PARLIAMENT OF VICTORIA

LEGISLATIVE COUNCIL
Legal and Social Issues Committee

# Inquiry into the Victorian Government's COVID–19 contact tracing system and testing regime

Parliament of Victoria
Legislative Council Legal and Social Issues Committee

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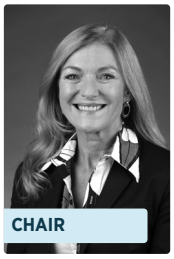
# Committee membership

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# About the committee

## Functions

The Legal and Social Issues Committee (Legislation and References) is established under the Legislative Council Standing Orders Chapter 23—Council Committees and Sessional Orders.

The committee's functions are to inquire into and report on any proposal, matter or thing concerned with community services, education, gaming, health, and law and justice.

The Legal and Social Issues Committee (References) may inquire into, hold public hearings, consider and report on other matters that are relevant to its functions.

The Legal and Social Issues Committee (Legislation) may inquire into, hold public hearings, consider and report on any Bills or draft Bills referred by the Legislative Council, annual reports, estimates of expenditure or other documents laid before the Legislative Council in accordance with an Act, provided these are relevant to its functions.

Government Departments allocated for oversight:

- Department of Health and Human Services
- Department of Justice and Regulation

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This report is available on the Committee's website.

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# Terms of reference

## Inquiry into the Victorian Government's COVID-19 contact tracing system and testing regime

That this House requires the Legal and Social Issues Committee to inquire into, consider and monitor the capacity and fitness for purpose of the Victorian Government's COVID-19 contact tracing system and testing regime, and in doing so consult with businesses, including small business representatives, the community sector and Victoria's multicultural communities, and provide a report to the House no later than 14 December 2020.

# Chair's foreword

The Legal and Social Issues Committees was given this Inquiry into the Victorian Government's COVID-19 Contact Tracing System and Testing Regime on 28 October and the final report was adopted less than six weeks after that on 10 December.

Our government and our systems have been challenged in an unprecedented way in 2020, as have jurisdictions across the globe. The COVID-19 pandemic created upheaval for our health sector, our economy and our way of life. It has put many people at risk. People lost their lives as a result of the pandemic and I am very sorry for those friends and family dealing with the pain that will have caused.

Victoria's contact tracing system and testing regime are critical elements of our infection control response to COVID-19, or indeed any communicable disease.

The Committee's goal during this inquiry was to understand the position Victoria is in now in relation to the capacity and fitness for purpose of the contact tracing system and testing regime.

I am grateful to the Department of Health and Human Service leadership responsible for the implementation of Victoria's approach for their cooperation with the inquiry. With their assistance the Committee was given the opportunity to form a view about the current system and how it will serve us into the future. Practices can always be reviewed retrospectively but right now what is imperative is ensuring we have a system that can serve Victorians well—a system in which we can have confidence.

I believe that lessons have been learnt by government, the public sector and the health sector about how we deal with emerging threats to public health particularly infectious disease control.

Victoria now sits in the enviable position of having effectively eliminated COVID-19 from our community through testing and contact tracing but also significant restrictions on citizens. We have many hard working health professionals and public sector officers to thank for their contribution and I commend them all for their work. I also acknowledge the outstanding part played by Victorians.

The contact tracing process and testing regime in place now should be subject to ongoing monitoring and improvement and I hope the Committee's recommendations can assist the Government with that work. However Victoria's processes are robust and have been implemented in response to what has been learnt over the last months. We are now far better prepared should Victoria face a similar situation in the future.

Thank you to all of our stakeholders for their invaluable submissions to this inquiry—we have drawn heavily on your contributions in the report. I particularly thank the Parliamentary Budget Officer at the Parliament of Victoria Mr Anthony Close for the valuable information provided.

In relation to the preparation of this report I wish to thank the team in the Council Standing Committee's Office who worked on this inquiry—Inquiry Officer Caitlin Connally, Research Assistants Meagan Murphy and Holly McLean, Justine Donohue and Cat Smith for administrative assistance, and Senior Committee Manager Lilian Topic. We gave them a very short timeframe in which to complete this inquiry and the Committee thanks them for taking on that challenge so professionally and diligently.

I would also like to thank my colleagues on the Committee for the constructive and open way that they worked together on an issue that is of great importance to our communities.

I commend the report to the House.

**Fiona Patten**
**Chair**

# Findings and recommendations

## 1 Why did the Committee undertake this inquiry?



## 3 What did this inquiry not address and why?

## 5 How has Victoria's contact tracing system and testing regime evolved since January 2020?

## 7 What are the key performance indicators and benchmarks for COVID-19 contact tracing and testing?

# What happens next?

There are several stages to a parliamentary inquiry.

## The Committee conducts the Inquiry

This report on the Inquiry into the Victorian Government's COVID-19 contact tracing system and testing regime is the result of extensive research and consultation by the Legislative Council's Legal and Social Issues Committee at the Parliament of Victoria.

We received written submissions, spoke with people at public hearings, reviewed research evidence and deliberated over a number of meetings. Experts, government representatives and individuals expressed their views directly to us as Members of Parliament.

A Parliamentary Committee is not part of the Government. Our Committee is a group of members of different political parties (including independent members). Parliament has asked us to look closely at an issue and report back. This process helps Parliament do its work by encouraging public debate and involvement in issues. We also examine government policies and the actions of the public service.

You can learn more about the Committee's work, including all of its current and past inquiries, at: https://www.parliament.vic.gov.au/lsic-lc.

## The report is presented to Parliament

This report was presented to Parliament and can be found at: https://www.parliament.vic.gov.au/lsic-lc/inquiries/article/4574.

## A response from the Government

The Government has six months to respond in writing to any recommendations we have made. The response is public and put on the inquiry page of Parliament's website when it is received at https://www.parliament.vic.gov.au/lsic-lc/inquiries/article/4575.

In its response, the Government indicates whether it supports the Committee's recommendations. It can also outline actions it may take.

# 1 Why did the Committee undertake this inquiry?

## 1.1 Motion in the House

A motion on 28 October 2020 to undertake an Inquiry into the Victorian Government's COVID-19 contact tracing system and testing regime was supported by the Legislative Council without opposition.

The Committee was asked to report by 14 December 2020, an unusually short timeframe of six weeks.

## 1.2 Terms of Reference

The Terms of Reference ask the Committee to inquire into the capacity and fitness for purpose of the Victorian Government's COVID-19 contact tracing system and testing regime. They also request that the Committee consult businesses, including small business representatives, the community sector and Victoria's multicultural communities in order to determine the capacity and fitness for purpose of the Government's approach:

> That this House requires the Legal and Social Issues Committee to inquire into, consider and monitor the capacity and fitness for purpose of the Victorian Government's COVID-19 contact tracing system and testing regime, and in doing so consult with businesses, including small business representatives, the community sector and Victoria's multicultural communities, and provide a report to the House no later than 14 December 2020.

## 1.3 Why an inquiry into testing and contact tracing?

### 1.3.1 An overwhelmed system

There is no question that the Victorian Government and its agencies, in particular the Department of Health and Human Services, faced an unprecedented public health challenge in 2020. This is true for jurisdictions across the globe.

The testing regime and contact tracing system adopted in Victoria in response to the pandemic was significantly overwhelmed following a large-scale outbreak in June 2020.

### 1.3.2 What this report seeks to achieve

This report seeks to, where possible, assure Victorians that the testing regime and contact tracing system currently in place is:

- fit for purpose, and
- has sufficient capacity to adapt to a variety of pandemic scenarios.

In this report the Committee seeks to identify issues that arose during the pandemic and assess decisions that were made by the Victorian Government and its agencies which led to the system becoming overwhelmed. The report seeks to determine whether the Victorian Government has recognised that elements of its response to COVID-19 were not adequate and whether the system has been refined as a result.

The Committee makes recommendations in relation to issues which we believe require addressing by the Government as a matter of urgency.

Despite the effective elimination of the virus in Victoria at the time of writing it is important to know that our testing regime and contact tracing system is fit for purpose and has the capacity required to manage and prevent further outbreaks and to support the public health system response.

**FINDING 1:** Despite the effective elimination of the COVID-19 virus in Victoria after a second wave of infections, Victorians need to be confident that the public health system is prepared to effectively respond to new COVID-19 outbreaks.

**RECOMMENDATION 1:** That the Government engage with the evidence from the experience of the pandemic that our public health system requires review, testing and enhancement and a more decentralised, community-based approach to fulfil its function of identifying and preventing or minimising public health risks to the community.

# 2 What was the Committee's process for this short but important inquiry?



## 2.1 Submissions

The Committee advertised the inquiry and called for submissions through its News Alert Service, the Parliament of Victoria website and print, online and social media. The Committee approached stakeholders inviting them to make a submission to the inquiry. Stakeholders included government departments, local health officials and agencies, health practitioners, business and industry representatives, information management and technology companies, peak bodies and various community groups, including those representing Victoria's culturally and linguistically diverse communities (CALD). CALD communities were provided with information translated into five languages chosen to target communities where COVID-19 outbreaks took place. The material used is available on the Committee's website.

The Committee received a total of 36 submissions, with 2 granted confidentiality by the Committee. The identities of stakeholders who provided confidential submissions and the content of their submissions were not published on the Committee's website. Confidential submissions inform the Committee's understanding but are not used substantively in this report. A list of submissions is included in Appendix 1. Public submissions are available in full on our website.

## 2.2 Public Hearings

The Committee held three public hearings via videoconference for this inquiry.[1] Hearings were held online due to restrictions in place in response to the COVID-19 pandemic.

Public hearings were held on the following dates:

- 16 November 2020
- 18 November 2020
- 23 November 2020.

A list of witnesses who appeared at the hearings to provide evidence is included in Appendix 1. Transcripts of evidence are available in full on our website along with answers to questions on notice taken at the hearings.

1 AV link undertaken by Zoom

## 2.3 Acknowledgement of contributions to the inquiry

The Committee thanks all stakeholders who provided evidence to this inquiry, particularly given the short timeframe they were asked to respond in. Each stakeholder that made a submission or appeared at a hearing made a significant contribution to the Committee's understanding of the important issues surrounding the government's response to COVID-19 and the testing regime and contact tracing system established in Victoria.

The Parliamentary Budget Officer Mr Anthony Close provided a submission at the request of the Committee. The submission provides budgetary figures for expenditure in relation to COVID-19 contact tracing and testing including payments made to third parties. The Committee thanks Mr Close for responding so quickly and positively to the request.

We are grateful to the Victorian Department of Health and Human Services and the Australian Government Department of Health for their cooperation in providing information, and submissions, at the request of the Committee.

## 2.4 Scope of the inquiry

The Terms of Reference for this Inquiry asked the Committee to explore two key considerations in assessing the effectiveness of Victoria's public health response to the COVID-19 pandemic: capacity and fitness for purpose. The Committee's focus was to do this in the context of the questions that are currently of utmost importance to Victorians:

- **Does Victoria's COVID-19 contact tracing system and testing regime have sufficient capacity to cope with a range of pandemic scenarios?**

  This includes considering the development of Victoria's approach. It has also meant examining whether there are gaps evident in the contact tracing system and testing regime. Capacity was measured through examining:

  - The personnel, resource and technology requirements needed to properly support a full-scale and adaptable end-to-end contact tracing system and testing regime
  - Whether these requirements have been met and the work that was undertaken to ensure that a robust contact tracing system and testing regime is now in place in Victoria.

- **Is Victoria's COVID-19 contact tracing system and testing regime fit for purpose and able to support Victoria's public health response to the COVID-19 pandemic?**

  This includes considering whether the processes and procedures in place for contact tracing and testing can be rapidly deployed and can adapt to a variety of pandemic scenarios such as a third large-scale outbreak or COVID-normal. This will be achieved if we are successful in:

- identifying performance indicators and key benchmarks
- constantly measuring the performance of Victoria's contact tracing system and testing regime against those benchmarks
- developing accessible systems to communicate with Victoria's multicultural community
- protecting the privacy of Victorians by collecting, storing and using only data reasonably necessary to manage the state's public health response to the pandemic.

Each Chapter of this report seeks to answer an important question related to these overriding concerns.

### 2.4.1 Defining 'capacity' and 'fitness for purpose'

As discussed above, the Terms of Reference request that the Committee focus on 'capacity' and 'fitness for purpose'.

#### Capacity

Capacity, or capacity building, in public health refers to the:

> ... development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors to prolong and multiply health gains many times over.[2]

Capacity building aims to ensure that a public health system is properly resourced and has a skilled and well-trained workforce, and personnel, to achieve health improvement which can be 'multiplied and sustained over time, independent of external events.'[3]

In the context of contact tracing and testing, looking at the issue of capacity requires determining if Victoria's healthcare system is appropriately structured, staffed and resourced to respond to the varying scenarios and challenges the pandemic might present. Furthermore, a proper assessment of capacity building within Victoria's contact tracing and testing approach needs to consider whether the system can quickly mobilise capacity if Victoria experiences a third large-scale outbreak of positive cases.

#### Fitness for purpose

'Fitness for purpose' refers to how well a system or service can fulfil its intended goals or expected outcomes. These goals and outcomes are established by the user or beneficiary of the service whose expectations set the parameters on whether the service is adequate and fulfilling its need. The concept of 'fit for purpose' has a presence

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2 Christoph Aluttis et al., 'Public Health and Health Promotion Capacity at National and Regional Level: A Review of Conceptual Frameworks', *Journal of Public Health Research*, vol. 3, no. 1, 2014, doi: 10.4081/jphr.2014.199.

3 Ibid.

in Australian consumer law, where a consumer is guaranteed that a product must be 'reasonably fit for any purpose specified by the customer and agreed by the seller'.[4]

In the context of this inquiry, the Committee has been asked to determine if the Victorian Government's COVID-19 contact tracing system and testing regime is fit for purpose. This requires examining whether the system—delivery and technology—choices made to develop contact tracing and testing in Victoria is sufficient to support Victoria's wider public health response to the COVID-19 pandemic. In the Committee's view, the question of fitness for purpose relates to three central considerations, all of which have underpinned this inquiry and the concerns raised by stakeholders:

1. The ability of contact tracing and testing to rapidly respond, control and isolate positive cases or outbreaks amongst the Victorian community.
2. A contact tracing and testing framework should seek to limit the restrictions imposed on Victorian citizens and businesses.
3. The sensitive and personal data collected through testing and contact tracing, including its storage, use and accessibility, should always find the right balance between personal privacy considerations and protecting public health.

## 2.5 Structure of the report

The report is organised into Chapters which begin with a key question. The Committee provides a response based on the evidence received in submissions, at hearings and through our research. The Committee makes its own findings in relation to that evidence and in some cases, the report makes recommendations for change.

Throughout the course of the inquiry the Committee heard from stakeholders that there is a lack of public and easily accessible information on COVID-19 contact tracing and testing, related to:

- What the contact tracing sytstem and testing regime looks like in Victoria, particularly the recent digitisation of the system and how this compares to models in other jurisdictions
- How the system has been implemented in Victoria and who is responsible for its operation; including which companies have been contracted by the Victorian Government to supply services or personnel to this operation
- What are the benchmarks or key indicators which demonstrate that a contact tracing system and testing regime is working efficiently and effectively?
- Information around the storage, usage and accessibility of the sensitive and personal data collected by contact tracers

4 Consumer Affairs Victoria, *Product does not do what the salesperson said, or the consumer asked for*, October 2020, <https://www.consumer.vic.gov.au/products-and-services/problems-with-a-product/product-does-not-do-what-the-salesperson-said-or-the-consumer-asked-for#> accessed 23 November 2020.

- The capability of Victoria's redeveloped contact tracing system to address lessons learnt throughout the pandemic, including whether Victoria's system can adequately respond to a variety of pandemic scenarios (e.g., a third wave or COVID-normal)
- Any developments or changes to Victoria's COVID-19 testing approach.

The Committee attempts to fill gaps in the provision of information to the public within this report, if not directly then by providing links to information that is available to the public. Where information is not publicly available the Committee recommends that it be made public.

Despite the suppression of the virus in Victoria and the drop in cases it remains important that measures are in place that will protect us if needed and that are transparent and understood by the community.

# 3 What did this inquiry not address and why?



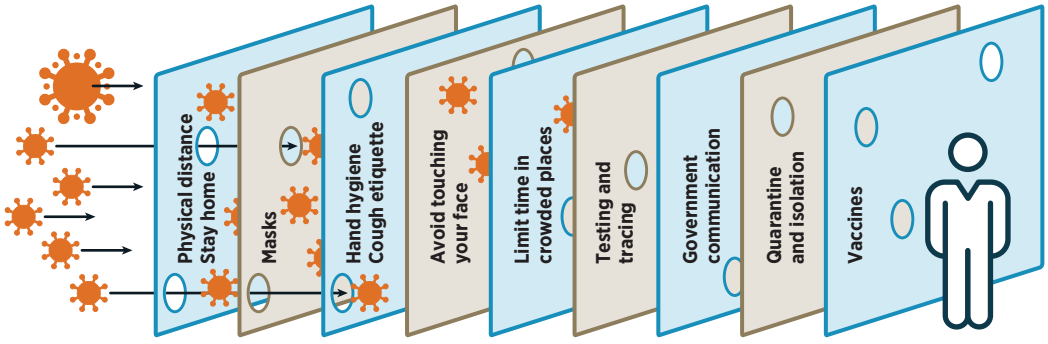
## 3.1 What this inquiry does not address

This inquiry has a specific focus on examining the capacity and fitness for purpose of the Victorian Government's testing regime and contact tracing system. The Committee has been guided by both the Terms of Reference and the very short reporting time allocated to complete the inquiry, in determining its approach.

The Committee acknowledges that there are broader interrelated issues that are directly connected to the topics of testing and contact tracing but which the Committee could not examine in depth. A robust response to COVID-19 in any jurisdiction includes a multi-tiered approach. Testing and contact tracing and are only two, albeit critical, elements amongst a range of necessary measures. The infographic below (Figure 3.1) illustrates other, complementary measures required. The Committee believes there is merit in reviewing the other elements of a robust pandemic response illustrated below and in determining how these were implemented in Victoria. This review should take place once recent changes are embedded.

Throughout the course of the inquiry, the Committee consistently heard from many stakeholders that there were significant gaps in public knowledge and understanding of the function and purpose of the various systems in place to address COVID-19. The Committee's approach in this report is to address the gaps in public understanding related to the Victorian Government's testing regime and contact tracing system. Significant issues raised by stakeholders at our hearings or in submissions, but which are outside the scope of the terms of reference are discussed briefly in the section below. The Committee believes this should be addressed by the agencies responsible for sharing this information or bodies responsible for scrutinising various parts of Victoria's COVID-19 response.

**Figure 3.1 Steps involved in responding to COVID-19**




Source: Legislative Council Legal and Social Issues Committee.

**FINDING 2:** A robust response to COVID-19 in any jurisdiction should include a multi-tiered approach. Contact tracing and testing are only two, albeit critical, elements amongst a range of necessary measures in effective communicable disease control.



### 3.1.1 Issues raised with the Committee that were outside the scope of this inquiry

As discussed above, several issues were raised by stakeholders that were outside the scope of the inquiry's focus on Victoria's testing regime and contact tracing system. These are raised briefly below. The Committee believes each of these issues should be considered in depth in the appropriate forum.

#### COVIDSafe App

The COVIDSafe applicatioin (app) is the smart tool developed by the Australian Government to support contact tracing systems in place in each state and territory by helping to identify people that have been exposed to coronavirus. The app requires installation and registration on individual smart phones and includes a requirement to provide a name, age range, phone number and postcode. The app works in the background of a person's smart phone, using Bluetooth to locate and record contact with other devices. Contacts recorded and stored in the app are kept for 21 days in line with COVID-19 test result and incubation period turnaround times.[5]

The COVIDSafe app is an initiative of the Australian Government and is not overseen by the Victorian Government. The Victorian Government's contact tracing system runs separately to the COVIDSafe app, with the latter intended as a supporting tool for contact tracing.

Several stakeholders raised concerns about the effectiveness of the COVIDSafe app in assisting contact tracing efforts. The following excerpts are taken from stakeholders who contributed to the inquiry and represent the views they expressed about the COVIDSafe app:

- Humans differentiate between an insignificant contact and a significant contact, and I believe that contact tracing has been superior with the humans being able to do that because they can do it rapidly. It is very difficult when you have got a COVIDSafe app that may pick up a lot of contacts that were through a glass wall or door, where you actually have not spent 15 minutes within a metre of them.[6]
- … in the light of the failure of the COVIDSafe app to provide reliable and accurate information, the Victorian State Government should have considered the possibility (would obviously involve consultations with the Federal authorities) of advising people of Victoria NOT to rely on the App too much! In some of the other States and

5 Department of Health, *COVIDSafe app*, October 2020, <https://www.health.gov.au/resources/apps-and-tools/covidsafe-app#what-covidsafe-is-for> accessed 23 November 2020.

6 Professor Mary-Louise McLaws, public hearing, via videoconference, 18 November 2020, *Transcript of evidence*, p. 32.

> Territories of Australia, deployment of the App, may (just may!) have had its merits but in Victoria, as far as contact tracing and keeping the public safe is concerned—it has not been the case…and the sense of the of the "false security" can only do harm![7] [emphasis in original]

- … a Smartphone App configured like the existing COVIDSafe App cannot deliver the necessary data inputs in a timely manner no matter how many downloads there have been of an app. The same app does nothing to facilitate the operation of public transport, venues, events cafes, restaurants, retail, and workplaces in a safe COVID normal world. Its failures and flaws contributed significantly to the problems faced by contact tracing in Victoria in the second wave.[8]

In the Committee's view, the effectiveness of the COVIDSafe app for Victoria's contact tracing efforts was insignificant. The app has not been nominated as a key tool for contact tracing by the Department of Health and Human Services. The app's developer told a Senate Committee that it had 7.1 million registered users. The app cost $4.3 million to develop.[9] Another $5.2 million has been spent on operational and usage costs[10] and almost $7 million on advertising, taking total expenditure up to $16 million.

The app has helped find an additional 17 contacts not found through manual contact tracing.

The app was discussed during hearings for the Parliament of Australia's Select Committee Inquiry into COVID-19. Members expressed concern about the usefulness of the app for contact tracing with witnesses unable to confirm the extent of use or efficacy of the app.

The Committee received no evidence that the Federal Government's COVIDSafe app was effective or contributed to supporting Victoria's public health response.

### Hotel quarantine program

Some stakeholders raised the use of hotel-based quarantine for (primarily) travellers returning to Victoria. Some of the issues that arose from hotel quarantine are related to the issues before this inquiry. The Committee acknowledges this as an area of concern for stakeholders.

Evidence presented to the Committee indicated that Victorians do not wish to quarantine in a hotel setting. It was suggested that our focus should be on developing wraparound support services to ensure that any Victorian who can isolate at home is not prevented from doing so.

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7 Dr Michael Baron, *Submission 11*, p. 3.

8 Parousya Technologies, *Submission 22*, p. 1.

9 Mr Randall Brugeaud, Chief Executive Officer, Digital Transformation Agency, Commonwealth Senate Community Affairs Legislation Committee, estimates hearing, Canberra, 29 October 2020, *Transcript of evidence*, p. 63.

10 Ibid.

This point was raised by Dr Mukesh Haikerwal, a General Practitioner in Altona, who stated that:

> We need to establish wraparound services so that people feel safe to isolate, they feel safe to go and get tested and they feel safe to quarantine as a family. People do not want to be put into hotel quarantine; they want to be with their families. How can we help them do it safely? Who is going to take the dog for a walk? Who is going to get the shopping? Who is going to get the grants from the state government or the federal government? This is what was done, and real-life needs were addressed so people felt comfortable to then go and be isolated.[11]

The Committee heard that the hotel quarantine program will remain a critical site for vigilance in relation to potential outbreaks. At a public hearing, Professor Brett Sutton, Chief Health Officer, Department of Health and Human Services, explained that:

> We have invested enormously in the interim recommendations from the inquiry into hotel quarantine, and I have got a lot of confidence in the way that that will be implemented going forward. But it remains inherently risky because that is where our positive cases are going to emerge. Some of those individuals will need hospital care, and our hospital systems will need to be ready to respond with all of the standards that we know need to be applied to infectious or potentially infectious cases.[12]

Mr Jeroen Weimar, Commander of Testing and Community Engagement, Department of Health and Human Services, told the Committee that the Department is preparing to conduct ongoing surveillance testing in hotel settings once international arrivals recommence:

> We are getting very focused on people coming into Victoria, particularly obviously international arrivals when they start up again, and how we ensure that people who are coming into contact with international arrivals through hotel quarantine are regularly tested, because they start to be the new front line, to minimise the risk of COVID transmission coming back into the community. So very high levels of surveillance testing—asymptomatic testing—in those kinds of settings will be really important, and of course that ongoing work with all Victorians around maintaining that focus on coming forward with symptoms.[13]

## Restrictions

Some stakeholders raised issues relating to the economic and personal wellbeing effects experienced by Victorians at times during the pandemic when restrictions were significant.

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11 Dr Mukesh Haikerwal, General Practitioner, public hearing, via videoconference, 18 November 2020, *Transcript of evidence*, p. 47.

12 Professor Brett Sutton, Chief Health Officer, Department of Health and Human Services, public hearing, via videoconference, 23 November 2020, *Transcript of evidence*, p. 30.

13 Mr Jeroen Weimar, Commander of Testing and Community Engagement, Department of Health and Human Services, public hearing, via videoconference, 23 November 2020, *Transcript of evidence*, p. 9.

Issues raised relating to the mental health and wellbeing of Victorians are of concern to the Committee and careful assessment and ongoing monitoring of the potential adverse impacts of restrictions should take place.

