terminal clean (winding up of the hotel quarantine program) -– when the hotel is ceased being used as a quarantine hotel, all hotels rooms and communal areas will have an exit deep clean and disinfection.

## 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.

Cleaning should be performed by environmental service staff who have been appropriately trained and is in line with their position/role description.

## 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<br>(stainless steel, uncoated steel, zinc coated steel, aluminium) | Detergent + Disinfectant*<br>*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<br>(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<br>If launderable, wash on warmest possible setting according to manufacturer's recommendations with laundry detergent |
| Fabric – common areas[1]<br>(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<br>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.

(a) Wear appropriate personal protective equipment as outlined in the Personal Protective Equipment (PPE) section below.

(b) Thoroughly clean surfaces using detergent (soap) and water.

(c) 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.

(d) 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.

(e) Wipe disinfectant off surfaces to prevent damage.

(f) 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.

(g) 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 who have confirmed COVID-19, wear a full-length disposable gown, surgical mask, eye protection and gloves.

Exit deep clean of close contacts and/or quarantined guest rooms, wear routine PPE

For terminal clean, wear routine PPE

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.

A clear process should be  in place to direct cleaning staff to the type of cleaning required for communal and exit hotel room cleaning (i.e. to inform cleaning staff whether the room has hosted either COVID-19 positive guests or guests who have not been suspected or confirmed to have COVID-19).

## 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 and disinfection of guest room for a confirmed COVID-19 case

All rooms that have accommodated a confirmed COVID-19 guest should have an exit deep clean and disinfection 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.

## Exit deep clean of a guest room for a DHHS close contact or quarantined case who were never confirmed as having COVID-19

All rooms that have accommodated a DHHS cleared close contact or quarantined case (i.e. that have never had a confirmed COVID-19 test result) should have an exit deep clean performed.

All frequently touched surfaces outlined in Table 3 should be cleaned using a detergent.

Soft furnishings or fabric covered items (for example, fabric covered chairs, mattresses or window furnishings) that cannot 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.

## Terminal clean

All rooms and communal areas that were used for quarantine purposes should have an exit deep clean performed at the conclusion of the hotel quarantine period.

For communal areas in addition to meeting the daily cleaning requirements all floor surfaces and soft furnishings will be cleaned following the requirements for an exit deep clean and disinfection.

## Guest cleaning

To have a process in place to allow guests to access cleaning equipment and products in order to clean their own rooms, as required.

## Management of linen, crockery and cutlery

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 management

Quarantine red hotels waste should be disposed of in the clinical waste stream

Quarantine hotels -aste 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<br>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<br>Soft furnishings – spot cleaned | Yes |
| **Chairs - upholstered** (e.g. fabric padded chairs, sofas, office chairs) | Twice daily – hard surfaces<br>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


- Cleaning and disinfecting to reduce COVID-19 transmission: Tips for non-healthcare settings, 20 March 2020, <https://www.dhhs.vic.gov.au/business-sector-coronavirus-disease-covid-19>
- 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>

# RE: CONFIDENTIAL: New Outbreak - Rydges, Swanston St

**From:** "Brett Sutton (DHHS)" <REDACTED

**To:** "Simon Crouch (DHHS)" <REDACTED>, "Finn Romanes (DHHS)" REDACTED

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

**Date:** Tue, 26 May 2020 20:28:12 +1000

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Thanks Simon – I think there's no rationale to inform residents other than if there has been exposure of if there is proactive media planned.

Brett

**Adj Clin Prof Brett Sutton** MBBS MPHTM FAFPHM FRSPH FACTM MFTM
**Victorian Chief Health Officer**
**Victorian Chief Human Biosecurity Officer**
Regulation, Health Protection & Emergency Management
Department of Health & Human Services | 14 / 50 Lonsdale St
REDACTED e. REDACTED
health.vic.gov.au/public-health/chief-health-officer
twitter.com/VictorianCHO

Please note that I work from home on Thursdays and am contactable on the numbers above.

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**From:** Simon Crouch (DHHS) <REDACTED>
**Sent:** Tuesday, 26 May 2020 8:10 PM
**To:** Finn Romanes (DHHS) <REDACTED; Brett Sutton (DHHS) <REDACTED
**Cc:** REDACTED>; Pam Williams (DHHS) REDACTED Jason Helps (DHHS) <REDACTED; SCC-Vic (State Intel Manager) <sccvic.stateintelmgr@scc.vic.gov.au>; REDACTED <REDACTED>; Kira Leeb (DHHS) REDACTED REDACTED REDACTED REDACTED REDACTED Sarah McGuinness (DHHS) REDACTED REDACTED; press (DHHS) <press@dhhs.vic.gov.au>; DHHS EmergencyCommunications (DHHS) <em.comms@dhhs.vic.gov.au>; Kym Peake (DHHS) REDACTED Jacinda de Witts (DHHS) <REDACTED Annalise Bamford (DHHS) REDACTED Melissa Skilbeck (DHHS) REDACTED
**Subject:** CONFIDENTIAL: New Outbreak - Rydges, Swanston St

Dear Finn and Brett

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

household)

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

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

At this stage there are no identified close contacts at work.
There are 5 household close contacts REDACTED All are currently well and in home quarantine.

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

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

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

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

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

Thanks
Simon

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

# The Department of Health and Human Services

ABN 74 410 330 756

and

**Health Education Collaborative Pty Ltd**

# COVID-19 - Delivering training to the incoming IPC Outreach Nurses

# Agreement

Date of Agreement:

Contract Reporting System Reference No: **C9303**

Procurement Agreement

Revised February 2020

Department of Health and Human Services

50 Lonsdale Street, Melbourne, Victoria

# Part 1

| | | |
|---|---|---|
| **Item 1** | Contractor | Health Education Collaborative Pty Ltd<br>ABN 94 629 654 520<br>73 Durrant Street, Brighton, VIC, 3186<br>M: REDACTED<br>E: REDACTED |
| **Item 2** | Project: | **COVID-19 - Delivering training to the incoming IPC Outreach Nurses** |
| **Item 3** | Goods or Services to be provided to the Department | 1. Delivering / facilitation of training to the incoming IPC Outreach Nurses commencing in the new role.<br>2. Delivering training onsite at identified high risk facilities – a combination of on-the-job training to embed the classroom / online learning component as well as training facility staff in certain aspects of IPC.<br>Commencement date: The date the department signs this Agreement<br>Completion date: 3 months from commencement |
| **Item 3a** | Delivery Point: | Training to be delivered at 50 Lonsdale Street, Melbourne, unless requested by the department to be held at another location |
| **Item 4** | Fees and Expenses | **Professional Fee**<br>The Professional Fee payable will be calculated in respect of each person named or designated below at the rate and up to the maximum amount(s) set out below. |

| Name or Designation | Daily Rate | Maximum Amount (GST not applicable) |
|---|---|---|
| Bruce Greaves | $850 | $20,000 |

Maximum Amount payable for Fees and Expenses: **$20,000 (GST not applicable)**

(All fees and Expenses are GST inclusive unless otherwise stated – Clause 4.4)

| | | |
|---|---|---|
| **Item 5** | Contractor's Key Person<br>(if applicable, the person who will provide the Services – clause 3.4) | Name: REDACTED<br>Telephone: REDACTED<br>Email: REDACTED |
| **Item 6** | Representatives<br>(clause 3.6 and 3.7) | (a) Contractor: REDACTED<br>Address: 73 Durrant Street, Brighton, VIC, 3186<br>Telephone: REDACTED<br>Email: REDACTED<br>(b) Department: Katherine Ong<br>Address: 50 Lonsdale Street, Melbourne, VIC, 3000<br>Telephone: REDACTED<br>Email: REDACTED |
| **Item 7** | Project Intellectual Property<br>(clauses 6.2, 6.3 and 6.4) | Department will own Project Intellectual Property<br>No |
| **Item 8a** | Insurance requirements (clause 9.1):<br>Amount of Public Liability Insurance | $10,000,000 for any one claim |

| | | |
|---|---|---|
| **Item 8b** | Is Product Liability Insurance required? | No |
| **Item 8c** | Amount of Product Liability Insurance (if applicable): | $5,000,000 for any one claim |
| **Item 8d** | Amount of Professional Indemnity Insurance: | $1,000,000 for any one claim |
| **Item 8e** | Maintenance of Cover period: | 6 years |
| **Item 9** | Licence Fee<br>(if applicable, clause 6A.8) | Nil |
| **Item 10** | Special Conditions | Nil |

This agreement is made between the Department and the Contractor upon and subject to the Conditions set out in Part 2.

# Execution

Executed as an agreement

**Executed by the Department**

**SIGNED** by **Jacinda deWitts, Deputy Secretary, Public Health, Emergency Operations and Coordination** as authorised representative for the **Secretary to the Department of Health and Human Services** for and on behalf of the **STATE OF VICTORIA** (ABN 74 410 330 756).

REDACTED

Date: 16 June 2020

**Executed by the Contractor**

**EXECUTED** by **Health Education Collaborative Pty Ltd (ACN 629 654 520)** in accordance with section 127 of the *Corporations Act 2001* (Cth):

REDACTED

Signature of Director

By executing this Agreement the signatory warrants that the signatory is a director of the Contractor

REDACTED

Name of Director (block letters)

Date: 10/6/20

# Part 2 Conditions

## 1 Definitions and Interpretation

1.1 In this Agreement:

**Agreement** means this agreement comprised of Parts 1 and 2, the Schedule and any attachments or annexures.

**Background Intellectual Property** means Intellectual Property in any Material prepared or developed prior to the Commencement Date, and includes improvements to such Intellectual Property developed during the period of the Agreement but excludes Project Intellectual Property.

**Business Day** means a day which is not a Saturday, Sunday or public holiday in Victoria (being a public holiday appointed under the *Public Holidays Act 1993* (Vic)).

**Child-Related Work** has the same meaning as under the *Working With Children Act 2005* (Vic).

**Confidential Information** of a party means any information or data, including Personal Information, whether or not in a material form, which is confidential to the party, including confidential information created, acquired, collected or developed for the purpose of the Project or obtained during the term of this Agreement, but not information in the public domain other than as a result of breach of this Agreement.

**Code of Conduct** means the Code of Conduct for Victorian Public Sector Employees 2015 (as amended from time to time) issued by the Victorian Public Sector Commissioner pursuant to section 61 of the *Public Administration Act 2004* (Vic).

**Commencement Date** means the earlier of:

(a) the date specified by the Department in Part 1 for the Contractor to start providing Services; and

(b) the date on which the Department signs this Agreement.

