T R A N S C R I P T

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into the Victorian Government's Response to the COVID-19 Pandemic

Melbourne—Tuesday, 12 May 2020

Members

Ms Lizzie Blandthorn—Chair
Mr Richard Riordan—Deputy Chair
Mr Sam Hibbins
Mr David Limbrick
Mr Gary Maas
Mr Danny O'Brien
Ms Pauline Richards
Mr Tim Richardson
Ms Ingrid Stitt
Ms Bridget Vallence

WITNESSES

Ms Jenny Mikakos, Minister for the Coordination of Health and Human Services: COVID-19,

Professor Brett Sutton, Chief Health Officer,

Ms Kym Peake, Secretary,

Mr Terry Symonds, Deputy Secretary, Health and Wellbeing,

Ms Jacinda de Witts, Deputy Secretary, Public Health Emergency Operations and Coordination, and

Mr Greg Stenton, Deputy Secretary, Corporate Services, Department of Health and Human Services *(all via videoconference)*.

The CHAIR: We will welcome people back to the public hearings for the Public Accounts and Estimates Committee's Inquiry into the Victorian Government's Response to the COVID-19 Pandemic. The Committee will be reviewing and reporting to the Parliament on the responses taken by the Victorian Government, including as part of the national cabinet, to manage the COVID-19 pandemic and any other matter related to the COVID-19 pandemic. Can all mobile telephones please be turned to silent. All evidence taken by this Committee is protected by parliamentary privilege. Therefore you are protected against any action for what you say here today, but if you repeat the same things outside of this forum, including on social media, those comments may not be protected by this privilege.

We welcome the witnesses that are joining us via Zoom. We have the health Minister, the Chief Health Officer and the Department of Health and Human Services. You will be provided with a proof version of the transcript for you to check. Verified transcripts, presentations and handouts will be placed on the Committee's website as soon as possible. The hearings may be rebroadcast in compliance with standing order 234. Can I ask that photographers and camerapersons follow the established media guidelines and the instructions of the Committee secretariat.

Thank you, Minister, thank you, Health Officer, for joining with us today. We invite you to make a brief opening statement/presentation of 8 minutes. We ask for the Hansard record that you state your name, your position and the organisation you represent for broadcasting purposes. This will be followed by questions from the Committee. Thank you.

Hearing suspended.

The CHAIR: Can you hear us?

Ms MIKAKOS: Yes.

The CHAIR: Excellent, thank you. Welcome, Minister. Welcome, Chief Health Officer. We welcome you to the Committee. We are obliged to go back through the spiel that you did not hear earlier, so apologies for anyone who is watching this in another forum.

We welcome you, Minister and Chief Health Officer, to the public hearings for the Public Accounts and Estimates Committee's Inquiry into the Victorian Government's Response to the COVID-19 Pandemic. The Committee is reviewing and reporting to the Parliament on the responses taken by the Victorian Government, including as part of the national cabinet, to manage the COVID-19 pandemic and any other matter related to the COVID-19 pandemic. Mobile phones to be turned to silent, please.

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in compliance with standing order 234. I would ask photographers and camera persons to follow the established media guidelines and the instructions of the secretariat.

We now invite you to make a brief opening statement—no more than 8 minutes. Please state your name, your position and the organisation you represent for Hansard's purposes. This will be followed by questions from the Committee. Thank you.

Ms MIKAKOS: Well, thank you and good morning, Chair and Committee Members. Jenny Mikakos, Minister for Health, Minister for Ambulance Services and Minister for the Coordination of Health and Human Services: COVID-19.

Normally I would be happily speaking to you today on another record Labor health budget, but instead today we are examining Victoria's response to a once-in-a-generation global pandemic, which we are still experiencing and which is challenging nations all around the world.

I want to start today's hearing by going back to January when the severe acute respiratory syndrome coronavirus 2, which I will be referring to as coronavirus, first became apparent outside of China. Victoria's first case was the nation's first case, and this occurred on 25 January—only 106 days ago.

This modelling shows the trajectory Victoria was on before the introduction of physical distancing, restricted activity and the stay-at-home orders. In fact if we had done nothing at all, it would have been much worse than this. The figure on the left shows the projected number of daily coronavirus cases if only quarantine and isolation measures were in place. In this scenario, and I am hoping you can actually see the—

Mr HIBBINS: Sorry, is there supposed to be a presentation that we are seeing? The Minister seemed to indicate that we should be seeing it.

Visual presentation.

Ms MIKAKOS: Apologies.

The CHAIR: Thank you.

Ms MIKAKOS: We will go to the chart. So as you see there, the figure on the left shows the projected number of daily coronavirus cases if only quarantine and isolation measures were in place. In this scenario Victoria would have seen up to 58 000 new coronavirus cases per day at the peak of the pandemic, overwhelming our health system and costing thousands of lives. The data also reveals that if a business-as-usual approach was adopted, 10 000 intensive care beds would have been required and we would have seen 9200 Victorians presenting to hospital every single day.

It was these dire predictions, which we have seen unfolding across the world, that got us moving as quickly as we did. From January we started working to make sure we could see it quickly, isolate it quickly and respond to it quickly. This has involved a massive boost to our public health team. The Government initially invested $37 million to increase surveillance, allowing for more targeted case identification and contact tracing, isolation advice and confirmation of individuals who are no longer infectious. We scaled our public health team up to more than 1000 disease detectives working around the clock on the public health response to coronavirus in Victoria and expanding on our contact tracing capability. The team has implemented a new contact system to send daily messages to close contacts of confirmed cases and recently returned travellers using an Australian-based system called Whispir.

More recently, on 27 April, the Premier and I launched a massive testing blitz, which has seen more than 160 000 Victorians get tested over two weeks across more than 90 different sites. And just yesterday we announced a further $20 million investment into more testing, new rapid response outbreak supports, research and ongoing testing of sewerage. These increased testing, tracing and outbreak response measures will ensure coronavirus continues to be quickly detected and controlled in Victoria as we begin to cautiously ease restrictions.

All of these investments were of course supplemented by the state of emergency, which was first declared on 16 March and has since been extended twice, providing Victoria's Chief Health Officer and his delegate with the emergency powers needed to take action to contain the spread of the virus and reduce the risk to the health of Victorians.

As well as investing in our public health team, we made significant investments to prepare our hospitals for what the modelling told us was coming. Our public hospitals are world class, meaning we were well placed to respond to the pandemic. But as the modelling showed, this pandemic could have overwhelmed our hospital system very quickly had we not acted. Our massive $1.9 billion investment included significant funding for equipment and consumables which would allow us to establish an additional 4000 ICU beds across the state. It also includes $437 million for our hospitals to prepare for and treat the expected surge in patients to get us through the predicted pandemic peak. We established more than 60 screening clinics in our health services, community health centres and GPs throughout Victoria. More than half are in our regions. Our agreement with Victoria's private hospitals added over 8500 private hospital beds and significant workforce capacity to our response. And we saw a rapid expansion of innovative models of care such as telehealth, delivering more care into people's homes to keep them and our dedicated healthcare workers safe—a lasting legacy of the pandemic, I hope.

As well as upgrading existing hospital beds, we brought more online as part of our $1.9 billion investment. New projects have already been completed across the state to allow the state's hospitals to build more bed capacity and recommission buildings no longer used for health care. More than 300 ICU and general inpatient beds have already been delivered, including 45 beds at Bendigo Hospital, 50 consulting rooms and beds at the former Geelong private hospital site at Baxter House and 140 beds at Casey Hospital. More than 70 beds have been completed ahead of schedule as part of Shepparton hospital's redevelopment and will be available later this month, and works are well underway to recommission 84 beds at the former Peter MacCallum centre. The additional inpatient and ICU capacity would not only help manage increased demand from the coronavirus pandemic but also ensure Victoria's hospitals can continue to treat patients with other conditions at the same time.

As part of that COVID-19 response planning we have also been actively working with our health services to build their workforce capacity and their capabilities. We launched the Working for Victoria health portal, which has seen more than 14 800 healthcare workers and students register their interest in supporting the health system as part of the pandemic response. We also launched several training packages to prepare our existing workforce with the clinical skills they need to support COVID-19 patients, especially in critical care roles, such as in intensive care units. We have established a centralised PPE procurement and distribution process as well as a PPE task force, bringing together key people from the health sector and the department to ensure access and communication around PPE. And we have provided support for our frontline healthcare workers through the Hotels for Heroes program, providing free accommodation to workers who are required to self-isolate because they have tested positive to COVID-19 or have been exposed to a suspected or confirmed case of COVID-19.

The department has not only invested in health. Ministers Foley, Donnellan, Williams and Wynne have been working hard with and investing in their sectors to help protect some of Victoria's most vulnerable people.

As well as taking decisive action as a State, we have worked as part of the national cabinet to help slow the curve, moving quickly at each stage in the process based on the specific situation in our state. On 18 March national cabinet agreed that jurisdictions would limit indoor gatherings to no more than 100 people and outdoor events to no more than 500 people. On 29 March national cabinet endorsed supported guidance that no more than two persons should gather in both indoor and outdoor settings. On 25 March national cabinet agreed to new and enhanced social distancing measures, building on the existing measures that were in place. On 29 March national cabinet extended guidance on these restrictions to recommend states limit indoor and outdoor gatherings to two persons only. National cabinet advised individuals should stay at home unless it was for specific purposes. At each stage we moved quickly to implement these decisions through our public health directions, made possible by the declaration of the state of emergency.

So as we move to ease restrictions from tonight, we must never forget that, sadly, 18 Victorians have already died from coronavirus. I want to express my sympathy and my thoughts for those families but also for those Victorians who are at home at the moment or in a hotel and are self-isolating because either they have coronavirus or they are a close contact of someone who has coronavirus.

The CHAIR: Thank you, Minister. That concludes the time for your presentation. I will hand to Gary Maas, MP, for the first questions.

Mr MAAS: Thank you, Minister, for your appearance today. Also thank you to our Chief Health Officer and to departmental officials as well. Thanks for that presentation, Minister. I really appreciated the historical context

that you went into with that presentation, and that was something that I would like to continue to tease out a little bit more in detail. On that basis, would you be able to outline when the department first became aware of the threat that coronavirus presented and what you did to prepare for that threat?

Ms MIKAKOS: Thank you very much for that question. I think it is very important to go back to those first principles, because the point that I was seeking to make in my opening remarks was that this is a new virus, one that has only been known to countries outside of China this year and one that we are learning more about each and every day. So it is an evolving situation, and we look to our clinicians and our medical researchers and scientists to help us learn more about this virus.

Back in early January the Department of Health and Human Services first became aware of this new infectious disease caused by coronavirus. We are aware that the outbreak began in Wuhan in China, and as I said, we are learning more about it each and every day. Our Government has acted swiftly and decisively as new evidence regarding COVID-19 has come to light. There has been a rolling series of responses, reflecting an agile and comprehensive Victorian response.

There are a few points I want to make in relation to this. On 10 January Victoria's Chief Health Officer, Professor Sutton, who you will hear from shortly, issued an alert for patients who had travelled to Wuhan, China, and had experienced the onset of fever and respiratory symptoms within two weeks of return. We then had on 20 January the Australian Health Protection Principal Committee, the AHPPC, comprising the state and territory chief health officers and the Chief Medical Officer of Australia, meet to consider a national response to COVID-19, and on that same day my department formed an incident management team to coordinate a public health response and the department started to develop a mathematical model to estimate scenarios of the likely magnitude and timescale of the COVID-19 epidemic.

So from early 2020 the department started working with Victoria's health services to prepare for a COVID-19 pandemic. This involved health services updating their own pandemic plans, assessing who could set up screening clinics and working to assess and expand testing capacity and also assess personal protective equipment, or PPE, needs. The COVID-19 pandemic plan for the Victorian health sector was released by the Premier, me and the Chief Health Officer on 10 March. Also, on 23 March the aged-care sector plan was released. A significant amount of funding has been rolled out by our Government to drive the COVID-19 response, including to buy extra equipment such as beds, ventilators, PPE and dialysis units and to expand our ICU capacity.

As I said, we had our first case in Victoria on 25 January. I remember it well. It happens to be my birthday, and it was not the birthday present I wanted. On 26 January our public hotline was set up. It is staffed by registered nurses to provide support and advice to the public and operates on a 24/7 basis. Our Nurse-on-Call was quickly expanded to provide Mandarin and Cantonese language translators if requested. We also expanded our response through the state emergency management team, and the state coordination team were called together on 2 February. The State Control Centre was activated to oversee and coordinate the response to COVID-19 on 11 March.

In addition to enforced containment measures, Victoria Police established the coronavirus enforcement squad on 23 March. A state of emergency was declared in Victoria at midday on 16 March and extended twice, and it has underpinned our response to the pandemic by enabling the Chief Health Officer to issue a range of directions and restrictions on activities designed to reduce transmission and flatten the curve.

On 29 March I launched the Working for Victoria health portal to assist health services to build their capacity and their capability. And as I said earlier, we have had 14 600 healthcare workers and students putting up their hand, being prepared to step up and assist Victorians in their time of need. We have had repeated expansions to our testing criteria over time as well, based on evidence-based advice, and we have been seeking to provide up-to-date advice to the community and to health practitioners.

The point I would like to make also, Chair, in response to the Member's question is that whilst we have acted decisively, I think—and the work that we have all done as a Victorian community, and I am very grateful to Victorians who have overwhelmingly done the right thing and helped us to flatten the curve—this pandemic is not over. We compare very favourably to other countries who also acted early, like South Korea and New Zealand, but we know that if you act too quickly, if you act hastily, you can have second waves and you can have spikes. That is something that I noted even this morning in the media, reading the Federal Treasurer's comments,

that if you have a second wave, it will be a huge cost to the economy. I think it was an estimate of a billion dollars a day that I saw in those media reports; that is something that business, of course, would not like to happen, and none of us would like to have a need for those restrictions to be reimposed.

What we have done by acting early and acting decisively is we have avoided the catastrophic outcomes we have seen in places like Europe and New York and many other parts of the world. We are very, very grateful for the fact that Victorians have abided by the advice issued by the Chief Health Officer and implemented by our Government, but there is still a long way to go. I want to stress that today, that now is not the time for complacency. The modelling that I have been discussing with you and sharing with you, which we released many weeks ago, shows us that if we were to be complacent, if we were to act too quickly or too broadly, then we could have a rapid spread through the community. That is possible. Again, even now as we move to ease restrictions it is important that people still abide by the advice and continue to follow the restrictions so we can avoid a second wave of infection.

Mr MAAS: Thank you, Minister. You have made several references to the modelling. Could I just take you now to the assumptions that underpinned the modelling, and could you tell us what they were and also how did Victoria's modelling compared with other jurisdictions?

Ms MIKAKOS: Thank you for that further question. When we released the modelling many weeks ago we also did publish the underlying assumptions behind that modelling on the website. And the key point that I would like to make in relation to those assumptions is that the modelling was done on the basis of only five infected individuals arriving in Victoria. So if you think about some of those very, very large numbers that I just spoke about before, potentially 36 000 Victorians losing their life, the 58 000 infections a day and that huge spike in demand that we would have had in our hospital numbers, it is really important to remember that that modelling was based on five individuals—only five individuals. So we have more than five active cases in Victoria now. We have many more than 100 active cases in Victoria at the present time. We have had cases of community transmission identified in recent days and particularly as a result of the testing blitz. About 30 individuals were identified through the two-week testing blitz that we did.