The economic consequences of COVID-19 restrictions on individuals, businesses and the community sector have also been discussed widely in the community. Mr Tim Piper, Director, Victoria, Australian Industry Group raised the issue of costs incurred by businesses relating to compliance with COVID-19 restrictions:

> Well, the cost to the economy is obviously quite significant, because it means that we have got inherent inefficiencies within the businesses, and so our manufacturing is reduced, our construction is reduced, even our retail. You walk into a retail store, you can only have two or three people in there in the small stores, people move on. So I guess while the cost is intangible at the moment, it is very obvious that it is costing us all—and even in a COVID-normal situation it is high. [14]

In the Committee's view, extensive investigation of the economic and other impacts of restrictions should be undertaken. The Committee believes that the government's focus on the health and safety of every Victorian including vulnerable cohorts has been the correct focus. It also notes the views of the Grattan Institute that those jurisdictions which did not impose restrictions when cases of COVID-19 escalated would suffer more economically in the long term.[15] Nevertheless, the Committee believe that government responses should endeavour to limit personal and economic consequences as much as reasonably possible.

**RECOMMENDATION 2:** That the Public Accounts and Estimates Committee examine the following issues in depth during their inquiry into the COVID-19 pandemic response:

- Wrap-around services that could be implemented to support individuals who are unable to isolate in a hotel setting because of health reasons.
- The cost effectiveness of the contact tracing system and testing regime including examining ongoing contracts and their efficacy.
- The impact of restrictions that have been implemented, including determining if their benefits have outweighed the social; physical and psychological health; and economic outcomes.

Investigate the extent of support that was offered to the Victorian Government by the Federal Government and how that process was managed.

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14 Mr Tim Piper, Director, Victoria, Australian Industry Group, public hearing, via videoconference, 16 November 2020, *Transcript of evidence*, p. 84.

15 Stephen Duckett and Will Mackey, *Go for zero: How Australia can get to zero COVID-19 cases*, Grattan Institute, Melbourne, 2020.

## 3.2 Other assessments of our response to COVID-19

The Committee has outlined several issues above that were raised in evidence by stakeholders. These are important but outside the scope of this inquiry.

For those readers who wish to explore these further the publications cited below examine Victoria's response to COVID-19 across a range of issues:

- Inquiry into the Victorian Government's Response to the COVID-19 pandemic, Parliament of Victoria, Public Accounts and Estimates Committee[16]
  Information available includes public submissions to the inquiry, transcripts from public hearings and an interim report.
- COVID-19 Hotel Quarantine Inquiry[17]
  Information available includes submissions, exhibits, transcripts from hearings, orders and rulings made by the Board of Inquiry, the inquiry's practices and procedures, and an interim report.
- National Contact Tracing Review[18]
  A report is available which reviews COVID-19 contact tracing and outbreak management systems and processes in all states and territories.
- National Hotel Quarantine Review[19]
  A report is available which reviews hotel quarantine arrangements in all jurisdictions, except Victoria. Victoria's system was not reviewed because there is a separate dedicated inquiry.

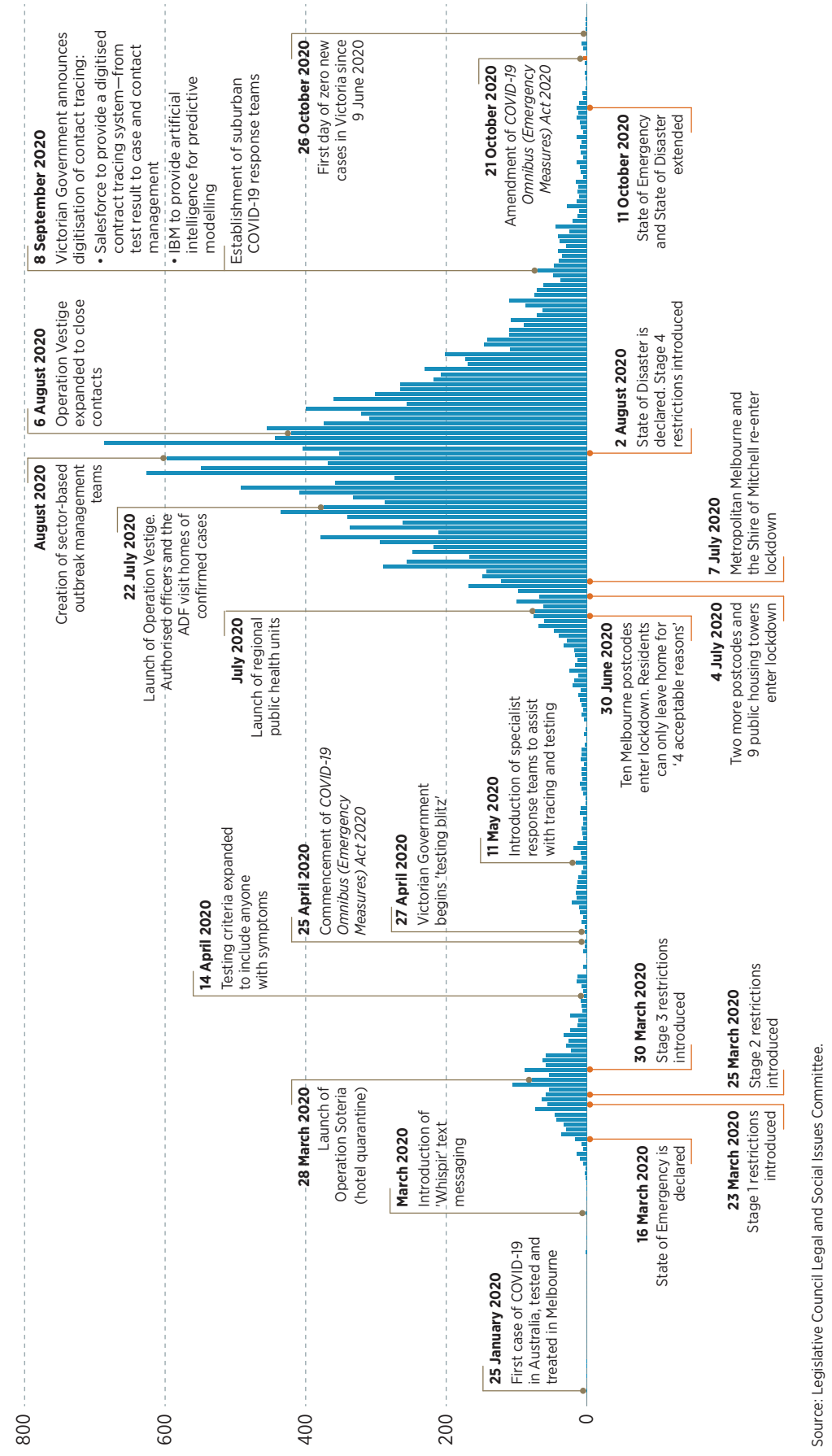
16 <https://www.parliament.vic.gov.au/paec/inquiry/1000>

17 <https://www.quarantineinquiry.vic.gov.au>

18 <https://www.health.gov.au/resources/publications/national-contact-tracing-review>

19 <https://www.health.gov.au/sites/default/files/documents/2020/10/national-review-of-hotel-quarantine.pdf>

# 4 What were some of the key events in relation to the Victorian Government's response to COVID-19?




Source: Legislative Council Legal and Social Issues Committee.

# 5 How has Victoria's contact tracing system and testing regime evolved since January 2020?

## 5.1 An unprecedented challenge

To properly assess the efficacy and performance of Victoria's testing regime and contact tracing system, it is important to understand those processes. It is also important to understand how they intersect. This Chapter focuses on examining how Victoria's approach to testing and contact tracing has evolved into its current iteration. It seeks to highlight the catalysts for change to the approach and to understand the overall purpose underpinning it.

The Committee heard from stakeholders that COVID-19 was—understandably—a challenge to the Victorian Government and its agencies. This was especially the case in relation to the Department of Health and Human Services, a Department which was challenged on many levels.

## 5.2 What is contact tracing?

The definition of 'contact tracing' varies across different jurisdictions, however, there are several common components. The World Health Organization's Contact Tracing Guidelines and the *National Contact Tracing Review* report use the same definition:

> Contact tracing is the process of identifying assessing and managing people who have been exposed to a disease to prevent onward transmission. When systematically applied, contact tracing will break the chains of transmission of COVID-19 and is an essential public health tool for controlling the virus.[20]

The Victorian Government provides a more detailed definition of contact tracing on the Department of Health and Human Services website:

> Contact tracing is a process of gathering information about the people who someone with coronavirus (COVID-19) has had contact with, and locations the person has been when they are infectious. Contact tracing is a critical part of our effort to slow the spread of coronavirus (COVID-19) in Victoria. When a person is tested for coronavirus (COVID-19) they also provide their contact details. If the test shows that the person has coronavirus (COVID-19), their test results and contact details are sent to the Department

20 World Health Organization, *Contact tracing in the context of COVID-19: Interim guidance*, 10 May 2020, <https://apps.who.int/iris/bitstream/handle/10665/332049/WHO-2019-nCoV-Contact_Tracing-2020.1-eng.pdf> accessed 30 November 2020.; National Contact Tracing Review, *National Contact Tracing Review: A report for Australia's National Cabinet*, Australian Government, Canberra, 2020.

> of Health and Human Services (DHHS). DHHS will then contact the person with coronavirus (COVID-19) to do contact tracing. Contact tracing helps us understand how someone may have caught coronavirus (COVID-19), and to identify any close contacts of the person to ensure they isolate at home. Identifying positive cases of coronavirus (COVID-19) and their close contacts is essential to help slow the spread of coronavirus in our communities.[21]

Although they have some differences, the definitions above are a useful guide for what sits within the scope of contact tracing.

The Committee notes that in much of the literature on contact tracing, it is defined in broad terms and often includes a vast number of disease control elements. In order to best address capacity and fitness for purpose within the limited timeframe of this inquiry, the Committee has decided to adopt a focused interpretation of contact tracing. Areas within scope of the adopted definition include:

- Testing and the testing system
- Governance
- Pathology—capacity and turnaround times
- Surveillance
- Technological improvements
- Data and decision-making
- Public communications.

Other areas, while interrelated and important components, were not the focus of the Committee during this inquiry:

- Outbreak, site and case management
- Infection control
- Quarantine and isolation
- Clearance criteria
- Interjurisdictional coordination (specifically, the relationship between Victoria and the Federal Government to manage contact tracing).

**FINDING 3:** Contact tracing is part of a wider process of detection of positive cases and isolation of close contacts. While it is important to identify, or 'trace' the contacts of a confirmed positive case, the communication, engagement, and information provided by government about isolation processes and contact tracing itself are important factors that must be embedded within effective contact tracing management.

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21 Department of Health and Human Services, *Contact tracing data: What is contact tracing*, December 2020, <https://www.dhhs.vic.gov.au/contact-tracing-data-covid-19> accessed 9 December 2020.

## 5.3 The role of the Department of Health and Human Services

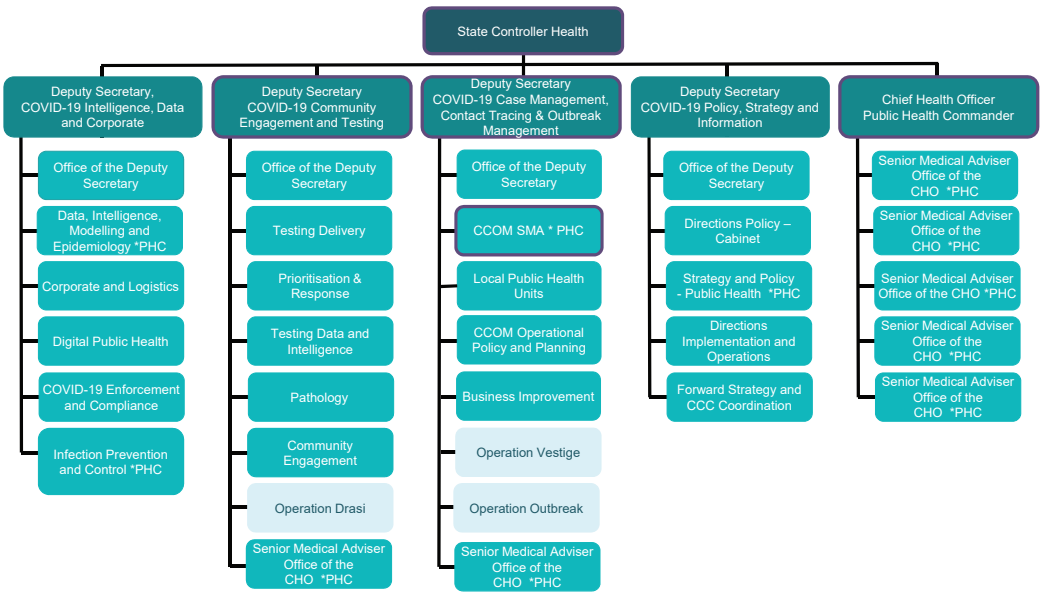
The Department of Health and Human Services (DHHS) is responsible for overseeing, implementing and enforcing Victoria's contact tracing system and testing regime, and much of the Victorian Government's COVID-19 response more generally.

In response to the COVID-19 pandemic, the Department of Health and Human Services established an 'emergency management structure' to organise its approach. At a public hearing, Professor Euan Wallace, Secretary, Department of Health and Human Services, explained the governance structure of the Department's Public Health COVID-19 Command:

> My predecessor, Kym Peake, as secretary, established an emergency management structure to deal with the health issues that were presented by the pandemic. This structure in front of you is just the Public Health COVID-19 Command component of that overarching emergency management structure... The key thing is that there has been a very linear reporting structure through to the state controller for health, which is the Secretary for the Department of Health and Human Services.[22]

Figure 5.1 provided by the Department of Health and Humans Services shows the command structure for Public Health COVID-19. This structure was in place at the time of writing. It is important to note that this command structure has evolved over time in response to management of the pandemic.

**Figure 5.1 Public Health COVID-19: command and control**

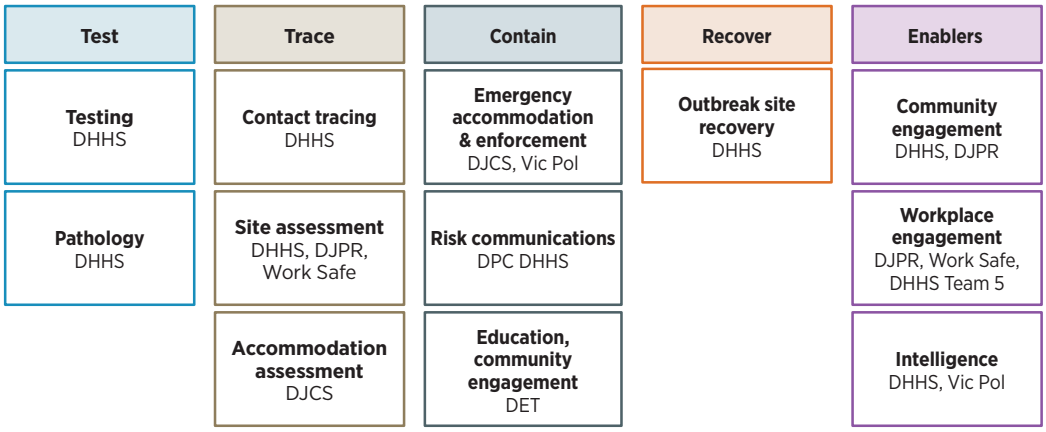



Source: Department of Health and Human Services, *Inquiry into the Victorian Government's COVID-19 contact tracing system and testing regime,* supplementary evidence received 23 November 2020, p. 3.

22 Professor Euan Wallace, Secretary, Department of Health and Human Services, public hearing, via videoconference, 23 November 2020, *Transcript of evidence*, p. 2.

It should be noted that Victoria's broader COVID-19 response is coordinated across several agencies and government departments, Figure 5.2 shows the responsible agencies for each element of Victoria's response

**Figure 5.2 Responsible agencies for Victoria's COVID-19 response**




Source: Victorian Government, Department of Health and Human Services, *Submission 23,* p. 30.

## 5.4 What is Victoria's testing regime?

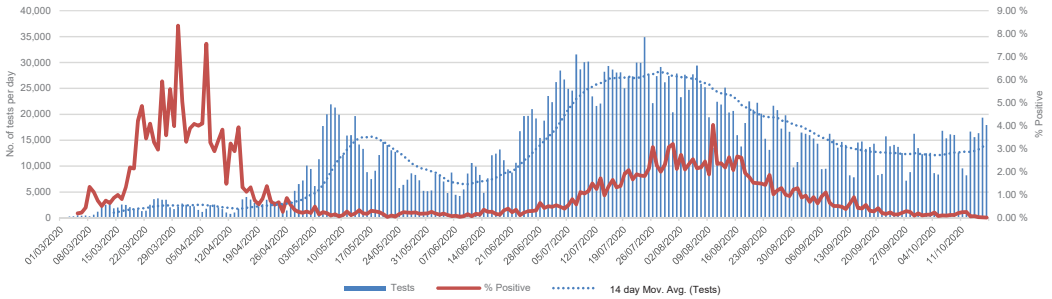
Since the pandemic began in January 2020, Victoria has had to pivot its approach to testing, depending on the type of outbreak and source of transmission, to cope with huge amounts of data, cases and contacts. Evidence to the Committee noted that the key challenge for testing, and the most important thing for the DHHS to do, is to:

- create easy physical access to testing
- give people confidence that they should get tested without delay
- diversify the testing process for different cohorts.

The Victorian Government has a complex range of services to achieve this that are described below.

Trends in the level of testing have ebbed and flowed drastically over the course of the pandemic. The following infographic (Figure 5.3) shows testing levels for the first 10 months of the pandemic in Victoria (January 2020 to October 2020). The chart indicates no testing in January, a ramp up in March, April and May, a drop off in May and June, and a steep ramp up in July, a gradual dipping down in August and gradual pick up at the time of receiving evidence for this inquiry.

**Figure 5.3** Number of tests and positive cases between 1 March 2020 to 11 October 2020



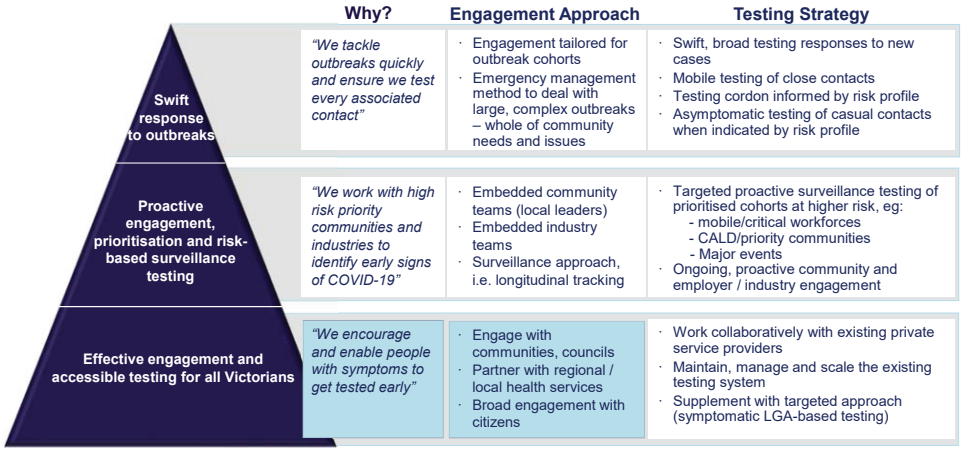

Source: Department of Health and Human Services, *Inquiry into the Victorian Government's COVID-19 contact tracing system and testing regime,* supplementary evidence received 23 November 2020, p8.



## 5.4.1 Testing strategy: the current approach

The Committee heard that from the beginning of August 2020, the Victorian Government moved to a three-tiered approach to community engagement and testing. The image below (Figure 5.4) explains the Victorian Government's approach at each level.

**Figure 5.4** Community Engagement and Testing Tiered Approach




Source: Department of Health and Human Services, *Inquiry into the Victorian Government's COVID-19 contact tracing system and testing regime,* supplementary evidence received 23 November 2020, p11.

## 5.4.2 Testing capabilities and capacities

Victoria has approximately 210 testing sites around the state. These sites form a network for early detection of COVID-19 in a community.

The Victorian Government told the Committee that the number of people who are getting tested remains high. According to World Health Organization guidelines, for every positive test there should be 30 negative tests.[23]

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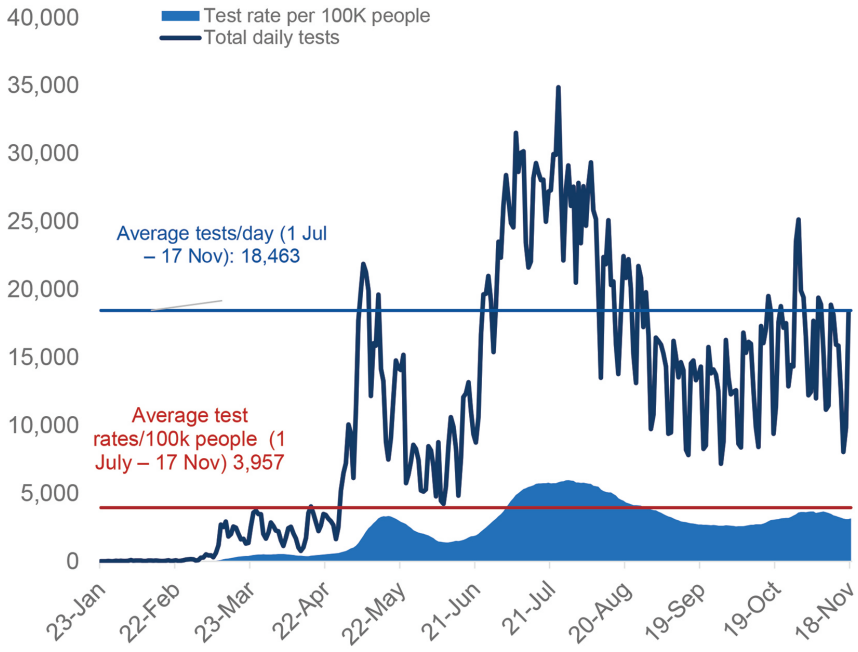
23 World Health Organization, *Coronavirus (COVID-19) Testing*, December 2020, <https://ourworldindata.org/coronavirus-testing#tests-per-confirmed-case> accessed 9 December 2020.

The Victorian Government set a benchmark of around 1500 tests for every 100,000 people over a two-week period, which is approximately 1.5% of the population over two weeks (this is predominantly for metropolitan Melbourne). Between 1 July 2020 and 17 November 2020, Victoria have averaged 3,957 tests per 100,000 people.

**Figure 5.5 Testing rate in Victoria per 100,000 people**




Source: Victorian Government, Department of Premier and Cabinet, Parliament of Victoria Public Estimates and Accounts Committee, supplementary evidence received 27 November 2020, p 9.

In relation to pathology and turnaround times for test results, at the time of writing the Department of Health and Human Services reported that Victoria is achieving 95% for next day turnaround. The Committee believes this is a very encouraging result.

### 5.4.3 Ease of access to testing sites

'Ease' and 'access' are listed among the optimal characteristics for testing in the National Contact Tracing Review.[24]

The backbone of the Victorian testing response is fixed testing. Fixed testing in Victoria is conducted from a range of facilities including large scale drive-throughs which are run through health services, walk-through sites, individual private pathology providers, respiratory clinics, retail sites and more.

According to evidence provided by the Victorian Government, Victoria's testing sites have good territorial penetration, with almost all of Metropolitan Melbourne within 10 km of a fixed-testing site. Across regional Victoria, there is significant coverage around where the populations are.

24 National Contact Tracing Review, *National Contact Tracing Review*, pp. 20–1.

**FINDING 4:** Maintaining ease of access to testing will give Victorians confidence that they can be tested without delay.

**RECOMMENDATION 3:** That the Victorian Government ensure that Victoria's testing regime includes diverse processes for different cohorts and testing sites have good territorial reach.

**FINDING 5:** All of Metropolitan Melbourne should be within 10km of a fixed-testing site and there should be significant coverage with testing sites across regional and rural Victoria.



### General Practitioner led respiratory clinics established by the Australian Government

In a submission to the Committee the Australian Government Department of Health told the Committee that they had funded the establishment of 28 General Practitioner led respiratory clinics in Victoria. The first of these opened on 1 April 2020.[25] Two of these clinics are run by Aboriginal community-controlled health services. Appendix 4 lists all of the Victorian respiratory clinics and their opening dates.

The Australian Department of Health's submission also explained the outcomes of the Victorian clinics from 1 April 2020 to 22 November 2020:

- 220,000 assessments; averaging around 500 assessments per week during June and July
- Over 199,800 tests
- Detection of approximately 480 positive cases[26]

## 5.4.4 Types of testing available

### Swab Testing

The following table (Table 5.1) created by the Committee provides an overview of Victoria's approach to COVID-19 testing based on the swab collection method. Alternative methods for testing are described below.

25 Australian Government Department of Health, *Submission 36*, p. 12.

26 Australian Government Department of Health, *Submission 36*, p. 13.

## Table 5.1 Overview of Victoria's COVID-19 testing approach

| | |
|---|---|
| **Process for COVID-19 testing** | • People experiencing any symptoms are required to get tested.<br>• A person should attend the testing clinic closest to them (either a GP or drive-through clinic).<br>• The test takes approximately 1 minute and involves a sample swab from the back of a person's throat or nose.<br>• Alternatively, a person can opt for a saliva test, which involves providing approximately 2ml of saliva for testing (quicker but reduced accuracy)<br>• Sample is sent to laboratory for electronic processing.<br>• Self-testing kits are also available (but have since stopped).<br>• Suspected cases can request testing to be completed at their place of residence by mobile testing teams<br>• Wastewater testing used to assess the presence of COVID-19 fragments in a local area |
| **Criteria for COVID-19 testing** | • Returned travellers<br>• Close or casual contact of a confirmed case<br>• Experiencing symptoms such as: fever, sore throat, cough, fatigue, difficulty breathing, runny nose, loss/change in smell or taste<br>• Experiencing community-acquired pneumonia with no other cause<br>• Healthcare worker with direct patient contact and have a fever over 37.5°C and an acute respiratory infection |
| **Method of notification** | • Text message<br>• Phone call from public health official (eg GP)<br>• ADF personnel conducting "door knock" services for those who cannot be contacted via phone |
| **Responsible for Notification** | • The GP or health services provider ordering a COVID-19 test is responsible for notifying the person of their results<br>• Pathology service providers will notify DHHS of all positive cases |
| **Testing Approaches** | • Direct outbreak monitoring<br>• Asymptomatic, close contact and rapid response surge capacity deployed<br>• At risk cohorts<br>• Ongoing presence, asymptomatic and additional resources provided to fixed site (surge workforce, popup sites)<br>• General Population<br>• Encouragement for symptomatic people to come forward to get tested, incorporating testing into general service providers |
| **Testing Targets** | • 1.5% of the population for each LGA |
| **Testing capacity** | • Current capacity of 15,000 tests with 95% receiving results within 24 hours, however suggestion that the system can only manage 20,000 tests before timing is affected<br>• Planned initiatives to engage greater testing capacity (35,000 tests processed with 80% of tests notified <24 hours) |
| **Testing locations** | • Majority of metropolitan residents are within 10km of a testing site<br>• Majority of regional residents are within 20 km of a testing site |

Source: Legislative Council Legal and Social Issues Committee.