**Completion Date** means the earlier of:

(a) the date specified by the Department in Part 1 for completion of the Services; and

(b) the date this Agreement is terminated in accordance with clause 10.

**Contractor** means the entity described in Item 1 of Part 1.

**Delivery Point** means the Delivery Point specified in Item 3a of Part 1.

**Department** means the State of Victoria as represented by the Department of Health and Human Services (ABN 74 410 330 756), and includes the Secretary Body Corporate.

**Fees** means the fees and expenses specified in Item 4 of Part 1.

**Goods** means the goods to be supplied by the Contractor as set out in brief in Item 3 of Part 1 and more fully set out in the documents attached at the Schedule.

**GST Act** means *A New Tax System (Goods and Services Tax) Act 1999* (Cth).

**Key Person** means the person(s) specified in Item 5 of Part 1.

**Health Information** has the meaning given to it under the *Health Records Act 2001* (Vic).

**Intellectual Property** means trade marks, patents, designs, circuit layouts, copyrights, know-how and all other rights as defined in Article 2 of the Convention Establishing the World Intellectual Property Organisation (including all statutory and other proprietary rights in respect of them).

**Law** means:

(a) the law in force in Victoria, including common law, legislation and subordinate legislation;

(b) ordinances, regulations and by-laws of relevant government or local authorities; and

(c) all other lawful requirements of public bodies and other competent authorities in any way affecting or applicable to the Services or the Project (including any codes of practice, codes of conduct or similar

requirements that would apply due to the particular type of Services or Project).

**Material** includes any Record, computer software, data, documentation, designs, drawings, reports, notes, calculations, specifications, photographs, audio-visual materials, recordings, manuals, tools and anything else which is in a material form (which, for the avoidance of doubt, includes information stored in an electronic form).

**Maximum Amount** means the amount specified as such in Item 4 of Part 1.

**Personal Information** has the meaning given to it under the *Privacy and Data Protection Act 2014* (Vic).

**Project** means the project to be undertaken by the Contractor, for which the Services are to be provided as set out in Item 2 of Part 1.

**Project Intellectual Property** means Intellectual Property in any Material created, discovered, brought into existence, modified or otherwise acquired as a result of, for the purposes of, or in connection with the Project, the Services or this Agreement.

**Proposal** means the proposal or quote submitted by the Contractor in relation to the Project and which is attached to this Agreement.

**Public Sector Employee** has the same meaning as in the *Public Administration Act 2004* (Vic).

**Record** means any document within the meaning of the *Evidence Act 2008* (Vic), including:

(a) anything on which there is writing;

(b) anything on which there are marks, figures, symbols or perforations having a meaning for persons qualified to interpret them;

(c) anything from which sounds, images or writings can be reproduced with or without the aid of anything else; or

(d) a map, plan, drawing or photograph.

**Recordkeeping** means making and maintaining complete, accurate and reliable evidence of business transactions in the form of recorded information.

**Representative** means, for each party, the person specified as such in Item 6 of Part 1 (or a replacement approved by the other party).

**Secretary Body Corporate** means the Secretary to the Department of Health and Human Services, a body corporate established under section 16 of the *Public Health and Wellbeing Act 2008* (Vic), or its successor at law.

**Services** means the Goods and/or services to be provided by the Contractor as set out in brief in Item 3 of Part 1 and more fully set out in the documents attached at the Schedule.

**Standards** means the standards established under section 12 of the *Public Records Act 1973*.

**State** means the State of Victoria.

**Supplier Code of Conduct** means the Supplier Code of Conduct issued by the Victorian Government for suppliers providing goods or services to the Victorian Government (as amended from time to time).

**Third Party Intellectual Property** means all Intellectual Property owned by a third party.

**Working With Children Check** has the same meaning as under the *Working With Children Act 2005* (Vic).

**Working With Children Check Card** means a card issued with an assessment notice under the *Working With Children Act 2005* (Vic) confirming that the person has satisfactorily completed a Working With Children Check and has been assessed as suitable to engage in Child-Related Work.

## Definitions for Information/Communications Technology (ICT) Procurements

1.1A The following definitions apply if this Agreement is for an ICT Procurement or a procurement that incorporates or includes an ICT Procurement.

**Acceptance** means written notification by the Department that acceptance test criteria or alternative acceptance formalities that have been agreed upon by the parties in writing, have been satisfied.

**Associated Documentation** means documentation that is created by the Contractor and is associated with Developed Software in that it either describes the characteristics of the Developed Software or provides instructions on how to use, install or configure the Developed Software.

**Associated Tools** means any tools, object libraries or methodologies created by the Contractor in connection with the Developed Software.

**Developed Software** means Software created by the Contractor under this Agreement.

**Existing Software** means Software in respect of which the Contractor is the owner of Intellectual Property rights or in which the Contractor has sufficient rights to grant sub-licences.

**Existing Tools** means tools, object libraries or methodologies existing at the commencement of this Agreement and that are owned by the Contractor, or in which the Contractor has sufficient rights to grant sub-licenses.

**Hardware** means the machines, wiring and other physical parts of a computer.

**ICT Goods** means any Software, including the Developed Software, or Hardware.

**ICT Services** means any services relating to information and/or communications technology and includes any services relating to ICT Goods.

**ICT Procurement** means any purchase of ICT Goods or ICT Goods and ICT Services.

**Software** means any "computer program" as defined in the Copyright Act 1968 (Cth), namely, a set of statements or instructions to be used directly or indirectly in order to bring about a certain result and includes but is not limited to:

(a) "firmware" (a computer program stored in integrated circuits, read-only memory or similar devices); or

(b) a new and independent software application; or

(c) an enhancement or modification to an existing software application.

**Victorian Public Entity** or **VPE** means an "authority" as defined in the *Audit Act 1994* (Vic).

**Victorian Government** means each and every "authority" as defined in the *Audit Act 1994* (Vic).

1.2 In this Agreement:

(a) a reference to a party includes that party's successors and permitted assigns;

(b) including and includes are not words of limitation;

(c) a requirement to do anything includes a requirement to cause that thing to be done and a requirement not to do anything includes a requirement to prevent that thing being done.

1.3 In performing this Agreement, both parties must act reasonably and in good faith.

## 2 Term of this Agreement

2.1 This Agreement will commence on the Commencement Date and, subject to this clause 2 and clause 10, will conclude on the Completion Date or such other date as agreed in writing between the parties.

2.2 If the Contractor does not perform the Services or complete the Project to the reasonable satisfaction of the Department by the Completion Date, this Agreement will continue (without the Contractor being entitled to any further payment) until:

(a) the Services are performed, and the Project is completed, to the reasonable satisfaction of the Department;

(b) the Department waives the right to insist on satisfactory performance of the Services; or

(c) the Department elects (in its sole discretion) to end this Agreement by notice in writing to the Contractor,

but the operation of this clause will not be construed as a waiver by the Department of any of its rights.

## 3 Contractor's obligations

3.1 The Contractor must provide the Services during the term of this Agreement in accordance with this Agreement to the satisfaction of the Department.

3.2 The Contractor must:

(a) provide the Services in a proper, timely and efficient manner using due care, skill and diligence and at all times in accordance with standards reasonably to be expected from a prudent, expert, ethical and experienced provider of the kind(s) of goods and services such as the Services;

(b) ensure that any person employed or engaged by the Contractor to perform any work under this Agreement possesses adequate levels of skill and experience to perform that work to the satisfaction of the Department;

(c) ensure that the Services and the provision of the Services comply with all applicable laws, regulations and standards, as current from time to time;

(d) comply with and ensure that its employees, agents and contractors comply with the Department's lawful directions and policies while on the Department's premises;

(e) in the provision of the Services, comply with the lawful requirements or policy of any government agency affecting or applicable to the provision of the Services; and

(f) if the Services include Goods, the Contractor must deliver the Goods to the Delivery Point and by the time for delivery as specified in this Agreement or as otherwise agreed by the parties in writing. Unless otherwise provided in this Agreement, delivery will not be taken to have occurred until delivery is acknowledged in writing by the Department.

3.3 Without limiting clause 3.2, if, in the course of providing the Services, the Contractor or an employee, agent, officer or subcontractor of the Contractor:

(a) supervises Public Sector Employees;

(b) undertakes work that is of a similar nature to the work undertaken by Public Sector Employees at premises or a location generally regarded as a public sector workplace; or

(c) uses or has access to public sector resources or information that are not normally accessible or available to the public,

the Contractor must comply, or ensure that its employee complies (as applicable), with the Code of Conduct as if the Contractor or its employee were a Public Sector Employee.

3.4 If a Key Person is nominated under this Agreement, the Contractor must cause the Key Person to provide the Services, and may only replace that person with a person of similar qualifications, skill and experience who is approved by the Department in advance.

3.5 The Contractor warrants to the Department that the provision of the Services does not and will not infringe any right of any third party (including any Intellectual Property Right), law, regulation or rule.

3.6 The Contractor must ensure that its Representative oversees the provision of the Services and that its Representative and Key Person are available to meet and consult with the Department's Representative as reasonably required by the Department.

3.7 Each party's Representative will be the agent of the party, with authority to bind it regarding all matters relating to the Project and the Services (excluding, in relation to the Department, matters relating to any increase of the Maximum Amount).

**Recordkeeping**

3.8 The Contractor will:

(a) implement and administer a Recordkeeping system that creates and maintains full and accurate hard copy and/or electronic Records for the Services in accordance with the Standards; and

(b) store all Records created and maintained for the Services in accordance with the Standards; and

(c) ensure the security of Records created and maintained for the Services in accordance with the Standards.

3.9 The Contractor must immediately provide access to the Department to Records relating to the Services in any of the following circumstances:

(a) in accordance with the requirements of the *Public Records Act 1973* and all relevant legislation including the *Freedom of Information Act 1982* and the *Evidence Act 2008*; or

(b) to the Representative upon request in writing.

3.10 The Contractor must immediately provide the Victorian Auditor-General or Victorian Ombudsman with access to the Records relating to the Services upon request in writing from the Department.

3.11 The Contractor must only dispose of a Record in accordance with the Standards and in accordance with any specific instructions provided by the Victorian Government from time to time.

3.12 When transferring custody of Records to the Department, the Contractor must transfer the Records in a format and manner which allow the Records to be quickly and easily retrieved,

reviewed and utilised by the Victorian Government.