So we know what the modelling tells us—and those underlying assumptions—is that only a very small number of active cases walking around in the community and not being subjected to the types of restrictions that we have put in place since about the middle of March could lead to these really catastrophic consequences. So I really cannot stress that enough. Our modelling aligns also with the Australian Government's modelling. There were also different scenarios that were examined by the Commonwealth as part of their modelling and related to three different scenarios: uncontrolled spread; isolation and quarantine; and isolation, quarantine and social isolation.

So we know that the more effective the measures that can be put in place the more we can help to flatten the curve. I believe that Victorians have embraced the need for caution, the need for all of us to make very big sacrifices, and I acknowledge the huge sacrifices that have been made by our state, by our community, to date. We have achieved great gains together, and it is important that we do not go backwards and lose the benefit of all the sacrifices that we have all collectively made.

Mr MAAS: Thank you, Minister. The Government released the *COVID-19 Pandemic Plan for the Victorian Health Sector*. How did that help prepare our health sector for the upcoming pandemic?

Ms MIKAKOS: Thank you. We released the *COVID-19 Pandemic Plan for the Victorian Health Sector* on 10 March and also on 23 March the aged care sector plan. That plan set out a comprehensive four-stage response to COVID-19. The first stage of the response, which Australia was in at the time, focused on containment, identifying any possible cases and isolating those who are infectious as well as their close contacts. Some of the immediate measures introduced included dedicated screening clinics and increased testing at more Victorian labs, with healthcare workers who are unwell given priority so that they can get the all clear and return back to their all-important work. The further stages of the plan set out actions to slow the spread of COVID-19 in the community to manage demand on hospital resources, to respond to a severe outbreak and to recover as quickly as possible.

So the Government was very up-front with the fact that these measures would be disruptive, they would be wideranging and they would lead to things like an increased use of telehealth for medical consultations, the cancellation of large public gatherings or the closing of schools and universities. So all of these things were

outlined in that plan back in the middle of March, and none of these decisions were taken lightly; they were all proportionate to the threat that we saw. This plan has helped us to prepare for the significant risk that COVID-19 has posed, particularly for vulnerable members of the community. But as we have stressed many times, we know from overseas experience that this is not an elderly person's disease. We have had very young and in fact healthy individuals die from COVID-19 overseas, and so it is important that all of us are alive to the risks and continue to take this very seriously.

Mr MAAS: Thanks, Minister. The declaration of a state of emergency provides the Chief Health Officer with additional powers to issue directions. Would you be able to tell us what directives were made and when and how they helped keep Victorians safe?

Ms MIKAKOS: Thank you for that question. Look, the advice that the Chief Health Officer has given to me was that there was a serious and potentially catastrophic risk to public health arising from COVID-19. As a result I declared a state of emergency throughout Victoria under section 198 of the *Public Health and Wellbeing Act 2008*. The Chief Health Officer advised that more significant targeted action was required to slow the transmission of COVID-19. As a result of that advice, a declaration of a state of emergency was declared at midday on 16 March 2020 to flatten the curve of COVID-19 and manage the spread of the coronavirus. This was extended for a further four-week period on 12 April 2020 until midnight on Monday, 11 May 2020, which was again extended yesterday.

So these extensions, these declarations of a state of emergency, have enabled the Chief Health Officer and his delegate, the Deputy Chief Health Officer, to have the emergency powers needed to take action to contain the spread of the virus and reduce the risk to the health of Victorians. It has also enabled the Chief Health Officer to develop directions to implement decisions of the national cabinet. These powers, through the Act, have enabled a number of directions to be put in place, and in the interests of time I am very happy to provide the Committee with a list of the historic directions that have been issued as well as all the current ones. Just to draw to the Committee Members' attention, a new set of directions were signed and put up on the department's website yesterday that apply to today, and then post 11.59 pm tonight they will apply to the period beyond that until 11.59 pm on 31 May. So I am very happy, in the interests of time, to provide you with the expansive list of all of those directions.

Mr MAAS: That would be appreciated. Thank you, Minister. As we know, cruise ships are at high risk of infectious diseases breakouts. I was hoping you would be able to expand on your cruise ship directive and how the management of cruise ships in Victoria was perhaps different to others.

Ms MIKAKOS: The Government has taken a very precautionary approach to cruise ships because we know that they are at a high risk of infectious disease outbreaks, particularly given the density and the duration of cruises and the mixing patterns of people on board.

The department took decisive action here. They issued a Victorian cruise ship docking direction on 19 March. This ensured that any person disembarking at a port in Victoria from a cruise ship was required to self-isolate for 14 days after disembarkation. If I give you an example of them going above and beyond this, I take you to the example of the *Golden Princess*, which arrived in Melbourne on 19 March. Several passengers were reported as being unwell and some had travelled on a flight that had a confirmed case of COVID-19, so the department's advice and their approach was to determine that pratique would not be granted to the vessel and that testing of all unwell passengers would be required to be undertaken and results received prior to allowing disembarkation of any passengers.

I know that the company, Carnival Cruises, was not particularly thrilled about that, but when the *Golden Princess* docked on 19 March departmental officers attended with nurses to test the unwell passengers. Results from all swabs were provided to the ship company around 4.00 pm. Thankfully all tests did prove to be negative and then pratique was granted and passengers allowed to disembark into self-isolation as per the cruise ship docking direction. All passengers were handed information about self-quarantine and had it read out to them.

I note that on that same day the *Ruby Princess* docked in Sydney, and I am advised that there was a very different approach taken in New South Wales about the disembarkation of passengers prior to being tested or any advice being given to them about their need to self-quarantine for a period of time.

So I think the very cautious approach that has been undertaken in Victoria in relation to cruise ships has served us well. We have had more than 30 Victorian—

The CHAIR: Thank you, Minister. Mr Maas's time has expired. I will hand to the Deputy Chair, Richard Riordan, MP.

Mr RIORDAN: Thank you, Chair. My first question this morning is to Professor Sutton. Professor, I would like to know a little bit about the modelling. We heard quite a bit from the Premier this morning and again from the Minister, and presumably you are the person who provides the modelling. In February and March with that earlier modelling, and we saw it again today from both the Premier and the Minister, it was said that 58 000 cases a day were going to be diagnosed with COVID and we could expect 537 people a day dying. Presumably this information is what formed the basis of your advice to the Government and presumably the harsh lockdown and the continued lockdown in Victoria is based on that modelling, and I say that because today we have not seen any other modelling other than that modelling.

So as we look at what has actually happened in Victoria, with .04 of 1 per cent of those targets being met—and that is a great thing, that is a win for Victoria—but with such a huge discrepancy between what you have based the decision-making on and what has come about, what do you say to that, and secondly, have you created more modelling based on what has actually happened in Victoria?

Prof. SUTTON: Thank you, Deputy Chair, and thank you, Chair and Committee, for the opportunity to speak. The modelling is actually independent of me. It is provided through a collaboration of Monash University, University of Melbourne and Peter Doherty Institute modellers. They have provided assumptions on the modelling that we aligned with the same assumptions that have been provided to the Commonwealth with respect to modelling in Australia. The modelling was based on some presumptions that had been understood from the outbreak as it occurred in Wuhan initially, in Hubei province, and essentially what it modelled was what happens when all you are doing is contact tracing—isolating those individuals that you find to be infectious and quarantining their close contacts. The modelling takes into account that two-and-half individuals are infected for every one infectious case. That certainly appears to be how it played out in Hubei province and China more generally in the beginning of their outbreak. And it is the same thing that happened across Europe and indeed North America—that in the early stages, when spread was largely unmitigated by having restrictions in place, for every 10 individuals there were 25 infected in the next generation of infections. So the modelling made an assumption that at some point the contact tracing that you can do, the isolation of individuals and of their close contacts, escapes you because the numbers become so very great.

Mr RIORDAN: So, Professor, to get to the point: has that modelling been updated given the circumstances? I mean, at 58 000 people a day and 537 people a day dying, the Victorian people could rightly understand the harsh conditions and your continued advice that restaurants and cafes do not open. But when we are at 0.04 per cent of that figure—nowhere near it—it has not been our experience at all, and in fact looking at world statistics no jurisdiction anywhere in the world reached those types of numbers. What continued advice do you give to the Minister and the Premier that they should continue based on those figures?

Prof. SUTTON: Well, the assumptions remain true in terms of the counterfactual as long as we do not have the physical distancing restrictions in place to some degree. What has been modelled is what it would look like if we only had a 25 or a 33 per cent reduction in the transmission from an infectious individual to their contacts, and that modelling has shown that we would have a slow but steady increase in cases. So what we have been able to achieve is a reduction in the transmission from an infectious individual even greater than the 25 or 33 per cent modelling.

Mr RIORDAN: So the answer is no to updated modelling? There is no updated modelling?

Prof. SUTTON: The updated modelling has been done, again in line with what has been done nationally.

Mr RIORDAN: Could that be supplied to the Committee?

Prof. SUTTON: I imagine so, yes.

Mr RIORDAN: Okay, so you will supply it to the Committee. While we are on the theme of modelling, have you provided to the Government the modelling on the consequences of these decisions? So, for example, we are

hearing extensively about mental health and we are hearing extensively about the challenges for families and schools and of course the huge stress and strain that has been put on many, many, many small businesses, and particularly in my own electorate. Have you done modelling on the cost benefits of the decisions that you have requested the Government make to keep us safe? So while we know that the modelling that we base it on is 0.04 per cent outcomes, have you also looked at what the other costs in making those decisions are—a rise in mental health, suicides; complexities in family arrangements; business failure? Have those other factors been looked at in terms of deciding what to do for Victorians?

Prof. SUTTON: Not from myself. I have been very clear in my advice to Government and to the Department of Health and Human Services about some of those consequences that are very apparent. I have been very public in my concerns about that. We were left with effectively an impossible decision of allowing 58 000 new cases a day at the peak of this outbreak if it were unmitigated and the 10 000 ICU admissions or the consequences that are apparent to you and to me of the physical restrictions being in place for a protracted period of time. I have recognised the challenges with respect to psychological wellbeing, mental health and family and interpersonal violence and indeed the economic consequences, but my office does not play the role of modelling economic consequences.

Mr RIORDAN: Okay, so if you do not model that, have you modelled the consequences of cancelled elective surgery where, I think the Minister pointed out, of 4000 ICU beds I believe currently there are less than 10 people occupying those? There are literally thousands of people around Victoria who have much-needed and anticipated surgery for complications that will be leading to stress, pain, discomfort and other health complications. Have you modelled the effect of this prolonged shutdown of elective surgery?

Ms MIKAKOS: Just in relation that question—

Mr RIORDAN: Sorry, Minister; the question is to the health officer. He is providing you with the health advice, so—

Witness interjecting.

Mr RIORDAN: I have got questions for you; do not panic.

Ms MIKAKOS: Hang on, so there are different—

Mr RIORDAN: No, Minister—

The CHAIR: Deputy Chair, could we just hear what the—

Mr RIORDAN: No, the question was to the Chief Health Officer, not to the Minister.

The CHAIR: Deputy Chair, I understand that, but the Minister is trying to offer an explanation as to why she can offer something to this, and then I am sure she will—

Mr RIORDAN: That would be up to the Chief Health Officer to say he cannot answer the question, Chair—sorry.

The CHAIR: Deputy Chair, I understand that.

Ms MIKAKOS: What I am trying to explain to Mr Riordan is that there are different parts of the Department of Health and Human Services that play different roles. The Chief Health Officer leads the public health response. I have also the Secretary of the department here, Kym Peake, as well as Terry Symonds who is the Deputy Secretary, who actually leads this part of the department that relates to our—

Mr RIORDAN: So, Minister, just in brief, I do not need a rundown of your department. Just quickly, the Chief Health Officer has not provided you advice on the added health cost to the Victorian community of not having this modelling done?

Ms MIKAKOS: The main thing is that issues around elective surgery and our operations of our public hospitals should not be directed to the Chief Health Officer but to other officials who are here and able and willing to assist you.

Mr RIORDAN: Okay. I am sure the Chief Health Officer could have answered that question for me, Minister.

As you are so keen for a question this morning: Minister, can you confirm that on 27 April the management of Cedar Meats was told by your department that there was no risk to their plant despite an employee testing positive after an incident on 24 April?

Ms MIKAKOS: Sorry, this was on 27 April you are asking—okay. Look, firstly, I know that there has been a lot already said about the time lines in relation to this. Firstly, can I say that the department began all appropriate contact tracing—

Mr RIORDAN: No, Minister, excuse me—

Ms MIKAKOS: of cases of coronavirus—

Mr RIORDAN: I do not need the rundown; I have got the time line. I just want to know: can you confirm on 27 April that the management of Cedar Meats was told by your department that there was no risk to their plant?

Ms MIKAKOS: I am going to ask my officials to supplement my answer in a moment, but I do want to make the following points, and that is—

Mr RIORDAN: Sorry, Minister, we have limited time. We do not need the longwinded departmental brief that you have got in front of you, just a yes or no. Did your department notify Cedar Meats?

Ms MIKAKOS: I am able to answer your question however I wish, and that is—

Mr RIORDAN: Well, Minister, I will take that as a no because you cannot answer it, and we will move to the next question.

Ms MIKAKOS: I would be happy to answer.

The CHAIR: Deputy Chair, the Minister is attempting to answer your question.

Mr RIORDAN: She is wasting time.

The CHAIR: At the moment you are the one who is wasting the time by not letting the Minister answer the question. I am sure if you let the Minister answer the question, she will then appropriately pass to the next person who can supplement her answer.

Mr RIORDAN: I have got 30 seconds for her answer. A yes or no does not take longer than 30 seconds.

Minister, next question: why did your department fail to notify the federal Department of Agriculture knowing that visiting health inspectors and many other business-related entities going in and out of Cedar Meats had been put at risk?

Ms MIKAKOS: Okay. So Mr Riordan, I am very happy to answer all of your questions. You just need to have a little bit of patience. So just in relation to Cedar Meats, the point that I am wishing to make is that all appropriate contact tracing began once it was clear that there were cases of coronavirus diagnosed in workers who attended shifts at Cedar Meats, and initial contact tracing at the company focused on getting close contacts quarantined and tested as the first few cases worked in the same area. This was followed by further contact tracing to identify any other visitors or contractors that may have been on site.

So in relation to your specific question, the advice that I have is that initial contact tracing at the company focussed on those most at risk, including employees, and that subsequent contact tracing was undertaken to identify any other visitors, including the meat inspectors. The advice that I have is that the information was provided to DHHS by the company on Monday, 4 May.

Mr RIORDAN: And so it would concern you then that livestock transport companies, for example, were not contacted?

Ms MIKAKOS: The point that I am making, Mr Riordan, is that the department, DHHS, was not aware inspectors had been at the facility until they were notified of that subsequently. So unless the public health team

is advised by a business that there are other visitors on site, then of course they are unable to do the contact tracing and notify those inspectors that there may well be a risk to them. So of course it is important that businesses share that information so that our disease detectives can do all of that work.

Mr RIORDAN: So it was up to the business to let the departmental people know what businesses were entering in and out of the factory, the abattoir?

Ms MIKAKOS: The advice is that the information was provided to DHHS by the company on Monday, 4 May—this is the inspectors. That is how contact tracing works.