The Victorian Government has also developed and explored several alternative testing modalities which can be used to detect positive cases or identify the presence of coronavirus fragments within a local community.

The Victorian Government submission outlined alternate and less invasive personal test methods that are currently being explored:

> While PCR testing is the 'gold standard' for diagnosing COVID-19, it relies heavily on clinical resources to collect the sample, requires sophisticated laboratory equipment and can take up to 24 hours to produce a result. The nasal swab is also often reported as being an uncomfortable experience and may discourage people from coming forward for testing, especially for surveillance testing.
>
> DHHS is seeking to explore the feasibility and utility of diversifying into emerging testing technologies to support surveillance testing.
>
> In partnership with the Peter Doherty Institute three technologies are being piloted with consideration for broader roll out late in 2020:
>
> - saliva testing – allows for application of PCR technologies to saliva samples collected with specialised swabs
> - antigen testing – near point-of-care swab that when combined with chemicals can return a result in 10–20 minutes
> - rapid molecular testing – simplified process that avoids the heating and cooling cycles necessary for standard PCR.
>
> Saliva, antigen and rapid molecular technologies are undergoing in-laboratory and clinical validation, before moving to in-field trials in late November and December. If these technologies demonstrate strong performance and the supply chain remains sufficient, they will be rolled out at scale in December and January.[27]

## Rapid Response Testing

In August 2020, the Victorian Government established Rapid Response Testing Teams which can be deployed to undertake quicker surveillance testing in high-risk industries. In its submission, the Victorian Government described the purpose of the Rapid Response Testing Teams:

> RRTTs [Rapid Response Testing Teams] are quick to deploy and are highly mobile meaning they can set up on-site and undertake a range of testing to assist with public health actions, such as surveillance and outbreak management.
>
> The establishment of the Rapid Response Testing Teams has significantly enhanced the ability of DHHS to deploy mobile and flexible testing capacity across the state, often within 24 hours. RRTTs are being deployed in response to a range of both time critical and proactive testing needs.[28]

There are currently 11 rapid response teams that the Victorian Government deploys to outbreak areas of concern or risk. This allows for resources to be concentrated on certain localities based on need and risk-prioritisation.

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27 Victorian Government, *Submission 23*, p. 23.

28 Ibid., p. 15.

The work on rapid test technology was further explained by Mr Weimar at a public hearing:

> [The Department of Health and Human Services] have been doing a series of trials with the Doherty Institute around antigen and rapid molecular testing modality, so we have had about six different testing platforms that we have been exploring and deploying here in Victoria to see whether we can use them as part of our testing regime. We are close to finalising our work, particularly on the antigen test, and the beauty of the antigen-testing platform is, although it still is provided under a clinical environment, so it still needs clinical supervision and clinical control—you cannot just hand it out like a box of lollies; we still have to administer it in a secure environment—it provides a response within 15 to 20 minutes, so it allows a far more decentralised rapid turnaround of testing results. Although it does not have the same specificity and sensitivity as the PCR test, it does give you a much earlier way of sorting out the wheat from the chaff, and particularly in those screening-type scenarios, that is something we are now starting to really look at: how we can deploy that antigen platform going forward.[29]

Alongside the Rapid Response Testing Teams, the Victorian Government has also established Roving Testing Squads which are 'smaller community health provider operated squads that… proactively engage with local priority communities on the ground.'[30] These squads work alongside the Rapid Response Community Engagement Teams to:

> … build confidence and trust in priority communities through engagement and education with LGA communities, and work in tandem to support contact tracing and facilitate effective isolation in the event of an outbreak.[31]

The Committee supports the establishment of rapid response testing teams to improve the efficiency and responsiveness of Victoria's testing regime.

### Asymptomatic testing

Asymptomatic testing is an enhanced testing surveillance approach which aims to conduct as many tests as possible by also testing people who do not have symptoms.

Coming out of the peaks of Victoria's second, and largest, COVID-19 outbreak the Victorian Government pivoted towards expanding the testing regime to include asymptomatic testing. The purpose of asymptomatic testing, as part of an enhanced testing regime, is to capture more data about the prevalence of COVID-19 in the community.

In November 2020, the Victorian Government announced it would be conducting an asymptomatic testing blitz in Melbourne's North-West, encompassing the City of Hume and City of Wyndham. The goal of the blitz was to conduct 500,000 tests on people

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29 Mr Jeroen Weimar, *Transcript of evidence*.

30 Victorian Government, *Submission 23*, p. 16.

31 Ibid.

residing in those areas regardless of if they had symptoms.[32] The testing drive in these areas began on 15 November 2020 with the establishment of four pop-up testing sites. Hume and Wyndham were selected because of the high number of cases both areas have experienced throughout the pandemic.[33] Participation in the testing drive is voluntary.

The Victorian Government has also established asymptomatic testing for public sector residential aged care workers. The purpose of this program is to more rapidly identify any positive cases amongst workers and residents which would put entire facilities at very high risk. Asymptomatic testing of public sector residential aged care workers commenced on 19 October 2020 and will continue until January 2021, with frequent reviews of the program conducted throughout.



Asymptomatic testing requirements for all care facilities, including residential aged care, are outlined in the Workplace (Additional Industry Obligations) Directions (No 13) issued by the Victorian Chief Health Officer. The Directions prescribe that:

> (13) An employer in relation to a Work Premises that is a care facility in Victoria must:
>
> (a) carry out surveillance testing for SARS-CoV-2 on its employees and contractors in relation to the care facility, where directed by the Chief Health Officer or their delegate, and in accordance with the requirements of the Department; and
>
> *Note: the Department of Health and Human Services may set different surveillance testing requirements for different care facilities (e.g. based on the type of facility, or location), depending on associated levels of risk.*
>
> (b) keep records of surveillance testing of employees and contractors for SARS-CoV-2.[34]

In its submission, the Victorian Government explained the industries involved in the asymptomatic surveillance testing program and its purpose:

> While ensuring that the pathology system is able to meet daily demand associated with symptomatic and outbreak related testing in an absolute priority, DHHS has established an asymptomatic surveillance testing program across key industries such as aged care, health services and food supply. The surveillance testing program will support the range of strategies being put in place to make these workplaces safe, and to help build confidence in key sectors.
>
> Health services will implement surveillance testing in line with current testing programs available for staff, such as testing responses for outbreaks.

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32 Sumeyya Ilanbey and Noel Towell, 'Huge new COVID testing blitz to target Melbourne's north-west', *The Age*, 9 November 2020, <https://www.theage.com.au/politics/victoria/huge-new-covid-testing-blitz-to-target-melbourne-s-north-west-20201109-p56cz4.html> accessed 27 November 2020.

33 Department of Health and Human Services, *Wyndham and Hume testing drive*, November 2020, <https://www.dhhs.vic.gov.au/wyndham-and-hume-testing-drive-covid-19> accessed 27 November 2020.

34 Workplace (Additional Industry Obligations) Directions (No 13), 20 November 2020, *Public Health and Wellbeing Act 2008* (Vic) s 200(1)(d).

> The Commonwealth announced in July 2020 that five COVID-19 testing teams would be deployed to test staff and residents of residential aged care homes. Participation in the program was voluntary for facilities and staff, and uptake has been around 50% of providers.
>
> Regular surveillance testing of aged care workers could also contribute to prevention of, or earlier detection and control of, outbreaks in aged care residential settings.
>
> Other priority industries for surveillance testing of staff are those industries involved in food manufacturing and supply, meat processing, supermarket distribution and refrigerated logistics.[35]

Professor Catherine Bennett, Chair in Epidemiology, Institute of Health Transformation, Faculty of Health, Deakin University, discussed some of the general findings from asymptomatic testing she was aware of:

> We were asking about asymptomatic testing all the way through, particularly where we had exposure sites, so people were at higher risk. The feedback—without being given the actual numbers, the indication was that the yield was very low with asymptomatic people. If you are not finding it with symptomatic, you are less likely to find it with asymptomatic because they will form a much smaller proportion of cases even when you are in the middle of a wave. In a way that is what the sentinel surveillance is doing. It is actually saying, 'We're going out and we're testing asymptomatic people'—they shouldn't be at work if they're symptomatic anyway—and that is giving us a read on what is happening in the wider community. My understanding is there are 3000 to 4000 tests a week already being completed under those programs, and as they extend into these other important workplaces, then that number will go up. So I think that is a really important way to approach it because you are also focusing on those areas where if there is a problem, you do want to know about it very early and to shorten that time.[36]

Mr Paul Guerra, Chief Executive, Victorian Chamber of Commerce and Industry, believed that to help the Victorian economy coming out of the second wave, asymptomatic testing of high-risk industries would be important.[37]

The nasal swab typically used for COVID-19 testing can be an invasive and uncomfortable experience for people; as asymptomatic testing in the community relies on people volunteering it was important that this issue was addressed. Mr Weimar (Department of Health and Human Services) told the Committee that the Victorian Government is building its saliva testing capability particularly for asymptomatic testing:

> we have also been developing and working on is our saliva-testing platform, and we now use saliva-based testing, where people suck on a straw, for the significant part of our ongoing asymptomatic surveillance testing program. It is much less intrusive, it is much

35 Victorian Government, *Submission 23*, p. 17.

36 Professor Catherine Bennett, Chair in Epidemiology, Institute of Health Transformation, Faculty of Health, Deakin University, public hearing, via videoconference, 16 November 2020, *Transcript of evidence*, p. 48.

37 Mr Paul Guerra, Chief Executive, Victorian Chamber of Commerce and Industry, public hearing, via videoconference, 16 November 2020, *Transcript of evidence*, p. 78.

> less uncomfortable and of course it reduces one of the major obstacles that we face, particularly in doing frequent asymptomatic surveillance testing. So the saliva platform is something we will continue to use and build upon.[38]

Some stakeholders told the Committee that asymptomatic testing should have been deployed during Victoria's second wave. In particular, that any close contact of a confirmed case, regardless of whether they were exhibiting symptoms, should be tested. Dr Mukesh Haikerwal, a General Practitioner based in Altona North, told the Committee that:

> One is that we are not supposed to test people if they are negative, if they have no symptoms. I said in public on the radio, 'Actually, I'm going to test anybody who comes here who is the direct contact of a positive. They won't have symptoms. I'm going to test them. I want to keep my community safe, and I want to do it today, tomorrow, not next week or the week after, when DHHS is going to see them. Put me in jail, but that's what I'm going to do. It's really important that people get tested now and stop that magnifying of effects if you do not get in early and lock people down and get them to isolate early'. So that has been a major issue. The actual words—we are not allowed to use the words 'asymptomatic testing', federally and state, number one.[39]

In the Committee's view, asymptomatic testing is an important tool for an enhanced testing regime. It can be particularly useful for protecting high-risk sectors or industries through enhanced surveillance of any possible positive cases which could lead to an outbreak amongst a facility or industry. However, establishing requirements for asymptomatic testing in particular sectors should not include provisions which unduly or unreasonably compel an employee to get tested if they are not exhibiting symptoms. Instead, the decision to get tested as an employee in a high-risk sector should remain voluntary and alternative monitoring provisions put in place such as daily temperature screening and formal declarations of being symptom-free. The Committee found this to be the case for the Victorian Government's public health residential aged care worker asymptomatic testing program.

There should be a degree of caution when conducting an asymptomatic testing blitz more broadly in local communities. While the Committee can appreciate the efficacy of this approach it needs to ensure that it is only conducted on a voluntary basis with no pressure to participate. The current testing blitz being conducted in the City of Hume and City of Wyndham is voluntary; and any asymptomatic testing programs developed in the future should also be.

**FINDING 6:** Some general practitioners initiated and undertook asymptomatic testing in their communities.

38 Mr Jeroen Weimar, *Transcript of evidence*, p. 9.

39 Dr Mukesh Haikerwal, *Transcript of evidence*, p. 45.

**FINDING 7:** The Victorian Government is developing alternative testing modalities including at-home testing, rapid response testing, surveillance testing, asymptomatic testing and wastewater testing.

**FINDING 8:** Asymptomatic testing is an important tool for an enhanced testing regime.

**RECOMMENDATION 4:** Asymptomatic testing should continue to be voluntary for all Victorians.



### Wastewater testing

Wastewater testing is used to monitor for the presence of SARS-CoV-2 (the virus which causes COVID-19) within a local area through detecting viral traces in samples taken. Wastewater testing is a collaborative research initiative between Australia and New Zealand, with each state and territory participating. It is a useful tool for monitoring the presence of coronavirus around the state and particularly in wastewater treatment plants near border areas; this can be used to tell if cases in one jurisdiction might have entered another.

Victoria is collecting samples from 43 wastewater treatment plants around the state, each serving a 'variety of small, medium and larger communities ranging from 800 to around 100,000 in the largest regional centres.'[40]

Victoria has so far found wastewater testing to be helpful in identifying coronavirus fragments. Mr Weimar told the Committee that:

> … they are really good canaries in the coalmine. It does not tell you who has got COVID; it tells you that there has been some COVID activity in the area and it really allows you to narrow in. It will be very important for a COVID-safe, COVID-normal summer for us to continue to use that sewage platform.[41]

Through wastewater testing, Victoria can identify where traces of the virus exist and at-risk communities can appropriately respond, such as through a call-out for testing. On 20 November 2020, the Victorian Government urged residents in Altona and surrounding suburbs to get tested for COVID-19 after samples taken from the Altona sewage catchment showed traces of the virus. This was detected following eight weeks of no positive cases in the area.[42]

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40 Victorian Government, *Submission 23*, p. 17.

41 Mr Jeroen Weimar, *Transcript of evidence*, p. 9.

42 'People urged to get tested after coronavirus fragments detected in Melbourne sewage', *SBS News*, 21 November 2020, <https://www.sbs.com.au/news/people-urged-to-get-tested-after-coronavirus-fragments-detected-in-melbourne-sewage> accessed 27 November 2020.

In its submission, the Victorian Government explained the benefits of wastewater surveillance:

> After the end of the Victorian second wave, it is now possible to initiate wastewater surveillance in the Melbourne metropolitan area for the purpose of the early detection and the program is working on defining sub-catchments with around 100,000 and feasibility to deploy additional upstream sampling.
>
> Samples of wastewater are collected from treatment plants and in the network, both in metropolitan and regional locations. These samples are analysed for fragments of COVID-19.
>
> If fragments of COVID-19 are detected in the wastewater of an area where there have not been recent positive cases, local communities can be more vigilant, increase clinical, and help health authorities to target public health advice to minimise transmission.[43]



The Committee, in the short time it completed this inquiry, did not have sufficient opportunity to inquire into why the Victorian Government did not initiate wastewater surveillance until after the second wave.

**FINDING 9:** The Victorian Government did not initiate wastewater surveillance until after the second wave.

**RECOMMENDATION 5:** Pending further research into its validity, the Victorian Government should continue to incorporate wastewater testing into an ongoing disease surveillance program.

### At home-testing

In mid-August, the Victorian Government launched at-home testing, putting in place arrangements for those who required access to testing from home.

Originally designed for people who are mobility-impaired or may have physical difficulties getting tested, the Committee heard that there had been a stronger uptake of this type of service than expected. Other barriers to getting tested, be it embarrassment, social pressure, complexity of family arrangements within the home, have made at-home testing increasingly popular.

Since its inception the Call-to-Test program has tested just under 2000 individuals, 68 of whom were in regional Victoria.

### Saliva testing

Saliva testing particularly has a key role in identifying the prevalence of COVID-19. The Committee notes that saliva testing had been significantly rolled back so that

43 Victorian Government, *Submission 23*, p. 17.

further research could be conducted to improve its accuracy. The Committee heard from industry representatives that there is further need for saliva testing as it is easier to administer the test and has a rapid turnaround time.

Mr Tim Piper, President, Australian Industry Group, noted its significance as business began to reopen and mandatory workplace testing was introduced in certain industries:

> There are about 95 companies in Victoria that have to have testing of about 25 per cent of their workforce every week. Some of them have been operating and using saliva testing over the past few weeks, and that has been very positive and enabled workers to get it done extremely quickly. In about 15 minutes you find out whether you have COVID or not, with about 75 per cent accuracy. That has now been removed from those companies because it was seen as a pilot. They have not been given a reason why it has been removed, but it has been. It is voluntary testing, and the companies are already finding a lack of willingness to undergo the nasal testing, so they are worried that they are going to have a significant reduction from where they were. They had almost a total acceptance of the saliva testing before but now it has dropped off significantly, and I think it is something we need to be very conscious of, because if it is voluntary test, people do not want to have it as regularly as they are going to be required to in the future.[44]

**RECOMMENDATION 6:** The Committee encourages further research into and development of saliva testing technology and other non-invasive, quick turn-around technologies, for wider roll out in industry and time-critical situations.

### Surveillance testing approaches adopted in Victoria

Surveillance testing helps to gauge the prevalence of a disease within a community by periodically evaluating samples from randomly selected non-symptomatic individuals within that community.

The Australian National Disease Surveillance Plan for COVID-19 states that 'a high rate of well-targeted testing is essential to provide confidence that cases will be detected as control measures evolve.'[45]

The Committee heard that over the past 10 months, the Victorian Government has increased its use of surveillance testing, moving from short-term blitz testing to long-term surveillance in its testing approach. At the time of writing, the Victorian Government was proactively testing a number of high-risk workplaces, such as Victoria's:

- **Public Sector residential aged care**: Around half of the workforce is tested every week in metropolitan Melbourne.

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44 Mr Tim Piper, *Transcript of evidence*, p. 79.

45 Communicable Diseases Network Australia, *Australian National Disease Surveillance Plan for COVID-19*, May 2020, <https://www.health.gov.au/sites/default/files/documents/2020/05/australian-national-disease-surveillance-plan-for-covid-19.pdf> accessed 30 November 2020.

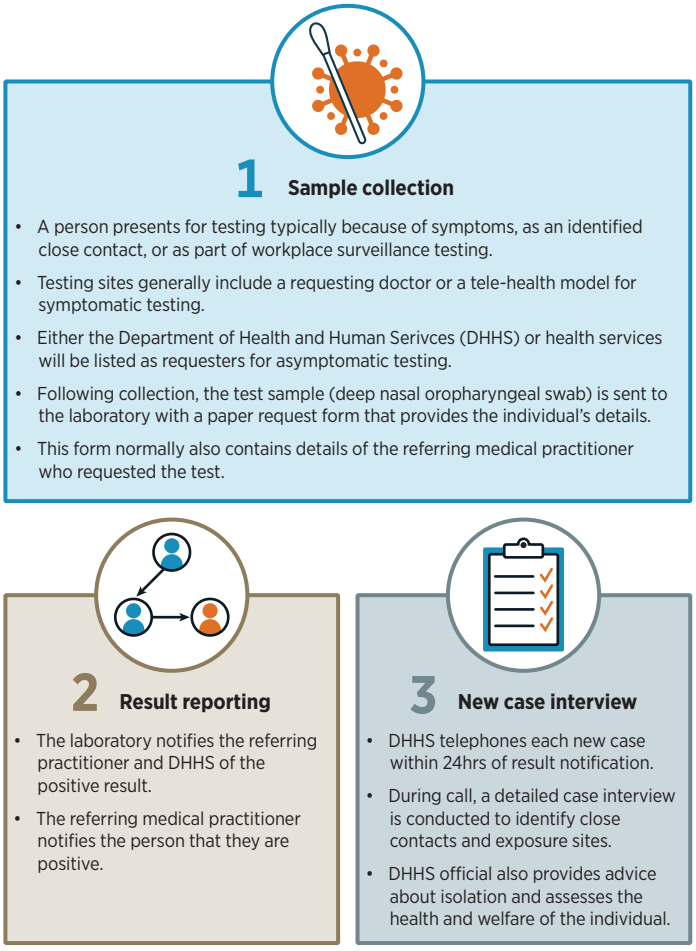
- **Food industry**: workers are subject to surveillance testing requirements, with businesses required to test 25% of their workforce every week.
- **Seasonal horticultural workers**: are not allowed to relocate from Melbourne to commence work without proof of a negative testing result, and on-farm surveillance testing in horticulture areas closer to metropolitan Melbourne is undertaken by Department of Health and Human Services officials, as workers are likely to commute daily for work (rather than relocate).[46]

## 5.5 The process of contact tracing

The following figure (Figure 5.6) provides a high-level overview of Victoria's current contact tracing process, from testing to case and contact clearance, setting out the broad steps in sequence.



**Figure 5.6** Victoria's current contact tracing system (overview)

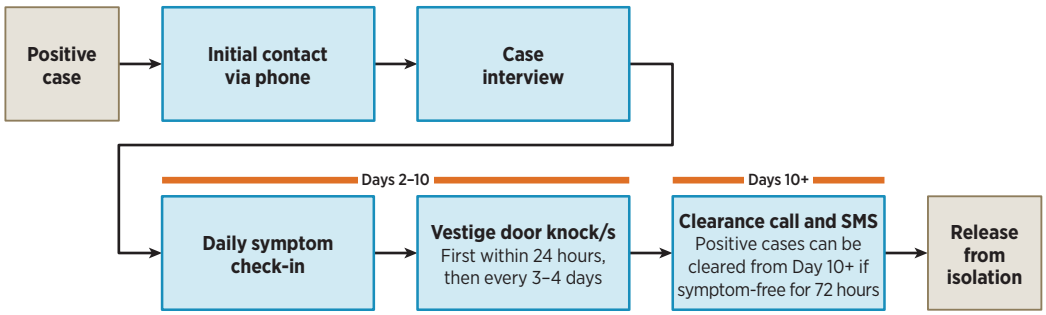



Source: Legislative Council Legal and Social Issues Committee. Information from Victorian Government, Department of Health and Human Services, *Submission 23,* p 7.

46 Victorian Government, *Submission 23*.

Case interviews are a crucial part of contact tracing used to identify close contacts of a confirmed case, their movements, and the quarantine or isolation procedures in place. There are seven broad steps involved in the case interview process, these are outlined in Figure 5.7.

**Figure 5.7 Case interview process**



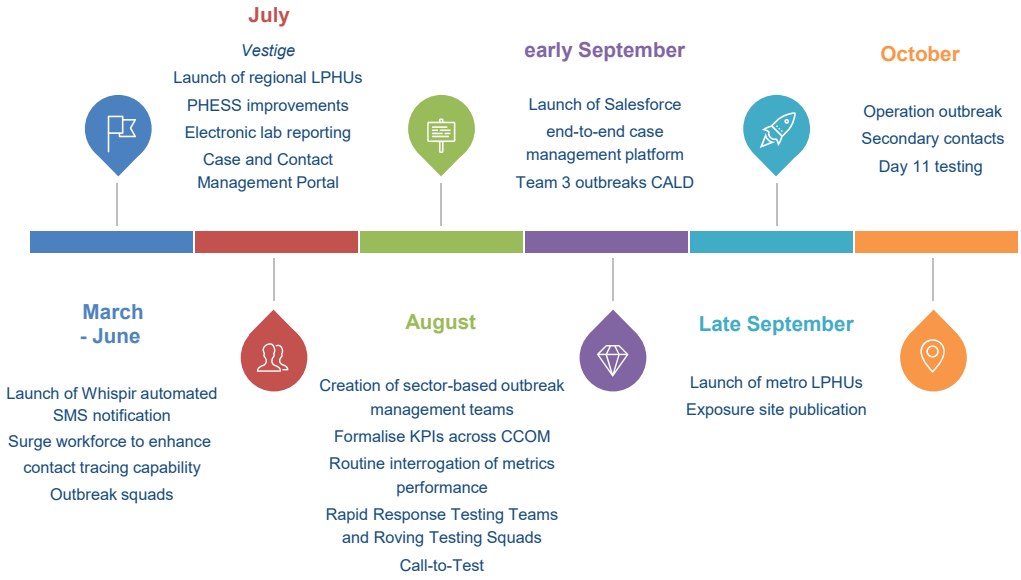

Source: Legislative Council Legal and Social Issues Committee. Information from Victorian Government, Department of Health and Human Services, *Submission 23,* p 8.

For a more fulsome discussion of the issues that relate to contact tracing, please refer to Chapter 9.

Victoria's contact tracing system has evolved throughout the pandemic. At the time of writing, Victoria had recently adopted an automated and centralised digital process through the provision of Customer Relationship Management technology by cloud computing company Salesforce. This technology established an end-to-end contact tracing system. This replaced the version of contact tracing deployed during Victoria's second wave which relied on manual data collection and case interviewing, several companies responsible for different components and a highly centralised public health response sitting within the Department of Health and Human Services.

Figure 5.8 presents a high-level overview of the adaptations made to Victoria's contact tracing system in response to the evolving pandemic.

**Figure 5.8** Contact tracing developments




Source: Department of Health and Human Services, *Inquiry into the Victorian Government's COVID-19 contact tracing system and testing regime,* supplementary evidence received 23 November 2020, p12.