3.13 Upon completion, expiry or termination of this Agreement, the Contractor will transfer all Records created and maintained for the Services provided by the Contractor to the Department in a format and manner which allow the Records to be quickly and easily retrieved, reviewed and utilised by the Victorian Government.

**Working With Children and Background Checks**

3.14 Without limiting clause 3.2, if, in the course of providing the Services, the Contractor or an employee, agent or subcontractor of the Contractor (including a volunteer) engages in Child-Related Work, the Contractor must:

(a) ensure that all such persons have and maintain at all times while engaging in that Child-Related Work a current and valid Working With Children Check Card permitting them to engage in that Child-Related Work; and

(b) as soon as possible upon request by the Department, provide evidence to the Department's satisfaction that any such person engaging in Child-Related Work has a current and valid Working With Children Check Card permitting them to engage in that Child-Related Work.

3.15 Without limiting clause 3.2, if requested by the Department, the Contractor will at its own cost undertake probity and/or background checks or investigations on any person employed or engaged by the Contractor (including a volunteer) to perform work or carry out its obligations under this Agreement, including without limitation investigations as to criminal and police records (including National Security Clearance and finger printing). The probity and/or background checks or investigations required under this clause must be undertaken before the relevant person employed or engaged by the Contractor (including a volunteer) commences work under this Agreement.

3.16 Where the results of any probity and/or background checks or investigations undertaken in accordance with clause 3.15 reveal outcomes or other information that may be relevant as to whether it is appropriate for the relevant person to perform work or carry out the Contractor's obligations under this Agreement, the Contractor will disclose those results to the Department and will, if requested by the Department, prevent the relevant person from performing work or carrying out the Contractor's obligations under this Agreement.

3.17 The Contractor must procure such consents or permissions as are required by Law to facilitate and complete the probity and/or background checks or investigations referred to in clause 3.15 and lawfully disclose the results of such checks or investigations to the Department in accordance with clause 3.16.

**Labour Hire Services**

3.17A Without limiting clause 3.2, if, in the course of providing the Services, the Contractor provides labour hire services within the meaning of the *Labour Hire Licensing Act 2018* (Vic), the Contractor must:

(a) ensure that the Contractor holds a licence that is in force per section 13 of the *Labour Hire Licensing Act 2018* (Vic) and which does not have any conditions that could reasonably prevent the Contractor from providing the Services;

(b) as soon as possible upon request by the Department, provide evidence to the Department's satisfaction of such licence; and

(c) notify the Department of any changes to the conditions or validity of the licence throughout the provision of the Services.

**Supplier Code of Conduct**

3.18 The Contractor acknowledges that:

(a) the Supplier Code of Conduct is an important part of the State's approach to procurement and describes the State's minimum expectations regarding the conduct of its suppliers;

(b) it has read the Supplier Code of Conduct; and

(c) the expectations set out in the Supplier Code of Conduct are not intended to reduce, alter or supersede any other obligations which may be imposed on the Contractor, whether under this Agreement or at Law.

# 4 Payment

4.1 The Contractor must:

(a) submit invoices for payment for the Services monthly in arrears, or in accordance with such other milestone payments specified in Item 4 of Part 1; and

(b) provide information in support of the value of any invoice if requested by the Department.

4.2 Unless the Department questions or disputes any amount stated in an invoice, the Department will pay the invoiced amount within thirty (30) days of receiving a valid invoice.

4.3 The Contractor may only claim expenses on the basis of actual expenses incurred, in accordance with the limits specified in Item 4 of Part 1, as evidenced to the satisfaction of the Department, and only if the Department agrees in writing before the expense is incurred.

4.4 Unless otherwise stated, in respect of any taxable supply by the Contractor, the Department is not required to pay to the Contractor any additional amount (for the GST or otherwise) beyond the amount specified in this Agreement as being payable. Words in italics have the meanings given to them in the GST Act.

4.5 If the Maximum Amount payable under this Agreement is more than $25,000, the Department may withhold 20% of any amount payable to the Contractor until the Department is satisfied that the Project is completed.

4.6 If an amount is due and payable by the Department to the Contractor under this Agreement and remains unpaid, the Department will pay simple interest on the daily balance of the unpaid amount. Interest:

(a) will be calculated at the rate for the time being fixed under section 2 of the *Penalty Interest Rates Act 1983* (Vic), starting from the day after the amount became overdue;

(b) will not be payable in respect of a period during which any amount is disputed; and

(c) will only become payable after the Contractor gives the Department notice under clause 4.7 requesting payment of interest.

4.7 For the purposes of clause 4.6, notice cannot be given prior to, or more than 30 days after, the day on which the amount becomes overdue. Notice must be in writing and delivered to:

Manager Accounting Services
Department of Health and Human Services
GPO Box 4057
Melbourne 3001.

4.8 If the Services include Goods, title in the Goods will pass to the Department upon payment for the Goods. Risk in the Goods will pass to the Department when the Goods are delivered to the Delivery Point and the Department acknowledges receipt of the Goods in writing.

# 5 Confidentiality and Privacy

5.1 Each party must keep the Confidential Information of the other party absolutely confidential and must not communicate, publish or release, or permit the communication, publication or release of any Confidential Information except:

(a) as is necessary for the parties to perform their obligations under this Agreement; or

(b) as required by law.

5.2 The Contractor must not collect, use or disclose Personal Information or Health Information in connection with this Agreement except to the extent reasonably necessary for the performance of its obligations.

5.3 The Contractor must cause its officers, employees, contractors and agents to comply with the provisions of the *Privacy and Data Protection Act 2014* (Vic) and the *Health Records Act 2001* (Vic) and their respective Information Privacy Principles and Health Privacy Principles and any applicable code of practice, with respect to any conduct by the Contractor for the purposes of this Agreement in the same way and to the same extent as the Department would have been bound by them in respect of that conduct had it been engaged in by the Department.

5.4 The Contractor must:

(a) procure from each person employed or engaged by it for this Agreement an undertaking that is consistent with the Contractor's obligations under clause 5.1

before giving them access to any Confidential Information;

(b) on being informed, or otherwise becoming aware, of any breach or anticipated breach of the undertaking given under clause 5.4(a), take such action as may be necessary to enforce that undertaking, including all reasonable actions directed by the Department, and the Contractor authorises the Department to enforce that undertaking if the Contractor fails to do so.

5.5 The Contractor must keep all Confidential Information secure for so long as that Confidential Information is within its control, and in so doing must ensure that the Confidential Information is protected at all times from access, use or misuse, and damage or destruction, by any person not authorised by this Agreement to have access to it.

5.6 The Contractor must return to the Department all copies of the Department's Confidential Information at the end of this Agreement.

5.7 Despite anything else in this Agreement:

(a) the terms of this Agreement may be disclosed to the public, including disclosure on the internet, provided such disclosure does not involve trade secrets or proprietary information of a party where disclosure would result in a significant commercial disadvantage to that party; and

(b) if requested by the Auditor-General or the Ombudsman of the State in the course of performing their statutory duties, Confidential Information and the terms of this Agreement may be disclosed to the Auditor-General or the Ombudsman as the case may be.

## 6 Intellectual Property

6.1 The Background Intellectual Property of each party remains the property of that party.

6.2 Subject to clauses 6A.1 and 6.8, the Contractor will own all Project Intellectual Property unless Item 7 of Part 1 states that the Department will own the Project Intellectual Property.

6.3 Subject to clause 6A.1, if Item 7 of Part 1 to this Agreement states that the Department will own the Project Intellectual Property:

(a) exclusive ownership of all Project Intellectual Property vests in the Department, and on or before expiry or termination of this Agreement, the Contractor must deliver the Project Intellectual Property to the Department; and

(b) the Contractor assigns to the Department exclusive ownership of all Intellectual Property in Materials created or acquired in the course of providing the Services or otherwise for the purposes of the Project.

6.4 The Contractor grants to the Department, and the Department accepts, a non-exclusive, irrevocable, world-wide, perpetual, royalty-free licence to use, reproduce, publish, communicate to the public, adapt, modify, exploit and sub-licence:

(a) the Project Intellectual Property, if not owned by the Department;

(b) the Contractor's Background Intellectual Property comprising part of the Services, to the extent necessary to enable the Department to enjoy the full benefit of the Project, the Services and this Agreement;

(c) any Third Party Intellectual Property comprising part of the Services, to the extent necessary to enable the Department to enjoy the full benefit of the Services, the Project and this Agreement.

6.5 Where the Secretary Body Corporate is not a party to this Agreement, the Contractor agrees that all licensee rights referred to in clause 6.4 may also be exercised by the Secretary Body Corporate on behalf of the Department.

6.6 If the Contractor's employees or contractors own the Intellectual Property in any materials created or acquired under this Agreement, the Contractor will procure that the owner of that Intellectual Property will assign those rights to the Contractor so that the Contractor can assign them to the Department as required under clauses 6.3 and 6.4.

6.7 In relation to any material in which the Contractor or a person employed or engaged by it has a moral right (as defined in the *Copyright Act 1968* (Cth)), the Contractor consents, and will procure the consent of any person employed or engaged by it, to the Department, doing or omitting to do anything that, but for this consent, would

constitute an infringement of those moral rights. The Contractor must ensure that any such consents are genuinely given and not obtained by duress or by the making of any false or misleading statement.

6.8 The Department will own all Intellectual Property in Records of the Services provided by the Contractor.

## 6A Information/Communications Technology (ICT) Procurements

6A.1 This clause 6A will apply if this Agreement is for an ICT Procurement or a procurement that incorporates or includes an ICT Procurement.

6A.2 Subject to clause 6A.2A, the Intellectual Property in all Developed Software, Associated Documentation and Associated Tools created, discovered, or brought into existence as a result of, for the purposes of, or in connection with the Project, the Services or this Agreement, vests in and is owned by the Contractor.

6A.2A The Department will own all Intellectual Property in Records of all ICT Services provided by the Contractor.

6A.3 Upon the creation of any Developed Software, Associated Documentation or Associated Tools, the Contractor must give written notice to the Department identifying the Developed Software, Associated Documentation or Associated Tools and must provide to the Department a copy of the Developed Software (including source code), Associated Documentation and Associated Tools to which the notice refers upon Acceptance by the Department of that Developed Software, that Associated Documentation or those Associated Tools, as the case may be, or within 14 days of a written request from the Department.

6A.4 Except where expressly stated to the contrary, this Agreement does not affect the ownership of Intellectual Property in data (if any), Existing Software, Existing Tools or other items that existed at the commencement of this Agreement.