Mr RIORDAN: Contact tracing helps also when people know that they have been put at risk. But, Minister, today how many Cedar Meats employees are still waiting to get their results?

Ms MIKAKOS: Well, I will have to seek some further advice in relation to the latest number, but what I can say to you is that—

Mr RIORDAN: Can we just have the advice then? I just want to know how many.

Ms MIKAKOS: Yes, when the number is available. But the advice—

Mr RIORDAN: Is Professor Sutton best to answer that?

Ms MIKAKOS: Well, I am happy to ask him to supplement, but the advice that was given to the company was to act swiftly to get staff tested. A very significant number of staff have already been tested, and I will just have to seek—

Mr RIORDAN: Minister, the question was: how many are outstanding? Professor Sutton?

Ms MIKAKOS: that information and we will see if that is available.

Prof. SUTTON: We will need to follow up that information. As you would be aware, there are hundreds of staff who are currently quarantined. Some of those individuals will remain well and have no requirement for testing. But some, including over the last 24 hours, may have become symptomatic and therefore been prompted for testing, so we would need to see if anyone has been tested over that relevant period who would of course still be waiting on their test result if it has only been taken today.

Mr RIORDAN: So the biggest outbreak in the state has not been given extra priority to get sorted, so there are still employees there that have been waiting 48, 72 hours for results?

Prof. SUTTON: No, what I have said is that some individuals who have been in quarantine, who might have been perfectly well and you do not test well individuals necessarily—

Mr RIORDAN: But I thought we had changed our protocol to test anybody, and particularly people who were at risk. So wouldn't people in Victoria assume that everyone at Cedar Meats has been tested?

Prof. SUTTON: Yes, so they would have been, but there are individuals who have remained well who might have become symptomatic and that should prompt a follow-up test, some of which might have been taken recently and therefore might still be outstanding in terms of a result. But I am very happy to follow up and give you an exact figure.

Mr RIORDAN: Yes. So further to the process and the follow-up, I understand that employees who were working in the boning room with the second case on the 24th waited for a week to be contacted to get tested, and then also had to wait more than a week to get their results. Is that what we would call rapid contact tracing in Victoria? Is that a standard that the Premier told us was a fantastic effort? Would you characterise it as a fantastic effort?

Prof. SUTTON: So the first case that was identified in the boning room did not identify any close contacts, and therefore that would not have prompted—

Mr RIORDAN: No, the second case in the boning—

Prof. SUTTON: Case 2, who was the first case in the boning room, did not identify any close contacts so would not have prompted—

Mr RIORDAN: Excuse me, Professor Sutton. I do not know whether you have been in a boning room. I have got the largest one in Victoria, I think, in my electorate. I am a regular visitor. You cannot be in a boning room by yourself. It is a room with up to 50, 60, 70, 80, 90 people at very close quarters. We know internationally boning rooms and meat processing plants have been problematic. How could anyone for a minute not think that they would need to contact work colleagues of the people in the boning room?

Prof. SUTTON: I did not speak to this specific case myself, but the contact tracers we go through are very rigorous and standard process of interviewing individuals who have been identified as positive—

Mr RIORDAN: Do you think it is prudent that as the person in charge of the contact tracing that you should be asking questions about how people in a packed boning room, you would not naturally assume to check with their fellow co-workers?

Prof. SUTTON: You cannot give information—private medical information—about a confirmed case with a disease that, as we know—

Mr RIORDAN: Well, in a democracy we do not tend to lock everybody up and tell them to stay home and close businesses. These are extraordinary times. I think most people in a workplace, particularly a boning room workplace, would expect to be contacted.

Prof. SUTTON: Just to finish, that individual was spoken to. He identified working separately from others in the boning room on a machine that was separate to his colleagues.

Mr RIORDAN: Professor Sutton, I again say: please visit the boning room. You cannot be in isolation in a boning room, full stop.

The CHAIR: Deputy Chair, I would appreciate if you could let the Chief Health Officer answer your questions before you repeat them.

Mr RIORDAN: Sorry, Chair, but we are getting fobbed off with this bureaucratic rhetoric that the boning room—taking on people at face value. We are told we have virus detectives out there, and the people of Victoria need to know that those virus detectives are not just taking everything on face value. And, quite frankly, on face value a boning room is an obvious spot to test with fellow co-workers.

The CHAIR: Deputy Chair, your time has expired. I will pass to Ms Pauline Richards, MP.

Ms RICHARDS: Thank you, Minister. If you will indulge me, Chair, I would like to ask you to also pass on our appreciation to you all—both Professor Sutton and Ms Peake's team as well—for what must be extraordinary hours and work that is being undertaken.

Minister, I am interested in unpacking how the Chief Health Officer interacts with groups like the Communicable Diseases Network Australia and the AHPPC, the Australian Health Protection Principal Committee. How does that operate?

Ms MIKAKOS: Thank you, and I appreciate you acknowledging the hard work of our various officials here. There have been people who have been working non-stop on keeping Victorians safe since January, and I am very grateful to them for the tremendous work that they have been doing.

In terms of the work of the Chief Health Officer, he is playing a very important role in terms of his participation on a national basis through the AHPPC, informing, advising the Premier prior to those national cabinet meetings, then feeding into the advice to the Crisis Council of Cabinet and providing advice to me and to the Victorian Government. There are a number of standing committees as part of that AHPPC process, including the Communicable Diseases Network Australia, and the Chief Health Officer, Professor Sutton, before referred to that work in terms of the work that it has led to in terms of the modelling and other advice that has been developed. The Communicable Diseases Network Australia provides national public health coordination and leadership and supports best practice for the prevention and control of communicable diseases. So both the CDNA and AHPPC have been playing a very important role in advising various governments during this pandemic.

Ms RICHARDS: Minister, I know there has been some pretty significant investment in surveillance—a $37 million investment, I understand. Could you explain how that supported the Victorian Government's response to COVID-19?

Ms MIKAKOS: Thank you. So we have had very significant support via Government—as you mentioned, $37 million of investments—to increase surveillance to allow for more targeted case identification, contact tracing, isolation advice and confirmation of individuals who are no longer infectious. This is a team that started off with 57 individuals and has now grown to a team of more than 1000 disease detectives. It involves a contact tracing team that includes epidemiologists, public health clinicians, logistics, phone operators and data entry staff, all of whom support the central task of case and contact tracing. They are working 24 hours a day, seven days a week. They are effectively calling people who have been diagnosed with coronavirus to determine where those people have been and who they have been in contact with and ensure all close contacts are found and people receive the advice that they need. They send daily messages to those close contacts as well—the close contacts of the confirmed cases as well as recently returned travellers, and through the Whispir system they are sending messages to Victorians to ensure that they are able to confirm that they are still in quarantine and provide advice on their condition and the status of their test results.

I think that the public health team is doing a tremendous job. It is very difficult work; it is challenging work. There may be some who may seek to second-guess that work, but they are experts in this field, and I note that their work has also received the commendation of the Chief Medical Officer, Professor Brendan Murphy, most recently. And in respect of Cedar Meats he did make some very complimentary comments about the work that the public health team in Victoria have been doing.

Ms RICHARDS: Thank you, Minister. And as recently as yesterday, another significant announcement—a $20 million investment again. Could you explain how that investment will help Victoria manage coronavirus as it eases restrictions—what difference that will make?

Ms MIKAKOS: Thank you. Look, the very important announcement that the Premier and I made yesterday—$20 million to invest in further testing, outbreak squads, prevention and research into coronavirus. We have had a tremendous result in the past two weeks, with more than 160 000 Victorians presenting to be tested as part of our testing blitz. I am very, very grateful for the fact that Victorians did heed the Premier's call to go and get tested, even if they had mild symptoms. We wanted to be armed with those results in terms of making those very important decisions that have had to be considered and were announced both yesterday and today, and that is after seeing about 140 000 of those samples being analysed. I am very grateful for the tremendous work that our pathology labs have also undertaken, processing such a huge volume of swabs to identify about 30 individuals unrelated to any outbreaks or overseas travel. I think that is a very positive result. It says to us that we are heading in the right direction and that we can have, I guess, a greater sense of confidence to go forward in terms of the easing of restrictions that will commence from 11.59 pm tonight.

But it is important to understand that there is still a risk that we will have further outbreaks, and this is why we have put this investment in to enable further testing to continue. We have set ourselves a target of another 50 000 tests this week and 150 000 tests by the end of May, and the results of that further testing will enable us again to be able to consider options and make informed decisions about what might potentially change again in the month of June and beyond. We will need to continue to do testing right throughout the rest of this year and potentially into 2021. We might still be talking about COVID-19 into next year, sadly, and it is incumbent on all of us to do the right thing so we can try and minimise that from being the case. So we will be increasing our surveillance also through greater testing of sewage samples to be able to identify whether we have outbreaks in regional communities in different parts of the state that might not be apparent from people going and getting tested. We have seen people with very mild symptoms as part of this blitz test positive, and that is why it is important that people take this issue very, very seriously.

The resources, the funding, that we announced will also enable an outbreak management unit to be established in the department. New rapid response teams will also be established to prevent, respond to and limit outbreaks. They will essentially be supported by a dedicated whole-of-government joint intelligence unit, involving WorkSafe, the EPA, industry specialists and Safer Care Victoria. These teams will establish local testing, infection prevention and control and outbreak management where and when it is needed. Utmost they are also going to play a preventative role in terms of working with industry, alongside businesses, to make sure they can visit high-risk facilities, businesses and industries and work with local services on things like infection control

and prevention. So these rapid response squads, as well as the continued mobile testing units, will continue to operate into the rest of the year and will play a huge role to prevent outbreaks from occurring in the first place but also to respond to contain them when they do occur.

I note that the Prime Minister himself did acknowledge late last week, in terms of the announcements that he made about the three-stage, three-step process that the national cabinet had agreed to, that it is likely that we will continue to see outbreaks as we ease restrictions. That has been acknowledged by all governments. This is why we put these preconditions in place as part of this funding announcement yesterday to ensure we have got additional capacity there to do more testing, to do more contact tracing and then also to be able to respond to any outbreaks that we see in our community.

Ms RICHARDS: Thank you, Minister. In your earlier evidence you reminded us that the pandemic is not over, and I note the Government has invested $8 million as part of a public health package and another $6 million previously to the Peter Doherty Institute. So of course the other side of this is our investment in research, and I am interested in finding out a little bit more about how that will help us in the response to COVID-19.

Ms MIKAKOS: Look, I am very proud that our state has world-class, world-leading medical researchers and scientists based here who are really leading the efforts in response to this coronavirus. We have had amazing work already through the Peter Doherty Institute being the first lab to effectively be able to do that groundbreaking work on that virus, the first lab outside of China, being able to share that work with other labs around the country and internationally. We made an announcement on 3 March to provide $6 million to the Peter Doherty Institute for it to work together with the Burnet Institute and other experts to fast-track treatments and a potential vaccine. And as part of the announcement that we made yesterday, $8 million of that $20 million package is also for further funding for research in this field as well. So that of the $8 million there will be a further $6 million that will be provided to the Peter Doherty Institute, and this is to enable work around studies and clinical trials on the long-term effects of COVID-19.

I was very interested for us to do this work. I had seen some international reports about potentially long-term impacts on human health as a result of someone having contracted COVID-19. So this will be looking at things like the effects of COVID-19 on someone's major organs, their immunity, antibodies, on vulnerable children and families, on healthcare workers. We need to really look at whether there are long-term health implications for someone who has contracted and then recovered from coronavirus. As I have said at the outset, this is a new virus—we all know that—and there is more that we need to learn about it, and we need to understand what the long-term implications might be for human health as well as our health system. So the funding for that research is going to be critically important in terms of giving us that greater understanding, and we will also be providing, of that $8 million, $1 million to determine best clinical practice for responding to COVID-19.

So there is a great deal of work there that is underway. We all hope of course that our scientists internationally collectively will be able to develop a vaccine, because that would certainly be a game changer for how we respond going into the future, but it is important to understand that a potential vaccine might be some time off. The estimates have been 12 to 18 months away. It is also possible we may never get a vaccine. Novel coronavirus is a type of coronavirus, but we have seen others in the past like SARS and MERS have never had a vaccine developed and they have been around for many, many years or have been around for many years. So it is important that we do not make assumptions about a potential vaccine whilst we certainly keep working towards developing a vaccine.

Ms RICHARDS: Thanks, Minister. Our medical researchers are the pride of our state. We have had some evidence already about testing criteria, so I would just like to pursue that a little bit more please, Minister. Can you explain how our testing criteria have changed over time?

Ms MIKAKOS: Thank you. We have had about 17 changes to the testing criteria over time. Initially the criteria were very targeted, enabling testing only amongst those with clinically compatible symptoms and recent travel history to Wuhan, China. These aligned with the national criteria and advice from the AHPPC. The testing criteria expanded as the global understanding of this novel disease evolved, enabling improved case ascertainment over time.

Some of those key changes that have occurred, for example—as I said, there have been 17 different changes—are: on 1 February the epidemiological criteria changed to include travel to all of mainland China, not just Hubei

province; on 4 February the clinical criteria changed to fever or acute respiratory infection; on 2 March the suspected case definition then included travel within 14 days to any of Hong Kong, Japan, Singapore, Thailand, Indonesia, Iran and South Korea; on 3 March the suspected case definition expanded to include admitted healthcare workers with serious pneumonia or anyone critically ill with pneumonia with no other known cause; on 9 March again the suspected case definition expanded to include any returned travellers from any country outside Australia with a clinically compatible illness; on 15 March the suspected case definition expanded to include healthcare workers with a fever and an acute respiratory infection; and then, on 20 March, patients admitted to hospital with acute respiratory tract infection and fever should be tested. On 14 April I announced another significant expansion so it would include only clinical criteria—that was anyone with fever or acute respiratory infection-type symptoms—and this meant that the requirements to meet the epidemiological criteria, such as recent travel, close contact or working in certain occupations, were no longer necessary. Then on 27 April the Premier and I announced a massive testing blitz to seek to target 100 000 tests over a fortnight, and as you have heard, we exceeded that by over 60 000. The criteria at that point were expanded to include mild symptoms as well, such as chills, sore throat and loss of sense of smell. In addition the testing criteria targeted specific groups of people to be tested even if they were asymptomatic, including Aboriginal people, people with chronic health conditions, people who work on construction sites and in supermarkets and healthcare workers.

So this has been a process of responding to the evolving understanding of this virus over time. The criteria have changed many, many times in accordance with the nationally agreed approach by the AHPPC. We did in fact lead that process on many occasions, and we did end up having the most generous testing criteria in the nation. This has enabled more and more people to be tested, and I am very pleased about that.

People have overwhelmingly embraced the need to be tested in the sheer numbers that we have seen as part of this testing blitz, but we have been as part of this testing blitz targeting specific professional groups. Many people have been safely working from home in recent weeks, but we have had many parts of the economy that kept on going, particularly those people who provide food on our tables or who are part of our manufacturing industry, our construction industry and our health services. Therefore we thought it was appropriate to support them, together with our emergency services workers, by enabling them to get tested as a priority. So the testing blitz enabled many of those groups to be able to access testing, including, as I recall, I think it was 37 000 healthcare workers and aged-care workers as well, as part of that testing blitz. So that has given us a degree of confidence that we have not got widespread spread of the virus in healthcare services.