**FINDING 10:** The use of manual data entry processes at the beginning of the pandemic meant that the system for contact tracing and recording of testing was not fit to deal with any escalation in cases and led to significant errors.

## 5.5.1 Digitising systems to speed up and expand capacity of contact tracing

A large part of Victoria's contact tracing evolution has been the introduction of digital systems to help with end-to-end contact tracing.

### Upgrading the Public Health Event Surveillance System

The Victorian Government made the initial decision to repurpose its existing communicable diseases track and tracing system, the Public Health Event Surveillance System (PHESS), to manage its COVID-19 case, contact and outbreak management process. During Victoria's second wave, PHESS was managing an unprecedented volume of data. This, according to the Victorian Government, 'affected system performance and reporting timeliness.'[47]

In July 2020, as case numbers increased, PHESS underwent a suite of digital improvements, including:

- Upgrading the software and migrating the system to the Microsoft Azure platform
- Application monitoring and improvements to configuration settings

47 Ibid., p. 25.

- Implementing a separate database for negative test results
- Implementing secure remote access.

The Victorian Government explained to the Committee the benefits of digital improvements to PHESS:

- Expanded capability to process higher volumes through automated workflows
- Enabled multiple workforces (internal and external) to use concurrently.[48]

### Introduction of digital customer relationship management



In addition to the improvements discussed above, Salesforce was selected on 28 August 2020 to provide a Customer Relationship Management (CRM) platform built to accelerate the contact tracing process.

The Committee notes that Salesforce first offered its contact tracing end to end software to the Victorian Government on 24 March 2020, but this offer was declined. On 24 July 2020, following an invitation by the Victorian Government, Salesforce presented its contact tracing capabilities to the Department of Health and Human Services.

The Victorian Government told the Committee that acceleration of contact tracing can occur because the steps are automated:

> This acceleration is afforded by automation of almost all steps from the moment a positive case is notified, including case allocation, case alert, contact notification, isolation/quarantine messaging etc.[49]

The focus of Victoria's COVID response is 'test, trace and isolate', with contact tracing encompassing the latter two aspects of trace and isolate. Aside from acceleration capabilities, the Victorian Government described other benefits of its CRM platform:

> ... the ability to provide simultaneous users contact tracing across DHHS' CCOM team and local public health units. This will help synchronise all local public health units and central DHHS teams to monitor and rapidly contain future transmissions of COVID-19.[50]
>
> ...
>
> The case management system allows for prioritisation of cases to create a multi-tiered tracing effort (primary and secondary close contacts).

48 Ibid.

49 Ibid., p. 26.

50 Ibid.

Using the Salesforce technology, contact tracing goes through a series of automated steps which allows for prioritisation of and adaptation to complex outbreaks and larger case numbers. The process involved includes:

- A central database within the Department of Health and Human Services that receives test results as they are processed
- Results are automatically sent to Salesforce's technology which automatically starts the contact tracing process
- Using risk-prioritisation, a close contact is allocated a response time which can be escalated if it is at risk of lapsing
- Close contacts are notified and given advice about testing and isolation.



The Salesforce solution has SMS capability built into it which allows it to contact identified close contacts from within the system ensuring the contact tracing can remain integrated and centralised from a technology perspective. According to Mr Michael Bonaddio, Principal Architect, Salesforce, the Victorian Government decided to pivot to using Salesforce technology to send SMS messages for engagement.[51] Mr Bonaddio stated one of the reasons for using the Salesforce SMS capability was that the system 'supports two-way messaging, so if people were to respond to that, conversations can be had with citizens through that process.'[52]

**FINDING 11:** Salesforce first introduced their end-to-end system to the Victorian Government in March 2020.

### Introduction (and subsequent cessation) of services for health tracing

On 18 July 2020, American-based technology company IBM was approached by the Victorian Government to determine whether its i2 analyst platform could assist Victoria with COVID-19 data analysis. At this time positive cases were steadily increasing but not reaching the peak numbers experienced during August, with a total of just under 2,000 positive cases recorded on 20 July 2020.[53]

On 29 August 2020, IBM was awarded a $4.197 million tender by the Department of Health and Human Services for 'enhanced health tracing'.[54] The i2 platform was purchased as a tool for predictive modelling of COVID-19 data to inform policy and public health decisions.

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51 Mr Michael Bonaddio, Principal Architect, Salesforce, public hearing, via videoconference, 16 November 2020, *Transcript of evidence*, p. 9.

52 Ibid., p. 10.

53 Victorian Government, *Submission 23*, p. 12.

54 Buying for Victoria, *Contract - C9466A*, <https://www.tenders.vic.gov.au/contract/view?id=187636> accessed 30 November 2020.

A news article published by The Age outlined the intended purpose for procuring the platform:

> The software will provide deeper and quicker analysis to identify links between cases, emerging trends in geographic areas or workplaces and provide speedy insight into outbreaks...[55]

At a public hearing, Mr Charles Agee, General Manager, Global Technology Services, Australia and New Zealand, IBM Services, clarified that the i2 platform is designed as 'an analyst tool, intended to assist a user in performing their analysis', further stating 'it is not an AI tool', because it does not have capability to automate the analysis or to predict an alert.[56]



In early October, after a two-day period of use, the Victorian Government directed IBM to consider developing capabilities for predictive analysis and automated alerts using the i2 platform and to provide indicative timelines for completing that process. According to IBM Services, the Victorian Government needed these new capabilities because the situation had changed since IBM was first hired. While IBM did put forward some solutions to address the requested automation, ultimately, IBM's i2 platform capabilities did not extend to predictive analysis or automated alerts. Mr Agee described the needs the Victorian Government was seeking at the time through the i2 platform:

> During the week beginning Monday 12 October it became clear to IBM that the DHHS data analysis team required a system capable of alerting them to significant events or conditions that should be followed up by an analyst, in contrast to an analyst using the system to discover these conditions or events.[57]

As a result, the Victorian Government elected to stop pursuing the i2 platform for data analysis and requested IBM stop work. Mr Agee explained that:

> On 14 October the DHHS project manager requested IBM stop work on the i2 platform deployment. DHHS subsequently indicated their intention not to proceed to the next stage using the i2 platform's capabilities as its requirements had evolved.[58]

Evidence provided to the Committee is that the platform is not in use by the Victorian Government today. When the Committee asked about the cessation of IBM's work for Government, Mr Agee responded that this is not 'uncommon in technology projects.'[59]

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55 Henrietta Cook and Sumeyya Ilanbey, 'Artificial intelligence to help in the fight against COVID-19', *The Age*, 2 September 2020, <https://www.theage.com.au/national/victoria/artificial-intelligence-to-help-in-the-fight-against-covid-19-20200902-p55rsd.html> accessed 30 November 2020.

56 Mr Charles Agee, General Manager, Global Technology Services, Australia and New Zealand, IBM Services, public hearing, via videoconference, 18 November 2020, *Transcript of evidence*, p. 84.

57 Ibid., p. 85.

58 Ibid., p. 84.

59 Ibid., p. 87.

**FINDING 12:** The Victorian Government engaged IBM for an analytics platform. The Committee regards the engagement as a misguided and costly mistake given the platform's known lack of AI capacity.

### From manual to digital Test Tracker

Before updating to the current digital Test Tracker system, when an individual presented for a COVID-19 test Victoria had manual processes in place for gathering information.[60]

Test Tracker was piloted in September and October 2020. It is a real time digital tracking of the COVID-19 test from swab to result notification. The technology uses QR codes and enables people to self-register their test, or for testing staff to register on a person's behalf.



In its submission, the Victorian Government outlined how Test Tracker works:

- each [test] is recorded digitally and receives a unique identifier
- information provided at point-of-test includes key data needed if the result is positive
- the movement of the test sample can be traced in real time through until result
- test result available within 24 hours.[61]

Adopting a digital Test Tracker marks a significant shift in the Government's approach to contact tracing. While it was not made clear to the Committee whether a specific catalyst sparked the shift to a digital approach, the *National Contact Tracing Review* report outlined the changes associated with digital test tracking, it:

- Allows much of the manual processing of testing to be automated, and has the potential to link with downstream digital contact and case management tools (reduced errors)
- Allows for monitoring testing levels in different cohorts, such as geographic location (based on home address), occupation, and industries and cultural groups.
- Allows for targeted call-to-testing
- Saves valuable hours in notification of confirmed cases and contact tracing
- Collects data on language and country of birth, enabling measures such as ensuring an interpreter is present before a case interview begins.[62]

60 National Contact Tracing Review, *National Contact Tracing Review*, p. 70.

61 Victorian Government, *Submission 23*, p. 18.

62 National Contact Tracing Review, *National Contact Tracing Review*, p. 70.

**FINDING 13:** Appropriate data capture systems are now being rolled out throughout the state, however the length of time between the first COVID-19 case in Victoria on 25 January 2020 and the rollout of a digital test tracking system piloted in September and October 2020 is disappointing and inadequate.

### 5.5.2 Public communication platforms

The following companies were engaged to assist with public communication interfaces and efforts related to contact tracing.

#### Whispir



Whispir was first contacted by the Victorian Government to provide services for contact tracing on 17 March 2020 and began administering their communication service around 25 March 2020. The Australian-based communication platform is used to send daily messages to monitor close contacts of confirmed cases and returned travellers (when the state accepts them). Whispir provides the interfaces and the tools for the Victorian Government to invoke their own communications and processes.

The Committee notes that Whispir was contracted to provide close contact monitoring, rather than contact tracing perse. Nevertheless, Whispir's role in delivery of communications was key to optimising contact tracing efforts, therefore the Committee sees value in outlining some of the functions and benefits of the Whispir platform.

When providing evidence to the Committee, Mr Jeromy Wells, Chief Executive Officer, Whispir outlined how the platform's processes work in practice:

> When DHHS triggers that communication process it activates a Whispir workflow, and we will follow the business calls that have been mapped by DHHS. So we will send that communication to one or two—or if you wanted, you could send it to 9 million people. It would not matter. They are highly targeted, individual, personalised communications. And those people all respond in different ways, and then we will manage those responses and hand it off to various agencies as required by DHHS as defined in the workflow.[63]

Mr Wells identified five high level functions Whispir provides:

> At a high level we do five things. We provide the tools for companies or organisations like DHHS to coordinate, configure and construct their communications…
>
> The second thing that we do is we provide profile management tools, and that enables people to do highly targeted communications based on location or can in some instances be a large number of dynamic variables. In this instance most of the contact and the profile management has been managed in DHHS's other systems. We have been engaged to facilitate and manage the interactions.

63 Mr Jeromy Wells, Chief Executive Officer, Whispir Limited, public hearing, via videoconference, 16 November 2020, *Transcript of evidence*, p. 70.

> The third thing that we do is we provide tools for non-technical people to create business rules: 'So in the event that this happens, then do this'. A lot of that work is not around the primary outcome; it is around thinking about how you manage the exceptions. What do we do if a person has responded in this way and blah, blah, blah? So these interactions can become quite complex and involve multi departments or other agencies needing to hand this over to another agency and respond.
>
> The fourth thing that we do is we manage all the delivery channels to ensure a high-quality and timely service.
>
> The fifth thing that we do is we provide near real-time reporting so that DHHS or other agencies have the actionable insights that they need as fast as possible.[64]

Whispir outlined some of the positive outcomes of its implementation:

> In our own assessment in terms of activity we have saved between 50 000 and 75 000 person hours of time that would otherwise be taken up manually, through automation, since the beginning of COVID to now, which are resources that can be redeployed in other critical activities where people are providing high value.[65]



## Helloworld

On 27 March 2020, Helloworld Travel Ltd (Helloworld) commenced a $3.6 million contract with the Victorian Government for the provision of staff for the COVID-19 hotline.[66] The contract expired 27 July 2020. A second contract was engaged from 20 July 2020 to 'conduct contract tracing call centre services including performance of outbound calling activities to support DHHS contract tracing requirements.' This contract is valued at $7.6 million and is due to expire on 21 January 2021.[67]

The Committee had the opportunity to speak to Helloworld at a public hearing and clarify the scope of the work they were undertaking on behalf of the Victorian Government. Mr Andrew Burnes, Chief Executive Officer and Managing Director, Helloworld, explained that:

> We started this work at the beginning of April after liaising with the department around their needs for an incoming call service, providing advice to people ringing in wanting further explanation in relation to the quarantine rules et cetera that were in place from time to time. The second part of what we did was an outbound contact-tracing service for the Department of Health and Human Services, which I know is one of two focuses of this committee.
>
> We engaged up to several hundred of our personnel as the demand went up and down over the last eight months.[68]

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64 Ibid., pp. 67–8.

65 Ibid., p. 67.

66 Buying for Victoria, *Contract - C9233*, <https://www.tenders.vic.gov.au/contract/view?id=184878> accessed 1 December 2020.

67 Buying for Victoria, *Contract - C9460*, <https://www.tenders.vic.gov.au/contract/view?id=187146> accessed 1 December 2020.

68 Mr Andrew Burnes, Chief Executive Officer and Managing Director, Helloworld Limited, public hearing, via videoconference, 16 November 2020, *Transcript of evidence*, p. 55.

Mr Burnes also explained that the work engaged by Helloworld evolved over a short period from conducting outbound calls for contact tracing to also receiving in-bound calls for the COVID-19 hotline:

> Initially we were involved in contact tracing. That was our initial engagement. As people were testing positive, they were being spoken to by other services and then we were being provided with lists of people to contact who may have been either somebody who was COVID positive and was in self-isolation at
>
> home or, alternatively, a close contact of somebody who had been diagnosed with COVID, and we were talking to them on a daily basis whilst they remained in quarantine. It was about three or four weeks after we began that work that we actually started as well providing an incoming call service.[69]



To assist with training and preparation of Helloworld employees, who had no prior relevant experience in contact tracing or operating call centres, the Victorian Government provided:

- A script plus other relevant protocols (i.e. process for contacting an interpreter) to assist with contact tracing interviews[70]
- A two-day online training course conducted by the Department of Health and Human Services
- Continuous on-the-job training as the pandemic evolved and issues were identified.

**FINDING 14:** Victoria's redeveloped contact tracing system demonstrates that the Victorian Government responded to lessons learnt throughout the pandemic. Nevertheless, further refinements are needed to ensure that it is fit for purpose.

### 5.5.3 Shift from centralised to decentralised contact tracing

The Committee heard from many stakeholders that Victoria's centralised approach to public health administration (as opposed to its devolved approach to the hospital system) contributed significantly to the shortcomings and issues that are raised in Chapter 9 of this report. In response to the issues that arose the Victorian Government made adjustments to its approach to contact tracing.

In mid-July 2020, the Victorian Government established six regional public health units to allow locally based responses to outbreaks in those communities. During the end of Victoria's second wave, the Victorian Government extended this local-based response by establishing suburban units in metropolitan Melbourne.

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69 Ibid., p. 56.

70 The Committee requested a copy of the script used by Helloworld but at the time of writing had not received it.

The *National Contact Tracing Review* outlined the key tenets of a decentralised model:

> A decentralised model allows local teams to work independently while still being able to access resources from the central health department and other public health units...
>
> In a decentralised model, oversight and control reverts to the central health department in the event of an emergency, enabling a central coordination capacity to provide local health districts with information and expectations for locally appropriate implementation. This model also enables twinning of public health units to meet surge demands.
>
> Decentralised contact tracing teams should have access to centralised technology for case allocation, interviews and outbreak management. Whichever model – centralised or decentralised or mix of the two – local knowledge must be balanced with contact tracing expertise to achieve rapid and high-quality outcomes.[71]



The Committee notes that there are several drivers underpinning the shift to decentralised contact tracing:

- To use as a base upon which to build surge contact tracing capacity
- To allow for management of large quantities of data
- To ensure locally embedded health workers are linked with local health providers for testing
- To use locally embedded health workers who already have relationships with community members and community leaders and know the geography of the location.

**FINDING 15:** Local knowledge is an indispensable tool in establishing an efficient contact tracing system and broader public health response. Regional presence and local case managers are essential for establishing and maintaining a robust system of contact tracing and testing. Such an approach would have facilitated greater awareness of interactions of community members had it been in place before the height of the pandemic.

**FINDING 16:** Victoria's highly centralised healthcare system did not have the means to deal with regional cases effectively, which contributed to confusion and delays in contact tracing and test result management.

## 5.6 Commonwealth support

The Australian Government has provided a range of direct assistance to the States and Territories to assist them to manage their response to COVID-19. A submission provided by the Australian Government's Department of Health (Appendix 4) outlined the

71 National Contact Tracing Review, *National Contact Tracing Review*, p. 25.

Australian Government's outbreak related support to Victoria, in particular for contact tracing and testing. Detailed information about Commonwealth support and timelines for provision can be found at Appendix 4, but included the following:

- Facilitating cross-jurisdictional information sharing and information requests relating to domestic and international arrivals
- Establishment of a Victorian Contact Tracing Taskforce in July 2020 following a request from the Victorian Department of Health and Human Services to assist with contact tracing surge capacity.
- Facilitated on-ground assistance for Victoria's second wave outbreak from leading public health experts and practitioners around Australia
- Deployment of Australian Medical Assistance Teams and Personnel
- Provided medical resources and supplies from the National Medical Stockpile.
- Surge workforce personnel since March 2020.
- In collaboration with the Victorian Government, established the Victorian Aged Care Response Centre to support aged care providers experiencing outbreaks.
- Deployed five COVID-19 testing teams to test staff and residents in residential aged care in Melbourne and Mitchell Shire (16 July 2020).
- Primary care support, including establishment of General Practitioner led respiratory clinics (see section 5.4.3).
- Communications support, from June 2020 including multicultural communication support for Victorian outbreaks, from September 2020.

## 5.7 Future direction of contact tracing systems: establishing a national Data Exchange

The *National Contact Tracing Review* report recommended the development of a Data Exchange to facilitate data-sharing between all jurisdictions around Australia. A Data Exchange would allow 'contact tracing teams to search, request, share and transfer case and contact tracing data between states and territories' but only relevant data for contact tracing purposes (i.e., name, contact number, test results).[72] The report outlined several design assumptions for establishing a contact tracing Data Exchange:

- Each state and territory will continue to operate its own contact tracing system
- The Data Exchange will not hold contact data, modify contact data nor summarise contact data. It will act as a pipeline or a switchboard routing data between each jurisdiction's contact tracing system and from government data sources

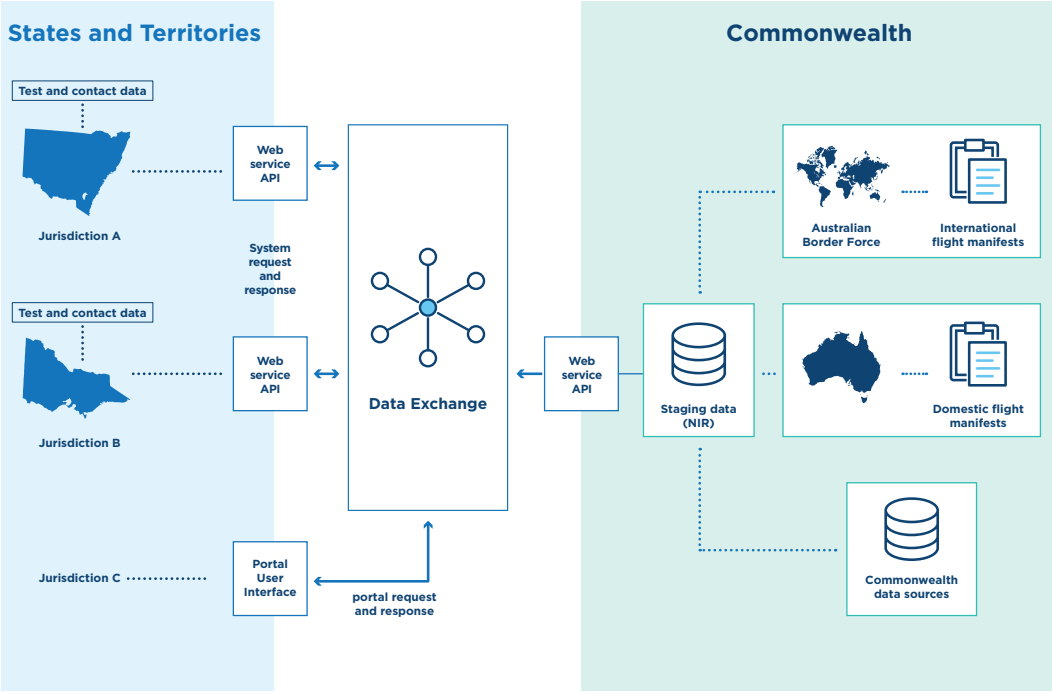
72 Ibid., p. 63.

- Each jurisdiction agrees to provide technical expertise to connect their contact tracing system (using an application programming interface, API) to the Data Exchange
- Where it is not practical to implement automated requests in a state system, officials of a jurisdiction's contact tracing system will be able to independently login to the Data Exchange using a centrally provided user interface
- The Data Exchange itself will not support surge assistance. Instead, the state, territory or Commonwealth staff providing assistance will be established as authorised users of the state or territory contact tracing system to which they are providing assistance.[73]

Figure 5.9 shows how a contact tracing Data Exchange would operate.



**Figure 5.9 Data Exchange model**




Source: National Contact Tracing Review, *National Contact Tracing Review: A report for Australia's National Cabinet*, Australian Government, Canberra, 2020, p. 64.

The report also provided a functional overview of a Data Exchange:

> The Data Exchange would be expected to be delivered using a modern Software-as-a-Service architecture using cloud-based infrastructure. High level system components of the Data Exchange would include:
>
> - The Data Exchange manages and logs requests and responses between jurisdiction-based contact tracing systems and government data sources.

73 Ibid.

- Decentralised data storage model with no contact tracing data stored in the Data Exchange. Data are not synchronised between systems and data sources. Only the Data Exchange event data relating to request and response metadata are stored.
- APIs to control the query request and response connections between the Data Exchange, each contact tracing system and government agencies. The APIs will meet the Whole of Government National API design standards.
- Agreed syntax for API queries and a mapping of minimum core data between contact tracing systems.
- Loose coupling of data transfers using an asynchronous API messaging architecture to maintain contact tracing system and data store autonomy and flexibility.
- Notification of failure to receive responses within a specified time frame.[74]



Table 5.2 outlines the high priority uses for a Data Exchange, which according to the report Victoria has 'indicated a willingness to be involved in implementing'.[75]

### Table 5.2 High priority uses for the Data Exchange

| Use case | | Utility | Immediacy | Priority |
|---|---|---|---|---|
| **1.** | **Enable faster contact tracing** | | | |
| 1.1 | Contact trace an international arrival accessing passenger manifest and contact details data | High | Medium term | **Medium** |
| 1.2 | Contact trace a domestic passenger accessing passenger manifest data | High | Near term | **High** |
| 1.3 | Confirm the international travel history of a domestic traveller | High | Medium term | **Medium** |
| 1.4 | Request contact details for a close contact from Commonwealth agency data sources | High | Near term | **High** |
| 1.5 | Request close contact data from another state or territory | High | Near term | **High** |
| 1.6 | Request close contact data from venue attendance registries | High | Near term | **High** |
| **2.** | **Coordination of contact tracing across state and territories** | | | |
| 2.1 | Request history for a close contact from another state | High | Medium term | **Medium** |
| 2.2 | Transfer a close contact to another state for ongoing contact tracing | High | Near term | **High** |
| 2.3 | Receive updates on a transferred close contact | Medium | Medium term | **Medium** |
| 2.4 | Notify the National Focal Point of a close contact who has departed Australia on an international flight | Low | Long term | **Low** |

Source: National Contact Tracing Review, *National Contact Tracing Review: A report for Australia's National Cabinet*, Australian Government, Canberra, 2020, p. 65.

74 Ibid.

75 Ibid., p. 64.

At a public hearing, Dr Alan Finkel, AO, Chief Scientist, Office of the Chief Scientist Australia, and Chair of the *National Contact Tracing Review* panel, explained the importance of establishing a national Data Exchange to the Committee:

> What is important is that as people are moving between states and territories across the borders it is necessary that contact tracing can seamlessly continue across those borders as people move. That is done at the moment at low numbers by telephone calls and email. That is not practical if the numbers are bad, so one of the things that we recommended in the report is that a data exchange be built. The data exchange really translates a request from one jurisdiction, finds the response and translates it back to the originating jurisdiction, because they all speak different languages or in computer parlance, they speak different syntaxes. The data exchange would not hold data; it would just be like a telephone line. The telephone line does not hold data but it joins two parties. When it joins two parties it really does not matter if the different people on the call—some are using iPhones, some are using Android phones and some are using a landline. The phone exchange takes care of that and similarly the data exchange that we propose would take care of all the disparities between the different systems.[76]

In its submission, the Public Health Association of Australia encouraged all Australian jurisdictions to participate in the development of a contact tracing Data Exchange.[77]

The Committee recommends that Victoria pursue, and encourage other jurisdictions to follow suit, the establishment of a national contact tracing Data Exchange. As state and territory borders reopen around the country it is important that all jurisdictions can continue to effectively monitor and trace confirmed cases and close contacts within their borders. This requires ongoing data sharing between the Commonwealth, states and territories. However, it is important to protect the privacy of citizens therefore only information necessary for contact tracing should be shared; this can include a name, contact number and test result if relevant.

**FINDING 17:** Data Exchange is required to assist effective contact tracing between jurisdictions to manage future outbreaks.

**RECOMMENDATION 7:** That the Victorian Government participate in the development, establishment and use of a national contact tracing Data Exchange as recommended by the National Contact Tracing Review.

76 Dr Alan Finkel AO, Chief Scientist, Office of the Chief Scientist Australia, public hearing, via videoconference, 18 November 2020, *Transcript of evidence*, p. 8.