6A.5 The Contractor hereby grants VPEs (including the Department), a non-exclusive, perpetual, irrevocable, payment free licence to exercise all rights of Intellectual Property in the Developed Software (including the source code), Associated Documentation and Associated Tools, except that neither the Department or any VPE may commercially exploit the Developed Software (including the source code), Associated Documentation or Associated Tools. This licence entitles other contractors engaged by the Victorian Government to do, on behalf of and subject to the control of the Victorian Government, anything that the Victorian Government is itself entitled to do under the licence.

6A.6 The licence granted in clause 6A.5 is not conditional upon any obligation by the Department or any other VPE to receive support, maintenance or other services, or to purchase Software, Hardware or other products from the Contractor or any third parties.

6A.7 For the avoidance of doubt, each VPE that is not a party to this Agreement may enforce the licence rights set out in clause 6A.5 as if it were a party to this Agreement.

**Use of Existing Software and Existing Tools**

6A.8 Where any Existing Software is necessary for the proper functioning (including as to functionality and performance) of any Developed Software, the Contractor grants to the Department on behalf of the State of Victoria a non-exclusive, perpetual and irrevocable licence, at the charges specified in Item 9 of Part 1:

(a) to use, support, maintain, modify, and enhance the Existing Software or to engage other contractors to use, support, maintain, modify and enhance the Existing Software on its behalf; and

(b) to use, reproduce, revise, adapt, and modify any technical and user documentation relating to the Existing Software for non-commercial purposes or to engage other contractors to do any of these things on its behalf.

6A.9 Where the exercise of a licence granted under clause 6A.5 or 6A.8 necessitates or involves use of any Existing Tools, the relevant licence is deemed to include an entitlement to use the necessary Existing Tools. The Contractor will provide those Existing Tools to the Department (for the Department and, in the case of a licence under clause 6A.5, for VPEs as well) at the same time as it provides the Existing Software or the Developed Software to which they relate.

6A.10 The Contractor warrants that it has the right to grant any licences it is required to grant under clauses 6A.5 and 6A.8, and indemnifies the Department in respect of all Liability the Department may incur in respect of any Claim for breach of Intellectual Property rights arising in any manner from or in any way connected with a breach of this warranty.

## 7 Status of Contractor

7.1 The Contractor is engaged as an independent contractor and nothing in this Agreement will be deemed to constitute the Contractor nor any person employed or engaged by it as an agent or employee of the Department or the State.

## 8 Indemnity

8.1 The Contractor indemnifies the Department against all Liability the Department may incur in respect of any Claim, including Claims in respect of:

(a) personal injury or the death of any person;

(b) loss of or damage to any property;

(c) breach of a person's Intellectual Property; or

(d) a contravention of the requirements of clause 5 or any applicable privacy legislation; or

(e) loss and damage in respect of a breach of the Recordkeeping requirements specified in clause 3,

arising in any manner out of a breach by the Contractor of its obligations under this Agreement, any negligent or unlawful act or omission or wilful misconduct of the Contractor or any personnel employed or engaged by the Contractor in the course of providing the Services.

8.2 For the purposes of clauses 8.1 and 6A.10:

'Liability' includes all damages, costs, expenses or loss;

'Claim' includes all demands, rights, actions, suits or proceedings of any kind; and

'Department' includes the Secretary to the Department of Health and Human Services, the Secretary Body Corporate, the State of Victoria and its officers and employees.

8.3 The Contractor's Liability under clause 8.1 will be reduced to the extent that Liability is caused or contributed to by the negligent or unlawful act or omission of the Department.

## 9 Insurance

9.1 The Contractor must on and from the date of this Agreement effect and maintain:

(a) public liability insurance coverage for at least $10,000,000 for any one occurrence;

(b) if the Services include the provision of goods, product liability insurance coverage for at least $5,000,000; and

(c) unless Part 1 states to the contrary, professional indemnity insurance coverage for at least $5,000,000 for any one claim,

with an insurer authorised under the Insurance Act 1973 and provide certificates of currency if the Department so requests. Any insurance policies that provide cover on a 'claims made' basis must be maintained for no less than six years after the completion of the Services.

## 10 Termination

10.1 The Department may terminate this Agreement at any time and in its sole discretion by giving 30 days prior written notice to the Contractor, in which case the Department must pay the Contractor for the Services provided prior to the date of termination and an amount equal to the extra costs necessarily incurred by the Contractor as a result of the termination (which the Contractor must keep to a minimum). The total amount payable under this clause will not exceed the Maximum Amount that would have been payable under this Agreement had it not been terminated, less any amount already paid by the Department under the Agreement.

10.2 The Department may immediately terminate this Agreement by notice to the Contractor if:

(a) the Contractor is in breach of its obligations under this Agreement, and does not rectify that breach within 7 Business Days after being requested to do so;

(b) the Contractor enters into any form of insolvency or external administration or bankruptcy;

(c) there is a change in the identity of the person who has control of the Contractor (that is, the person who has the power to direct or cause the direction of the management and policies of the Contractor, whether through ownership of voting securities, by contract or otherwise) from that which was in effect as at the date of this Agreement or in the case of a professional partnership that partnership merges or otherwise combines with another professional service firm without the prior approval of the Department; or

(d) the Contractor engages in any conduct which brings the reputation of the Contractor into disrepute and as a consequence the Department believes that its continued association with the Contractor will be detrimental to the reputation of the Secretary to the Department of Health & Human Services or the State.

10.3 Termination of the Contractor's appointment under this Agreement will not prejudice or affect the accrued rights, claims or liabilities of the Department under this Agreement.

10.4 The obligations in clauses 3.8, 3.9 and 3.10 [Contractor's Obligations], 5 [confidentiality and privacy], 6 [intellectual property], 8 [indemnity], 9 [insurance], and those relating to the consequences of termination, are continuing and survive the end of this Agreement, whether by completion, expiry or termination, and may be enforced at any time.

## 11 Contractor as trustee

11.1 If the Contractor is entering into this Agreement as trustee of a trust, the Contractor and its successors as trustee of the trust will be liable under this Agreement in its own right and as trustee of the trust. Nothing releases the Contractor from any liability in its personal capacity.

11.2 The Contractor warrants that at the date of this Agreement:

(a) the trust is a valid and subsisting trust;

(b) all the powers and discretions conferred by the instrument establishing the trust are capable of being validly exercised by the Contractor as trustee and have not been varied or revoked;

(c) the Contractor is the sole trustee of the trust and has full and unfettered power under the terms of the instrument establishing the trust to enter into and be bound by this Agreement on behalf of the trust;

(d) this Agreement is being executed and entered into as part of the due and proper administration of the trust and for the benefit of the beneficiaries of the trust; and

(e) the Contractor's right of indemnity out of or lien over the trust's assets is unrestricted and will take priority over the right of the beneficiaries to the trust's assets.

## 12 General

12.1 The laws of the State govern this Agreement, and each party submits to the jurisdiction of the courts of the State.

12.2 If any clause or part of any clause is in any way unenforceable, invalid or illegal, it is to be read down so as to be enforceable, valid and legal. If this is not possible, the clause (or where possible, the offending part) is to be severed from this Agreement without affecting the enforceability, validity or legality of the remaining clauses (or parts of those clauses).

12.3 This Agreement constitutes the entire agreement between the parties regarding the matters set out in it and supersedes all prior representations, agreements, statements and understandings, whether verbal or in writing, made before the execution of this Agreement.

12.4 An obligation or warranty on the part of two or more persons binds them jointly and severally and an obligation or warranty in favour of two or more persons benefits them jointly and severally.

12.5 Except with the prior written consent of the Department, the Contractor may not:

(a) assign the whole or any part of the Contractor's rights; or

(b) assign or sub-contract the whole or any part of the Contractor's obligations,

under this Agreement.

12.6 This Agreement may only be varied with the written consent of each party.

12.7 The Contractor confirms no conflict of interest exists in relation to this Agreement or is likely to arise during the period of this Agreement. The Contractor must inform the Department as soon as it becomes aware of any matter that may give rise to a conflict of interest.

12.8 In the event that there is any inconsistency or ambiguity between Part 1 and these Conditions (including any Special Conditions) and any attachments or annexures, Part 1 and these Conditions will prevail over the attachments or annexures.

12.9 In the event that there is any inconsistency or ambiguity between a Special Condition in Part 1 and these Conditions, the Special Condition will prevail over these Conditions.

# Schedule: Detailed description of Goods and/or Services

The Contractor will provide the Goods and/or Services more fully set on the attached documents (which are incorporated by reference into this Agreement).

| Document | Mark 'X' for all applicable |
|---|---|
| Project Brief | |
| The Contractor's Proposal | |
| The Contractor's Best and Final Offer | |
| Other: | |

# COVID-19: DHHS COVID-19 Infection Prevention and Control Training – Security Guards

V. 0.1

20 June 2020

*This is a living document and will be updated and reviewed regularly*

VICTORIA State Government | Health and Human Services

# Agenda

- How is COVID transmitted?
- What can you do to protect yourself and others?
- Practical exercises
- How to work with COVID **guests in a quarantine** hotel setting.
- What are 3 ways to reduce the risk of COVID transmission?

What is your role?