We have had, I think I recall, two people test positive as part of the 37 000 healthcare workers that got tested during the testing blitz. Many construction workers got tested and people in other sectors as well. There were health service staff attending the police academy able to test police officers across our state as well as other emergency services workers. So it is a tremendous effort, and I want to thank everyone who was involved with that blitz. It has really enabled us to develop those options and to consider all of those decisions that have been made and those announcements that have been made yesterday and today.

Ms RICHARDS: I have only got 10 seconds left, so I will again thank everyone for the extraordinary work. It has been a really extraordinary effort to get that number of tests done. Thank you very much for the contribution and your evidence.

Mr LIMBRICK: Thank you to the Minister and her staff for appearing today and the presentation earlier. Although I always enjoy asking the Minister questions in the chamber, today I would like to direct my questions to the Chief Health Officer, if that is okay. I would like to start with looking at the emergency declaration and the restrictions placed on Victorians through that declaration. I got asked a question last night, and I will start with a really simple question because I could not answer it. The last emergency declaration ended at midnight last night, is my understanding. Is that correct? And then the new one takes effect at midnight tonight, so what are we covered by today?

Ms PEAKE: I can certainly help you with that. So there are actually two sets of directions that were signed by the Deputy CHO last night and released. It was a set of directions that are operative until 11.59 tonight, which continue the existing stay-at-home and restricted activity directions, and then there was a set of directions that gave people notice about what comes into effect from 11.59 tonight.

Mr LIMBRICK: So it was extended by one day last night. Right; okay. I understand.

Ms MIKAKOS: So, Mr Limbrick, they were rolled over to enable many organisations to prepare. We did not want to just give people no notice whatsoever, so the same ones rolled over till 11.59 pm tonight, and then the new ones will kick in tomorrow.

Mr LIMBRICK: Okay, understood. It is my understanding that under these directions restrictions on the liberties of Victorians need to be reasonably necessary to prevent disease transmission, and many of the restrictions to the average person would appear to be sensible restrictions. But then there are other restrictions, such as the ones that have been in the media—things like playing golf and fishing and hunting and these sorts of restrictions—that many people, if they were doing it by themselves, do not really understand how they can reasonably prevent disease transmission. So, Professor Sutton, what sort of scientific evidence is used to come up with these restrictions on these things, that to many people may not make a lot of sense?

Prof. SUTTON: Thank you, Mr Limbrick. Essentially the drive with the restrictions is to try and reduce the likelihood of transmission from one infected individual to others and to bring that number of 2.5 down to below 1. For one particular activity there is no mechanism to model. We do not know the likelihood of transmission in a particular activity, even a particular high-risk activity. What we do understand is that there is a cumulative risk by virtue of all of those activities carrying on as usual, and that we need to try and reduce that effective reproduction number down below 1 by bundling a number of restrictions together in order to give us an assurance that for any one infected individual their likelihood of passing it on to even one other person is lower. The narrative and the restrictions were focused and continue to be focused on essential reasons for leaving home, and so the stay-at-home directions really did bundle in a number of essential reasons to leave home that related to work and education as necessary, care and compassion, emergency requirements, and food, but that other non-essential activities should be constrained until we can see the effects of what the restrictions bring into place.

They are impossible to model individually, but we know that we were having a doubling every three to four days in the early part of March and into late March. In effect it is the empirical evidence, the evidence that is shown by our gradually decreasing numbers from late March/early April to now, that is proof positive that those restrictions have done the right thing. We have got another period where we can look at empirical evidence in releasing those restrictions gradually and cautiously and with the precautionary principle in mind to see that we are still reducing the likelihood of passing the virus on to below one person for every infected individual. The precautionary principle is important; it is part of the *Public Health and Wellbeing Act*. I am bound to consider it in decision-making, and it states that:

> If a public health risk poses a serious threat, lack of full scientific certainty should not be used as a reason for postponing measures to prevent or control the public health risk.

So I have borne that in mind, and obviously the principle of the primacy of prevention:

> The prevention of disease, illness, injury, disability or premature death is preferable to remedial measures.

So although the bundle of restrictions might be seen as very significant, the consequences of having this pandemic get away from us are really so grave that on the ledger the restrictions are really seen as proportionate to the potentially catastrophic risk.

I did need to consider the Charter of Human Rights and Responsibilities in making those directions as well, and that means that all of those liberties and really important human rights, including freedom of association and freedom of movement, were considered and that the restrictions were proportionate to that very substantial risk.

Mr LIMBRICK: Thank you, Professor Sutton, for your answer. If it is not possible to determine scientifically through modelling which particular activities do and do not present certain risks, how do you make the decision between which activities should be prohibited and which should not? Because the example given to me was surfing was okay and fishing was not. To most people they would seem to be fairly similar risk profiles. How can you make that decision that surfing is okay and fishing, for example, is not?

Prof. SUTTON: In a sense these are not easy decisions to make. There is some arbitrariness; that is why you will see an enormous variety across jurisdictions in Australia. The Northern Territory restricted golf, Tasmania restricted golf to two persons per hole, other states and territories have made different choices. But the effective focus that I had was: what is essential for people's physical and mental wellbeing? What are the really key elements—those essential things that people might leave home for or need to leave home for? And what are some non-essential things that for a period of time—and this will change over the coming weeks or days—can be

considered non-essential? So golf, in my view, some other activities were really recreational and did not provide exercise. There were other alternatives for people's physical health—walking, running, cycling—that were available to them. And most water-based activities are clearly exercise; you get your heart rate up in doing them—surfing, paddleboarding and the like. But for some there is a grey area between recreation and sporting activity. We took a view that there were a number of exercise activities that were clearly available to people and that some of those more discretionary activities—hunting, fishing and the like—were not exercise and could be deferred for a time, not cease forever, obviously deferred for a time because they were non-essential.

Mr LIMBRICK: Thank you, Professor Sutton, for your answer. That does clarify it. With regard to the bundling of some of these restrictions, I note that in the Federal Government's staged plan—presumably we will be having something based on that—one of the things that was bundled was brothels. In fact the majority of sex workers in Victoria do not work in brothels and the activities might have differing risk profiles. Will consideration and clarification be given to that community once we reach these different levels of easing?

Prof. SUTTON: Yes. As for all specific industries, all specific settings, we need to give consideration to them over time, and part of the principle of the directions in Victoria was that of collaboration—another one of the key principles in the Public Health and Wellbeing Act. So we really have taken guidance from national cabinet decision-making and tried to effect that as much as possible. At times we have been more precautionary, perhaps, than some other jurisdictions, but we really have tried to reflect the national cabinet decision-making in doing as they recommended for state and territory legislation.

Mr LIMBRICK: Onto another issue: have there been any cases of community transmission within supermarkets that you are aware of?

Prof. SUTTON: Not that I am aware of. I think it is one of those really difficult circumstances to again definitively answer. People will report their close contacts. If we can identify an individual is positive, we know where that transmission has occurred, and so often we find that the obvious close contacts are their friends and family, those who share their household. If they have picked it up and we cannot identify a close contact, all we can presume is that they picked it up somewhere outside of their home or workplace or other areas of prolonged close contact. That might be a supermarket, but equally it might have been on a surface that they have touched on public transport or someone they have passed in the street who happened to be particularly infectious or coughed and sneezed at the wrong time. So it is very difficult to say it has definitely been picked up in the supermarket.

Mr LIMBRICK: Thank you, Professor Sutton. One specific issue around a transmission vector that I have made a request to the health minister to seek advice on is on the issue of re-usable bags at supermarkets. I actually contacted Dr Ryan Sinclair from Loma Linda University in California. He has done research into this issue and has actually written an op-ed on the issue urging jurisdictions to temporarily prohibit them, and in fact many US jurisdictions have been following that advice. What consideration was given to this particular disease transmission vector in Victoria?

Prof. SUTTON: Thank you. I should offer you a correction. I am aware now of one transmission at Coles Brandon Park, but the details I will need to look into for you. I suspect it was a workplace transmission and there was a known close contact through working, rather than a surface, that you might have been alluding to.

The issue of plastic bags really is for the committee that now reports into AHPPC and to national cabinet, which is an infection control expert group. They have considered evidence around infection prevention and control, and I think the issue you raise is one for them to provide AHPPC with expert advice in relation to it. I would note that no surface really presents a risk to an individual if we can maintain really significant hand hygiene and if we can overcome the habit of touching our faces, as you are doing, as most of us do every 3 minutes—20 times an hour. We need to recognise that surfaces then contaminate us and potentially transmit when we touch our noses, touch our mouths, and it is not a packaging or a particular environmental surface in and of itself that will necessarily pose a risk. But it is clear that the virus can survive on all surfaces for a period of time—stainless steel in a cold, low-humidity environment for a number of days but other surfaces for a much shorter period of time. It is unclear whether they can sustain, even if virus is detectable, a high enough level of virus for it to be a risk of causing disease or a transmission risk. But it is an important question that you raise, and it is one for the national infection control expert group.

Mr LIMBRICK: Thank you, Professor Sutton, for your answer. Onto a different topic: in my previous career I have been involved in management groups that have done pandemic simulations. When was the last planned pandemic simulation in Victoria, and when was it actually conducted?

Prof. SUTTON: There have been several over the last 12 months. I cannot tell you when the most recent one was, but I have been involved in a number, including at the State Control Centre with Emergency Management Victoria last year. There was another one at Melbourne City Council, and we have done some over the last couple of years in collaboration with the Office of the Chief Veterinary Officer and the Department of Environment, Land, Water and Planning around a potential disease that is transmitted from animal-to-animal initially and then jumps into human pandemic potential, so there have been several just in the last 12 months.

Ms MIKAKOS: Mr Limbrick, I think the Secretary might also been able to add some more information for you.

Ms PEAKE: Thank you. I was just going to add that, in addition to Professor Sutton's reference to the State Control Centre, as a departmental executive we run regular exercises as well and we did run an exercise certainly in the last quarter of last year.

Mr LIMBRICK: Thank you very much for that clarification.

Professor Sutton, another issue I would like to move to is around the COVIDSafe application that is being used for contact tracing. It has been put to me by several IT experts that the application on certain devices such as iPhones will not actually work unless it is in the foreground and running, so if it is in the background or the phone is locked, it will not actually work correctly. And the measurement of the number of people that actually have access to it, the Federal Government has been talking about the number of downloads. It is my understanding this is not a good metric for measuring whether an application is being used; it should be something like the daily active users. How will you be able to determine whether this application will be able to provide good data for contact tracing?

Prof. SUTTON: It is a good question. What I do know is that our contact tracers, our army of disease detectives, will continue to form the backbone of follow-up of close contacts and determining where people might have acquired their infection. But I have downloaded the app, the Minister has downloaded the app, the Premier has downloaded the app, and the proof will really be when we get data that we have not been able to identify through case interviews.

In a case interview we would ask all individuals during their relevant periods, so when they are infectious and 48 hours prior to developing symptoms, everyone that they have had more than 15 minutes of face-to-face contact with or more than 2 hours in one room. The app will be able to provide additional information for those circumstances where someone might have forgotten an individual where they have spent more than 15 minutes and obviously in those circumstances where they might be sitting in close proximity on public transport or in a queue where they might have been within 1.5 metres. We will see those circumstances where the app data provides us information that we had not already picked up through our contact tracing procedures over the phone in the traditional way.

It is very hard to predict how often that will occur. If there are 5 million downloads to date and the majority of those are active users, then something like 20 per cent of all individuals might have that Bluetooth enabled but that only means that a few per cent of total interactions between individuals will have that Bluetooth handshake. Nonetheless, if that provides an additional measure of close contacts that we would not otherwise have picked up through traditional contact tracing, then that has got to be seen as a useful, positive contribution.

Mr LIMBRICK: I believe we are out of time, so thank you very much, Professor Sutton.

The CHAIR: Thank you, Mr Limbrick. That does conclude your time. We will break now for lunch and we will resume at 1.20.

Mr RICHARDSON: Thank you, Minister, thank you, Chief Health Officer and department Secretary. I just want to take you, Minister, to questioning about the flattening of the curve. We spoke to the Premier this morning briefly about flattening the curve, and a lot of Victorians have this on the tip of their tongue now. While the latest data is encouraging and indicates that Victoria is doing well to flatten the curve, it clearly is a fragile situation.

When we look to examples like Singapore, which was seen as an exemplar, and other nations as well, we have to be vigilant. So given how fragile this situation is, are you able to outline how the Government is increasing the number of ICU and inpatient beds across our health system to protect Victorian lives?

Ms MIKAKOS: Thank you very much for that question. It is important that you have singled out countries like Singapore—a nation that is regarded really as an exemplary nation in terms of its approach to pandemics. They certainly were significantly impacted by the SARS pandemic many years ago. Coincidentally Professor Sutton and I had the opportunity to go and visit them in December, before this pandemic broke—well, at least we became aware in Australia of this pandemic earlier this year—and to have a look at the massive investment and the things that they have done to respond to these issues. They went early and they put restrictions in, but they eased off, and then they have had a huge spike in numbers in recent weeks. I think that just says to us that we need to be very cautious about how we go forward, that we cannot assume that we will not have a potential growth in numbers in the future. We certainly are doing extremely well in terms of flattening the curve and having a very small number of Victorians in hospital at the moment. That is something that we should be all pleased about, but it is no time for complacency.

This means that our hospital preparedness work continues. We are continuing to prepare for what is an incredibly fragile situation to make sure that our health system is as well-prepared as it possibly can be, and that is because when you are rolling out 4000 ICU beds and you are sourcing so much medical equipment and PPE and all the things that you need, these are not things that you can just do overnight at the flick of a switch; they do take a lot of lead-in time, particularly as it impacts on people's elective surgery and other activities in our health system.

As part of our response we have invested $1.9 billion into our health system to deliver more beds, ICU equipment, staff training, as well as PPE for our dedicated healthcare workers. One point three billion in funding was invested to establish an extra 4000 ICU beds across the public and private systems to respond to the pandemic and to protect lives. We are underway in rolling out that plan with our hospitals across certain areas, including activating uncommissioned capacity, purchasing private capacity, reconfiguring and optimising our public hospitals, recommissioning former closed sites and accelerating new projects in our capital program.

Together, the public and private hospital system in Victoria already has about 20 000 or more physical beds, including approximately 500 intensive care beds, but we know that they will not be nearly enough if the spread of the coronavirus gets out of control. So the Government has recently commissioned an additional 700 beds in public hospitals to be delivered by the middle of this year, and this comprises more than half ICU beds and the other half are critical care-enabled beds. They can be converted as we need them, although they will be used for other care until then.

Since 15 March more than 300 new beds have already been completed and are ready to treat patients. Another 500, or more than 500, ICU and critical care beds are currently being modified across multiple health services, and these will be delivered by the middle of this year. Then a further 1300 bed spaces will be converted into critical care spaces in operating theatres, recovery and other ward and emergency department spaces to treat COVID-19 patients as demand increases, and then a further 2000 beds are part of the plan and involve large scale ups of ICUs at major public and private hospitals through the deployment of modular buildings in hospital car parks and provision of ventilators and other equipment that we have ordered.

The planning and the investigations that are being conducted by my department to roll out this additional capacity across both metropolitan and regional sites to treat COVID-19 patients as demand increases, that work continues. The plan seeks to achieve over 4000 additional critical care beds and is made possible by accelerating our capital delivery program and undertaking a range of building modification works to change mechanical ventilation systems, create negative pressure zones, install medical, gas and electrical outlets as well as installing equipment to provide the high level of care needed for patients with COVID-19.