77 Public Health Association of Australia, *Submission 21*, p. 3.

# 6 What does contact tracing and testing look like in other jurisdictions?

**Table 6.1** COVID-19 overview—Victoria, New South Wales, South Korea, Singapore and NewZealand

| | | Victoria | New South Wales | South Korea | Singapore | New Zealand |
|---|---|---|---|---|---|---|
| Healthcare model | Centralised | ✓ | ✗ | ✓ | ✓ | ✗ |
| | Devolved | ✗ | ✓ | ✗ | ✗ | ✓ |
| Governing legislation | | *Public Health and Wellbeing Act 2008* | *Public Health Act 2010* | *Infectious Disease Control and Prevention Act 2009* | *Infectious Diseases Act 1976* | *Health Act 1956* |
| Summary of emergency powers | | **Section 113**—CHO can make examination and testing order for infectious diseases.<br>**Section 117**—CHO can make public health orders directing isolation or quarantine to prevent spread.<br>**Section 190**—Grants emergency powers to the Chief Health Officer to investigate, eliminate or reduce the risk to public health. | **Section 61**—Secretary may direct persons to undergo medical examination or testing.<br>**Section 62**—Provides for the making of a public health order directing a person to:<br>• identify close contacts<br>• undergo medical examination or test<br>• be detained for the duration of an order. | **Article 34**— Minister of Health and Welfare can implement crisis control measures against infectious diseases.<br>**Article 49** –Minister for Health and Welfare, can take preventative measures against infectious diseases. | **Section 15**—Provides for the isolation of certain persons who is, or is suspected to be, a case or carrier of an infectious disease.<br>**Section 19A**—Provides for surveillance and contact tracing measures. | **Sections 71 to 73**—Establish the special powers of the Medical Officer of Health to prevent the outbreak or spread of any infectious disease. Including requiring:<br>• a medical examination and test<br>• a person to isolate or quarantine. |
| Date of first confirmed case | | 25 January 2020 | 25 January 2020 | 20 January 2020 | 23 January 2020 | 28 February 2020 |

Source: Legislative Council Legal and Social Issues Committee.

**Table 6.2** COVID-19 testing regime—Victoria, New South Wales, South Korea, Singapore and NewZealand

| | | Victoria | New South Wales | South Korea | Singapore | New Zealand |
|---|---|---|---|---|---|---|
| Methods | Nasal swab | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Throat swab | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Saliva sample | ✓ | ✗ | ✓ | ✗ | ✗ |
| | Wastewater sample | ✓ | ✓ | ✗ | ✗ | ✗ |
| | Home testing kit | ✓ | ✗ | ✗ | ✓ | ✗ |
| | Serology testing | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Antigen testing | ✓ | ✗ | ✓ | ✓ | ✗ |
| | Rapid molecular testing | ✓ | ✗ | ✗ | ✗ | ✗ |
| | Blood sample | ✗ | ✓ | ✗ | ✗ | ✗ |
| | Point of care test | ✗ | ✗ | ✗ | ✗ | ✓ |
| Clinical criteria | | Symptoms:<br>• fever<br>• chills or sweats<br>• cough<br>• sore throat<br>• shortness of breath<br>• runny nose<br>• loss or change in sense of smell or taste.<br>Other less common symptoms may be considered in certain circumstances. | Symptoms:<br>• fever of 37.5˚C or higher<br>• cough<br>• sore/scratchy throat<br>• shortness of breath<br>• runny nose<br>• loss of smell<br>• loss of taste<br>Other less common symptoms may be considered in certain circumstances. | A person who develops a fever or respiratory symptoms (coughing, difficulty breathing, etc.) within 14 days of coming into contact with a confirmed case. Symptoms include:<br>• fever or chills<br>• cough<br>• shortness of breath or difficulty breathing<br>• fatigue<br>• muscle or body aches<br>• headache<br>• new loss of taste or smell<br>• sore throat<br>• congestion or runny nose<br>• nausea or vomiting<br>• diarrhea. | Any person diagnosed with an acute respiratory infection and is referred by a health professional. Symptoms include:<br>• fever (most common symptom)<br>• shortness of breath<br>• cough<br>• sore throat<br>• runny nose. | Any person that has cold, flu or COVID-19 symptoms should have a test. Symptoms include:<br>• a new or worsening cough<br>• fever (at least 38˚C)<br>• shortness of breath<br>• sore throat<br>• sneezing and runny nose<br>• temporal loss of smell.<br>Other less common symptoms may be considered in certain circumstances. |

| | | Victoria | New South Wales | South Korea | Singapore | New Zealand |
|---|---|---|---|---|---|---|
| Epidemiological criteria | | Close contact with a confirmed case.<br>Any person considered to be part of an outbreak investigation.<br>Returned international travellers.<br>Persons requiring surgery or a hospital stay.<br>Targeted testing programs for specified industry and workforce groups. | Casual contacts that have developed symptoms.<br>Close contacts with a confirmed or probable case.<br>People who have visited venues with confirmed cases.<br>Healthcare workers displaying symptoms.<br>Returned international travellers. | A person who is suspected of having the COVID-19 virus as per doctor's diagnosis of pneumonia of unknown causes.<br>A person who develops a fever (37.5˚C and above) or respiratory symptoms (coughing, difficulty breathing, etc.) within 14 days of travelling overseas<br>A person with an epidemiologic link to a collective outbreak of COVID-19 in Korea and develops a fever (37.5˚C and above) or respiratory symptoms (coughing, difficulty breathing, etc.) within 14 days. | All persons subject to a Quarantine Order or placed on Stay-Home Notice.<br>Close contact with a confirmed case and presenting with fever, cough or running nose.<br>Travellers entering Singapore and exhibiting fever and/or other symptoms of respiratory illness.<br>Travellers entering Singapore from a specified hot spot. | Close contacts of a confirmed case and develop symptoms.<br>Border workforce, including Managed Isolation and Quarantine Facilities.<br>Have visited a location of interest. |
| Testing process | | A swab is taken in the prescribed method (approx. 1 minute). Swab is sent to a pathology laboratory for analysis. The person who has had the test must self-isolate until the results of the test are provided. | | | | |
| Notification of results | SMS | ✓ | ✓ | ✓ | ✓ | ✗ |
| | Phone call | ✓ | ✓ | ✗ | ✗ | ✓ |
| | Other | ✗ | MyServiceNSW account | ✗ | Singpass Healthub | ✗ |
| Turnaround time | | Within 48 hours | Within 72 hours | Within 48 hours | Within 48 hours | Within 48 hours |
| Free testing | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Penalties | | All primary close contacts who refuse to be tested must spend an addition 10 days in isolation.<br>Return travellers who refuse to be tested must spend an addition 10 days in quarantine. | Return travellers who refuse to be tested must spend an addition 10 days in isolation. | A suspected case who refuses to get tested can be fined up to US$2,430. | Travellers entering Singapore that refuse to undergo testing may have their immigration facilities and work pass privileges revoked or shortened.<br>All travellers, including Singapore Citizens, who do not comply with testing or cannot be contacted may face penalties and be prosecuted under the Act. | Does not force individuals already residing in the country to undertake testing. |

Source: Legislative Council Legal and Social Issues Committee.

**Table 6.3 COVID-19 contact tracing—Victoria, New South Wales, South Korea, Singapore and NewZealand**

| | Victoria | New South Wales | South Korea | Singapore | New Zealand |
|---|---|---|---|---|---|
| Establishment of system | Utilised the Australasian Inter-service Incident Management System (AIMS) operating model to implement an Incident Management Team. | Utilised existing contact tracing teams used to combat infectious diseases | Utilised methods and teams established after the 2015 MERS outbreak. | Utilised existing infectious disease tracing teams. | Utilised existing communicable disease control systems. |
| Method | 1. Confirmed case identified.<br>2. Confirmed case called within 24 hours by DHHS official to explain isolation rules and conduct case interview.<br>3. Information about close contacts, exposure sites and individual's health and welfare is recorded.<br>4. Contacts identified contacted by SMS within 48 hours of the case interview and instructed to self-isolate and be tested on day 11 of the 14 days of isolation.<br>5. Cases cleared from isolation by an authorised officer.<br>6. Information regarding confirmed case locations published. | 1. Confirmed case identified.<br>2. Confirmed case called to explain isolation rules and conduct case interview.<br>3. Information about close contacts, exposure sites and individual's health and welfare is recorded.<br>4. Close contacts are notified and screened for possible symptoms; asked to self-isolate for 14 days.<br>5. Information regarding confirmed case locations published. | 1. Confirmed case identified.<br>2. Confirmed case interviewed and gives permission to obtain further information to verify details given.<br>3. Officials verify information provided with family, friends, healthcare workers and with the support of cross-agency collaboration.<br>4. Where information may be missing, officials may acquire objective (credit card transactions, mobile phone data) data to identify close contacts.<br>5. Officials review the collected information and analyse the network of transmission.<br>6. Contacts identified and contacted to isolate.<br>7. Ministry of Interior and Safety officials and local governments manage those under self-quarantine on a one-to-one basis.<br>8. Quarantined individuals checked on twice a day.<br>9. Information regarding confirmed case locations published. | 1. Confirmed case identified.<br>2. Confirmed case gives initial interview.<br>3. Initial report provided to Ministry of Health.<br>4. Contact tracing charted and mapped.<br>5. Contact tracing information verified and close contacts identified.<br>6. Close contacts are notified and screened for possible symptoms. If symptoms found, they are considered a suspected case.<br>7. Close contacts with no symptoms quarantine for 14 days.<br>8. Singapore Police assist tracing persons identified as close contacts who could not be reached.<br>9. Investigations into unknown close contacts utilise data analysis, on the ground patrolling and review of CCTV.<br>10. Daily conferences occur to transfer information between agencies<br>11. Use of TraceTogether App aids contact tracing efforts. | 1. Confirmed case identified.<br>2. Confirmed case called and provides detailed history.<br>3. Investigation into confirmed case to identify close contacts.<br>4. Close contacts are contacted by officials and requested to self-quarantine for 14 days and get tested.<br>5. Follow up calls made to confirmed case and close contacts to monitor symptoms and isolation.<br>6. The assigned healthcare provider will notify those in self-quarantine when they are permitted to leave. |

| | Victoria | New South Wales | South Korea | Singapore | New Zealand |
|---|---|---|---|---|---|
| Data collected or used | • Name<br>• Date of birth<br>• Residential address<br>• Suburb<br>• Postcode<br>• Email<br>• Mobile phone number<br>• Indigenous status<br>• Language spoken<br>• Date of test<br>• Date of onset of symptoms<br>• 14-day history of movements of locations visited<br>• Close contacts | • Indigenous status<br>• Symptoms<br>• Health Risk factors<br>• Date of onset of symptoms<br>• Close contacts<br>• Use of COVID-safe app<br>• Source of infection<br>• Overseas travel<br>• Contact with confirmed cases<br>• Two-week diary of locations and contacts<br>• Demographic | • Location of confirmed case<br>• 14-day travel history before the onset of symptoms<br>• Close contacts<br>• Credit card transactions<br>• Mobile phone GPS data<br>• Travel data<br>• Modes of transport taken<br>• Medical records | • Places visited in the previous 14 days<br>• Recent activity in the previous 14 days<br>• Close contacts and contact details | • Known close contacts<br>• Locations visited<br>• Age<br>• Gender<br>• Ethnicity<br>• Occupation<br>• Exposure setting |
| Monitoring | DHHS is in daily contact with all persons undertaking self-quarantine via SMS and/or phone calls and conducts daily symptom updates and welfare checks.<br>An in-person door knock visit in undertaken within the first 24 hours of self-isolation and then every 3 to 4 days of the isolation period. | NSW Health and Public Health Units monitor confirmed cases and close contacts for the duration of the isolation period to ensure all persons have adequate resources and support and monitor symptoms. | All persons undertaking self-quarantine are required to check their body temperature twice daily and report to an assigned case officer any symptoms.<br>The Self-Quarantine Safety Protection App connects those in self-quarantine with an assigned case manager.<br>Case managers can use the GPS data of those in self-quarantine to monitor their location, if consent is given. | Individuals who are under quarantine are monitored by video calls or the QO App at least three times a day.<br>Spot checks are carried out to ensure all persons under quarantine or isolation orders are adhering to conditions during the specified period. | Health authorities monitor persons in self-isolation and quarantine during the 14-day period and keep a record of symptoms that occur. |

| | Victoria | New South Wales | South Korea | Singapore | New Zealand |
|---|---|---|---|---|---|
| Technology developments | Test Tracker is QR technology that enables real time digital tacking from swab to result notification.<br>Victorian Government QR Code application. | NSW COVID Safe Check-in with the Service NSW App. | KI-Pass is a QR code based entry log system to record visitors at high risk facilities.<br>Implemented a new computer system that collects location information from telecommunication companies on confirmed cases.<br>Self-Quarantine Safety Protection App. | The TraceTogether Application was released on 20 March 2020, while the token was rolled out in June 2020. It has a similar function to Australia's COVIDsafe App. | A National Contact Tracing Technology solution was piloted on 27 March 2020 and deployed on 6 April 2020. Prior to this, contact tracing was a manual process. |
| Community engagement | The government publishes the whereabouts of confirmed cases on its websites to prevent additional infection. | | | | |
| Penalties | It is an offence not to comply with a public health order relating to testing, isolation and providing information, penalties may apply. | It is an offence not to comply with self-isolation or quarantine. Failure to do so may be punishable by fines, imprisonment or both.<br>The maximum penalty for failing to comply with a public heath order is 100 penalty units or 6 months' imprisonment, or both. | Those who violate self-quarantine guidelines may face up to a 10 million KRW fine or one year of imprisonment. | Persons non-compliant with quarantine orders may be required to wear an electronic tag or be detained in a suitable place.<br>Any person, without a reasonable excuse, contravenes an isolation order may be charged with an offence. First time offenders can be fined up to $10,000, jailed for up to 6 months, or both. | Failure or refusal to comply with, or delay in complying with, a direction or requirement of a medical officer of any person authorised person by a medical officer is liable on conviction to imprisonment for up to six months, or pay a fine of up to $4000. |

Note: The information in Table 6.1, Table 6.2 and Table 6.3 is current at time of writing (November 2020).

Source: Legislative Council Legal and Social Issues Committee.

# 7 What are the key performance indicators and benchmarks for COVID-19 contact tracing and testing?

## 7.1 Best practice models: public health surveillance and emergency management

The World Health Organization states that a comprehensive COVID-19 management model requires the following key actions:

- use, adapt and strengthen existing surveillance systems
- strengthen laboratory and testing capacities
- use, adapt and enhance the public health workforce to carry out case finding, contact tracing and testing
- include COVID-19 as a mandatory notifiable disease
- implement immediate reporting
- establish systems to monitor contact tracing activity.[78]

### 7.1.1 Testing

Benchmarks have been established nationally and internationally for a best practice system of testing for COVID-19. However as noted by Professor Mary Louise McLaws in her evidence to the Committee, 'there is no particular gold standard at the moment across the world.'[79] Testing instead should be tailored to the jurisdiction, but systems should be sufficiently prepared to conduct, record, and analyse at least 4 tests per million population every day with less than a 24-hour turnaround.

In its submission, the Victorian Government explained that 'testing is the first point at which many individuals engage with Victoria's testing regime and contact tracing system.'[80] There are a range of reasons to conduct widespread testing throughout communities:

- To understand the prevalence of COVID-19 within a community

78 World Health Organization, *Public health surveillance for COVID-19: Interim guide*, 2020, <https://apps.who.int/iris/bitstream/handle/10665/333752/WHO-2019-nCoV-SurveillanceGuidance-2020.7-eng.pdf> accessed 23 November 2020.

79 Professor Mary-Louise McLaws, public hearing, via videoconference, 18 November 2020, Transcript of evidence, p. 28.

80 Victorian Government, *Submission 23*, p. 13.

- To remove the burden of quarantining exposed cases
- To inform public health decisions for fast reactions to imminent threats.

Further to this, a report on the *Impact of delays on effectiveness of contact tracing strategies for COVID-19*, noted that:

> A testing delay of more than 1 day requires the tracing delay to be at most 1 day or tracing coverage to be at least 80% to keep *R*CTS below 1.[81]

The Communicable Diseases Network Australia noted that for initial contact:

> Public Health Units (PHUs) should, within one working day, notify the central state/territory communicable diseases unit of confirmed cases and COVID-19 deaths upon receipt of a notification/report.[82]

Dr Alan Finkel, Chief Scientist, Office of the Chief Scientist Australia led a review of approaches to contact tracing in Australia. The *National Contact Tracing Review* reported that a holistic testing regime should incorporate easily accessible, reliable and free tests with clear criteria for getting tested. [83]



For COVID-19, polymerase chain reaction tests (PCR) are the WHO-recommended method of confirming COVID-19. These tests take a sample and then repeatedly copy, or amplify, the genetic material until there is enough material to detect any traces of COVID-19 DNA.[84] While PCR is considered to be the most accurate method of testing, a range of other measures can be incorporated to indicate the presence and prevalence of COVID-19 in a community, including serological surveillance and wastewater testing.

Serological surveillance relies on blood testing to identify antibodies developed by the body in response to COVID-19. The World Health Organization notes that serology can be useful in identifying previously unrecognised cases of COVID-19:

> Population-based surveys of antibody seropositivity and the use of serology in specific settings/populations can help to provide estimates of the proportion of a population that has been infected by SARS-CoV-2 virus as measured by antibodies. Enhanced surveillance, surveys and outbreak investigations can assess the extent of infection in the general or subpopulations, in specific age groups and potentially, the proportion of unrecognized infections (e.g., asymptomatic or subclinical infections).[85]

Both the World Health Organization[86] and the *National Contact Tracing Review* noted that greater research needs to be done and 'public health, clinical and wastewater

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81 Mirjam Kretzschmar et al., 'Impact of delays on effectiveness of contact tracing strategies for COVID-19: a modelling study', *The Lancet*, vol. 5, no. 8, 2020.

82 Communicable Diseases Network Australia, *Coronavirus Disease 2019 (COVID-19): CDNA National Guidelines for Public Health Units*, 2020, <https://www1.health.gov.au/internet/main/publishing.nsf/Content/7A8654A8CB144F5FCA2584F8001F91E2/$File/COVID-19-SoNG-v3.10.pdf> accessed 23 November 2020.

83 National Contact Tracing Review, *National Contact Tracing Review*, p. 16.

84 World Health Organization, Public health surveillance for COVID-19.

85 Ibid.

86 Ibid.

sectors should build on existing research and field testing of wastewater detection to validate its role as an early signal of potential outbreaks.'[87]

**RECOMMENDATION 8:** That the Victorian Government is guided by the following indicators in relation to the ongoing development of their testing regime so that Victorians can be confident that the regime has capacity:

- easily accessible and reliable tests with clear criteria for getting tested
- tests are accurately recorded, and results are received by the patient within 24 hours
- surge workforce is available at short notice
- multiple testing strategies can be deployed (fixed, rapid response, mobile units).

### 7.1.2 Contact tracing

Contact tracing is an intervention to 'break the chains of human-to-human transmission, ensuring that the number of new cases generated by each confirmed case is maintained below 1'.[88] The process of contact tracing involves identifying anyone who may have been exposed to a positive case of COVID-19 and isolating them to stop further transmission.

The World Health Organization has outlined a number of measures to indicate a successful contact tracing system in the context of COVID-19, noting that it specifically 'requires identifying persons who may have been exposed to COVID-19 and following them up daily for 14 days from the last point of exposure.'[89]

The World Health Organization identifies four specific scenarios to guide the actions of contact tracing throughout the COVID-19 pandemic:

- **No cases**: a well-trained workforce should be identified, trained and on standby ready to respond to first cases.
- **Sporadic cases** or **clusters**: exhaustive contact tracing is essential for rapidly suppressing transmission.
- **Clusters**: contact tracing is essential for suppressing transmission and reducing transmission within clusters.
- **Community transmission**: contact tracing may be difficult when transmission is intense but should be carried out as much as possible, focusing on household contacts, health care workers, high-risk closed settings … and vulnerable contacts, as well as maintaining strong contact tracing capacity in areas with smaller clusters of cases.[90]

87 National Contact Tracing Review, *National Contact Tracing Review*, p. 16.

88 World Health Organization, *Contact tracing in the context of COVID-19*.

89 Ibid.

90 Ibid.

While widespread community transmission would challenge even the most established and capable systems, the capacity to trace contacts of positive cases can be managed with a multi-tiered approach. This can be achieved by establishing both a permanent workforce and a reserve workforce on standby to respond if the system is at risk of being overwhelmed. According to the *National Contact Tracing Review* report, when a system's permanent core workforce is at risk of being overwhelmed, it is best practice to have an additional workforce in reserve to ensure that any outbreaks can be appropriately managed:[91]

> All states and territories should employ a permanent workforce for tracing and outbreak management, with senior public health leadership, and should have an additional surge workforce trained and at the ready.

The Review advises jurisdictions to respond by implementing the following:

a. A scaled surge response activates based on case numbers and complexity.

b. Permanently employed contact tracing officers and outbreak management teams help train and direct the surge workforce.

c. Digital systems allow easy but secure onboarding of the surge workforce from within the state and territory, and from other jurisdictions.

d. Desktop simulations and functional simulation exercises are regularly run to ensure that the system can deal with sustained surge and extreme case numbers.

e. Surge capacities are planned between jurisdictions to allow for additional support to be provided before a state or territory reaches capacity.[92]

Further to this, an intelligent technology-based solution should allow for risk-based prioritisation of cases in order to ensure that surge capacity can manage any threat of being overwhelmed. The *National Contact Tracing Review* report argued that:

> In times of high daily new case numbers where the contract tracing workforce is unable to meet timeframes to make calls, confirmed cases are notified of a positive test result and directed to isolate through an automated text system, and followed up with a phone call from an authorised officer as soon as possible.[93]

### Process of best practice contact tracing

The first nation-wide recommendation in Australia for a timeframe to notify contacts was expressed in October 2020 in the Framework for National Reopening.[94] The Framework recommended a 48-hour window between confirmation of a positive test and notification of close contacts, however this recommended turnaround was

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91 National Contact Tracing Review, *National Contact Tracing Review*, p. 10.

92 Ibid., p. 16.

93 Ibid.

94 Department of Health, *Framework for National Reopening*, 2020, <https://www.health.gov.au/sites/default/files/documents/2020/10/framework-for-national-reopening-october-2020.pdf> accessed 24 November 2020.

described in the *National Contact Tracing Review* as 'inadequate from the point of view of suppressing community transmission.'[95]

The foremost research into the timeframe required to successfully prevent transmission was published by Utrecht University (Netherlands).[96] This approach was supported by the *National Contact Tracing Review* report which recommended a 48-hour window between a test sample being taken and primary contacts being notified of exposure to COVID-19. Unlike the approach set out by the Framework for National Reopening, this time period incorporates the time from a test being taken to positive results being received, which reduces the overall turnaround time.

In evidence provided to the Committee, multiple experts reiterated the significance of the 48-hour window from the time that the test sample has been taken. The following excerpts taken from the evidence received summarises the views expressed by the inquiry's stakeholders:

- Even at high case numbers test results should be available within 24 hours of the COVID-19 test sample being collected. Even at high case numbers for positive test results no more than 48 hours should pass between the time the test sample is collected and the close contacts of the confirmed case are told to quarantine. If an outbreak occurs, the authorities must bring people and technology rapidly to the front line in order to contain the outbreak.[97]
- … it is based on research that says 70 to 90 per cent of cases contacted and 70 to 90 per cent of all contacts found and isolated within 48 hours can reduce the R0 to less than 1. So, we should be looking at a 48-hour, not a 72-hour, benchmark.[98]
- Equally, minimising testing delay has had a very significant impact on reducing onward transmissions in many other jurisdictions. Optimising testing and tracing coverage and minimising tracing delays by the deployment of appropriate skills and software can further enhance contact-tracing effectiveness with the potential to prevent up to 80 per cent of all transmissions.[99]
- … the most important thing is actually getting onto those close contacts within the 48-hour period. And if you do, the data suggest that you can reduce the replication rate quite significantly—maybe by about 0.3 or 0.4, perhaps. So that is the significant effect.[100]



95 National Contact Tracing Review, *National Contact Tracing Review*, p. 10.

96 Mirjam Kretzschmar, 'Impact of delays on effectiveness of contact tracing strategies for COVID-19: a modelling study'.

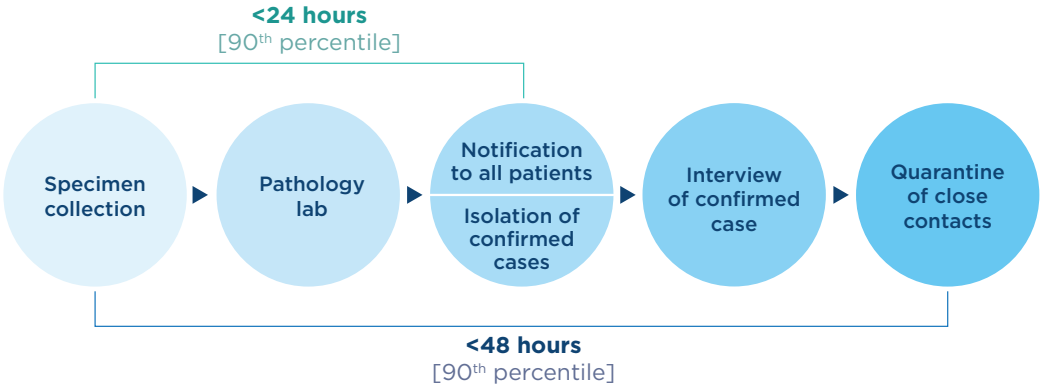
97 Dr Alan Finkel AO, *Transcript of evidence*, p. 2.

98 Professor Mary-Louise McLaws, *Transcript of evidence*, p. 29.

99 Professor Julian Rait, President, Australian Medical Association Victorian Council, public hearing, via videoconference, 16 November 2020, *Transcript of evidence*, p. 13.

100 Ibid., p. 14.

## Figure 7.1 Performance targets for end-to-end contact tracing




Source: National Contact Tracing Review, *National Contact Tracing Review: A report for Australia's National Cabinet*, Australian Government, Canberra, 2020, p. 56.