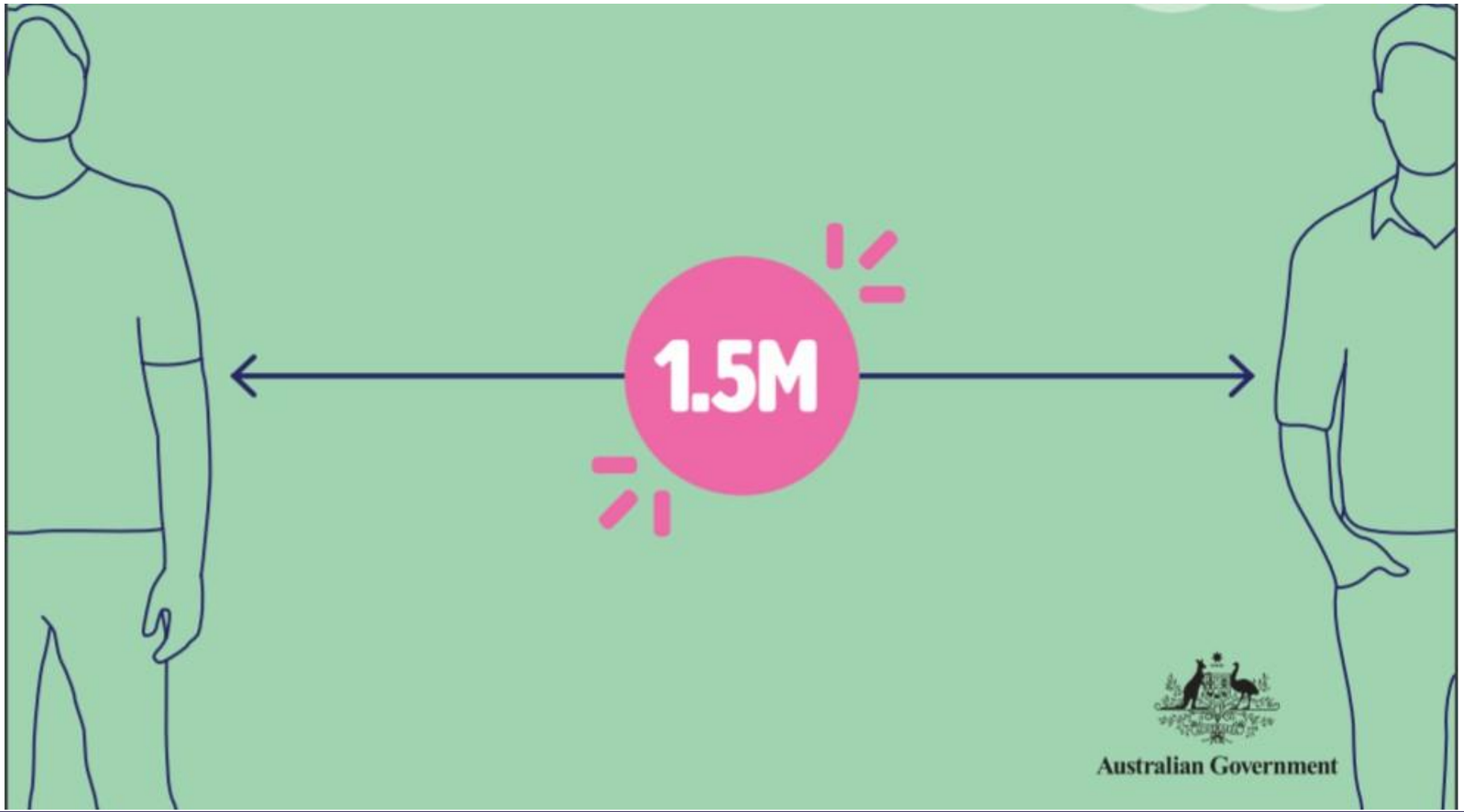
What are your concerns?

What do you know about COVID?

Whiteboard exercise
Discussion time

# Why are we practicing hand hygiene and cough etiquette?


# And physical distancing - why?




*Physical distancing, hand hygiene and cough etiquette can help prevent the transmission and reduce the spread of COVID-19. What is COVID-19 and how is it being transmitted?*

# What is COVID-19?

A virus that is capable of causing **severe acute respiratory syndrome, symptoms**

**Common symptoms:**

- Fever (temperature/feeling very hot)
- Shortness of breath (hard to breath)
- Dry cough
- Sputum production (thick spit)
- Sore throat
- Tiredness or fatigue (hard to keep going)

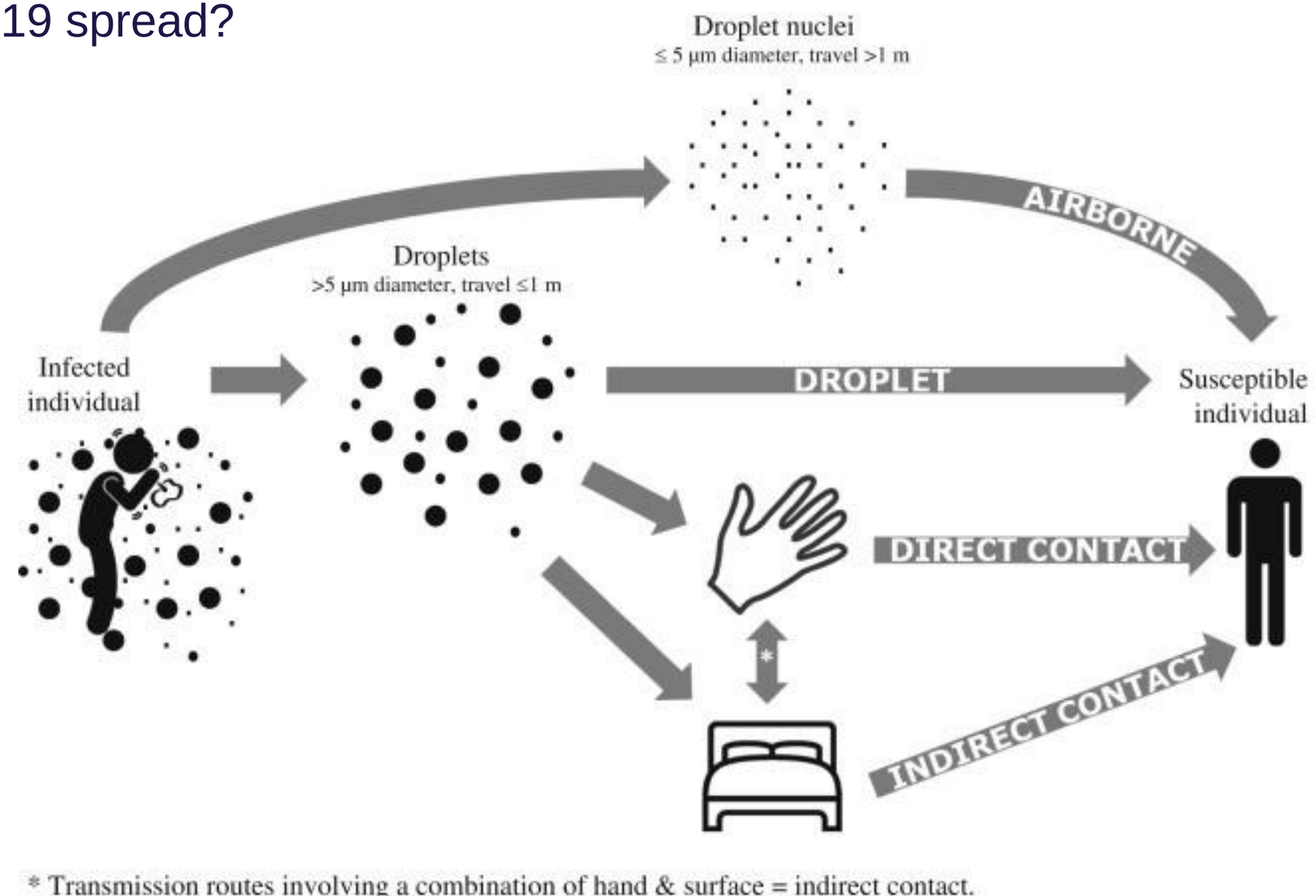
**Less common symptoms may include:**

- Headache
- Myalgia/arthralgia (sore joints and muscles)
- Chills
- Nausea and vomiting (sick tummy)
- Nasal congestion (blocked nose)
- Diarrhoea (runny poo)
- Haemoptysis (coughing up blood)
- Conjunctival congestion (sticky eyes)
- Loss of sense of smell/taste/appetite (not hungry)

# How does COVID-19 spread?

**COVID-19 can be aerosolized and transmitted in the form of droplets** (like a spray)

**How far do droplets travel?**




* Transmission routes involving a combination of hand & surface = indirect contact.

# Areas of hotels

# What do I do and when do I do it?

## Recommended PPE use According to Type of Activity

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

# Hand hygiene


## EFFECTIVE HAND HYGIENE IS MOST IMPORTANT THING TO DO

Wash hands with soap and water if you can see dirt OR use alcohol based hand rub continuously.

- Do it often
- Do it right

When:

- Before and after contact with a guest
- After touching a guest's things or their surroundings
- Before putting on and after taking off mask and/or gloves
- Before and after eating
- After going to the toilet

Gloves:

- NOT a substitute for hand hygiene
- NOT recommended for any security staff at any time
- NEVER put hand rub on gloved hands.

Coughing/sneezing

- Cough or sneeze into your inner elbow.
- Discard use tissues immediately.
- ALWAYS AVOID TOUCHING YOUR FACE

# How to handrub?

**RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED**

**Duration of the entire procedure:** 20-30 seconds

1a 1b

Apply a palmful of the product in a cupped hand, covering all surfaces;

2

Rub hands palm to palm;

3

Right palm over left dorsum with interlaced fingers and vice versa;

4

Palm to palm with fingers interlaced;

5

Backs of fingers to opposing palms with fingers interlocked;

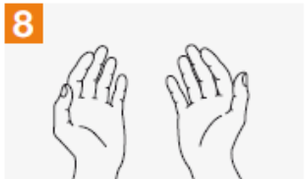
6

Rotational rubbing of left thumb clasped in right palm and vice versa;

7

Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

8



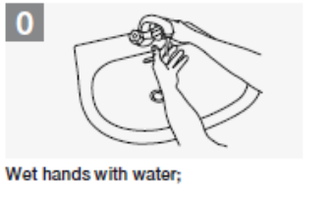
Once dry, your hands are safe.

# How to handwash?

**WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB**

**Duration of the entire procedure:** 40-60 seconds

0



Wet hands with water;

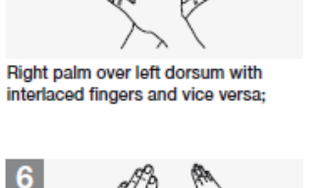
1

Apply enough soap to cover all hand surfaces;

2

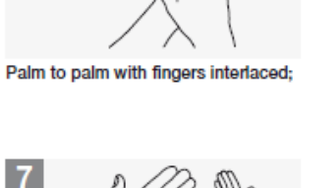
Rub hands palm to palm;

3



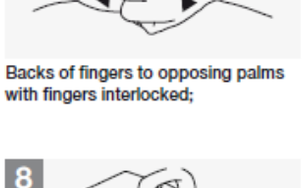
Right palm over left dorsum with interlaced fingers and vice versa;

4



Palm to palm with fingers interlaced;

5

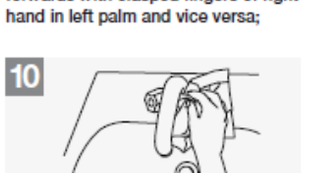


Backs of fingers to opposing palms with fingers interlocked;

6

Rotational rubbing of left thumb clasped in right palm and vice versa;

7



Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

8

Rinse hands with water;

9



Dry hands thoroughly with a single use towel;

10



Use towel to turn off faucet;

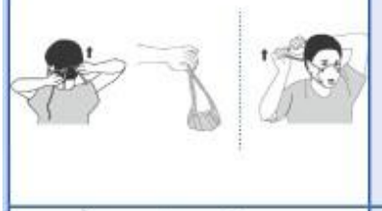
11



Your hands are now safe.