Whilst we are doing this huge amount of work to order this equipment and roll out these additional beds, we certainly hope that we never need them. I do not think I have any issues with people perhaps at some point in time saying that Victoria overprepared. We are better off being overprepared than underprepared, and I think it is important that we continue with this important work and make sure we have got all the contingencies that we may need built into the system. As I said, these beds cannot be turned on overnight, so we continue to do this work, understanding of course that ICU beds and turning a bed into an ICU bed has many important components

to it—from the workforce, the medical equipment, the PPE and everything that goes with it—and it takes a great deal of planning and thought.

Mr RICHARDSON: Thank you, Minister, and we have seen across Victoria that this pandemic touches each and every corner of our state, and locally people are jumping online to see how the virus is tracking in their communities, whether it is their municipalities, like the City of Kingston in my area as well. So in that context and the community nature and metropolitan nature of this pandemic as well, can you outline what metropolitan projects and additional projects the Government is investing in to get Victorians prepared for this?

Ms MIKAKOS: Potentially this pandemic could impact on so many different parts of the state. So that work, as I said, is continuing. In metropolitan areas, for example, we are recommissioning 84 beds at the former Peter Mac site, where construction works are in full swing at the moment. Work there is re-establishing air conditioning, power, plumbing and medical gases, facilitating access for patients, staff and visitors, and other minor building works. St Vincent's will operate the facility if it is required, and the current completion date we are expecting is by the end of this month.

In terms of Alfred Health, Austin Health and Monash Health, they are undertaking a range of building modification works at the moment to change mechanical ventilation systems, create negative pressure zones and install medical gas and electrical outlets as well as installing the equipment to create an additional 300 ICU beds. There is a further 500 or more ICU and critical care beds that are currently being modified across multiple health services, including the Royal Melbourne, Western Health, Cabrini, Mercy and many, many other sites, including your health service, Mr Richardson—Peninsula Health—I am sure you will be pleased to know, and they will be delivered by the middle of this year.

In terms of Monash Medical Centre in Clayton, the work there has involved installation of a two-storey demountable unit adjacent to the existing emergency department to provide an extra six resuscitation cubicles, and that work has now been completed. These fully equipped cubicles allow patients to be ventilated and, if needed, prepared for transfer to the ICU.

The Government has also announced $30 million to fast-track the commissioning of 140 beds at the new Casey Hospital tower. This comprises 128 inpatient beds and 12 ICU beds. This is the first time that that community near Casey Hospital are getting access to ICU beds in their own community, and I can advise the committee that patients have already moved into the tower and those ICU beds are expected to open very, very soon. There has also been of course the $135 million Casey Hospital expansion. That has included 160 additional beds and will enable the Casey Hospital to treat an extra 25 800 patients a year.

So that is a very significant addition to our capacity right across our metropolitan health services. I have only touched upon some. That work is continuing, but the important thing to note, as I have already outlined in some of those details, is some of those beds will be ready and available to us—building up that capacity in the system—by the middle of this year.

Mr RICHARDSON: I know, Minister, we have seen a number of cases in metropolitan municipalities, but our regional communities are not immune from the effects of the coronavirus pandemic. Can you update the committee on how that investment in regional communities and the preparedness is going as well?

Ms MIKAKOS: Thank you for that further question. We are making sure that regional Victoria is also benefiting from this $1.9 billion investment to increase ICU and inpatient capacity in our hospitals. So, for example, Baxter House, which is the former Geelong Private Hospital, has been recommissioned to keep regional Victorians safe with consulting rooms and virus clinic capacity at Barwon Health. Construction works have been completed on levels 2, 4 and 5 of the facility, creating more than 50 clinic consulting rooms and beds. A new acute respiratory assessment clinic is now open seven days a week for mild to moderately unwell patients. Works are now underway on level 3 of Baxter House to recommission additional recovery spaces that can be utilised for COVID patients as well as theatres for surgery for COVID patients and more ICU or ventilated beds if required.

Bendigo Health has received funding for an additional 45 beds effectively in response to the pandemic. These beds are now online and ready to accept patients if demand in central Victoria increases. The new hospital also has built-in capacity for 20 additional intensive care beds if they are required in emergency situations.

In a further boost for regional Victoria, Shepparton hospital has taken advantage of their new $229.3 million expansion project, with works underway to turn their new ED into a temporary ICU. Construction of the new inpatient tower has been accelerated to make more beds available as demand increases, and it is now complete. The new tower features 64 inpatient beds, 10 intensive care beds, eight operating theatres and a new kitchen, and it is expected that these beds will come online later this month.

My department is also working closely with health services, including those in regional areas, to deliver further intensive care beds, including additional capacity at Geelong, Warrnambool, Ballarat, Horsham, Mildura, Bendigo, Shepparton, Albury, Sale and Traralgon. This will allow for regional self-sufficiency, even with significant numbers of COVID-19 patients requiring ICU-level care. In addition, Alfred Health are expanding their capacity and will be able to provide telehealth support to any rural or regional ICU if required during the pandemic.

Mr RICHARDSON: Minister, just going to the workforce and training and support that is required and that underpins such an expansion—and obviously on International Nurses Day we give great thanks for the work that our health workers do, and particularly our nurses—how have those additional beds and additional staffing and equipment been rolled out, and can you outline what steps have been taken to ensure that our clinical staff have that support and the appropriate skills that they need?

Ms MIKAKOS: Thank you, and I want to take this opportunity to thank all of our dedicated healthcare workers, who have been doing a tremendous job. But I want to thank everyone working in our health services—from the doctors and nurses right through to the administrative staff, the cleaners and the cooks. You know, everybody that works in our health services always does an amazing job, particularly at this challenging time. I know when many of us have had, I guess, the ability to work from home, to keep ourselves safe, to have all those measures in place, these people have been willingly going to work every day, understanding that they and their loved ones may potentially be at risk because of how contagious this virus is. So I want to acknowledge them and also join you in acknowledging our amazing nurses. Today being International Nurses Day, we acknowledge them and we thank them for their care and their compassion that they give to their patients each and every day.

The workforce component has been a critical part of all of our hospital preparedness, making sure we have got the workforce there if we need to operationalise these extra ICU beds. So strategies have been developed to maximise the capacity of the existing workforce, including assessing the available workforce skill sets and planning how all clinical staff can be facilitated to work at the top of their scope of practice. Special training programs have been developed and launched to upskill clinical workforces to provide intensive care, initially focusing on those with similar transferable skills.

Plans are already underway to draw on around 1000 anaesthetists from the public and private sectors to harness their skills for critical care management. Nurses who already worked in surgical or perioperative settings can also be upskilled to work in intensive care settings. Medical staff who normally specialise in areas that may be less critical in a pandemic, such as orthopaedic surgeons, could also be redeployed to assist in other areas which require medical management, such as wound care and triage.

There is also a great deal of training that is occurring within health services around the correct use of PPE in order to keep our staff safe as well as the personal protective equipment task force that has been formed to ensure that supplies of PPE are available and distributed to staff who need them. Strategies have also been developed to bolster the supply of a skilled workforce. A workforce of intensive care specialists has been rolled out to not only meet the demands of the additional ICU beds that will be needed but also manage sick leave and self-isolation requirements for the existing critical care workforce. So this is why on 29 March we launched the Working for Victoria health portal, a new website calling on skilled healthcare workers to register their interest in joining the Victorian response to the coronavirus. Doctors, nurses, midwives, paramedics, allied health professionals, patient services assistants and students have been able to register through the web portal to work within the Victorian health system in response to the coronavirus. I am amazed and so grateful for the fact that we have had more than 14 600 expressions of interest to date, many of those from students of all professions, and I want to acknowledge these individuals and thank them. Whilst the immediate need is not apparent at this point in time, they remain ready and willing to assist their fellow Victorians should that be required.

Each ICU bed requires up to approximately $400 000 in equipment and consumables, from the frame and the mattress to the drips, the monitor and the all-important ventilator. Our investment as well is also securing the ICU

equipment such as dialysis machines, blood gas machines, patient monitors, ICU beds and mattresses, IV infusion pumps and ventilators as well as the staff and the physical space we need to meet potentially a surge in case load at the peak of the pandemic. So it is important to acknowledge that you cannot just flick a switch and turn an acute bed—

The CHAIR: Thank you, Minister. The Member's time has expired.

Mr D O'BRIEN: Minister, just very quickly following on from Mr Richardson's question: how many ICU beds do we currently have available in Victoria? I think the Premier said this morning 440. I am just checking whether that is right now, and then I note you said 350 additional by the middle of the year. Just as we speak would be useful. I think you just said it.

Ms MIKAKOS: The advice that I have is at this point in time we have 515 beds available.

Mr D O'BRIEN: Thank you very much.

Ms MIKAKOS: I have just been outlining to you the other tranches and how these have been rolled out and how we anticipate to have more of those beds available by the middle of this year.

Mr D O'BRIEN: Yes. Thank you. Professor Sutton, could I just ask a couple of questions to you back on Cedar Meats. With respect to the 2 April case there, did the Government ever confirm whether or not that person had actually been present on site in the previous four weeks?

Prof. SUTTON: We did. We confirmed flights with that individual, who was absolutely clear that he had not spent any time either as an infectious person or in a relevant period for potentially acquiring it.

Mr D O'BRIEN: What about with Cedar Meats themselves? Did you ask them to confirm?

Prof. SUTTON: No, the *Health Records Act* clearly places a very strong obligation on us not to share private medical information with anyone else other than for a [inaudible] in terms of a secondary purpose, so for the purposes of the contract tracing, if that information has not been made available to us. But by all accounts we had no information from that individual that would require us to contact his workplace.

Mr D O'BRIEN: The Premier spoke this morning in response to a Government question about returning travellers from overseas being forced into mandatory quarantine, and I am paraphrasing, but he effectively said they cannot be trusted, that is why we had to go to a mandatory. So how is it that those people cannot be trusted yet we just take someone's word for it when they are a confirmed case?

Prof. SUTTON: We have taken the advice of national cabinet on the issue of mandatory quarantine. It was obviously a recommendation of Australian Health Protection Principal Committee to national cabinet that it was an important consideration. I would not say that those individuals cannot quarantine necessarily outside of hotels, but the numbers were so significant and the need to address the importation of cases, which was really driving the doubling every three or four days of cases in Australia, was so great that national cabinet made the right decision in advising all states and territories to implement it, and the Prime Minister brought it in in a very short period of time because of that—a really exponential increase in cases outside Australia.

The issue of hotel quarantine is that we can oversight all of those individuals very closely. We do trust individuals, but there is certainly a risk of other family members sometimes visiting them at home, so it is not even the individual who might not abide by quarantine but others who would not protect themselves because that individual is home.

Mr D O'BRIEN: I appreciate the privacy issues, but this is a global pandemic and the spread is a particular issue.

Ms MIKAKOS: It is set out in legislation is the key point.

Mr D O'BRIEN: Well, there is a lot set out in legislation that the state of emergency has overridden, Minister, with respect. But Professor Sutton, can I ask then—

Ms MIKAKOS: Essentially you are saying that the public health team should breach the *Health Records Act*.

Mr D O'BRIEN: I am seeking to have the assurance, Minister, that the Government has done everything in its power to ensure that this did not expand, this particular outbreak. So my next question, I guess, Professor Sutton is: is it your view that the 2 April case was completely unrelated to the later cases at Cedar Meats on 24 April and onwards?

Prof. SUTTON: No. I am agnostic to the relationship with the 2 April case. What I do understand is that that individual provided information that meant that there were no close contacts to follow up in the workplace and that there was no suspicion that that individual had acquired it at the workplace. But in terms of the hypothesis of how that case might be related to later cases in the cluster, I am meant to be agnostic. We need to be open-minded about the networks of friends or family or more broadly in the community that might have meant that that individual is related to someone who also, through some chain of transmission that we have not identified, relates to other workers who later introduced it into the facility, so we will consider that, and that is a possibility.

Mr D O'BRIEN: Moving on then to the second case, 24 April. As we heard earlier, the department did not notify Cedar Meats until 27 April. Are you satisfied that that three-day delay was appropriate?

Ms MIKAKOS: Sorry, we did not establish that. You are making that assertion. There is—

Mr D O'BRIEN: Well, can you tell us when it was then?

Ms MIKAKOS: We have gone through time lines many times before, and I was actually trying to explain some of that earlier but was not given the opportunity by Mr Riordan.

Mr D O'BRIEN: A simple question then, Minister: when was Cedar Meats advised that there was a case at their facility?

Ms MIKAKOS: There was a case that was identified on 24 April. Once the diagnosis was confirmed, they then provided the department with advice about the nominated employer—that was Labour Solutions Australia, which I understand is a labour hire firm—and that company then informed Cedar Meats on that same day.

Mr D O'BRIEN: On the 24th?

Ms MIKAKOS: They were informed on the 24th about that specific case, and as Professor Sutton explained earlier, he was talking about the fact that that individual did not have any close contact with others in the workplace. That is what was identified through questioning of that individual. There was then a subsequent case identified on 26 April after an employee attended Sunshine Hospital with a workplace injury. That was on a Sunday, as I recall. The facility was closed because it was the Anzac Day weekend, so the department contacted Cedar Meats the next morning, on Monday, 27 April, to commence that investigation about a potential cluster because they then made the connection of two workers on the 24th and the 26th being individuals both working at the meatworks.

Mr D O'BRIEN: Minister and Professor Sutton, is there a gap in the system then if the department notified the employer but the employer was not actually the site of where the worker actually worked?

Prof. SUTTON: If we had been informed of the site where the worker had worked by that employee, we would have followed up directly with that site.

Mr D O'BRIEN: Surely he said, 'I work at Cedar Meats, the abattoir in Brooklyn'.

Prof. SUTTON: He gave the name of the labour hire firm as his employer and did not declare that he worked at Cedar Meats.

Mr D O'BRIEN: But wouldn't the first question be, 'Okay, it is a labour hire firm, where do you actually work'?

Prof. SUTTON: No. We were given the name of his employer, that we followed up with.

Mr D O'BRIEN: Minister, can I move on? Did the Australian Chief Medical Officer, Brendan Murphy, write to the Victorian Government seeking exemptions to restrictions on self-isolation for people suffering from mental health issues and those particularly with suicidal tendencies, and did you reject that request for exemptions?

Ms MIKAKOS: I will refer this question to the Secretary.

Ms PEAKE: Mr O'Brien, are you talking about people who are coming from overseas into the hotel quarantine?

Mr D O'BRIEN: No, no, I am talking about anyone who had particular mental health issues for whom any aspects of the lockdown would have caused particularly difficult problems for them and indeed exacerbated their mental health issues, so the fact that they could not go out or they could not go and visit someone—

Ms MIKAKOS: Just so we are clear. We are talking about hotel quarantine at this point.

Mr D O'BRIEN: No, I am not talking about that. Minister, I did not ask about hotel quarantine. I am asking: did you receive a direct request from the Australian Chief Medical Officer to allow exemptions for individuals with mental health problems to the very strict lockdown requirements, broadly speaking?

Ms MIKAKOS: But the only individuals who are required to quarantine in a hotel—

Mr D O'BRIEN: Minister, I did not mention quarantine. I am not asking about quarantine. I am talking about the broad series of lockdowns.