The capacity of a contact tracing system can be determined by measuring three key factors:

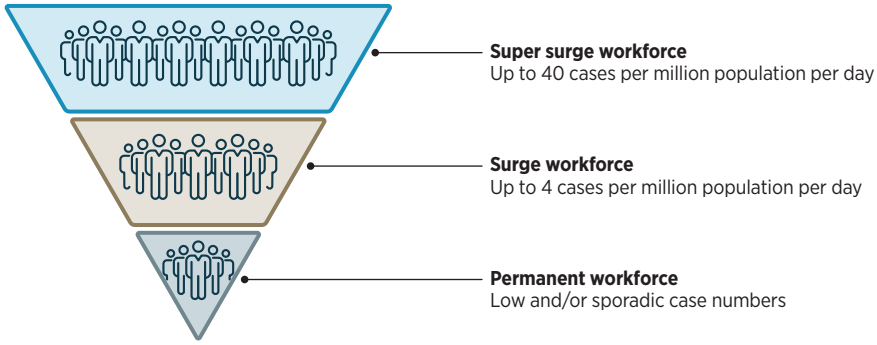
1. Time from test undertaken to primary close contact being notified and isolated.
2. Percentage of downstream contacts notified and quarantined within an arbitrary timeframe (generally 48 hours).
3. Percentage of identified upstream cases (source of infection).

The National Contact Tracing Review suggested nationally agreed metrics recommending the following:

- The number of hours from collecting the positive specimen to notifying the patient of their results should be less than 24 hours
- The number of hours from collecting the patient's COVID-19 specimen to notifying their close contacts that they must quarantine is fewer than 48 hours at the 90th percentile
- Both measures should be qualified with at least 80% of primary close contacts being notified
- A system has surpassed capacity when these measures are not being met. [101]

101 National Contact Tracing Review, *National Contact Tracing Review*.

**Figure 7.2** Model for building scalable contact tracing workforce




Source: Legislative Council Legal and Social Issues Committee. Information from National Contact Tracing Review, *National Contact Tracing Review: A report for Australia's National Cabinet*, Australian Government, Canberra, 2020, p. 11.

**FINDING 18:** Test results should be available within 24 hours of a sample being taken, maximising the likelihood that people will isolate themselves while awaiting test results. It should be no more than 48 hours in total from the time a test sample is first taken to the point at which close contacts of a confirmed case are notified that they must quarantine. Victoria is sitting well within the optimal range in relation to these metrics at present.

**FINDING 19:** The following are indicators of a contact tracing system that has the capacity to respond to a range of COVID-19 scenarios:

- The system can manage four new cases per day per million population (stress tested). It should be extreme stress tested at ten times the number (40 new cases per day per million population).
- The number of hours from collecting the positive specimen to notifying the patient of their results should be less than 24 hours.
- The number of hours from collecting the patient's COVID-19 specimen to notifying their close contacts that they must quarantine is fewer than 48 hours for more than 90% of cases (both of these measures should be qualified with at least 80% of primary close contacts being notified).

**RECOMMENDATION 9:** That the Victorian Government be guided by the following indicators in relation to the ongoing development of a contact tracing system so that Victorians can be confident that it is fit for purpose:

- facilitates multilingual communications through in-language resources
- cost-effectiveness
- technology captures nuances for each case and contact (number of persons per household, language, quarantine stage, time since test and more)
- risk-based prioritisation during super surges
- capacity to analyse data and identify links.

**FINDING 20:** An effective contact tracing system relies on a highly trained and qualified workforce built from a jurisdiction's existing public health sector. This should be extended to a surge workforce where possible, or alternatively training tools should be developed to ensure that people employed as part of a surge workforce are properly equipped to manage contact tracing.



## 7.2 Victoria's key performance indicators

### 7.2.1 What is the goal of Victoria's contact tracing system and testing regime?

The three major policy approaches to the management of COVID-19 are elimination, suppression and mitigation. Australia's national approach to the management of COVID-19 has predominantly focused on suppression. An article from *The Medical Journal of Australia* described the position of the Australian Government during Victoria's second wave:

> On 24 July, the Australian Health Protection Principal Committee recommended "that the goal for Australia is to have no community transmission of COVID-19", and on the same day Prime Minister Scott Morrison accepted and affirmed this recommendation, stating "The goal of that is obviously, and has always been no community transmission". Unfortunately, this first clear statement that Australia's goal is to eliminate community transmission was late in coming, as the Victorian outbreak was already in full swing, with case numbers peaking at a 5-day average of about 500 per day from 29 July to 5 August, resulting in a stage 4 lockdown commencing on 3 August.[102]

102 Tony Blakelyn et al., 'The probability of the 6-week lockdown in Victoria (commencing 9 July 2020) achieving elimination of community transmission of SARS-CoV-2', *The Medical Journal of Australia*, vol. 213, no. 8, 2020, p. 349.

Victoria's approach as stated by the Premier and Chief Health Officer has been suppression of COVID-19 in the community. The Committee notes that, at the time of writing, Victoria has effectively achieved local elimination as a result of its suppression strategy. However, understanding the approach to managing COVID-19 is significant in understanding the performance measures and key capacity indicators moving forward. Given the policy decision for suppression, Victoria has accepted the risk of low numbers of COVID-19 cases in the community and therefore commits to ongoing testing and contact tracing to survey and react to any clusters or outbreaks which occur.

In July 2020, Dr Nick Coatsworth, the Federal Deputy Chief Medical Officer, noted that elimination creates an unrealistic and unattainable state and as such should not be the goal of Australian jurisdictions:

> In Australia, we will continue to strive for local elimination wherever possible. We remain one of the world's most successful nations in the fight against COVID-19. We have achieved this, not by pursuing the false hope of elimination, but by realistic, pragmatic and proportionate action when it is most necessary.[103]

In order to move forward with limited movement restrictions, the Victorian contact tracing and testing regime must have capacity to react to and appropriately address cases, clusters and outbreaks without resorting to lockdowns each time.



### 7.2.2 What is the current capacity of Victoria's testing regime?

> The Victorian Government's submission to the inquiry outlines the ongoing developments to the testing and contact tracing approach in Victoria. It also describes improvements to related areas of importance in the approach to achieving public health outcomes:
>
> In response to the changing nature of the pandemic in Victoria, the Victorian Government's contact tracing and testing regime has, necessarily, seen considerable improvements across all areas. These changes have contributed to better COVID-19-related public health outcomes. Specifically, there have been improvements to testing processes and coordination, community engagement, the public sector workforce response, and interjurisdictional collaboration.
>
> The test, trace and isolate regime has been tested through Victoria's two waves of COVID-19. [104]

Professor Brett Sutton, Chief Health Officer, Department of Health and Human Services, outlined the increasing capacity of the Victorian testing regime as it has developed throughout the year:

> Victoria has done very well in relative terms in Australia … we have also gone through the ebb and flow of testing according to the transmission and the engagement of the community to come forward for testing. We have obviously had the most confirmed

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103 Dr Nick Coatsworth, *Eliminating COVID-19 a false hope*, media release, Australian Government, Canberra, 16 July 2020.

104 Victorian Government, *Submission 23*, p. 23.

> cases, but even for our population size—second in Australia—we have had very high testing numbers really from April onwards. Sometimes it has dropped off, in part because of engagement around testing, but the capacity has continuously increased over the course of the nine months of this pandemic.[105]

Both the historic structure and governance approach of the model and the current focus of the system are further addressed in Chapter 5.

### How many ongoing staff do we have access to? Can public health clinics maintain testing rates and balance core business?

The Committee was pleased to find that there was an impressive absence of transmission among staff conducting tests for COVID-19. This was a result of the strong infection control measures in place. This was outlined by Mr Weimar (Department of Health and Human Services) in his evidence to the Committee:

> ... for the 1600 or so staff who work across those testing centres, one of the strong elements of that testing performance has been its accessibility but also the high level of infection control. We have had no breakouts. We have had no risks and no negativity happening around the physical testing infrastructure, ensuring that we can provide that solution to people across the state. [106]

The Victorian Government submission outlined the Department of Health and Human Service's surge workforce that was implemented to collect samples:

> As COVID-19 case numbers began to increase in February and the response demands grew, DHHS started to activate surge workforce strategies, including the mobilisation of staff from across DHHS, as well as obtaining support from other departments and public sector agencies where required.
>
> Staff were recruited across intelligence and data modelling; case management, contact tracing, and outbreak management; policy and strategy support; as well as community engagement and testing services. This broad workforce pool enabled a flexible response that was able to scale up and down as demand for resources increased or decreased. [107]

However, there was minimal information given to the Committee around the workforce pool which contributed to the testing staff. The Committee was therefore unable to form an understanding of the workplace capacity for COVID-19 testing at the present time, nor can it comment on the fitness for purpose of the model. Furthermore, the Committee is not in a position to comment on the suitability and expertise of the workforce established to conduct COVID-19 testing.

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105 Professor Brett Sutton, *Transcript of evidence*, p. 4.

106 Mr Jeroen Weimar, *Transcript of evidence*, p. 5.

107 Victorian Government, *Submission 23*, p. 23.

## PCR Testing

As outlined in section 5.4.4, PCR testing was, at the time of writing, the most reliable test available to identify positive COVID-19 cases. In his evidence to the Committee, Dr Simon Crouch, COVID-19 Deputy Public Health Commander, Case Management, Contact Tracing and Outbreak, Department of Health and Human Services, said 'you are not a confirmed case unless you have a positive PCR result.'[108] The bulk of Victoria's testing is PCR testing.

Victoria's approach and strategies for COVID-19 testing have evolved throughout the pandemic as outlined in Chapter 5. In response to increasing community transmission, Mr Weimar told the Committee that the network of fixed sites with testing capability in Victoria has been maintained despite fluctuations in case numbers:

> Particularly over that March to June period there was a significant expansion of the testing network, and certainly by the end of July we were running around 200, 210 sites. We have maintained that level of network since then. There have been a few sites coming in, a few sites coming out, as you would expect.[109]

Mr Weimar contended that maintaining ease of access for Victorian residents to testing continues to be a consideration:

> … there are 106 testing centres across metro Melbourne. Everybody is within at least 10 km of a testing facility, and around 93 testing facilities are currently operating across regional Victoria—again, giving us good geographical coverage, ensuring everyone has got good and easy access to safe and effective testing arrangements. [110]

Further to this, the Committee noted that measures have been established to ensure that testing regimes can adapt to an escalating need for testing. This scalability has been identified as an important factor in a fit for purpose model, as described by Ms Fiona Brew, Chief Executive of Colac Area Health:

> in terms of testing, I think scalable testing is absolutely critical, and I have heard other people mention it. Our experience was that the only way we could actually achieve that was through the drive-through model, and we adopted that on many occasions.[111]

In order to achieve this scalability across the state, a range of additional measures for surge capacity and targeted testing are at the disposal of the public health team. In its submission, the Victorian Government noted that:

> Increased access to testing and associated communications … encourages testing participation particularly among communities that may not be frequent users of public health systems. There are now well-established programs to make testing more

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108 Dr Simon Crouch, COVID-19 Deputy Public Health Commander, Case Management, Contact Tracing and Outbreak, Department of Health and Human Services, public hearing, via videoconference, 23 November 2020, *Transcript of evidence*, p. 31.

109 Mr Jeroen Weimar, *Transcript of evidence*, p. 7.

110 Ibid., p. 5.

111 Ms Fiona Brew, Chief Executive Officer, Colac Area Health, public hearing, via videoconference, 18 November 2020, *Transcript of evidence*, p. 67.

> responsive, accessible and available, such as Rapid Response Testing Team, Roving Testing squads and Call-to-Test program.[112]

The Rapid Response Testing Teams and the Roving Testing squads add to the scalability, potential for mobilisation and adaptability within the current testing model by providing additional dedicated testing capacity above the baseline capacity of the public health network:

> RRTTs are quick to deploy and are highly mobile meaning they can set up on-site and undertake a range of testing to assist with public health actions, such as surveillance and outbreak management.
>
> The establishment of the Rapid Response Testing Teams has significantly enhanced the ability of DHHS to deploy mobile and flexible testing capacity across the state, often within 24 hours. RRTTs are being deployed in response to a range of both time critical and proactive testing needs. For example, RRTTs set up 3 of the 4 pop-ups in Casey and Dandenong, and they are also currently doing proactive onsite testing in major workplaces such as PACCAR trucks.
>
> Similar to RRTTs, Roving Testing Squads are smaller community health provider operated squads that specifically work with Rapid Response Community Engagement Teams and proactively engage with local priority communities on the ground.[113]



**FINDING 21:** Victoria is well placed to continue to provide accessible testing in relation to proximity and cost and has established a capacity to collect a high volume of PCR tests.

The Committee reiterates the significance of delivering test results within 24 hours and notes that the capacity of a testing system includes the ability to process and communicate results within a 24-hour window. This is the established benchmark set by the National Contact Tracing Review.[114] The Victorian Government submission noted that:

> … a key element of the COVID-19 response is to ensure that turnaround times for COVID-19 tests are 24 hours or less, even when the pathology system is under stress. Therefore, the performance of the pathology sector as a whole is critical. DHHS has undertaken short, medium term and sector wide reform to ensure that turnaround times are kept to a minimum.[115]

Table 5.1 Overview of Victoria's COVID-19 testing approach provides further information.

Both the expansion of pathology capacity and the redesign of notification and tracking processes has contributed to reduced turnaround times.

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112 Victorian Government, *Submission 23*, p. 15.

113 Ibid., pp. 15–6.

114 National Contact Tracing Review, *National Contact Tracing Review*.

115 Victorian Government, *Submission 23*, p. 14.

The Committee believes that limitations on pathology capacity have been addressed appropriately by the Victorian Government through a range of initiatives, and the evolution of this approach has been outlined in Chapter 5. The Victorian Government submission contended that 'ensuring that the pathology system is able to meet daily demand associated with symptomatic and outbreak related testing is an absolute priority'.[116] To this end, the Government, through the Department of Health and Human Services, has committed to the following improvements to Victoria's testing regime:

- working with each laboratory individually to develop surge plans and ensure that, in the event that demand for testing will impact on turnaround times for tests, testing load can be diverted to other laboratories where there is available capacity. This includes redirecting loads between public and private laboratories
- formalising protocols and processes so that DHHS can quickly re-direct testing volumes to laboratories with available capacity
- providing detailed performance data and feedback to laboratories so that they know how they are performing relative to their peers and can identify areas for improvement.

> DHHS is also working on identifying areas for improvement in pre-laboratory logistical and transport arrangements between testing sites and laboratories and will be undertaking analysis to identify the most effective improvement projects with private and public laboratories that will enhance pre-analytical turnaround times. This may include projects that increase courier frequency and timing on critical routes, together with initiatives to reduce the batching of specimens at testing sites prior to release to couriers. [117]

For medium-term assurances of testing capacity, the Victorian Government submission explained that ongoing negotiations are occurring with private pathology laboratories 'to commit to maintaining sufficient capacity and fast turnaround times, in return for a state guarantee of minimum testing volumes.'[118]

Regarding public pathology capacity, the submission outlined that:

> DHHS is working with public health services and equipment providers to fast-track equipment purchases and recruitment processes, recognising the risk that the deteriorating pandemic situation in Europe and the United States could have on demand for pathology equipment and supplies worldwide.
>
> Under agreement with suppliers, five new high-throughput machines are on-track to be fully operational by February 2021, and purchase orders for seven additional analysers by December 2020 are in progress.

116 Ibid., p. 17.

117 Ibid., pp. 14–5.

118 Ibid., p. 15.

The Committee is satisfied that the evidence it received demonstrates that the testing regime now in place in Victoria can process a greater number of tests within the recommended timeframes between samples taken and results being received.

**FINDING 22:** The Victorian Government has increased its capacity to manage a greater number of tests within the recommended timeframe between samples taken and results being received.

# 8 How does Victoria measure up against key performance indicators and benchmarks?

## 8.1 Is the current testing regime fit for purpose?

The Committee has considered the capacity and fitness for purpose of the current COVID-19 testing regime and notes the continual improvements to the regime undertaken by the Department of Health and Human Services.

The Committee notes that:

- The current test regime is accessible and free for people to access.
- Alternate mobile options are available for those who are unable to get to a testing site.
- There is proven capacity to safely collect a large number of test specimen in a short period of time.
- The Department have invested in, and continue to invest in, additional pathology capacity to ensure up to 15,000 tests a day can be processed within 24 hours at the 80th percentile. The Department is aiming to increase capacity to 35,000 tests, to be operational by February 2021.[119]

The Committee also notes that the Victorian Government is continuing to develop new technologies to further bolster its surveillance capacity as movement restrictions, both intra- and interstate, lift.

**FINDING 23:** The current COVID-19 testing regime is fit for purpose to monitor, process, identify, record and communicate up to 15,000 test results per day within a 24-hour window. The Victorian Government is investing in additional capacity which would allow 35,000 tests to be processed per day.

## 8.2 What is the current capacity of Victoria's contact tracing system?

The capacity for contact tracing is measured by the ability to identify and make contact with primary close contacts of a person who has tested positive to COVID-19. While elements of case management may be referred to when talking about systems and

119 Ibid.

communications, the Committee remains focused on the process of contact tracing and will not address ongoing contact management. This is outside the scope of this inquiry.

The Victorian Government has made a range of improvements to the contact tracing system as outlined in Chapter 5. Professor Euan Wallace, Secretary, Department of Health and Human Services, outlined the Victorian Government's confidence in the capacity of the contact tracing system:

> … the changes that we have put in place, the automation from end to end, from digital data entering at the time of the test all the way through to SMS texting going out to cases and then close contacts automatically, even allowing cases to enter their own information ahead of an interview, have taken us to a place today in Victoria that we estimate—and we estimate because of course we are not there, thankfully, and hopefully, as our Chief Health Officer said, we will not be again—we could cope with 500 new cases a day through the current system'.[120]

Further to Mr Weimar's evidence to the Committee that Victoria's current contact tracing system can accurately capture up to 500 new cases and their contacts per day, Dr Alan Finkel, Chief Scientist, Office of the Chief Scientist Australia, told the Committee that:

> If the numbers were in excess of that, then they could overflow back into the old system, which has by the way been tweaked and it is better than it was a few months ago.[121]

Dr Finkel also expressed his confidence in the turnaround times for testing and contact tracing and the capacity of the system moving forward:

> Victoria has come out of that overloaded situation. I have seen regular data in recent weeks that shows that the turnaround time from sample collection to people getting their results is actually very, very good, substantially below 24 hours. There might be outliers, but the vast majority of them are substantially below 24 hours. And 24 hours is a target, as you acknowledge, that we put into the report because it fits in with the overall target of 48 hours, which has been shown by modelling to reduce significantly transmission in the community compared to an unconstrained case.[122]

Dr Finkel also complemented the end-to-end contact tracing CRM:

> The system has settled down into actually quite a best-practice management structure for the project of the digital transformation and modernisation of the testing, contact-tracing and outbreak management system.[123]

**FINDING 24:** The introduction of a Customer Relationship Management system was a highly effective measure to facilitate rapid contact tracing.

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120 Professor Euan Wallace, *Transcript of evidence*, p. 12.

121 Dr Alan Finkel AO, *Transcript of evidence*, p. 9.

122 Ibid., p. 3.

123 Ibid., p. 5.

### 8.2.1 How many cases does the Salesforce system allow Victoria to manage?

Salesforce's capacity as both a positive case management system and a contact tracing management system has been demonstrated in other jurisdictions, as explained to the Committee by Ms Pip Marlow, Chief Executive Officer, Salesforce Australia and New Zealand, in her evidence:

> … we are supporting the state of California—they are ramping up to 10 000 contact tracers right now … If you look at the state of Illinois, which has over 300 000 cases that have been put through the Salesforce system, the maturity and the digitising of systems made a big difference there. … The stories are very different in every jurisdiction, because candidly the rate of COVID was very different in different parts of the world.[124]

The system allows faster and more accurate contact tracing and case management through a number of measures, including:

- automatically uploading positive test results from the DHHS database in near-real-time
- reducing manual input time
- providing scripts and prompts for contact tracers to ensure they have asked all questions
- allowing for prompts when a case needs to be actioned within a timeframe, including escalation to managers if this is not actioned
- facilitating a central end-to-end system record management process which allows overview of the entire matter
- sending automatic text message communications
- assigning cases to have a single case manager on an entire household

The significance of having a database which can support end-to-end contact tracing was explained by Dr Finkel:

> It can help at every phase. Pop-up test sites initially used paper forms for collecting patient information and tracking the test sample. When the numbers are high processing these paper forms leads to significant delays and the likelihood of data entry errors. A modern system based on digital data collection and digitally tracking the data all the way through and into the contact-tracing system is much more efficient and less error-prone. For contact tracing confirmed cases are allocated to a contract-tracing officer to call the patient and interview them to identify their close contacts and then alert those close contacts that they have been exposed and must start quarantine. These interviews often take up to an hour. Traditionally the cases are allocated manually to the contact-tracing officers and interview details are recorded on paper and then subsequently manually entered into a database to assist with follow-up. This manual

124 Ms Pip Marlow, Chief Executive Officer, Australia and New Zealand, Salesforce, public hearing, via videoconference, 16 November 2020, *Transcript of evidence*, p. 5.

> process works at low numbers but is easily overwhelmed when the case numbers are high. Moving to digital allocation of jobs and digitally prompted and digitally recorded case interviews is much more efficient and less error-prone.[125]

By expediting these processes, the CRM system has put Victoria in a better position to manage an influx of cases moving forward by better keeping up with incoming cases and identifying and contacting primary contacts within the recommended 48-hour window:

> … the first rule of contact tracing is do not let it get away from you. That has to be, if you like, front and centre, the core value that is necessary, and unfortunately that is what happened in that second wave…I do not know what the upper limit would be at the moment, but I suspect when you get up between 100 and 200 cases a day you are probably taxing even the best of systems globally. With IT and other things and a large workforce of several thousand people you can probably extend it even higher.[126]

The capacity of the CRM in the context of Victoria was explained by Mr Michael Bonaddio, Principal Architect, Salesforce, who told the Committee that:

> … around the tracing aspect, that is going into contacting people as soon as the positive test is captured and going through a process of then digitally capturing all their movements and so forth and who their close contacts are. That is all done electronically, and obviously then the next step in that is managing that process of isolation and making sure that we keep engaged with those members of the public that are in isolation.[127]
>
> The Salesforce solution also has SMS capability built into it, so the department has made a decision to pivot to using Salesforce technology to send SMS messages for engagement. That is obviously in a range of areas in the process, be that when a citizen gets a positive test result, those communications are going out and then on an ongoing basis once they are in isolation. So any messaging that is required to be sent out in relation to data that is held in the Salesforce platform is done using our SMS solution.[128]

The introduction of digitalised processes to Victoria's test and trace system has proven to be a key factor in streamlining processes and allowing greater scalability. Confidence in the digitised system was expressed by a number of witnesses appearing before the Committee:

- Victoria has made an enormous commitment to developing a brand-new system in parallel to the old system that it is in the process of switching over to, and that brand-new system allows everything to be done in real time. So, the data from the pathology labs comes into the Department of Health's new system in real time, and a positive case can be allocated to a case interview officer through that digital system, and then literally in real time the system prompts the case interview officer, who is a trained person but still needs to go through a formal interview process,

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125 Dr Alan Finkel AO, *Transcript of evidence*, p. 2.

126 Professor Julian Rait, *Transcript of evidence*, p. 7.

127 Mr Michael Bonaddio, *Transcript of evidence*, p. 3.

128 Ibid., p. 9.

and their results of that interview go straight back into that system and can be used by the outbreak management people. So that real-time aspect and full digitisation makes a huge difference.

- The other big benefit of a system like that is that it has what I call or many of us call easy onboarding. So, if there is a surge and you have tapped into your available surge workforce … and it is a really big surge and you need to reach out and there is available capacity in other states in Australia, you can onboard trained case interview officers from those other health systems into the new contact management system in Victoria very easily through multifactor authentication systems, the kind of stuff you have done in your own lives. The case officers do not have to be physically present in the building. It is just a modern system. It makes it easy to do things and to increase your workforce that way, so that is yet another benefit of the new technology.[129]
- A digital one-stop system would be ideal going forward. Certainly we managed to work with PHESS very quickly, within about a day of training and access. We also have an integrated clinical health system, and we have direct access to laboratory testing results, so we are able to integrate them, but a lot of that had to be done relatively manually.[130]
- …those things have created greater efficiency in the system, including the move to the new end-to-end CRM system that we will now benefit from. We are getting further along that path to having all those things in place to find, test, trace, isolate and support people but particularly to underpin that by appropriate lab services and a very agile data system—and one that now can talk nationally as well.[131]
- …that investment in a digitised system of collecting patient data and following that all the way through the system has made an important contribution.[132]
- The advantage of the digital system—well, there are many advantages because so much is happening in real time that each individual case officer and outbreak management officer can do more, but the other advantage is you do not lose track of what is going on, you do not lose cases and you get data reports.[133]
- I think the availability of digital tools is crucial to health care in the 21st century. More digital availability means there is sharing of information and that human error in entering data is cut down significantly.[134]



129 Dr Alan Finkel AO, *Transcript of evidence*, pp. 3–4.

130 Professor Eugene Athan, Director, Department of Infectious Diseases, Barwon Health, public hearing, via videoconference, 16 November 2020, *Transcript of evidence*, p. 37.

131 Professor Catherine Bennett, *Transcript of evidence*, p. 47.

132 Dr Alan Finkel AO, *Transcript of evidence*, p. 3.

133 Ibid., p. 6.

134 Adjunct Professor Russell Harrison, Chief Executive Officer, Western Health, public hearing, via videoconference, 18 November 2020, *Transcript of evidence*, p. 58.