# How do you remove masks?

*ALL PPE must be removed before exiting the facility*

| | |
|---|---|
|  | **6. Remove mask**<br>• **Front of mask is contaminated – DO NOT TOUCH**<br>• Ties – undo bottom tie first then the top<br>• Loops – remove loops from around ears<br>• Pull mask away from face without touching the mask<br>• Dispose of mask into a waste bin or receptacle |
|  | **7. Perform hand hygiene**<br>• Wash hands with soap and water or use an alcohol-based hand rub |

**Quarantine**: is a precautionary period of self-isolation for someone who is well, but is at risk of infection through their recent movements or exposure

**Isolation:** is when a person is confirmed or suspected to have COVID-19.

# Placeholder – case scenario

What is your role?

How to be safe at work?

How to keep your family and co-workers safe?

# Reduce your risk of Coronavirus (COVID-19)

Translated COVID-19 information is available in community languages at **dhhs.vic.gov.au/coronavirus**

How to scan a QR code

1. Open the Camera app on your phone
2. Hold your device so that the QR code appears on the screen
3. If your device recognises the QR code, tap the notification to open the link.

QR codes will work for most modern smartphones.

Coronavirus (COVID-19) homepage

Amharic
አማርኛ

Arabic
العربية

Assyrian
ܣܘܪܝܝܐ

Bengali
বাংলা

Burmese
မြန်မာ

Chaldean
ܟܠܕܝܐ

Chin
Hakha Chin

Chinese
Simplified / Traditional
简体中文 / 繁體中文

Cook Islands Maori
Kuki Airani Maori

Croatian
**Hrvatski**

Dari
دری

Dinka
Thuɔŋjäŋ

Fijian
Vosa Vakaviti

English

English Easy Read

Filipino (Tagalog)
Tagalog

French
Français

Greek
Ελληνικά

Gujarat
ગુજરાતી

Hazaraghi
هزاره گی

Hindi
हिन्दी

Indonesian
Bahasa Indonesia

Italian
Italiano

Japanese
日本語

Karen
ကညီ

Khmer
: ខ្មែរ

Korean
한국어

Macedonian
**Македонски**

Malay
Bahasa Malayu

Maltese
Malti

Nepali
नेपाली

Nuer
Thok Nath

Oromo
Oromo

Pashto
پشتو

Persian (Farsi)
فارسی

Polish
Polski

Portugese
Português

Punjabi
ਪੰਜਾਬੀ

Rohingya

Russian
Русский язык

Samoan
Samoan

Serbian
Српски

Sinhalese
සිංහල

Somali
Soomaali

Spanish
Español

Swahili
Kiswahili

Tamil
தமிழ்

Thai
ภาษาไทย

Tigrinya
ትግርኛ

Tongan
Tongan

Turkish
Türkçe

Urdu
اردو

Vietnamese
tiếng Việt

Zomi
Zomi

# DHHS IPC Cell Run Sheet – Security Guard Hotels (COVID-19)
# June 24/6/2020 @ 1400hrs, Stamford Plaza

**Date:** Wednesday 24 June 2020
**Venue:** Level 2 Blenheim Room Stamford Hotel, 111 Little Collins St, Melbourne
**Setup:**

- Data projector available – laptop only required
- Toilets very nearby which are suitable for hand hygiene (Glitterbug) exercise
- REDACTED - room setup complete with Alcohol Based handrub.
- REDACTED will organise cohorts of staff to attend at required time. There may be a 5 min delay each time as staff leave their post to attend.
- REDACTED will bring Glitterbug from DHHS and meet you there

**Audience:**

- 49 guards rostered on Day shift and 40 rostered on night shift. This will cover off all guards working at Stamford on 24/6/20.
- Break between day and night sessions as they may not all be exactly on the hour as it will take some time to change the guards over between sessions.
- Only need to train one set of relievers and both shifts are covered off.

**Session details:**

- **Session 1 @ 1400 –** Relievers X 15
- **Session 2 @ 1500** – Day shift various (Supervisor, foyer, escort guards, meal delivery, assigned relievers etc)
- **Session 3 @ 1600 –** Day shift Floor guards x 15
- **Session 4 @ 1700 –** Day shift Floor guards x 15

1800 - 1900 Break

- **Session 5 @ 1900** – Night shift various & floor guards x 15
- **Session 6 @ 2000** – Night shift floors guards x 15
- **Session 7 @ 2100** – remaining floor guards

**Contacts:**

- REDACTED (Shift Manager MSS Security) ph: REDACTED or email above
- REDACTED IPCON Hotels ph: REDACTED
- REDACTED IPCON Hotels ph: REDACTED
- REDACTED (IPC Cell Lead – Strategy, Policy and Planning) ph: REDACTED

**Parking:**

- Limited on street parking. Download Wilsons parking app and select the Parkade Cark Park 34-60 Little Collins street car park. Enter your booking time and select. The promo code is FREEDOM . It will only cost you $10 follow prompts
- To enter the car park you simply tap you card on entry and exit and will charge you the $10

**Session materials include:**

- Powerpoint slide deck
- PPE for Security information
- Elasticated masks (REDACTED can you assist with provision of these as I understand the tie version is problematic?)
- Glitterbug
- Evaluation/feedback form (Likert scale) - REDACTED to print if possible

# Outbreak summaries - 17 June

**From:** REDACTED

**To:** "Annaliese Van Diemen (DHHS)" <REDACTED>, "Brett Sutton (DHHS)" <REDACTED>

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

**Date:** Wed, 17 Jun 2020 23:29:21 +1000

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

Dear Annaliese and Brett,

Please see today's outbreak summaries below. There are one new outbreak. There are two new cases linked to one of the outbreaks.

REDACTED **Outbreak (new)**

- A single resident of this facility has tested positive. Symptom onset was on 14 June. The case is currently isolating at their facility. There are no other symptomatic staff or residents.
- The facility is a low level nursing home with 38 residents split across two levels.
- Pending further assessment and contact tracing, the facility has been advised to isolate all residents
- A Commonwealth first responder and department outbreak control squad visited the facility on 17 June
- All staff and residents who have been at the facility since 31 May are being tested. Testing commenced on 17 June through Melbourne Pathology
- The index case has been re-swabbed on June 16 and returned a negative result.

REDACTED **outbreak (formerly Monash Health)**

- There are seven cases linked to this outbreak
- A single case in a REDACTED child was notified to the department late on 13 June – symptom onset 11 June. The child has a complex medical history and has had significant healthcare contact. This case has deteriorated significantly and has been transferred to the REDACTED (critical but stable condition, remains intubated).
- A second case in a healthcare worker was notified on 14 June. This REDACTED REDACTED who visited the first case
    - Contact tracing at MMC conducted by Monash Infection Prevention and Control. 44 healthcare workers identified as contacts. Of these, 22 isolated as close contacts. These cases are being reviewed by the department. A further 20 HITH patients and family members were identified as close contacts
    - Further contact tracing of contacts outside of the hospital is being undertaken

- Five other HITH nurses visited the case. They have been contacted by both Monash and the department. All have been furloughed from Monash. Three have been identified as close contacts by the department and quarantined. All are asymptomatic and have tested negative on preliminary testing.
- Five additional family cases have been notified:
  - This includes three household contacts [redacted]). All currently asymptomatic.
  - Two other family members who had visited the household have also been identified ([redacted]t). Both symptomatic but well
  - All five are isolated
  - [redacted] worked as a [redacted] at [redacted] between June [redacted]. [redacted] have been contacted and advised on cleaning. No in-store contacts have been identified. WorkSafe have been notified.
- The source of acquisition for these cases remains unknown, although it is most likely to centre on the family rather than Monash Health – the outbreak has been renamed; people who have had contact with cases during their acquisition period have been asked to seek testing.

[redacted]

- Five confirmed cases have been linked to this outbreak.
- The initial index case has an unknown acquisition source and was notified to the department late on 10 June 2020
- Three cases are all people identified as close contacts of the index case; one is a [redacted] [redacted]
- The [redacted] worked at [redacted] on June 4 and 11, a [redacted] 2, 4 and 9 June and [redacted] on June 2, 5, 6 and 9 while asymptomatic. The [redacted] went into isolation immediately upon being informed they were a close contact of a confirmed case by the department on June 11. The [redacted] sought testing for COVID-19 while asymptomatic and was notified to the department as a confirmed case late on June 12.
- All three [redacted] practices have been notified and deep cleans have been conducted (on 13 June). [redacted] has no immediate plans to reopen as most of the staff are quarantined.
- All three [redacted] practices provided an initial list of potential close contacts ([redacted] – 8; [redacted] – 9; [redacted] – 10) – all have been contacted. Further information on the expanded number of contact dates has been requested from the practices.
- An early case from the [redacted] outbreak consulted the [redacted] case in this outbreak on June 2 during [redacted] acquisition period – however, this is 9 days before this asymptomatic [redacted] tested positive. Investigation into this link is ongoing.
- The fifth case saw the [redacted] at the [redacted] on 2 June and had a symptom onset of 12 June. [redacted] was notified to the department in the evening of 17 June.
- There are ongoing investigations based on the possibility that the [redacted] was infectious on 2 June. Contact tracing and testing is being planned for close contacts.
- Genomics for both clusters has been requested
- Case 4 attended [redacted] on 10 June for two hours while infectious. The clinic was closed, staff sent home, and two close contacts identified. The clinic has been cleaned and will have now reopened.
- This outbreak is active and under investigation. There is no projected closure date.