Ms MIKAKOS: I am trying to understand your question, and the individuals who are in mandatory hotel quarantine under a legal directive are in fact people returning from overseas travel. That is on the basis of a national cabinet decision.

Mr D O'BRIEN: Minister, I did not mention hotel quarantine. I am not sure why you are talking about hotel quarantine. I am asking about a specific request from the Chief Medical Officer, Brendan Murphy.

Ms PEAKE: Mr O'Brien, the stay-at-home directions—is that what you are referring to in terms of people who have been asked to stay at home except for particular reasons?

Mr D O'BRIEN: Well, yes. Not exclusively that, but all the restrictions that were imposed under the state of emergency.

Ms PEAKE: There are three reasons why people have been asked to stay at home. The first we have been talking about.

Mr D O'BRIEN: With respect, Secretary, I do not need to have the reasons listed to me. I am asking—

Ms MIKAKOS: It is important to understand your question.

The CHAIR: Mr O'Brien, I think the Secretary is trying to answer your question. If you will give her a moment.

Mr D O'BRIEN: With respect, Chair, I will ask the questions. You do not tell them how to answer them, you do not tell us how to ask them. I am just asking a very—

The CHAIR: Mr O'Brien, as the Chair I have the call, and what I am saying is that the Secretary is attempting to answer your question. If you stop repeating yourself, then she will be able to answer it.

Mr D O'BRIEN: I do not need the reasons why people can leave the house read out to me again to take up more time.

Ms PEAKE: Mr O'Brien, I am just trying to show the link. So there were three bases upon which we provided that advice to the community. The first is the returned travellers, which followed from advice from the AHPPC to national cabinet, which translated it into a legal direction. The second was for people who are confirmed cases or are close contacts of confirmed cases, and again that flowed from the advice of the AHPPC that Mr Murphy chairs. The third is the stay-at-home directions where there are limited, as you are aware, reasons for leaving home, which flowed from the advice from the Australian Health Protection Principal Committee through to national cabinet through to our directions and advice.

In each of those cases Professor Murphy chaired the committee that made the recommendations that led to the either legal restrictions or advice that we provided to the community. The reason I was asking which category you are talking about is because in relation to people who have mental health needs the legal requirements to stay at home were the subject of those recommendations from the Australian Health Protection Principal Committee. I am happy to go and have a look at whether there was a particular case where—

Mr D O'BRIEN: No, no. I just want a simple response.

Ms PEAKE: But in general the basis upon which all of our actions have been taken has been on the basis of the advice of the committee that Mr Murphy chairs.

Mr D O'BRIEN: I still have not got an answer to my question, Chair. This is why I am getting frustrated. I just want to know: did Professor Murphy write to the Victorian Government and ask that there be exemptions for people with mental health issues given that some of the restrictions would potentially exacerbate those mental health issues?

Ms PEAKE: As I was endeavouring to step out—

Mr D O'BRIEN: You have given me the background and the history—

Ms PEAKE: certainly not in relation to people who are confirmed cases, close contacts of confirmed cases or returned travellers. I am happy to go away and have a look if there was a request about an individual, but all of those requirements were on the basis of the advice from the committee that Professor Murphy chairs [inaudible] people with mental health conditions.

Mr D O'BRIEN: Minister, let me try and be really simple. Did the Federal CMO ask the Victorian Government to allow a little bit of compassion and leniency for people with mental health issues, and did you reject that request?

Ms MIKAKOS: I think the Secretary has just given you a very expansive answer.

Mr D O'BRIEN: Well, very expansive but did not actually answer the question. I am just asking: did you get a letter from Professor Murphy?

Ms MIKAKOS: The Secretary has just indicated to you that we are not aware of any request unless it related to a particular individual, and she is prepared to go and have a look further to see if there was one in relation to a specific individual.

Mr D O'BRIEN: Okay. Can I just go to the issue of PPE now. Secretary, it is well known that we had a shortage—there is a global shortage—of PPE. On what date did the department first place a bulk order for PPE to begin rectifying the shortage?

Ms PEAKE: I might actually get Mr Symonds to just step you through that, Mr O'Brien.

Mr SYMONDS: Hi, Mr O'Brien. Hi, Chair. Hi, Committee. Terry Symonds, Deputy Secretary of the department. We have ordered across all of the lines of PPE required for COVID. There are substantial orders outstanding, but there are more than 100 000 items in the warehouse currently for each of those lines of essential PPE. We have been placing bulk orders since the first awareness we had of the COVID pandemic and the likely impact it would have upon the system, and we have been placing orders.

Mr D O'BRIEN: Can I ask when that would have been, Mr Symonds? Do you know?

Mr SYMONDS: I will take that on notice and try and find out for you the exact date if that is the question.

Mr D O'BRIEN: Okay. Have there been distribution difficulties with PPE to hospitals, clinics and the like around the state?

Mr SYMONDS: We have established a statewide supply chain for PPE. The previous system, as you might know, was that each hospital was responsible for ordering their own PPE. We made a judgement early on that

we would not allow a situation in which health services might compete against one another and stockpile PPE at the expense of other health services—

Ms MIKAKOS: Or outbid each other.

Mr SYMONDS: or outbid each other and drive prices. We have consolidated supply chains to get to a point now where we have adequate supply of PPE across the state at a statewide level. I acknowledge that we have not been able at short notice to create a just-in-time distribution system that ensures that every unit and every hospital has the PPE that they want or need at a particular point in time, but we have adequate PPE across the system in total. We have a system for online ordering and same-day emergency orders to be filled, and I am aware that those orders go on all the time to make sure that hospitals get the stock they need to do their jobs.

Mr D O'BRIEN: Okay. Thank you, Mr Symonds. Perhaps take this on notice, but the Minister in her press release earlier committed funding to purchase 926 million gloves, 118.6 million masks, and you said I think we have got 100 000 things delivered now. Can I just get an update on that media release announcement—how much has actually been delivered and when the rest is expected to be delivered? I can take that on notice please, Mr Symonds.

Mr SYMONDS: I could answer that question for you now, Mr O'Brien.

Mr D O'BRIEN: Oh, fantastic; great.

Mr SYMONDS: We have 15 387 000 gloves in our warehouse currently. We have 930 000 face shields. We have 113 524 pieces of eyewear. We have 153 250 gowns. We have 13 039 900 surgical masks. We have 386 880 N-95 or respirator masks and 131 890 litres of hand sanitiser in the warehouse.

We have distributed to the sector over the last few days 2 890 000 gloves, 4500 face shields, 10 200 safety glasses, 68 200 gowns, 155 900 surgical masks, 16 920 N-95 masks and more than 6000 litres of hand sanitiser. We have deliveries coming in next week of more than 8 million examination gloves, half a million face shields, 700 00 gowns, more than 16 million surgical masks and more than 6 million N-95 masks. We obviously still have—

The CHAIR: Thank you. Sorry, I have to interrupt you there. The Member's time has expired. I will pass to Ingrid Stitt, MLC.

Ms STITT: Thank you, Minister. Can I pass on our thanks for your appearance today together with the Chief Health Officer and departmental officials in what must be a particularly busy time for you.

Minister, I wanted to ask you some questions about your responsibilities for ambulance services. Obviously our paramedics and ambulance first responders do an incredible job at the best of times and they have certainly met the challenges that we have seen recently with both the bushfires and the coronavirus pandemic. You have already outlined for the Committee today how our hospitals have prepared for the pandemic, but I also wanted to ask you for some details about how the Government is ensuring that Victorians have access to quality pre-hospital care through our ambulance services.

Ms MIKAKOS: Thank you for that question. I too want to acknowledge the truly amazing work of our paramedics, who put themselves in harm's way attending to cases not knowing if a patient potentially has coronavirus. I want to acknowledge them. They truly are heroes, and on behalf of every Victorian I want to thank them for their work.

We announced—or I announced together with Professor Tony Walker, actually—in recent weeks that we would fast-track the recruitment of 120 extra paramedics to boost the front line of our coronavirus response and ensure all Victorians get the health care that they need when they need it. The new paramedics will be brought forward from the next financial year to hit the ground from this month, and this means Ambulance Victoria will have the resources it needs to respond to the coronavirus pandemic and the flu season while still providing the very best care to all Victorians, no matter what their condition is.

Ambulance Victoria have started the selection process and are aiming to recruit 60 staff in May and in June. Just last week I had the real pleasure to meet the first 60 recruits. I had to meet them virtually, like we are having this discussion today. I just had a fantastic discussion with them about their backgrounds—they come from a huge

variety, a diverse range, of backgrounds professionally and from different parts of the state—and also a discussion about how we are tracking with the pandemic, and they were very interested in how we were going. The new recruits—41 women and 19 men—have come from a wide range of backgrounds, including former accountants, nurses, defence force personnel, flight attendants, allied health and event management, so they are really reflective of the community that they serve. The 120 extra paramedics will be based in metropolitan Melbourne and also large regional areas. The first 60 will be deployed in metro Melbourne, the Hume region, the Barwon south-west region, the Loddon Mallee region and the Grampians region.

Now, this comes on top of our Government's $1 billion investment in Victoria's ambulance service, funding 855 FTE new paramedics and on-road clinical staff, 35 new and upgraded ambulance stations and 51 emergency response vehicles across the state. Just in the most recent budget last year we committed nearly $300 million to support increasing demand, maintain improved response times and deliver on our election commitments so Victorians get the right emergency care quickly and when they need it. That also included $109 million to recruit more than 90 full-time paramedics, convert 15 single-crew stations to dual-crew stations in rural and regional Victoria, build and upgrade new stations and get new vehicles on the road, and we have already rolled out dual-crew upgrades in Rochester, Camperdown and Terang.

Ms STITT: Thanks, Minister. Can you outline how regional and rural Victorians are being supported to access paramedic care, pre-hospital care, during the coronavirus pandemic?

Ms MIKAKOS: Thank you for that further question. We have a really important service called the Adult Retrieval Victoria service that assists regional Victorians to get the support that they need. We have provided additional resources to Ambulance Victoria's Adult Retrieval Victoria service. This provides clinical information and coordinates the retrieval of patients from a centre where the services do not meet their clinical needs to a hospital where the appropriate level of care can be provided. Retrievals can be carried out by medical staff, nursing staff, MICA paramedics and ALS paramedics using Ambulance Victoria's fleet of on-road vehicles and aircraft.

Adult Retrieval Victoria liaise closely with public and private hospital critical care units across the state to monitor ICU capacity in near real time to facilitate access to critical beds when it is required. It does this through the Retrieval and Critical Health website, REACH, which receives near real time data from health services. In the face of the pandemic, additional resources have been allocated to Adult Retrieval Victoria, expanding it to make it a 24-hour telephone advice service to provide around-the-clock telehealth regional clinical support, coordination and critical care for a six-month period from April. This expansion means extra patient transport officers, administrative support officers, medical consultants, medical coordinators and critical care registered nurses so critically ill patients, particularly those in rural and regional Victoria, can be fully supported.

The REACH system has also been enhanced through the development of the Critical Health Resource Information System, CHRIS, which was developed by Ambulance Victoria together with the Australian and New Zealand Intensive Care Society, the Commonwealth Department of Health and Telstra, and has been piloted at select Victorian health services. So CHRIS is now a nationwide system that ensures COVID-19 data, such as the number of COVID-19 patients in ICU or the number of COVID-19 patients in ICU on a ventilator, continues to be collected directly from health services and acts as a single source of ICU data to allow states to make decisions around how to manage the distribution of patients during the pandemic, ensuring that patients get the treatment that they need regardless of where they live.

Ms STITT: Thanks, Minister. Can I ask what the impact of all of this has been on Ambulance Victoria's response performance?

Ms MIKAKOS: Look, this has obviously been a challenging time for all of our health services, including Ambulance Victoria; they have had to do a huge amount of work to prepare and to respond. So whilst the full effects of the pandemic will become clearer in the coming months, COVID-19 is currently having an impact on the entire ambulance case cycle times. As I mentioned earlier, all paramedics now need to respond to both confirmed and suspected COVID-19 patients as well as non-COVID patients, and they do not always know exactly what to anticipate when they arrive on the scene of someone's home or an emergency, so they have had to put in place infectious diseases protocols to ensure paramedics use PPE when attending cases, including suspected COVID-19 call-outs.

So we have seen longer call-taking times due to the additional screening questions being required at the point of the 000 call with the aim to establish potential COVID-19 patients. Paramedics at the scene are taking longer due to managing patients with heightened PPE requirements and hospital times are then lengthened due to the need to decontaminate vehicles and equipment after potential COVID-19 cases, leading to longer overall case times and impacting overall ambulance availability.

Ambulance Victoria is responding to an average of 700 call-outs per day that meet the requirements for a possible COVID-19 case and trigger the use of PPE. Of these, around 250 will be considered, upon assessment, as possible COVID-19 cases. Ambulance Victoria recorded a 35 per cent increase in call-outs for respiratory cases in the first three months of 2020 compared to the same period last year, a period marked by bushfires as well as the coronavirus pandemic.

In mid-March Ambulance Victoria was called to a large number of respiratory-related cases. On Thursday, 18 March, for example, there was a 36 per cent increase on the same day a week earlier and a 65 per cent increase on the same day last year in respiratory cases. And I point out that date because that is a couple of days after we declared the first state of emergency. It just shows you the circumstances we were facing at that point in time that led us to declare that state of emergency, the directions that were put in place, with the endorsement of course of the national cabinet, that national approach. Because we were seeing nationally, including in Victoria, a big spike in numbers back at that time, so that was putting pressure on Ambulance Victoria at that point.

I just also want to take this opportunity to stress that it is important that people still call 000 if they have serious health conditions, if they need that urgent help. I am concerned, and I know Ambulance Victoria are concerned, that there has been a decline in calls to 000. Whilst the community has been very alive to the risks of coronavirus, I think it is important that the community understands that all those precautions will be taken by our paramedics to keep them safe. We do not have a clear explanation for this, but it does appear that there is some anxiety potentially from members of the community to call for medical assistance if they require it, and that is concerning.

We have had our March quarter data published recently, where we saw an increase in code 1 emergencies. In the first quarter they responded to 77 380 code 1 cases, an increase of 6.5 per cent of code 1 cases across the State compared to the same time last year. Despite this increase in activity, response times remain strong at an average of 11 minutes and 39 seconds. This is more than 2 minutes faster than when we came to government. So Ambulance Victoria is still doing amazing work, still doing a great job in terms of meeting the performance targets or working towards those performance targets, and I want to thank them for the work that they are doing and particularly to commend and acknowledge the work of our paramedics.

Ms STITT: Thank you, Minister, for that detailed response. I think you can pass on from the Committee that our paramedics do an outstanding job. We are very proud of the work that they are doing.

Just in terms of supporting our healthcare workforce more broadly, I wanted to ask: you have given quite a bit of detail already around hospital preparedness and hospital workforce preparedness in dealing with the pandemic, but I think that we would all acknowledge that healthcare workers just by virtue of the type of work they are doing really are putting themselves at greater risk than other members of the community. Minister, we have heard reports of obviously small numbers of healthcare workers testing positive to COVID. We have certainly seen alarming scenes overseas of healthcare workers putting themselves on the front line and in harm's way. So can you outline for the Committee what measures the Government has taken to keep our healthcare workforce safe during the pandemic?