While the Salesforce system is an important factor in the improved contact tracing capacity, an additional consideration is the workforce employed to conduct contact tracing. As stated by Dr Finkel:

> I put it to you... that with Victoria at the moment going onto the new system where the test results are flowing through the system digitally and then into the contact-tracing management system based on Salesforce, I personally cannot see how in future cases could actually get lost. It may be that the human beings at the terminals of the system are overwhelmed. In the future if the numbers are just vast, they might not have time to deal with those cases, but the systems need to be designed on a risk-minimised basis to do less and less and less per case as the numbers go up.[135]

The Committee found it difficult to determine how many contact tracers were employed by the Victorian Government, and how those employees were recruited. The Department of Health and Human Services provided information on the fortnightly headcount for staff working within the Case Contact and Outbreak Management (CCOM) unit (Table 8.1).

However, advice provided to the Public Accounts and Estimates Committee on 30 November 2020 stated that 'as at 10 August 2020, the number of staff in the contact tracing team was 2,625.'[136] The Committee notes the large discrepancy between data provided to the two Committees.



135 Dr Alan Finkel AO, *Transcript of evidence*, p. 6.

136 Department of Health and Human Services, Inquiry into the Victorian Government's response to the COVID-19 pandemic hearing, response to questions on notice received 30 November 2020, p. 6.

**Table 8.1** Case contact and outbreak management fortnightly headcount

| | Pay period | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 11/10/20–24/10/20 | 27/9/20–10/10/20 | 13/9/20–26/9/20 | 30/08/20–12/9/20 | 16/8/20–29/8/20 | 2/8/20–15/8/20 | 19/7/20–1/8/20 | 5/7/20–18/7/20 | 21/6/20–4/7/20 | 7/6/20–20/6/20 |
| Australian Defence Force | 24 | 68 | 68 | 68 | 183 | 183 | 183 | – | – | – |
| Case, Contact and Outbreak Management | 529 | 480 | 484 | 473 | 603 | 444 | 377 | 358 | 329 | 286 |
| Commonwealth and other states | 113 | 81 | 76 | 243 | 244 | 360 | 6 | 6 | 6 | 6 |
| Health Direct | 200 | 200 | 200 | 200 | 150 | 150 | 150 | – | – | – |
| Helloworld | 28 | 39 | 34 | 36 | 37 | 37 | 62 | 31 | 22 | 22 |
| Local Public Health Units | 209 | 212 | 212 | 212 | 212 | 102 | 77 | – | – | – |
| Office of Deputy Secretary CCOM | 7 | 7 | 6 | 6 | 7 | 6 | 6 | 5 | 5 | 4 |
| Operational Policy and Planning | 12 | 12 | 12 | 12 | 9 | 10 | 10 | 10 | 10 | 8 |
| Outbreak Squads | 49 | 44 | 42 | 41 | 41 | 40 | 39 | 37 | 37 | 33 |
| Senior Medical Adviser Office of CHO | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| Stella | 34 | 34 | 34 | 48 | 48 | 48 | 24 | – | – | – |
| **Total** | **1210** | **1182** | **1173** | **1344** | **1539** | **1385** | **939** | **452** | **414** | **364** |

Source: Victorian Government, Department of Health and Human Services, *CT2a Workforce data,* supplementary evidence received 13 November 2020, p 3.

The Committee notes that this evidence does not specifically outline the number of staff assigned to contact tracing, and therefore is unable to comment on the ongoing output capacity of the contact tracing system. The Committee suggests that greater scrutiny is required to understand how contact tracers are recruited and selected, given that there are contracts with multiple service providers.

Mr Andrew Burnes, Chief Executive Officer, Helloworld, explained that his company had been engaged to provide contact tracing services for the Victorian Government:

> The second part of what we did was an outbound contact-tracing service for the Department of Health and Human Services, which I know is one of two focuses of this Committee. [137]

The public tender won by Helloworld was valued at $7.62m for a six-month engagement, however the Committee was unable to ascertain whether the full value of the contract has been, or will be, paid. The Committee also notes discrepancies in the data provided by the Department and the number of staff Mr Burnes said were engaged in contact tracing services.

### Were staff appropriately trained?



The Department of Health and Human Services provided job cards for the recruitment of contact tracing staff. Qualifications required by candidates included a tertiary degree in health science, nursing, medicine or related public health fields, with a post graduate qualification highly regarded. However, the Committee was unable to verify the qualifications of each of the contact tracing staff as that data was not provided by the Department.

Additional training was provided by the Department, and the Committee notes that the workforce proactively sought information to continually improve their approach to contact tracing:

> So things like looking at the processes we were using in New South Wales and Victoria, we absolutely used those same contact-tracing techniques, those same systems…as Euan really stressed, a workforce really open to working extremely hard, also always learning. And regularly, I would say—more than two or three times a week—people would be reflecting on journal articles that they had read internationally, lessons that they had seen. So for my sense in coming from other workplaces, it was very much a learning environment and an environment very committed to the people of Victoria and more broadly to the health and wellbeing of the people of Australia.[138]

The Committee also received evidence suggesting that an ideal ratio was 5 contact tracers per positive case yet was unable to discern what the actual ratio for the

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137 Mr Andrew Burnes, *Transcript of evidence*, pp. 55–6.

138 Ms Sandy Pitcher, Deputy Secretary, Case Management, Contact Tracing and Outbreak Management, Department of Health and Human Services, public hearing, via videoconference, 23 November 2020, *Transcript of evidence*, p. 26.

Victorian system was. This information was requested from the Department but, at time of writing, had not been provided.

Given the lack of available information around the workforce, the Committee cannot make an informed comment on whether or not the capacity of the workforce is appropriate to handle a larger outbreak.

Further to this, the Committee noted that information about multilingual contact tracers was difficult to access, and therefore cannot comment on whether the staffing was fit for purpose in that regard.

## Figure 8.1 Job card—New case officer

**TEAM OBJECTIVES:**

- Investigate and follow up all new confirmed cases
- Identify contacts of all new confirmed cases
- Undertake a risk assessment of all new confirmed cases
- Interview all new confirmed cases
- Contact all close and causal contacts and provide advice and recommendations on isolation and exclusion
- Provide public health advice and support to cases, contacts and members of the community

**CASE OFFICER OBJECTIVES:**

1. Reports to New Case and Contact Tracing Team Lead
2. Provides advice and recommendations on public health advice and case risk assessment
3. Communicate situational awareness to Team Lead
4. Meets reporting deadlines on case and contact management

**Initial actions:**

1. Interview all new confirmed cases and contact identified close and casual contacts
2. Identify outbreaks and clusters associated with new cases
3. Maintain data and information standards for Intelligence and Operations lead
4. Enter data and ensure data quality of information being entered into PHESS
5. Report escalated advice and information requests to Team Lead from case and contact tracing team
6. Provide recommended adjustments to case and contact workflows to Team Lead

**Additional tasks:**

9. Manage information and correspondence through CDIR and Public Health Operations Inbox
10. Enter confirmed cases – questionnaires information into PHESS
11. Receive list of laboratory results from VIDRL each day and enter them in the PHESS provisional field

**Qualifications**

- Tertiary degree in health science, nursing, medicine or related public health field
- Post graduate qualification in public health, environmental science or public policy would be desirable.

**VPS Classification:**

- VPS 4

**References:**

*1. EDRM Reference:*

- *WORK/20/136 Novel Coronavirus (2019-nCoV) – January 2020 – Active*
- *IIEF/20/1047 Public health – Health Protection – COVID-19-Planning and Intelligence*

*2. F: \\N060\Group\PH*

*3. Microsoft Teams Reference:*

- *CDES shared-DHHS-GRP*

*4. Public Health Event Surveillance System (PHESS)*

- ***internal DHHS intranet access required***

*5. PowerBI*

*6. Virtual support – TC and Mobile Support*

*7. H03.06 SEMT Situation Report SOP*

*8. infectious.diseases@dhhs.vic.gov.au*
*cdir@dhhs.vic.gov.au*
*publichealth.operations@dhhs.vic.gov.au*

*9. DHHS Coronavirus 2019 (COVID-19) Guidelines for health services and general practitioners – Version 13 – 15 March 2020*

**Additional tasks:**

9. Manage information and correspondence through CDIR and Public Health Operations Inbox
10. Enter confirmed cases – questionnaires information into PHESS
11. Receive list of laboratory results from VIDRL each day and enter them in the PHESS provisional field

*8. infectious.diseases@dhhs.vic.gov.au*
*cdir@dhhs.vic.gov.au*
*publichealth.operations@dhhs.vic.gov.au*

*9. DHHS Coronavirus 2019 (COVID-19) Guidelines for health services and general practitioners – Version 13 – 15 March 2020*

*10. DHHS Case and Contact Management Guide*

*11. Phone access*

**Additional tasks if the Special Advice role is not activated**

**Minimum Skill Set**

- Office 365 proficiency
- Adapt and learn new systems quickly
- Follow direction and guidance on processes and escalate when needed
- Ability to manage difficult conversations and stakeholders
- Complete writing and reporting tasks accurately and efficiently

**Internal DHHS Training requirements**

1. General Induction - Candidate Readiness Assessment
2. New Cases - Candidate Readiness Assessment
3. Experience in Triage & Notification, New Contact, Existing Contact or Existing Confirmed Contact teams

Source: Victorian Government, Department of Health and Human Services, *CT2a_1 – CCOM job cards,* supplementary evidence received 13 November 2020, p. 8.

**FINDING 25:** The external workforces contracted to provide system support were not a cost-effective choice, nor were some of those employed qualified to understand all the public health elements of the role.

## 8.3 Digitisation

As discussed in section 5.5.1, the digitisation and integration of Victoria's end-to-end contact tracing system was built and supported by Salesforce, whose services were procured by the Victorian Government in August 2020. This section focuses on explaining the current state of Victoria's COVID-19 contact tracing system. It also looks at the reasons Victoria has chosen to digitise contact tracing and the efficacy of digital contact tracing.

The *National Contact Tracing Review* report outlined the benefits of a digital contact tracing system:

> Efficiency is enhanced if contact tracers follow digital interview forms and record the responses directly into computer systems rather than rely on paper-based forms and subsequent data entry. A fully digital contact tracing system dramatically improves the efficiency of contact tracing but is dependent on well trained contact tracers and expert public health oversight in important interpretive phases such as complex cases, difficult interviews, cluster analysis and outbreak responses.[139]

The report went on to argue that the automation of contact tracing systems is important to build capacity especially if positive case numbers rise in a community:

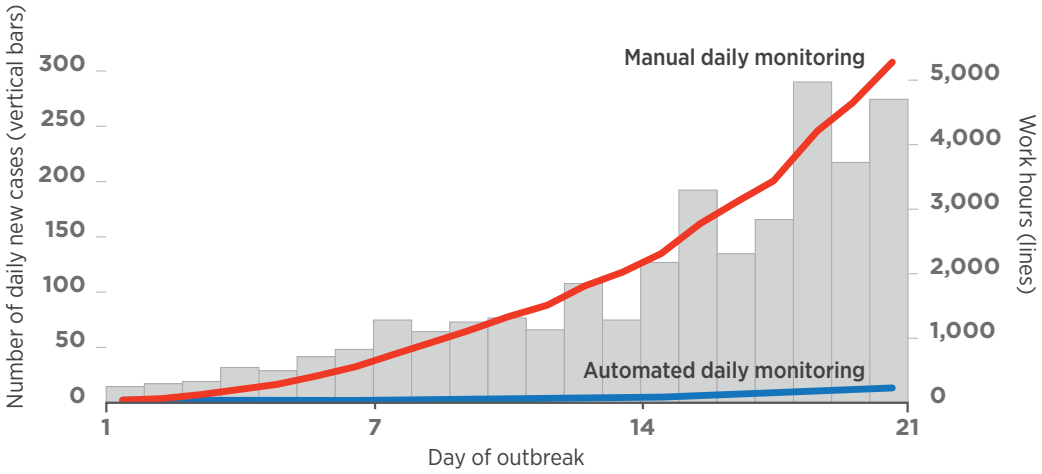
> Automation, where possible, of contact tracing and case management can significantly reduce workload, particularly during periods of high case numbers. When case numbers rise, the workload associated with daily monitoring activities (e.g. manually sending a text message or an email) rises rapidly. Automating this process can significantly reduce the elapsed time to notify close contacts and provide more efficient daily management of confirmed cases and close contacts in isolation and quarantine, respectively. Importantly, this automation will decrease the burden on the public health workforce which can then concentrate its efforts and expertise on outbreak management.[140]

Figure 8.2, taken from the Review's report, shows the time saved through automated daily monitoring.

139 National Contact Tracing Review, *National Contact Tracing Review*, p. 54.

140 Ibid., p. 69.

**Figure 8.2 Times saved through automated daily monitoring**




Source: National Contact Tracing Review, *National Contact Tracing Review: A report for Australia's National Cabinet*, Australian Government, Canberra, 2020, p. 69.

Some of the other benefits of a digital contact tracing and outbreak management system for COVID-19 include:

- Text messaging capabilities can be used to inform close contacts of a positive case and provide quarantine directions so long as this is followed up with a phone call from health officials as early as possible.
- In the event positive cases surge, automated text messages can replace the practice of health officials notifying a person of their test results and provide quarantine directions and other advice to infected persons.
- Digital contact tracing via technology such as QR codes can be immediately fed into databases recording test numbers, positive cases, close contact details, response times and other essential information.

However, whilst a digital contact tracing technology can assist significantly with the efficiency of the system, it cannot 'replace the need for well-trained contact tracers and expert public health oversight.'[141] A breadth of well-trained and expert people contributing to contact tracing is especially important 'where there are critically important interpretive requirements such as difficult interviews, cluster analyses and outbreak responses.'[142]

The Victorian Government explained that by establishing a digital contact tracing system essential data is more easily collected, collated and analysed to inform performance metrics and policy decisions. The Victorian Government's submission stated:

> Throughout the pandemic, the Victorian Government has placed an emphasis on using data to drive decision-making. This evidence-informed approach has been a

141 Ibid., p. 71.

142 Ibid.

> hallmark of Victoria's interventions, whether restrictions or system enhancements, and likely underpins results the like of which have not really been seen in any other similar jurisdiction internationally.
>
> Comprehensive data are collected from each case. This includes information on the timing of infectious period (i.e. generally considered the two days prior to symptom onset) and the locations a person visited and thus could have exposed others to the virus.
>
> The data inform a suite of metrics, calculated daily, to allow the Victorian Government to better understand pandemic progression and ensure targeted responses including enhanced testing and engagement. Local data are used to develop mathematical models that informs policy and analyses and forecasts, run weekly, to inform the response.[143]

### 8.3.1 System integration

An important component of Victoria's digital contact tracing system is that it integrates the entire system end-to-end by establishing a wholesale customer relationship management system that covers all the steps involved in contact tracing (from case identification to close contact isolation). Previously, Victoria's contact tracing system involved several companies dealing with different steps of the process, manual processes for inputting data and movement of data to a centralised database from third-party sources. The new digital system brought together with Salesforce technology aims to automate much of the contact tracing process so that the process happens more rapidly and efficiently.

The Victorian Government emphasised to the Committee that the automation and digitisation of the contact tracing system would allow it to accelerate turnaround times and responsiveness:

> A CRM [customer relationship management] was built to… the contact tracing process across testing, positive case interview, identification of close and secondary contacts and their isolation or quarantine.
>
> This acceleration is afforded by automation of almost all steps from the moment a positive case is notified, including case allocation, case alert, contact notification, isolation/quarantine messaging etc.
>
> The CRM has also been configured to allow self-entry of information by a case ahead of interview. The selection of Salesforce as the vendor of the CRM also allows future alignment and sharing with Western Australia and South Australia.
>
> It will cover the whole program of contact tracing – from positive result coming in, the interviews, follow-up phone calls and coordination of Operation Vestige to the clearance of cases and contacts to be managed all within the one system.

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143 Victorian Government, *Submission 23*, p. 27.

> An important feature of the CRM is the ability to provide simultaneous users contact tracing across DHHS' CCOM [Case, Contact and Outbreak Management] team and local public health units. This will help synchronise all local public health units and central DHHS teams to monitor and rapidly contain future transmissions of COVID-19.[144]

The Committee notes with interest the indication by the Victorian Government that part of the reason for selecting Salesforce as the contact tracing vendor was that it would better facilitate system alignment with Western Australia and South Australia.

In its submission, Salesforce described the role its technology has in implementing and integrating the Victorian Government's contact tracing processes:

> Salesforce is responsible for the provision of our cloud platform for the Government's contact tracing solution with the implementation delivered by a System Integrator. The Victorian Government determines the appropriate contact tracing business processes and procedures, which are defined by DHHS and then implemented on Salesforce's technology platform.
>
> The Salesforce platform provides the technology capability to support contact tracing and includes comprehensive case management and automated notifications via SMS or email. The system collects data which is stored securely in Australia.[145]

At a public hearing, Mr Bonaddio (Salesforce) explained the effect system integration will have on tracking contact tracing response times:

> At a higher level, all the test results are essentially centralised within a DHHS database that has those lab results immediately. As they land into that solution they are sent to Salesforce via system-to-system integration—so it happens automatically; there is no manual intervention—and that kicks off a process to essentially track the response time, and it is managed very robustly in the platform for that particular case. Different cases might have different response times required, depending on the setting in which they land. So, for example, aged care might have different response times to members of the general public, but each of those response times is closely monitored, and if there is any risk of breaching those response times, there are appropriate mechanisms to then escalate that to team leaders.[146]

Mr Bonaddio further explained how the end-to-end contact tracing system developed by Salesforce uses 'system-to-system integration' to ensure a positive case record for contact tracers that is easily followed up on:

> So if we go back to the core process, being test, trace and isolate, you know, as soon as a positive case lands in Salesforce, we have obviously got that system-to-system integration that is creating that positive case record for contact tracers to follow up on. As soon as it lands in Salesforce, there is an SLA, or what we would call a 'response time', attached to that particular case, and that is again monitored quite closely. And, you know, there are mechanisms in place to warn against it being breached. So let us

144 Ibid., p. 26.

145 Salesforce, *Submission 8*, p. 2.

146 Mr Michael Bonaddio, *Transcript of evidence*, p. 3.

> for argument's sake say it is 24 hours. If there has been no action on that particular case within say 20 hours, that will be escalated to a team lead to act on. So we have got that sort of robust capability to make sure that, you know, things are not necessarily breached and actually can be taken in advance of that. So those are sort of some robust mechanisms that are built into the Salesforce platform. And again, they are configurable based on the setting and the information we have about that positive case.[147]

Several stakeholders raised concerns about how third-party applications would integrate into Victoria's contact tracing system and whether this would still cause the same issues experienced during the second wave. Stakeholders queried how QR code technology would be fed into the contact tracing system especially if a business elects not to use the Victorian Government's QR code but another third-party option.

Mr Paul Guerra, Chief Executive, Victorian Chamber of Commerce and Industry, argued that the Victorian Government needs to focus on third-party integration with the Salesforce system and also on providing the appropriate support to businesses to implement a government supported QR code:

> I think the government needs to focus on the integration of third-party apps and QR codes with the Salesforce system that is being invested in. I also know that some of our members who may not be able to afford third-party apps would greatly benefit from a government-provided one, either developed in house or purchased from the market…[148]



Mr Sven Bluemmel, Commissioner, Office of the Victorian Information Commissioner, posited a scenario to the Committee whereby third-party integration into Victoria's contact tracing system could allow a business to spam a customer or contacts using the data collected, despite the clear assumption from Victorians that data given to QR codes was only accessible by the government.[149] Mr Bluemmel encouraged the development of a government app:

> Going into the contact-tracing phase that we are now in with organisations, the sorts of things I would be concerned about are—and government is taking these concerns on board—you can imagine going to your local cafe and being asked to scan a QR code, and if you ask the person at the front desk, 'Well, why do I need to do that?' the person says, 'It's a government COVID thing'. Okay. So a person might think, 'Well, it's government. I might not like the government, but it's the government; it's not a social media company, and it's not a marketing company. Okay, I'll provide my information'. Now, of course, if that app is then actually provided by a private sector organisation—and of course there are several that provide these sorts of services for loyalty programs, for table bookings—if they then integrate the contact tracing into that, you can easily see a scenario where you go into the cafe, you sign in and you scan and then you start getting spam from the restaurant, from a company, from whatever, saying, 'You might also enjoy this'. In your mind you are going, 'I gave this to the government, and now I'm getting spammed'. These are the sorts of nuances where trust can break down. So what

147 Ibid., p. 7.

148 Mr Paul Guerra, *Transcript of evidence*, p. 78.

149 Mr Sven Bluemmel, Commissioner, Office of the Victorian Information Commissioner, public hearing, via videoconference, 16 November 2020, *Transcript of evidence*, p. 26.

> is really encouraging there is that certainly in Victoria there is that greater move that the government itself will make available the technology and the app to do that, because then that can be protected. The cafe itself may well have a turnover of under $3 million. I do not regulate them; the Australian Information Commissioner does not regulate them. There might be a gap there, but if as little information is collected as possible to do the job and that information is then protected and only shared where absolutely necessary and with the right people, we can build that level of trust much more.[150]

Ms Marlow (Salesforce) acknowledged to the Committee that the implementation of Salesforce's contact tracing system in Victoria is an 'iterative process' which includes further consideration of integrating QR technology as Victoria continues to reopen:

> We did three sprints over eight weeks, which was the scope of work that the department had as part of that, which got a phase 1 parallel system up and running, and post that we have moved into the next phase, which the government is working more of an iterative process where they then take that first implementation, start to work on further work around user interfaces, simplification, and then over time I would imagine what other services citizens will need, and supports.
>
> ...
>
> How do you as you reopen the state think about integrating QR technology when you go into a restaurant into a system? So I think it is an ongoing maintenance model and innovation about how you might continue to think about the things you want the system to do.[151]

Mr Bonaddio (Salesforce) contended that the integration of QR codes into the contact tracing system would assist with the acceleration of the process:

> In terms of the capture of that information and where efficiencies can be made, there are certainly process improvements that are possible in automation, so sending automated messages, which obviously currently exists. But I think one of the key things that is going to help accelerate that process is the integration of QR code solutions that can help understand where a person has been and where they have checked in automatically. All of a sudden you have gone from this process where you are asking for that information over the phone to having that information be ingested into the contact-tracing application for the purpose of validation with the person on the phone, so that can save on that data-entry process.[152]

In the Committee's view, some of the shortcomings and therefore key points to be learnt from contact tracing in Victoria resulted from the system being made up of components supplied from several companies which were not fully integrated into one end-to-end system. System integration is a vital component of a fit for purpose contact tracing system as it enables the responsiveness and adaptability of that system. By integrating

150 Ibid.

151 Ms Pip Marlow, *Transcript of evidence*, pp. 4–5.

152 Mr Michael Bonaddio, *Transcript of evidence*, p. 11.

its contact tracing system through Salesforce technology the Victorian Government has stated that it now has an appropriate end-to-end contact tracing system which can:

- prioritise high-risk close contacts
- identify and escalate contact tracing actions when necessary
- determine appropriate resources for a case or outbreak.

However, the capacity of Victoria's digitised contact tracing system has not been fully determined as this technology was only recently commissioned in Victoria, once case numbers had steadily declined. The Committee is confident that the centralisation and automation of the contact tracing data system has expanded its capacity, however, it was unable to ascertain the limitations and difficulties it may face. In essence, the system has not been tested. The Committee suggests ongoing modelling occur on the potential or expected capacity of Victoria's contact tracing system and that the results of this modelling be made public.

**RECOMMENDATION 10:** That the Victorian Government conduct modelling studies on its digital contact tracing system to better understand its expected and potential capacity. The results of these studies should be made public.



### 8.3.2 System responsiveness

The Committee heard that Victoria's digital contact tracing system has been developed so that it can prioritise making contact with high-risk close contacts first, such as health care workers. Mr Bonaddio (Salesforce) told the Committee that:

> An interview is held and that information is captured. Some of the information that is captured may be used to prioritise other contacts. For example, if someone has been interviewed and they work in an aged-care setting, there are processes in place that can help escalate tracing that particular person's close contacts to make sure that outbreaks in sensitive settings can be contained.[153]

According to information provided by Salesforce, the end-to-end contact tracing system that was developed incorporated an ability to establish differing response times depending on the sensitivity and potential risk to a close contact once a case interview with a positive person was completed.[154] This meant that close contacts who worked in healthcare or aged care were allocated faster response times due to their higher risk profile, and that if there was a risk of breaching response times it could be escalated to a team leader.[155] The prioritisation of high-risk close contacts within the automated system has meant that Victoria's contact tracing is more responsive.

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153 Ibid.

154 Salesforce, *Submission 8*, p. 3.

155 Mr Michael Bonaddio, *Transcript of evidence*, p. 3.

However, the Committee acknowledges that the provision of Salesforce technology did not occur until 28 August 2020 as positive case numbers in Victoria began to steadily decline. Therefore, the robustness and responsiveness of the digital contact tracing system was not tested during the high positive case numbers experienced during Victoria's second wave. This makes it difficult for the Committee to comment or conclude on the efficacy of the system's responsiveness and whether the methods put in place to prioritise and manage risk-based response times works effectively when the system is at-risk of reaching capacity.

Stakeholders told the Committee that system responsiveness is not just about the responsiveness of the technology Victoria's end-to-end contact tracing system is built on but also the personnel and on-the-ground resources which collect information and put the digital contact tracing system to work. The Committee was concerned to understand whether the provision of additional contact tracing personnel within the Department of Health and Human Services prior to the pandemic would have meant better control of both outbreaks experienced in Victoria. Of even more concern to the Committee was the knowledge that several reports existed which recommended increased staffing for Victoria' public health units. This issue is discussed in more detail in section 9.2.