[redacted] **Cluster**

- Twelve confirmed cases have been linked to this outbreak. All cases are related but live in five different households (including one house that has close contacts only).
- The index case is unknown and continues to be investigated.
- Two cases (children) attend [redacted], and one of these children attended school on 2 days while potentially infectious.
  - The school closed prior to Monday and underwent cleaning. IPC nurses visited and close contacts were identified and are being contacted by DHHS to isolate.
  - The case that attended school has the earliest symptom onset identified in this outbreak, and acquisition testing of students at school prior to 3 June has been requested.
  - The school plans on reopening on Friday the 19 June
- Two cases attend [redacted] – one while infectious on June 9 and 10
  - The school closed prior to Monday and underwent cleaning. IPC nurses visited and

close contacts were identified and are being contacted by DHHS to isolate.
    - The school plans on reopening on Friday 19 June.
    - A notification from a parent of children at [redacted] is currently under investigation.
- A childcare centre co-located with [redacted] elected to close (decision by council) for a clean, and will remain closed while the primary school is closed. There has been no cases associated with the childcare centre and DHHS has not identified any risk to the staff or children at the centre.
- One case attends [redacted], but did not attend while infectious. DHHS has not identified any risk to the staff or children at the centre as the case was not there while infectious. However the centre closed for a clean and will reopen on Thursday the 18th of June.
- One case underwent day surgery at the [redacted] while potentially infectious. IPC at the [redacted] were contacted and close contacts identified and have been isolated.
- One case attended the [redacted] while potentially infectious. IPC were contacted at the [redacted] although no close contacts were identified (the case was managed with appropriate COVID precautions during their presentation)

[redacted] **Cluster**

- A total of 13 cases have been associated with one large family group comprising [redacted] households and their contacts. 9 cases live in one household. 4 cases live in another household.
- This first case diagnosed in this outbreak attended [redacted] hospital on 11 May, which was on the same day as a case from the [redacted] cluster. The [redacted] case had already been confirmed and was managed in appropriate IPC precautions. Initial genomic analysis has suggested a possible relationship between the [redacted] cluster and the [redacted] outbreak, however this may reflect some degree of community transmission stemming from the [redacted] outbreak rather than a direct link.
- The outbreak response squad has visited all four households associated with this family group on 31 May and reported on adequacy of isolation, infection prevention control measures and any other welfare needs.
- Two families were provided with alternative accommodation to assist with appropriate isolation and quarantine.
- All family members assessed as close contacts have been tested and returned negative results.
- End of quarantine period testing completed in house C, with all results negative.
- End of quarantine period testing in house D has been undertaken, with all results negative.

<u>Complex cases to note:</u>

**Stamford Plaza complex case**

- A single case was notified to the department on 16 June in a contracted staff member (security guard) who worked at the Stamford Plaza hotel on Little Collins Street. The Stamford Plaza is currently closed to the public and is operating as a mandatory quarantine hotel.
- The case did not attend work while unwell and was tested quickly when they developed symptoms on the 15 June. However, the case did work at the hotel during their infectious period on 13 and 14 June. The source of acquisition for this case is currently unknown.
- A deep clean of the hotel commenced at 1pm on 16 June
- All staff members and contractors who spent 30 minutes or more at the Stamford Plaza Hotel between Monday June 1 (14 days prior to symptom onset in the case) and Wednesday 17 June have been asked to undergo testing for COVID-19 as soon as possible
- Staff members and contractors who spent 30 minutes or more at the Stamford Plaza Hotel on **Saturday 13 June** and/or **Sunday 14 June** are now considered **close contacts** and are being advised to **quarantine** for a period of 14 days. This includes all staff and contractors who worked day, afternoon or night shifts on Saturday 13 June and all staff and contractors who worked day or afternoon shifts on Sunday 14 June. It also includes **security staff** who worked the night shift on Sunday 14 June.
- Staff members and contractors who spent 30 minutes or more at the Stamford Plaza Hotel between Monday June 1 and Wednesday 17 June but **did not work** on Saturday 13 June OR Sunday 14 June are considered exposure site contacts. These staff may return to work if they can provide evidence of a negative test result on or after 17 June 2020. Staff should be advised to be aware of COVID-19 symptoms. If they develop any symptoms, they should be advised not

to attend work and to seek further testing.
- Department outbreak control squad nurses have visited the site to assess the situation. They will be delivering face-to-face education in the coming days.

REDACTED **(complex case)**
- Single case in a REDACTED was notified on 17 June. Case worked for one day during their infectious period and a number of days during their acquisition period.
- Staff member was asymptomatic when tested and was tested only because REDACTED had mild symptoms (child's test -ve).
- Four household contacts (husband, 9yo, 11yo and 2yo). Older children attend REDACTED REDACTED. All family members to be tested 18 June.
- Childcare centre contacted. Compiling contact details for children and staff. Total children ~125, anticipated that ~32 children will be close contacts and at least 3 staff members.
- Centre to close from tomorrow for deep clean, outbreak squad visit and full risk assessment.
- Unclear acquisition. No direct epidemiological link established to REDACTED students, however centre reports that many children have older siblings who attend the school.

REDACTED
- Single case in REDACTED who attended REDACTED during RE acquisition period. Not Aboriginal or Torres Strait Islander. (Further details regarding PPE being sought)
- Attended protests with three friends (close contacts). Not part of organised group.
- Worked at REDACTED during infectious period. REDA aware and will close on 18 June for deep clean. Likely staff group from two shifts worked while infectious will be considered close contacts.
- REDACTED management to be contacted early 18 June for awareness only.
- Four household contacts and three social contacts identified.

REDACTED **ea (complex case):**
- A single case in a client of this Disability Support Service was notified to the department on 9 June. The case has REDACTED and complex care needs. They became symptomatic on 5 June and were tested on 8 June.
- The infectious period has been assessed as commencing on 3 June and the acquisition period from 22 May to 4 June.
- The case lives at home with their family and has two carers who attend the home regularly.
- The case attended the facility for day visits on 4 June and 5 June while infectious as well as 2 June during their acquisition period.
- Four staff members of the service have been identified as close contacts; all have tested negative on an initial round of testing but remain in quarantine.
- Five clients have been identified as close contacts; four have been tested (all negative), one did not agree to testing.
- Five household close contacts have been identified; all have tested negative on an initial round of testing but remain in quarantine.
- Three REDAC of a RE service have been identified as close contacts; all have tested negative on an initial round of testing but remain in quarantine
- A further five clients and twelve staff have been tested as possible asymptomatic sources. All have tested negative.
- All close contacts have been asked to have a further round of testing on day 11 of their quarantine period. Retesting began on 16 June.
- Two clients who are close contacts live in a residential care facility – they are isolating there and carers have been advised to use PPE.
- There is no clear source of infection for the case. Three close contacts of the case (1 x household, 2 x carers) have reported symptoms but all have tested negative.
- Home testing was arranged for some clients who were distressed by testing elsewhere or for whom transfer to a testing centre was challenging.
- The facility has been closed for cleaning and until further assessments of staff and clients are completed. Facility plans to delay reopening until 22 June for their own operational reasons.
- The outbreak squad visited the facility to supervise cleaning and provide further assessments on 10 June.

REDACTED **Complex Case**
- Single case in a REDA who worked at this facility during their acquisition period but not

during their infectious period.
- The case was asymptomatic at the time of testing and remains well
- All symptomatic residents over the previous weeks have been tested for COVID-19 and returned negative results. There are currently no residents with respiratory illnesses.
- All residents have been isolating in their single rooms with staff using appropriate PPE, and the facility is closed to visitors and new admissions.
- Cleaning of the facility commenced 10 June.
- A site visit occurred on 11 June and identified there will be ongoing need for assistance from DHHS and Commonwealth to support infection control practices.
- Index case underwent subsequent testing and received two negative PCR results 24 hours apart. Index case cleared from isolation 12 June.
- All staff and residents have now been tested with only two results outstanding (both staff).
- BUPA Clayton were advised late Wed 17 June that restrictions could be lifted at the facility. The two staff members with outstanding test results will not return to work until their results are available.
- This case will no longer be reported

REDACTED **Complex Case**
- Single case in a child who attended the preschool during infectious period on June 10
- Symptom onset on 11 June, acquisition source is as yet unknown
- There are 25 internal/site close contacts (22 students, 3 staff) and 12 external close contacts (family members and friends). Testing was advised for close contacts from the pre-school and occurred on 13 and 14 June. All results received have been negative. There is 1 close contact with a pending test result
- The preschool was closed on 12 June and underwent cleaning and an outbreak squad site visit and will remain closed until at least 17 June.
- The preschool has been advised that they may re-open. This case will no longer be reported

Kind regards

Clare

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

Follow the Chief Health Officer on Twitter @VictorianCHO



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**From:** Naveen Tenneti (DHHS) <Naveen.Tenneti@dhhs.vic.gov.au>
**Sent:** Wednesday, 17 June 2020 8:38 PM
**To:** Simon Crouch (DHHS) <Simon.Crouch@dhhs.vic.gov.au>; Clare Looker (DHHS) <Clare.Looker@dhhs.vic.gov.au>
**Cc:** Sarah McGuinness (DHHS) <sarah.mcguinness@dhhs.vic.gov.au>
**Subject:** Outbreak summaries - 17 June

Hi Clare/Simon,

Outbreak summaries below

**Dr Naveen Tenneti**
**Strategy, Planning and Policy Lead – Case, Contact and Outbreak Management**

**Strategy, Planning and Policy Lead – Case, Contact and Outbreak Management**
COVID-19 Public Health Incident Management Team
Department of Health & Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
p. 9096 5774 | m. 0447287365 | e. naveen.tenneti@dhhs.vic.gov.au
The Department of Health and Human Services respectfully acknowledges the Traditional Owners of country thoughout Victoria and pays its respect to the ongoing living cultures of Aboriginal peoples.

# Re: Hotel security and AO staff PPE guide

**From:** REDACTED

**To:** REDACTED REDACTED (DHHS)" REDACTED REDACTED REDACTED REDACTED

**Cc:** "COVID19InfectionControl (DHHS)" <covid19infectioncontrol@dhhs.vic.gov.au>

**Date:** Tue, 28 Apr 2020 10:34:50 +1000

**Attachments:** PPE Advice for hotel Security MA comments_DC.docx (61.14 kB)

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Attached

Regards

REDACTED

www.infectionprevention.com.au

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**From:** REDACTED

**Date:** Tuesday, 28 April 2020 at 10:21 am

**To:** REDACTED

REDACTED

**Cc:** "COVID19InfectionControl (DHHS)" <COVID19InfectionControl@dhhs.vic.gov.au>

**Subject:** RE: Hotel security and AO staff PPE guide

I would suggest a general reminder about the need for hand hygiene should they ever feel they may have contaminated their hands.