Ms MIKAKOS: Thank you. I want to acknowledge again the dedication of our healthcare workers. There have been a number of measures that we have put in place to keep healthcare workers safe. A big part of that has been to encourage the community to do the right thing, to stay home and to follow the directions. We have always framed our messaging to the community about doing the right thing to protect our health system. We are all in this together, and with people staying home we have managed to flatten the curve and to drive down the growth in the new cases—and that benefits all of us. Because if we have a heart attack, we have a stroke, we have cancer, we have some other non-COVID-related illness, we are then able to utilise the beds and the workforce is available to support us and our loved ones. That has been a key part of the thinking behind our pandemic response: to preserve and support our health system. We have seen what happens overseas when this is allowed to get out of hand and we have people unable to access a ventilator or an ICU bed or get the medical care that they need in the

home. We do not want to be them. We are grateful for the fact that Victoria, Australia, is not in that position. That has been a key part of it, of course.

On a more granular level, Mr Symonds just before was taking you through the power of work that has gone to secure adequate supplies of PPE. The great irony of all of this is that Wuhan in China is actually a global centre of production, manufacturing surgical masks. You can understand that when the pandemic started there, there were global supply chain issues for the whole world, all seeking to obtain the PPE that they needed, as they obviously looked to preserve supplies for their own citizens. This is why we have always acknowledged that there have been international supply chain issues, and we worked really hard to source items by also encouraging local production of critical items.

We identified a company in Shepparton. We worked with the Commonwealth to ensure that they were able to start manufacturing masks in Victoria, and similarly we have been working with other companies to manufacture ventilators and other critical things that we need as well. So Mr Symonds was telling you about the sheer volume of numbers—the orders that we have put in place. Hundreds of millions of items that we have placed orders for, things that are coming into our centralised warehouse and distribution system every day, that are getting pushed out the door, being delivered to our health services.

We have had some unique challenges in Victoria, unlike other states, I should point out, in that we have the most devolved health system in the country. Where you have a situation where every health service competes with each other to secure PPE, that would not serve anybody well, and it would particularly mean that regional health services would be at a particular disadvantage because they would be outbid, outpriced by bigger metropolitan hospitals. So we moved to create effectively a centralised supply chain. My department worked very closely in partnership with Health Purchasing Victoria and Monash Health to establish a centralised statewide procurement and supply chain for critical PPE and equipment, and this I believe is making a huge difference to the supply of PPE to our hospitals, our pop-up testing clinics, quarantine hotels and others, including to private hospitals as well where they have been undertaking public activities such as COVID-19 treatment and public elective surgery.

So we have millions of items already supplied to our health services, and that work continues unabated, particularly now that we have started to resume elective surgery in accordance with the decision that was made by the national cabinet first to pause it and then to recommence with baby steps small numbers of less urgent elective surgery. It is important that clinicians and others working in our hospitals have got the confidence that they need by us providing them with that PPE equipment.

We have also introduced other initiatives. One that I am particularly proud of—I believe we were the first state to do this—was our Hotels for Heroes program where we have provided emergency accommodation to healthcare workers if they need it to reduce the risk of transmitting the virus to their families. We worked closely with local councils to deliver free on-street parking for healthcare workers around Victorian hospitals. I want to acknowledge the Municipal Association of Victoria for their support in assisting to facilitate this and in engaging directly with local councils. We have supported our clinical workforce with access to psychosocial support, with the ongoing Government support for the Victorian Doctors Health Program, the Victorian Nursing and Midwifery Health Program—

The CHAIR: Thank you, Minister, I will just stop you there. The Member's time has expired, and I will pass to Sam Hibbins, MP.

Mr HIBBINS: Thank you, Chair, and thank you, Minister, Professor Sutton and secretaries for appearing today. I want to continue on with the theme of protection and safety for healthcare workers. Can I ask whether COVID patients are being isolated in negative pressure isolation rooms? You referenced negative pressure isolation zones in an answer to an earlier question. For the benefit of the Committee, negative pressure isolation rooms in hospitals are sealed rooms that safely vent the air to reduce the risk of transmission occurring, which is recommended by the World Health Organization for use in infectious respiratory diseases. Can I ask, are COVID patients being isolated in negative pressure isolation rooms, and what is the total number of negative pressure isolation room beds in Victorian hospitals?

Ms MIKAKOS: Thank you, Mr Hibbins. The advice that I am receiving is that that is not necessary for every patient that is required to be treated for COVID-19 in our hospitals. You might have noticed every day when the Premier and I and others—the Chief Health Officer and others—go out and talk about numbers in our hospital

system we daily reports separate numbers for those in hospital and a separate number for those in ICU. You can understand from that that not every patient requires the same level of care. Obviously it is assessed on the basis of their particular circumstances and clinical need, but if there is further information we can provide in relation to that, we will see if we can locate that for you.

Mr HIBBINS: So in terms of just how many negative pressure isolation beds there are in Victorian hospitals?

Ms MIKAKOS: We will have to take that on notice for you.

Mr HIBBINS: When you say patients within ICU, do you infer from that that ICU is then negative pressure isolation rooms?

Ms MIKAKOS: No.

Mr HIBBINS: No. Okay.

Ms MIKAKOS: I might ask Mr Symonds—do you want to speak further on that? No. What I was just suggesting is that obviously the clinical need of every patient will differ. Depending on their circumstances they will be afforded the appropriate equipment. But, you know, if this all gets away from us, of course we will never, ever have enough ICU beds, and we were very clear about that right from the outset.

Mr HIBBINS: And how many of the 515 ICU beds that we have are in negative pressure isolation rooms?

Ms MIKAKOS: I will have to take that one on notice.

Mr HIBBINS: Okay. Well, in terms of the expansion of—I mean, there has been a lot of focus on securing PPE, but obviously negative pressure isolation rooms reduce the risk of transmission within hospitals themselves and with the healthcare workers. So within the expansion of beds and ICU beds, what is the Government actually doing to increase the number of negative pressure isolation rooms in hospitals?

Ms MIKAKOS: I think we will come back to, perhaps, the issue of negative pressure. As I have said, the advice that I have is that it is not necessary for all patients requiring clinical care. But we will come back to you with some further information.

Mr HIBBINS: So you do not have any further—I mean, you indicated in a previous answer that part of the expansion of ICU beds and increased beds in hospitals was increased negative pressure zones.

Ms MIKAKOS: Yes.

Mr HIBBINS: When we talk about negative pressure zones are we talking about negative pressure isolation rooms?

Ms MIKAKOS: Yes, but I do not have a number for you, so we will take that on notice and come back to you.

Mr HIBBINS: No further information?

Ms MIKAKOS: But there are other services who I am aware of have increased negative pressure isolation rooms. I just do not have a total number for you, but we will seek to endeavour to collate that number.

Mr HIBBINS: That would be greatly appreciated. Moving on to the funding arrangements for private hospitals, my understanding is the State Government has paid private hospitals to make available or potentially make available their capacity, including ICU beds, diagnostics and staff, and that the agreement is that the private system will be reimbursed at cost per activity plus retention payment. Can you give the Committee some understanding in terms of some more details around that? How much of that capacity has been used within the private system, how long will the ongoing retention payments be made and what has been the total funding allocated, or what will be the total funding allocated?

Ms MIKAKOS: Sure. Thank you. I will ask Terry Symonds to add further to my answer in a moment, but just to firstly explain that we have struck a deal with our major private hospitals to ensure our public and private hospitals work effectively as one system to respond to the pandemic. Victoria led the way and was the first state

to land this deal following a Commonwealth decision to guarantee the viability of all private hospitals Australia wide after non-urgent surgery was suspended from the start of April in line with a decision of the national cabinet that was based on advice from the AHPPC.

This deal is about making sure the Victorian Government can make use of our entire healthcare system. It has also ensured the ongoing viability of our private hospitals in Victoria, securing many thousands of workers' jobs as well as securing an additional 8500 hospital beds, including 170 ICU beds and 200 emergency medicine beds to add to our response, and potentially adds an additional 15 000 nurses and around 1000 medical staff to our capacity. It has also enabled us to work closely with our private hospital systems to provide greater flexibility in terms of our public health response. For example, we hired 200 nurses from both the Epworth and Cabrini hospitals early on to be part of our contact-tracing work, and we are grateful to them for that. But I will ask Mr Symonds to add a little bit more granular detail for you in relation to some of those specific questions you had.

Mr SYMONDS: Hi, Mr Hibbins. Thanks for the question. I think one of the questions you might have asked was how long the agreement was in place.

Mr HIBBINS: Correct.

Mr SYMONDS: The agreement allows for the State to effectively suspend the agreement at a point where certain conditions are met. Those conditions include, for example, the full lifting of restrictions that have been imposed by national cabinet. That is obviously not something that has a fixed time line. National cabinet, like all of us, are waiting to see the course of the pandemic. The agreement could then be suspended by the State for a period of up to six months so that we have the agreement and the capacity of private hospitals at hand in the event of a second wave or where we needed to actually deploy that capacity. So the short answer to the question is when conditions have been met that allow private hospitals to operate in a more normal environment, subject to restrictions, and then subject to a period of up to six months and if the State is satisfied that we have so far escaped the threat of a second wave in terms of the pandemic.

Mr HIBBINS: And in terms of the total funding?

Mr SYMONDS: So the funding you alluded to yourself is a formula that requires activity undertaken in private hospitals to be cost shared by the State and Commonwealth and for a residual component to be funded by the Commonwealth for all those that do not exceed allowable costs that are agreed between private operators and the State. We are a long way from knowing exactly what that is going to be. It is going to require a reconciliation process. It is also going to require knowing how much activity they are doing.

Mr HIBBINS: Is there a to-date figure?

Mr SYMONDS: No.

Ms MIKAKOS: No.

Mr SYMONDS: There was a commitment to keep their doors open that was made nationally by all jurisdictions and the State and agreed with private operators, and we have not reconciled that to work out exactly what that cost should be, or is. We are keeping their doors open as per the agreement.

Mr HIBBINS: It is an open-ended figure at this stage.

Mr SYMONDS: It is not open-ended. It is limited by the agreement in terms of allowable costs, but translating that into dollars is not an enterprise we are in a position to do right now. One of your questions was about what use has been made of private hospitals. I am pleased to share examples, so Warringal Private Hospital across the road from Austin Health is undertaking a portion of Austin Health's cardiac surgery program. Two theatres and one endoscopy room as of this week are dedicated to public lists. Cabrini is undertaking urgent category 1 and urgent category 2 public patients from Monash and the Alfred. The Melbourne Private is doing the same for patients from Melbourne Health. Holmesglen is caring for public patients referred from Sandringham, part of Alfred Health. The Avenue is undertaking public endoscopy. In rural and regional Victoria—

Mr HIBBINS: I do not want you to think that I do not think that is wonderful that that is happening, but I guess we took a long time to get to not the answer that I was looking for, for a figure, so I think if you do not

mind we might just move on, and if there is further information you can furnish to the Committee around those funding arrangements that would be greatly appreciated.

Mr SYMONDS: I guess I was just showing why we cannot reconcile to an actual number: because the activity is dynamic and it is still going up and down at different hospitals under the agreement.

Mr HIBBINS: Minister, you indicated to or alluded to a question I wanted to ask in one of your earlier answers. It is about the devolved nature of Victoria's health system. Yes, on one hand you have got competing health bodies, but then you have also got a system where I think the public hospitals have done an incredible job. The State has had to step in and bail out the private hospitals, and we have got a system where essentially in terms of GPs, who are federally subsidised, the State does not have any control over them. Can you just outline some of the challenges that you have been faced with in terms of dealing with a very fragmented health system, and given that it has been shown to not work well in a crisis, is there any move to be shifting back to a more centralised State-run system?

Ms MIKAKOS: Thank you for that question. As I alluded to earlier, we do have a very devolved system. It is unique how devolved we are in Victoria in that we have the most separate health services of any state that I am aware of, in fixed contrast to how New South Wales Health operates and how Queensland operates. Just in terms of sheer numbers, that does present some challenges. We have played a very important role working with Health Purchasing Victoria to coordinate that procurement and distribution of PPE. I was very concerned about how health services were going to manage that independently in the face of a global supply chain shortage, so we had to take those steps. But I think your question touches upon some other issues, and it also relates to the intersection with the Commonwealth. For example, whilst we have been securing PPE for our hospitals, those pop-up screening clinics et cetera, the Commonwealth has been providing PPE to GPs and other primary carers through their national stockpile.

I have to admit—and I do not want this to sound critical in any way because Minister Hunt and I have had a very, very constructive relationship all along in how we have been working together in the best interests of making sure that Victoria and Victorians are looked after in response to this pandemic—that we have had issues around GPs accessing PPE. Now, one issue I have raised with Minister Hunt in the past that is worthy of further conversations beyond this pandemic is to look at how we play a bigger role as a state in our primary health networks, PHNs. Now, the PHNs are the distribution points for PPE for GPs and other primary carers at the moment, so this is your dentists, your pharmacists as well as your GPs. If we had some ongoing representation and a more coordinated way for the PHNs to work with our health services, I think that would serve Victorians well, it would serve the nation well. So I think the question you have asked is a very good one.

I am hoping that there will be some, I guess, lasting reforms that we will put in place here in responding to this pandemic, such as these distribution procurement processes that were put in place, strengthening the relationships with the Commonwealth around the role of the PHNs and potentially also retaining the greater utilisation of telehealth, which has been a significant achievement by our health services, providing easier access for care for patients. There are many things that I hope we can look back on, come next year, and say, 'Well, these things worked well and are worthy of continuation'. But this is not the time to be, I guess, introspective and having those deep conversations, but we are alive to them, alive to the opportunities that this presents—the fact that we need to be innovative and flexible in how we respond to this pandemic—and we are alive to looking for those opportunities. And when we have not a formal review but an opportunity to review as a department how we went, in coming months, then we will be reflecting on these opportunities and hopefully embedding them into the future.

Mr HIBBINS: Will that involve reflecting on the public-private nature of our hospital system and the fact that you have had to bail them out during a crisis, and will there be any looking to move towards a more centralised public hospital system?

Ms MIKAKOS: Well, there are only so many levers that I have as a state health minister. As I said, we have had really good relationships and a constructive dialogue as health ministers. Both Minister Hunt and I and other state and territory health ministers speak to each other weekly at the very least. In the early period it was far more regular than that—far more regular than that. So we are always looking to share ideas with each other and looking to opportunities for reform. I guess that is a more challenging one in terms of they are levers really that fall to the Commonwealth in terms of how the private hospital system works, the issue around the private health insurance

rebate, the value that consumers feel or patients feel or may not feel that they get from private health insurance and the pressures that that then puts on our public health system. These are conversations that I have been having with my counterparts, and no doubt those conversations will continue into the future.

Mr HIBBINS: Thank you, Minister. I want to move on to PPE. A lot of the PPE having to be bought is disposable, which obviously requires that it gets bought and it is thrown out and we have to look at new supplies, but some intensive care units are equipped with high-quality reusable respirators which can be cleaned and their filters changed between users. Is this something that is currently in the mix, and to what extent are they being sourced and purchased?