Regards,

REDACTED

REDACTED



---

**From:** REDACTED

**Sent:** Tuesday, 28 April 2020 10:18 AM
**To:** REDACTED
REDACTED
REDACTED
**Cc:** COVID19InfectionControl (DHHS) <COVID19InfectionControl@dhhs.vic.gov.au>
**Subject:** Re: Hotel security and AO staff PPE guide

Oh no sorry REDACT I didn't think that you were, perhaps more just overstating the requirements

I will leave the final decision up to REDAC TED

Thanks
REDACTED
www.infectionprevention.com.au

---

**From:** REDACTED
**Date:** Tuesday, 28 April 2020 at 10:08 am
**To:** REDACTED
REDACTED
**Cc:** "COVID19InfectionControl (DHHS)" <COVID19InfectionControl@dhhs.vic.gov.au>
**Subject:** RE: Hotel security and AO staff PPE guide

Hi REDACTE

I certainly wouldn't want to give the green light to touching the mask – but wondered if we need to indicate that if touched, the mask nbeed to be discarded, hand hygiend and then apply a new mask correctly? Or is this overstating the requirements?

Regards
REDACTED

COVID-19 Response OPERATION SOTERIA
Department of Health & Human Services
M: REDACTED
E: REDACTED
e: DHHSOpSoteriaEOC@dhhs.vic.gov.au

---

**From:** REDACTED
**Sent:** Tuesday, 28 April 2020 10:01 AM
**To:** REDACTED

REDACTED

**Cc:** COVID19InfectionControl (DHHS) <COVID19InfectionControl@dhhs.vic.gov.au>
**Subject:** Re: Hotel security and AO staff PPE guide

Hi All

I have accepted REDACTED changes, attached clean doc

REDACTED I note your comment re "if they did" I don't believe we should be adding anything, because if we do it will be like giving them the green light to do so

I think just to leave as is

Regards
REDACTED

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infection prevention australia

---

**From:** REDACTED
**Date:** Tuesday, 28 April 2020 at 8:19 am
**To:** REDACTED
REDACTED
**Cc:** "COVID19InfectionControl (DHHS)" <COVID19InfectionControl@dhhs.vic.gov.au>
**Subject:** RE: Hotel security and AO staff PPE guide

HI REDACTED,

Just a couple of minor suggested changes. Otherwise, it is great.

Thanks.

Regards,
REDACTED

REDACTED

**From:** REDACTED
**Sent:** Monday, 27 April 2020 7:21 PM
**To:** REDACTED
REDACTED

**Subject:** Hotel security and AO staff PPE guide
**Importance:** High

HI All

See attached, I hope I have accurately captured all of your comments

NO gloves recommended at all

Regards
REDACTED

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**From:** REDACTED
**Date:** Monday, 27 April 2020 at 6:41 pm
**To:** REDACTED
REDACTED

**Subject:** RE: Hotel visits to check on IC and updated list

Thanks REDACTED and REDACTED

If this agreed position could be incorporated into the information sheet, we can then work on progressing it for approval and release.

Kind regards
REDACTED
REDACTED

COVID-19 Response OPERATION SOTERIA
Department of Health & Human Services
M: REDACTED
E: REDACTED

e: DHHSOpSoteriaEOC@dhhs.vic.gov.au

**From:** REDACTED
**Sent:** Monday, 27 April 2020 5:30 PM
**To** REDACTED
REDACTED
**Subject:** Re: Hotel visits to check on IC and updated list

Thanks REDAC

I agree, mask is all they require and HH

Thanks
REDACTED

www.infectionprevention.com.au

infection prevention australia

**From:** REDACTED
**Date:** Monday, 27 April 2020 at 5:18 pm
**To:** REDACTED
REDACTED
REDACTED
**Subject:** Re: Hotel visits to check on IC and updated list

Hi,

I discussed with RED & Finn a few weeks ago staff accompanying people downstairs for breaks etc. I advised no gloves for AOs/security but hand hygiene for them and person leaving the room. Person leaving the room also to be advised not to touch anything on the way out/down. AO/Security to touch lift buttons, open doors. Less contamination risk that way.

Regards,
REDACTE

**From:** REDACTED
**Sent:** 27 April 2020 16:52
**To:** REDACTED
REDACTED (DHHS)REDACTED
**Subject:** RE: Hotel visits to check on IC and updated list

Hi REDACT

Another request for these amendments please.

Could you please add a tab to the table :

Direct contact by security Accompanying clients for fresh air/exercise breaks from room to outside ( try to maintain 1.5 metre distance) Security to wear mask ?do they wear gloves ( they touch the lift buttons etc). Clients to wear Masks.

Could you also add to the header Authorised Officers so it reads Personal Protective Equipment (PPE) advice for hotel based security staff and Authorised Officers in contact with COVID-19 quarantined clients.

The Authorised Officers are in the same situation as the security staff and rotate through the hotels. Most are not familiar with the used of PPE either.

Thanks very much

REDACTED

REDACTED

COVID-19 Response OPERATION SOTERIA
Department of Health & Human Services
M: REDACTED
E: REDACTED

e: DHHSOpSoteriaEOC@dhhs.vic.gov.au

---

**From:** REDACTED
**Sent:** Monday, 27 April 2020 12:45 PM
**To:** REDACTED (DHHS) REDACTED (DHHS) REDACTED
**Subject:** Re: Hotel visits to check on IC and updated list

Thanks very much REDACTED

Agree, thanks makes sense

Regards

REDACTED

www.infectionprevention.com.au

---

**From:** REDACTED
**Date:** Monday, 27 April 2020 at 12:24 pm
**To:** REDACTED (DHHS)"REDACTED
REDACTED
REDACTED

**Subject:** Re: Hotel visits to check on IC and updated list

Hi everyone,

I am very comfortable with advising them not to wear PPE where not required (i.e. can maintain physical distancing). This is in accordance with all of our other PPE recommendations for HCWs etc so is best to hold that line.

REDACTE - There has been an update to the National PPE guidance for hospitals which states that airborne/contact precautions are not required for patients with severe coughing (a withdrawal of previous advice). Link to the updated document below. Hopefully this will provide reassurance for the nurses who are taking swabs that P2 respirators are not required when taking swabs from suspected cases, even if they cough.

https://www.health.gov.au/resources/publications/interim-recommendations-for-the-use-of-personal-protective-equipment-ppe-during-hospital-care-of-people-with-coronavirus-disease-2019-covid-19

You may not have had my DHHS email before, but please use this as the IPC Cell log all of our queries and responses (including keeping copies of documents we have approved etc). My email is REDACTED and the general IPC Cell email is COVID19infectioncontrol@dhhs.vic.gov.au which is always good to cc so that REDACT makes sure things ae followed up on.

Thanks.

Regards,
REDACT

REDACTED

Microbiological Diagnostic Unit Public Health Laboratory

**The Peter Doherty Institute for Infection and Immunity**
792 Elizabeth Street | Melbourne | Victoria | Australia | 3000
doherty.edu.au

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**From:** REDACTED
**Sent:** 27 April 2020 12:09
**To:** REDACTED (DHHS)
REDACTED
**Subject:** RE: Hotel visits to check on IC and updated list

Hi REDACT and REDA

REDA and I have just had a conversation and agree that we should not include masks where they are not required. REDACT, can you please update the document properly and include information on page 2 on how to use and dispose of masks and gloves properly?

Regards
REDACTE

REDACTED

COVID-19 Response OPERATION SOTERIA
Department of Health & Human Services
M: REDACTED
E: REDACTED

e: DHHSOpSoteriaEOC@dhhs.vic.gov.au

**From:** REDACTED
**Sent:** Monday, 27 April 2020 12:04 PM
**To:** REDACTED (DHHS) REDACTED (DHHS) REDACTED
**Subject:** Re: Hotel visits to check on IC and updated list

Thanks REDACTED and REDAC TED

I advised NO to masks, and totally agree they don't need them and don't wear them correctly.

So I shall wait to hear back from REDA and REDA CTED and if the document can be formalised that would be great and circulated

Much appreciated

REDACTED

www.infectionprevention.com.au

**From:** REDACTED
**Date:** Monday, 27 April 2020 at 12:01 pm
**To:** REDACTED (DHHS)" REDACTED
**Subject:** RE: Hotel visits to check on IC and updated list

Hi REDACTED and REDA

I agree we need to have this information. In fact I wrote something similar on my first day at the hotels – second day after the quarantine started. And I've been the hotel PPE gestapo every time I go to a hotel! I spend quite some time with REDACTED to explain these issues.

While I understand the security guards wanting to wear masks, it gives them a (false) sense of security) my main concern is that they have no idea how to use them safely – they hang them under their chins while eating on a meal break, constantly touch the masks to adjust them (and then don't perform hand hygiene), or have them fitted under their nose. They are then not

disposed of property – I've seen them on the street outside the hotel door. I'm concerned that masks are therefore more of a hazard than a help.

I've made some minor amendments to the information – just as a start. I think we need to land the decision on the use of masks where REDACT has indicated security guards want them – either yes or no. On the reverse side we need simple and specific instructions for the security guards on how to use a mask and gloves.

Regards
REDACTE

REDACTED

COVID-19 Response OPERATION SOTERIA
Department of Health & Human Services
M REDACTED
E REDACTED

e: DHHSOpSoteriaEOC@dhhs.vic.gov.au

---

**From:** REDACTED
**Sent:** Monday, 27 April 2020 8:15 AM
**To:** REDACTED (DHHS) REDACTED (DHHS)
REDACTED
**Subject:** Hotel visits to check on IC and updated list
**Importance:** High

Hi REDA and REDACT

I have been doing checks on hotels as requested and the biggest issue to date is the non compliance with security and AO staff

Just wearing masks and gloves everywhere and putting ABHR on gloves.

Had some wins yesterday which was good and the PPE advise for hotel based HCW had made its way to Novotel

The REDACTED thought it was very helpful, but I'm wondering if we can "simplify" it even further and I have made some changes, please see attached for comment

Sorry I'm not sure if security come under your jurisdiction but I do think this would be beneficial, also for AO staff

Nursing staff were all happy, the only comment was around swabbing and it not being specified as an AGP so I think they will be still wearing a N95 if they have them, but otherwise they were all good

Should I be submitting a time sheet or anything sorry, don't want to be doing the wrong thing

Also could I please get an updated hotel list with new clients coming in and of course that is only if you want me to keep visiting? No issue if not

Thanks

REDACTED

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# Outbreak summaries - 27 May

**From:** "Simon Crouch (DHHS)" REDACTED

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

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

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

---

Dear Finn and Brett

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

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

REDACTED

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

REDACTED

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

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

REDACTED

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

REDACTED

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

REDACTED **Fawkner and Craigieburn**

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

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

**Cedar Meats**

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

**Rydges**

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

Thanks
Simon

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