Ms MIKAKOS: Yes, thanks. That is a good question. I will look for some advice on this issue because obviously we have got a very contagious virus and the issue of safety has been the paramount consideration here. We were talking about healthcare workers and their potential of contracting coronavirus, and the advice that I have is, thankfully, I believe only about 12 per cent of healthcare workers have contracted COVID-19 to date. It has been shown to be directly related to being in the workplace. There are some still obviously under investigation—about 12 per cent—so overwhelmingly through close contacts and moving around in the community. But in terms of re-using PPE equipment, I am not sure if Mr Symonds has something he can add on this. We might need to take this one on notice and come back to you. We are obviously very interested as a longer term proposition beyond the pandemic to make our health services more environmentally sustainable. That is something that I am personally very committed to, but note this is very challenging when we have a very contagious virus and there are challenges with adequately cleaning and re-using those items. But I will ask Mr Symonds to see if he can add to my comments.

Mr HIBBINS: I meant specific items.

Ms MIKAKOS: Yes, on the issue of the respirators I believed you asked specifically?

Mr SYMONDS: We have a PPE task force administratively to perform that is chaired by our Chief Medical Officer that includes clinicians from a range of disciplines. They have looked specifically at the question of reprocessing and re-use of items and getting of items.

The CHAIR: I am sorry to cut you off there. Hopefully you might provide that answer to the Committee on notice. The Member's time has expired.

Ms VALLENCE: Thank you, Minister, Chief Health Officer and everyone else in the room for appearing. My first question is to you, Professor Sutton. On the schools matter, on closures and the return to the classroom, on what date did you change your view and advice that it was okay and acceptable for students to return to the classroom?

Prof. SUTTON: Thanks, Ms Vallence. It has been an issue under active consideration every day through this entire pandemic. Obviously there was advice to the Department of Education and Training on emergency offsite schooling. That occurred during the holiday period between the Victorian school terms. But I had made a commitment to look at the results of the testing blitz, and it was through that period and obviously towards the end of that blitz period that I had the data on the over 160 000 tests that had been done that gave me satisfaction that I could provide advice to cabinet and in particular the Department of Education and Training that schools could return to onsite schooling—

Ms VALLENCE: Is it fair to say that you changed you view just this weekend?

Prof. SUTTON: It is fair to say that towards the end of that blitz period is when I became satisfied the results of the testing indicated that community transmission in Victoria was sufficiently low that a return to onsite schooling was appropriate.

Ms VALLENCE: And, Professor Sutton, is it your advice or a Government decision on waiting another four weeks to return to the classroom?

Prof. SUTTON: Well, I know that from the announcement today and Minister Merlino has made the point that they have needed to be in discussions with schools, so it is really an operational decision about preparedness for all of the things that have been advised, like AHPPC nationally as well as the specific advice that we have

given in Victoria about the kinds of things that need to be in place in schools in order to minimise the risk of transmission even as kids return to school.

Ms VALLENCE: Thank you. I will just move to testing, still with you, Professor Sutton. The Premier earlier admitted that there were supply chain pressures with testing kits, and I am interested to know: what date did you identify that stocks were critically low and how low did they reach? What number of kits did we reach at that low critical level in early March?

Ms PEAKE: Thank you, Ms Vallence. I might get Mr Symonds to add to my comments, but we did not reach a point in Victoria where we had critically low testing kit supplies. It is the case that there have been supply chain challenges overly on testing reagents and extraction kits, but we did not reach a point where we were critically low, and our decisions around testing criteria, which is more in the bailiwick of Professor Sutton, really followed transmission. It commenced with a strong focus on returned travellers and their close contacts, then moved to really focus in on the very vulnerable groups in our community and the vulnerable sites for transmitting the disease and then moved through to broader community transmission. But I will just ask Mr Symonds to comment on the testing kit supplies.

Prof. SUTTON: Before Mr Symonds comes, just an update on a couple of outstanding points. One was the swabs that might still be outstanding for Cedar Meats employees. I have been informed that there are no employees who have been tested where there are results outstanding.

Ms VALLENCE: Right.

Ms MIKAKOS: Mr Symonds will just add further to your question because that is a different part of the department that does procurement and supply of—

Ms VALLENCE: We can just get on with the answer.

Mr SYMONDS: I can state the Secretary's answer that there has not been a point of critically low supplies. All jurisdictions in the world are aware that there are shortages globally of testing kits.

Ms VALLENCE: I appreciate that. We are just asking specifically for the Victorian circumstance. So I guess to flip back, and as Ms Peake mentioned flip back to the Chief Health Officer, when and what advice did you provide to the Government to narrow the testing criteria in early March, at a time when positive cases were peaking?

Prof. SUTTON: We have not narrowed the testing criteria. We have followed the national criteria that has been determined by the Communicable Diseases Network Australia, so we have either mirrored that specific definition for testing or been broader than that definition. We have gone by the national criteria for testing.

Ms MIKAKOS: We went above and beyond the national criteria on many occasions. In fact I spent a long period of time going through the 17-odd changes and a number of them in terms of how it was very targeted at the start and then just kept on being broadened, broadened, broadened—

Ms VALLENCE: We understand it was broadened and expanded, but it was narrowed and it was a narrow criteria early in March, so Professor Sutton—

Ms Mikakos interjected.

Ms VALLENCE: Thank you, Minister. Professor Sutton, it was narrowed in early March. Is it fair to say that really this was because you had such a low number of testing kits available and you had to ration the number of tests?

Ms MIKAKOS: That is not correct. We have just explained that—

Prof. SUTTON: The original national criteria are the criteria that Victoria followed. We were following the determination of the Communicable Diseases Network Australia advice to AHPPC, as were many other states and territories, on the specifics of the testing criteria.

Ms VALLENCE: So what was the lowest number of kits that we had in early March? What was the number of kits that we had available in early March?

Ms MIKAKOS: We are just going over the same issue.

Ms VALLENCE: We are not going over the same issue; we are asking expressly for a number. Perhaps we can have that tabled.

Ms MIKAKOS: The Secretary [inaudible] has just said to you that there was no critical shortage at that point in time.

Ms VALLENCE: I did not ask whether—

You have established the fact—

The CHAIR: Order!

Ms VALLENCE: that there was no critical shortage—

Ms MIKAKOS: Professor Sutton explained to you that the criteria has been changed in accordance with AHPPC advice. It has been followed on a national basis and it has been consistently broadened on 17 different occasions in Victoria, and in many instances we have actually gone above and beyond the national approach to the point where recently we have had the widest testing criteria in the nation.

Ms VALLENCE: Okay, let us move on. Professor Sutton, have testing kits at any stage been shelved or scrapped before distribution or recalled after distribution due to any concerns about the testing kits' efficacy?

Ms MIKAKOS: This is why I made it clear that there are different parts of the department that do different work, and it is actually Mr Symonds—

Ms VALLENCE: Just get an answer to the question. Whoever has got the answer to this question—

The CHAIR: Ms Vallence, I think the Minister is trying to give you an answer to the question by telling you you are asking the question of the wrong person, so if the best person to answer the question can be given the opportunity to come to the table, they could answer it.

Ms VALLENCE: They can claim that someone else is giving the answer they can—

The CHAIR: Well, you are not actually giving them an opportunity to arrive at the table.

Ms VALLENCE: If they were here, that would not be an issue.

Mr SYMONDS: Have kits been rejected? Is that the question?

Ms VALLENCE: At any stage, have any testing kits been shelved or scrapped prior to distribution or recalled after due to concerns that you had about their efficacy?

Mr SYMONDS: No, not aware of any.

Ms VALLENCE: No? Okay. To you, Professor Sutton: on 20 April you produced modelling in a press conference that said that said 650 people could have died each day at the State's coronavirus peak without any physical distancing, or in other words in total 36 000 Victorians. Why was the testing blitz not instituted at that point?

Prof. SUTTON: That modelling was based on physical distancing not being in place. We were obviously at a point there where physical distancing was in place and we had effectively changed the outcomes of the modelling because the assumptions were that we did not have restrictions on physical distancing when in fact they were in place and the empirical data showed that we were over the highest point of our epidemic curve and we were driving numbers down very significantly. And so the testing that was in place was appropriate to the kind of individuals who were being diagnosed at that time.

Ms VALLENCE: If the testing was appropriate at that time, which was at a peak, and you were putting out empirical evidence that suggested to what extent it could otherwise be, why then was there a testing blitz later, if testing was deemed appropriate at the time that positive cases were peaking?

Ms PEAKE: I might just assist you. We did actually expand the testing criteria on 14 April. All epidemiological requirements were removed and so testing criteria was expanded to be based on clinical symptoms only, and we were working very closely with the Commonwealth on expanding the GP clinics to make testing sites more available to people as well as expanding our own public health sites. So really over April there was a significant expansion of testing that was going on.

Ms MIKAKOS: If I can add also on the testing blitz, the thinking behind that most recent testing blitz has been to give us a sense of whether we can have a degree of confidence to make the decisions that we made. The announcements that have been made yesterday and today were about going and exploring whether we have got a greater degree of community transmission. The initial target groups—the high-risk groups—were identified internationally as returned overseas travellers and their close contacts. They have accounted for overwhelmingly the vast majority of infected Victorians, and now we are in a different phase and we are alive to looking at whether we have got more community transmission, and that is what the testing blitz did. It gave us the data—30-odd Victorians did test positive unrelated to outbreaks or overseas travel, and that tells us that we are heading in the right direction. That gave the Chief Health Officer the confidence to give advice to Government about the easing of restrictions. So that has been the thinking around the testing blitz.

Ms VALLENCE: Thank you, Minister. Professor Sutton, that testing blitz, which you were determined to do—and I can understand why you were determined to do that to see whether you could ease restrictions and so forth. But is it that the testing blitz was not done back when you made those comments earlier in April because, as the Premier mentioned this morning, there was a critical shortage of supply?

Prof. SUTTON: No, that is not the case. It really is the case that the most critical time to understand the situation is when you are about to make a change to restrictions that are in place. That needed to be the best-informed decision that we could possibly get to, and the testing blitz has delivered as many results and as many people tested as in all the time previous through the course of this pandemic in Victoria. So it really was about having the best available information at the most critical decision-making point.

Ms VALLENCE: On that point, Chief Health Officer, wouldn't it have been more critical to do that testing at the time when you knew that the positive cases were peaking, for example, in early March? Wouldn't we have had a better understanding at that point on community transmission, which we now know to be very low, had we done the testing in March?

Prof. SUTTON: Well, the testing that was done in March was focused on those individuals who were most likely to turn up positive.

Ms VALLENCE: Is it because we did not have sufficient testing capability at that time?

Ms MIKAKOS: I think you have asked the question about five times. I think we have addressed that point, and Professor Sutton is saying that the testing was targeted at the high-risk groups, which was the returned overseas travellers. That was the approach that was being taken by every state and territory in the nation at that time, and the criteria kept on changing nationally, and we were leading the pack in many, many respects.

Ms PEAKE: And in fact I might just add that from the middle of March the testing was expanded: on 15 March to include healthcare workers with a fever and acute respiratory infection; on 20 March to include patients admitted to hospital with acute respiratory tract infection and fever; on 29 March to include people with a history of fever, including night sweats, so a broader definition of fever. And that epi criteria was expanded to cover healthcare and resi aged-care workers and residents, workers in other high-risk settings, Aboriginal and Torres Strait Islander people—and I think the Minister talked about it—as well as frontline police and social services.

Ms VALLENCE: Thank you very much. Just conscious of time, we will move on to another topic. Minister, supported residential services that provide support to Victorians with mental health issues and disability have requested additional PPE, and we have got examples from well over six weeks ago of their requests to Minister Donnellan for additional PPE. Minister Donnellan responded saying that unless they actually had a

positive case they would be denied, so they have been denied this additional PPE. Do you think that is a satisfactory response from Minister Donnellan?

Ms MIKAKOS: It is an issue you will have to take up with Minister Hunt, because the Commonwealth Government has responsibility for PPE for the aged-care sector, as well as primary care, as well as disability.

Ms VALLENCE: It is Minister Donnellan in your Government who has expressly denied—

Ms MIKAKOS: I am explaining to you which government has responsibility for providing PPE for the aged-care sector. That is the Commonwealth—

Ms VALLENCE: In that case don't you think that Minister Donnellan should have directed that inquiry on rather than denying it outright? I guess also, given the distribution of PPE lies—

Ms MIKAKOS: I do not have any information around the claims that you are making. You are making assertions, but I am explaining to you that regardless the responsibility for PPE for that sector falls with the Commonwealth Government.

Ms VALLENCE: With the distribution of the PPE—

Ms MIKAKOS: But I can add further to that if you would like some further information.

Mr SYMONDS: I can read from a Commonwealth brief, which says:

> Advice for NDIS providers—

this is the Commonwealth's document—

> If NDIS and disability support providers are experiencing shortages—

it goes on to say—

> … the National Medical Stockpile may be able to provide a small supply to supplement existing supplies.

Ms VALLENCE: Thank you, we have got that published document. In terms of distributing, as Mr Donnellan has denied this and said, 'Well, it's not until there's a positive case in the disability services home that they would be able to get additional PPE', exactly how long will it take to distribute PPE to a disability service provider after a positive case has been confirmed?

Ms MIKAKOS: You would have to ask Minister Hunt that question. I have just explained to you that that sits—

Ms VALLENCE: The distribution?

Ms MIKAKOS: I have just explained to you that providing PPE to those sectors—aged care, disability, GPs, primary care—all sits with the Commonwealth.

Ms VALLENCE: So what about any state agencies, any state-managed providers? Are you saying that it is not your responsibility at all to provide—

Ms MIKAKOS: What I am saying is we provide PPE to public aged-care facilities because they are part of our public health services—

Ms VALLENCE: And that is where I am asking the question, Minister.

Ms MIKAKOS: You are talking about—

Ms VALLENCE: No, I am asking the question about state services.

Ms MIKAKOS: disability. You are talking about disability services.

Ms PEAKE: So disability providers get their PPE, as the Minister has indicated, from the national stockpile, and there is an email they write to and then there is a triage process that applies. In terms of aged care, we do provide to the public sector aged care. We have supplied 99 526 surgical masks and 200 N95 masks as at 11 May.

I understand that Commonwealth stocks for aged care, there are 469 500 surgical masks that have been applied for distribution in Victoria, 200 N95 masks—

Ms VALLENCE: Thanks, Ms Peake. If we could we just have those figures tabled rather than chewing up the time now.

Look, I will quickly move, noticing the time, to elective surgeries. On 15 March the Government announced a surgery blitz, and I would like to know exactly how many elective surgeries were completed under that program prior to the elective surgery shutdown.

Ms MIKAKOS: I will just ask Mr Symonds to respond to your question. To make the point of course that—

Ms VALLENCE: And whilst he is coming to the table I would also like to ask: what is the total number of elective surgeries on the waiting list as at this time?

Ms MIKAKOS: I will respond to the first question firstly. The Government made a commitment to try and get elective surgeries ahead of the peak of the pandemic. We were trying to be very proactive to assist Victorians. Subsequently, as nationally we started to see an increase in numbers in March—

The CHAIR: Thank you, Minister. Sorry to interrupt you. Perhaps you could provide those answers to the committee on notice—to those two questions.

That concludes our time. We thank you very much and the Chief Health Officer and your departmental officials for the time you have taken to spend with us in an exhausting process this afternoon. We very much appreciate your time. The Committee will follow up on any of the questions that were taken on notice in writing. The responses will be required within five working days of the Committee's requests. We thank you for your time. You will be provided with a Hansard transcript to check as well. That adjourns this session, and the committee will take a short break while we connect with the next witness. Thank you for your time.

Ms MIKAKOS: Thank you, Chair. Thank you, Members.

Prof. SUTTON: Thank you.

Witnesses withdrew.