Alongside the development of a digitised end-to-end contact tracing system, Victoria has established a more decentralised local health response to COVID-19 through the creation of public health teams embedded in metropolitan and regional communities. A decentralised and localised on-the-ground pandemic response supplemented by centralised end-to-end contact tracing technology allows for a more rapid response. The Public Health Association of Australia, based on the findings of the *National Contact Tracing Review* report, stated that:

> Victoria's recent move to a decentralised approach for regional cases has advantages in embedding teams in a local community, allowing some independence while retaining resources from the central health department and public health units, and twinning of public health units to meet surge demands. This approach still requires centralised technology for case allocation, interviews and outbreak management, balancing local knowledge with contact tracing expertise to achieve rapid and high-quality outcomes.[156]

Rapid testing and fast deployment of resources also contributes to a responsive contact tracing system. Mr Weimar (Department of Health and Human Services) explained that COVID-19 testing is a three-tiered process (Figure 5.4) culminating in a swift response to outbreaks:

> And then at the peak of the pyramid is that really swift response to outbreaks that Brett has spoken to. That has been critical to us to ensure that outbreaks are contained more quickly, and if you compare and look at the speed of response that we have accelerated over the last five or six months, you can really see how some of those recent outbreaks have been brought far more quickly to heel with fewer people impacted and less seeding out into the wider community. All that is based around a far more

156 Public Health Association of Australia, *Submission 21*, p. 2.

> mobile, far more agile and far more responsive testing system to go and achieve that, and with that, I will now hand over to Sandy to talk about some of the contact-tracing improvements.[157]

Rapid response testing is discussed in more detail in section 5.4.4.

As discussed earlier in this section, the Committee is unable to comment on whether Victoria's digital contact tracing system has the capacity required and is fit for purpose because it was introduced at the end of the second wave and has not been tested.

The Committee believes that an important part of system responsiveness is the provision of appropriate staffing. This would ensure that capacity and fitness for purpose can be maintained under a variety of scenarios, such as COVID-normal or a third large-scale outbreak. The Committee was disappointed to learn that recommendations to increase staffing levels within Victoria's public health units were not taken up by the Victorian Government. In the Committee's view, greater capacity in the public health system may have limited the need to deploy a surge workforce built from personnel outside of the health industry.

**FINDING 26:** Due to the late commencement of implementation of a digital contact tracing system at the end of August 2020, the Committee was unable to determine if the system has the appropriate responsiveness and robustness.

**RECOMMENDATION 11:** That the Victorian Government establish a trained reserve workforce for future public health emergencies.

### 8.3.3 Adaptability

A contact tracing system needs to be adaptable. Throughout a pandemic a jurisdiction is likely to encounter many varying scenarios which necessitate different tracing and outbreak management responses. The contact tracing response for a localised outbreak versus a large-scale state-wide outbreak is markedly different in terms of resources required and system pressure. Therefore, it is imperative that the Victorian contact tracing system is able to appropriately and rapidly respond to a variety of pandemic scenarios with sufficient capacity to prevent the system becoming overwhelmed.

During Victoria's second wave, the Committee has found, the contact tracing system and testing regime implemented and operated by the Victorian Government did become overwhelmed, was plagued by delays and demonstrated a lack of adaptability. In its submission, the Victorian Government outlined the ongoing improvements that were required as the pandemic unfolded:

> In response to the changing nature of the pandemic in Victoria, the Victorian Government's contact tracing and testing regime has, necessarily, seen considerable

157 Mr Jeroen Weimar, *Transcript of evidence*, p. 5.

> improvements across all areas. These changes have contributed to better COVID-19-related public health outcomes. Specifically, there have been improvements to testing processes and coordination, community engagement, the public sector workforce response, and interjurisdictional collaboration.
>
> The test, trace and isolate regime has been tested through Victoria's two waves of COVID-19.[158]

Whilst the Committee acknowledges that the Victorian Government implemented changes to testing and contact tracing throughout the pandemic , poor decision-making and the choice not to pursue an integrated contact tracing system in March 2020 resulted in a system which was overwhelmed and unable to adequately respond to contact tracing requirements during the second wave. The decision to build on existing systems, such as the Public Health Event Surveillance System, and rely on existing vendors without proper consideration of what was needed in Victoria caused several costly mistakes, all of which have damaged the lives and livelihoods of Victorians. Furthermore, evidence, which was available to the Victorian Government prior to the pandemic, showed that existing capacity, infrastructure and resources were insufficient.[159]

The establishment of an end-to-end digitised contact tracing system including automating and streamlining the process was a step in the right direction. The introduction of local health units responsible for contact tracing and outbreak management in discrete areas or specific high-risk groups was another positive step.



Mr Bonaddio (Salesforce) explained to the Committee how data captured through the system can be used to determine what resources are required:

> Some of those test results originate from more sensitive settings, where maybe the response time needs to be a bit shorter, and the platform has got the ability to adapt, so to speak, around those response times. Additionally, there is reporting that can provide visibility of how close the aggregate of cases are being managed within those response times, and that can inform the department around whether they need to scale up contact-tracing resources to be able to accommodate with that workload.[160]

However, these solutions were engaged or rolled out as Victoria's second wave was steadily decreasing. This makes it very difficult for the Committee to conclude whether the current contact tracing system is sufficiently adaptable. The Committee hopes that the new system is equipped to deal with a variety of pandemic scenarios including COVID-normal where much of the current surge workforce from sectors such as travel and tourism may be able to return to their substantive roles.

The scalability of a contact tracing system (its ability to adapt to increasing or decreasing numbers of cases) is vitally important to its successful operation and is a key measure of its adaptability and fitness for purpose. A scalable contact tracing system is

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158 Victorian Government, *Submission 23*, p. 23.

159 Tom Voigt, *Submission 13*.

160 Mr Michael Bonaddio, *Transcript of evidence*, p. 7.

able to rapidly and effectively respond to a variety of scenarios and quickly deploy the appropriate resources and personnel to assist with outbreak management; this includes resources such as technical capability, testing capacity, and workforce (including reserve and surge workforce) capabilities.

**FINDING 27:** The adoption of an end-to-end automated process for enabling and recording contact tracing and testing results occurred too late - after the second wave of infections in Victoria. This is despite approaches by technology providers with proven capacity in other contexts and jurisdictions made early in the Victorian pandemic.

**FINDING 28:** Scalability is a key measure in an adaptable and fit for purpose testing and contact tracing system. This includes technical capability, testing and pathology capacity, and a flexible workforce that can be activated or scaled down on short notice.

**FINDING 29:** Assessing the capacity and effectiveness of contact tracing is difficult because the system has only recently been redeveloped and some functions are yet to be rolled out and tested with the arrival of international positive cases.

# 9 What issues have been raised about contact tracing and testing in Victoria, and have they been resolved?

## 9.1 Issues raised in evidence

Throughout the evidence received by the Committee, a multitude of issues were raised with respect to the function, capacity and appropriateness of the contact tracing system and testing regime. This chapter will address a range of key issues:

- Preparedness
- Governance culture
- Financial viability
- Why the contact tracing system was overwhelmed
- Testing criteria
- Test Tracker
- Communication and public knowledge (including the availability and quality of communication for specific cohorts)

In some instances, the Committee was unable to determine if an issue has been appropriately addressed by the Victorian Government and calls on the Government to address any gaps or shortcomings as a matter of priority.

## 9.2 What opportunity did the Victorian Government have to prepare for pandemic contact tracing and testing? Why did it hesitate?

The overarching issue for many stakeholders was a perceived reluctance from the Victorian Government to appropriately prepare for the COVID-19 pandemic. This meant that much of the Government's responses have been crisis built and reactive leading to several mistakes and shortcomings that significantly impeded the effective operation of the system. Several submissions to the inquiry mentioned a range of reports that were provided to the Victorian Government which identified resourcing issues within the Communicable Disease Prevention and Control team of the Department of Health

and Human Services. Mr Tom Voigt, the former acting Manager, Communicable Disease Prevention and Control Unit stated in his submission to the inquiry that:

> I completed and submitted a final report titled 'Communicable Disease Prevention & Control – A Review of CDPC Staffing and Workload, May 2019 (Growth in the service demand versus changes in staffing)' prior to leaving the Department at the end of my locum appointment in May 2019, some 6 months prior to the emergence of COVID-19.
>
> At the time I recommended a two stage increase in staffing for the Contact Tracing team from its existing baseline number of 14 Public Health Officers (PHO's) to 24 Public Health Officers (an increase in staffing of approximately 60%) to allow existing workload demand to be met and to better prepare the CDPC unit for future outbreaks or surges in activity.[161]

Mr Voigt observed a number of inadequacies in the resourcing of the Department and included these observations in his report. He provided excerpts for the Committee in his submission:

> 'The number of Public Health Officers (PHO's) in Victoria responsible for investigating and responding to notifiable conditions is half the size of the next least resourced jurisdiction (New South Wales). This is despite Victoria having the highest population increase of all States and Territories since 2013'.[162]

The submission further outlined insufficient Public Health Officer resourcing, which was outlined in the report provided to the Department:

> After reviewing existing CDPC workload and identifying key areas of work that were either not being done or were being placed on hold due to workload exceeding existing staff capacity, it was evident that there needed to be an immediate increase in Public Health Officer staffing of 2.8 FTE or 20% simply to allow current workload to be addressed.[163]

The report recommended 'an immediate increase in staffing of 2.8 FTE (PHO's) within the CDPC unit to enable the team to continue to investigate and respond … in keeping with the level of activity reported in 2018'. In addition to managing the existing workload, Mr Voigt predicted an influx of referrals in 2019 and recommended staffing be increased by 7.2 full-time equivalent (FTE) staff members 'in an attempt to address long standing gaps and work that had been placed on hold or which was not being investigated adequately'.[164] These measures were recommended 'based on complexity of cases and increasing numbers of outbreaks allocated to the CDPC unit':[165]

> At the same time that an urgent and significant increase in additional staffing was being recommended for the Contact Tracing team in May 2019, it was also noted that Victoria's

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161 Tom Voigt, *Submission 13*, p. 1.

162 Ibid., p. 2.

163 Ibid.

164 Ibid.

165 Ibid.

> capacity to address and deal with respiratory outbreaks (Covid-19 is a respiratory illness) was less than optimal.
>
> Victoria does significantly less in respiratory (influenza) outbreaks than most jurisdictions and is subsequently unable to comply with recommended national guidelines, due to low capacity/insufficient staffing resources.'

The submission contends that multiple reports conducted in 2016, 2018 and 2019 came to similar conclusions in relation to increasing the number of Public Health Officers. However, Mr Voigt further notes that the funding and capacity of the Public Health Officers was not seen as a priority at the time:

> I worked alongside Dr Brett Sutton (Chief Health Officer) in presenting my findings and recommendations. Dr Sutton was in full support of the need for additional Public Health Unit staffing and was a very strong advocate for a stronger Public Health team and presence. Unfortunately, when this information was put before the appropriate DHHS Deputy Secretary the response was a very firm and direct 'no' and that no additional funding was available, nor would it be sought as the Public Health team was a low priority at that point in time.[166]

The Committee understands that the COVID-19 pandemic was unexpected and unanticipated, however it is very troubled by the Victorian Government's inability to address these identified shortcomings. The Committee does believe that the lack of willingness to invest in these resources indicates there may have been a complacency about public health and emerging threats.

**FINDING 30:** The Victorian Government had previously received reports which identified the need for additional contact tracing staffing resources but to the Committee's knowledge did not act on them.

**RECOMMENDATION 12:** That the Victorian Government increase the number of staff in the Department of Health and Human Service's public health units and contact tracing teams so that it is line with current recommendations.

The Committee also refers to the *Victorian health management plan for pandemic influenza*[167] and the *Victorian action plan for pandemic influenza* as working documents which outline key triggers for public health protection and disease management. Given the timeframe between the first case of COVID-19 in Australia and Victoria's implementation of a functional public health response, the Committee suggests that the Victorian Government had ample opportunity to implement proper preventative measures, community engagement strategies and to bolster its contact tracing systems.

166 Ibid., p. 3.

167 Department of Health, *Victorian health management plan for pandemic influenza*, Victorian Government, 2014.

**FINDING 31:** Despite the availability of the *Victorian health management plan for pandemic influenza* since 2014, there has been limited investment in and commitment to pandemic preparedness from the Victorian Government. This has resulted in the public health response and contact tracing being driven by a reactive crisis response leading to poor decision-making and unnecessary delays.

## 9.3 Governance culture

The culture of the Department of Health and Human Services and its executive was raised by a number of stakeholders.

There were claims made by stakeholders that there was a defensive culture evident in the approach of some of the Department leadership which may have impeded the implementation, operation and evolution of the testing and contact tracing systems.

Professor Julian Rait, OAM, Victorian Council, Australian Medical Association, spoke to the Committee about the experiences of the Australian Medical Association and its perception of the culture in the Department of Health and Human Services. He stated that:

> ... I think culturally there is a flaw in the department. We talk in health care about open disclosure—that is, when we make a mistake, we fess up to the patient and we tell them, 'Look, we're very sorry this particular error has occurred. It happened for this, this and this reason. But this is what we're going to do to fix it'. That open disclosure and honesty is what is expected of medical professionals, quite properly, and it is not something that has basically been modelled by the department at all. They have instead decided to be very defensive and keep their imperfections to themselves...
>
> I guess that this is what is very frustrating with the department—there is not that sense of humility and that willingness to learn or to admit that perhaps things could be done better. This is a very serious problem...I hope that this is a turning point for the Department and that they understand that they need to be more self-critical and not defensive about their shortcomings...
>
> We believe it is important that DHHS becomes less defensive and learns to benchmark its performance to other states and other jurisdictions while embracing a learning culture of continuous improvement.[168]

This issue was also spoken about by Mr Sven Bluemmel, Commissioner, Office of the Victorian Information Commission, in his response to a question during his appearance before the Committee. Mr Bluemmel was asked about a 'defensive culture' within Victorian Government agencies, Mr Bluemmel stated that:

> ... I would strongly agree with that. The other jurisdiction that my office oversees in Victoria is freedom of information, and in that space exactly what you have said there—

168 Professor Julian Rait, *Transcript of evidence*, p. 13.

> resisting disclosure, trying to find exemptions where you can, not putting things out that might be embarrassing or might show some mistakes—is something we deal with in the FOI space all the time...
>
> Now of course I cannot comment on the culture of DHHS about this particular matter or anything like that. That is not something that I have looked at, and it is not in my jurisdiction beyond the FOI space and the particular matters and so on. But in terms of the general conclusion of whether those things that you have mentioned in the abstract have a negative impact on trust, yes.[169]

He further noted that in the research conducted by his office:

> ... that the single most important factor in whether an agency is transparent and proactively accountable when it comes to information release is the culture of senior management—probably not entirely surprising, but really important to have that fed back...[170]

The Committee notes that a defensiveness or stubbornness seems to have played a role in the Victorian Government's delayed engagement with the Salesforce CRM. In his evidence to the Committee, Professor Euan Wallace, who took over as Secretary of the Department of Health and Human Services on 17 November 2020, confirmed that 'there were a number of approaches made to the department, and a decision was made to spend resources on improving or enhancing the existing PHESS database'.[171] The Public Health Event Surveillance System was used until the engagement with Salesforce and is currently being used parallel to the new system.[172] As discussed in Chapter 5, the system developed by Salesforce focuses specifically on contact tracing whereas the Public Health Event Surveillance System has broader public health applications.

In further explaining why the Victorian Government decided to develop a stand-alone contact tracing system, Professor Wallace also admitted to the Committee that 'no matter how many enhancements we made with PHESS we could never get the digital end-to-end system.'[173] Despite understanding the limited capacity of the existing system, the Victorian Government put off engaging a proven technology in favour of trying to repurpose a technology that it eventually understood was not fit for purpose:

> We had an operational system, and decisions were made, I think quite appropriately, to improve and enhance the system because the solutions would be delivered faster. It was then, in mid to late July, that we decided that future enhancements were beyond the current PHESS system and future enhancements would only be afforded by complete digitalisation end to end, hence then the engagement with Salesforce.[174]

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169 Mr Sven Bluemmel, *Transcript of evidence*, p. 30.

170 Ibid.

171 Professor Euan Wallace, *Transcript of evidence*, p. 13.

172 Victorian Government, *Submission 23*.

173 Professor Euan Wallace, *Transcript of evidence*, p. 14.

174 Ibid., p. 13.

In a response to a question on notice the Victorian Government said that 'The decision not to commence a Salesforce project in April was appropriate'[175] because:

1. The tactical Microsoft systems provided fully secure online access to digitised end-to-end support for testing and contact tracing. These systems were used by over 1300 staff in the department, the external call centres and in metro and rural health services to process over 2 million COVID-19 tests and over 3500 positive cases.
2. The project to implement the Salesforce CRM was a major undertaking. A team peaking at over 200 people (around 80 from DHHS) has been required to build a system capable of replacing PHESS and the tactical systems for COVID-19 cases.[176]

The Salesforce representatives said that the system was not designed to replace PHESS. Instead, 'the initial … set-up of the Salesforce platform, it has been designed to run in parallel with PHESS.'[177]

The capacity of the Microsoft systems to provide digitised end-to-end support was not discussed at hearings.

The Committee also notes the Victorian Government's contention that 'a project to implement a strategic contact tracing system replacement for PHESS using Salesforce was mobilised at the earliest practical opportunity.'[178] This is despite acknowledging that their interstate counterparts in Western Australia and South Australia had implemented the technology at the time.

The Department further outlined the logic behind the active decision not to engage Salesforce by stating that:

> Salesforce is one of the department's strategic technology platforms. At the time there were a range of existing Salesforce systems in the department – so Salesforce was well known to the CIO and the DHHS IT teams.
>
> The department received many offers of assistance from technology vendors. Each was assessed in terms of their relevance and utility in the pandemic response.
>
> Assessment of the Salesforce CRM system, including input from discussions with our WA and SA colleagues, indicated that implementation in the department would be a major project requiring significant resourcing and input from the testing and contact tracing teams. A major IT project was impractical because the teams were very stretched by the need to scale up testing and contact tracing operations to respond to the rapidly growing number of cases.

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175 Department of Health and Human Services, Inquiry into the Victorian Government's COVID-19 contact tracing system and testing regime hearing, response to questions on notice received 3 December 2020, p. 2.

176 Ibid., p. 1.

177 Mr Michael Bonaddio, *Transcript of evidence*, p. 8.

178 Department of Health and Human Services, response to questions on notice, pp. 1–2.

Representatives from Salesforce explained to the Committee that they were able to complete the initial implementation of the system in eight weeks:

> We did three sprints over eight weeks, which was the scope of work that the department had as part of that, which got a phase 1 parallel system up and running, and post that we have moved into the next phase, which the government is working more of an iterative process...[179]

The Committee views the reluctance by the Victorian Government to concede or acknowledge errors as a contributing factor in the substantial delays in the implementation of a suitable contact tracing management system. Further, the Committee notes that however capable the current contact tracing solution is, it was not available when the Victorian public needed it. This failure cost lives and was unable to be rectified without strict lockdown measures throughout the state.

Furthermore, the Committee notes that this lack of humility has the capacity to hinder progress by limiting opportunities for collaboration or building off developments made in other jurisdictions.

**FINDING 32:** Greater transparency in relation to processes and a willingness to acknowledge and take responsibility for failings by the Victorian Government would increase public trust and confidence in the capacity of the contact tracing system and testing regime.

## 9.4 Cost effectiveness



The Committee notes that the financial costs of the system were not addressed at length in evidence to the Committee, and there was a notable lack of transparency regarding provision of information about contracts with third parties. Further research was unable to unearth detailed information about these contracts including how they were initiated. The Committees advises that it is in the interest of the Victorian public to know the extent of the financial commitment to each element of the processes involved in the contact tracing system and testing regime.

The Committee did receive a general overview of funding and spending by the Department of Health and Human Services in a submission from the Victorian Parliamentary Budget Officer. However, the submission noted a limitation of the data provided was that it has 'only identified payments to third party service providers in 2020–21' despite funding commitments until 2024–5.

179 Ms Pip Marlow, *Transcript of evidence*, pp. 4–5.

The Parliamentary Budget Officer provided an overview of contact tracing and testing costs for Victoria (Table 9.1).

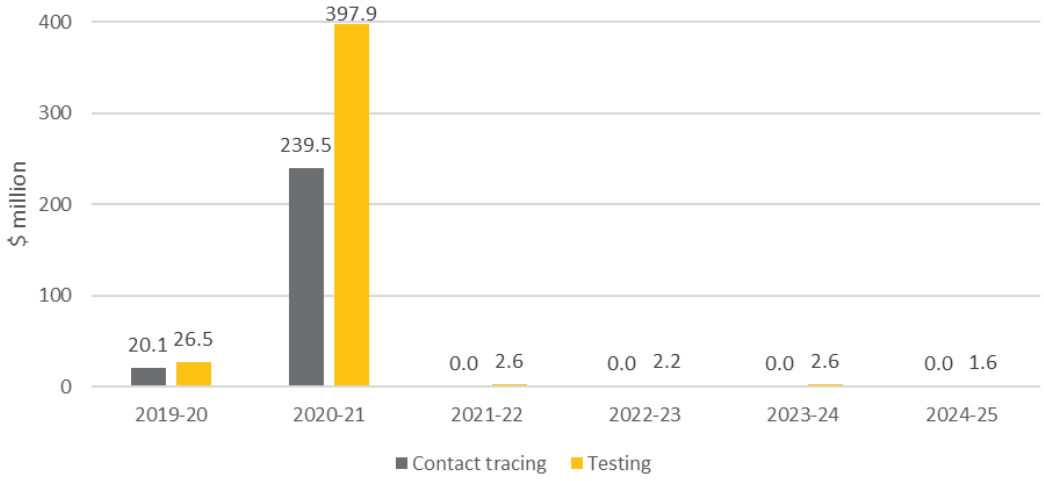
### Table 9.1 Contact tracing and testing costs

| Contact tracing costs include: | Testing costs include: |
|---|---|
| • Outbreak squads | • Testing delivery |
| • Local public health units | • Testing data and intelligence |
| • Case management | • Pathology |
| • Contact tracing and outbreak management | • Community engagement |
| • Operational policy and planning | • Prioritisation and response |
| • Operation Vestige | • Testing support costs |
| • Contact tracing support costs | |

Source: Anthony Close, Parliamentary Budget Office, *Submission 35*, p. 5.

According to the Parliamentary Budget Officer, the Victorian Government has budgeted $693.1 million for COVID-19 contact tracing and testing across 2019–20 to 2024–25. Around 92% of the funding for contact tracing and testing was budgeted in the 2020–21 financial year, with 67% more funding for testing than contact tracing.

### Figure 9.1 COVID-19 contact tracing and testing budget allocation




Source: Anthony Close, Parliamentary Budget Office, *Submission 35*, p. 6.

Table 9.2 shows the total budgeted versus total actual expenditure for contact tracing and testing. Total actual expenditure has only been calculated up to the 2020/21 financial year. The Committee notes that the Victorian Government has allocated funding for testing on an ongoing basis until 2024/25 but has not budgeted contact tracing beyond 30 June 2021.[180]

**Table 9.2 COVID-19 contact tracing and testing expenditure ($ million)**

| | 2019–20 | 2020–21 | 2021–22 | 2022–23 | 2023–24 | 2024–25 | Ongoing | Total |
|---|---|---|---|---|---|---|---|---|
| **Budgeted** | | | | | | | | |
| Contact tracing | 20.1 | 239.5 | – | – | – | – | – | 259.7 |
| Testing | 26.5 | 397.9 | 2.6 | 2.2 | 2.6 | 1.6 | 1.4 | 433.4 |
| **Total** | **46.7** | **637.4** | **2.6** | **2.2** | **2.6** | **1.6** | **1.4** | **693.1** |
| **Actual expenditure** | | | | | | | | |
| Contact tracing | 20.1 | 70.4 | – | – | – | – | – | 90.5 |
| Testing | 31.7 | 127.1 | – | – | – | – | – | 158.8 |
| **Total** | **51.9** | **197.4** | – | – | – | – | – | **249.3** |

Notes: Actual and third party figures are at 26 November 2020. Total is for period across 2019–20 to 2024–25 (excluding ongoing funding). Figures may not sum to totals due to rounding.

Source: Anthony Close, Parliamentary Budget Office, *Submission 35*, p. 7.

The above overview of contact tracing and testing expenditure shows that:

- Approximately 35% ($90.5 million) of the total budget for contact tracing has been spent
- Approximately 37% ($158.8 million) of the total budget for testing has been spent[181]

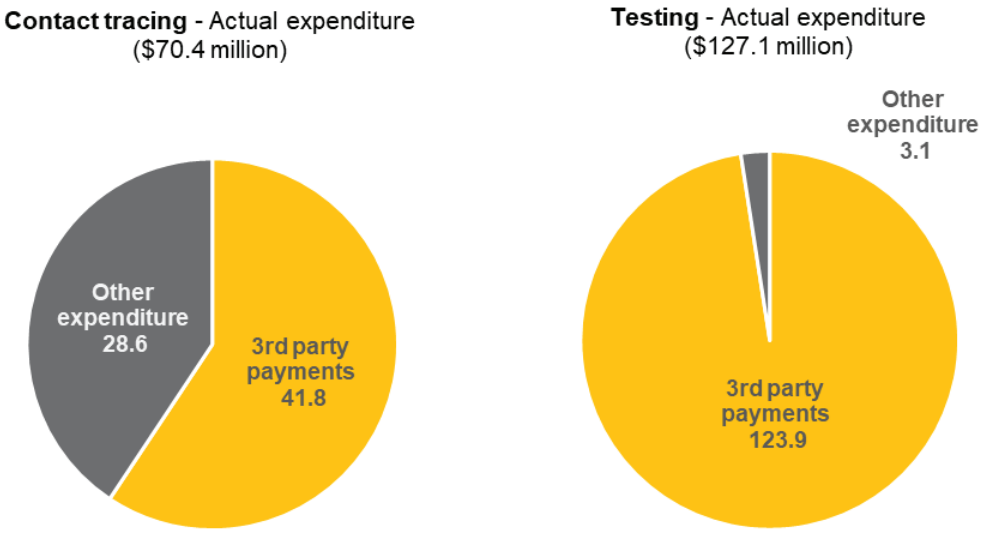
In its submission, the Parliamentary Budget Officer noted that the Victorian Government spent the majority of its budget for contact tracing and testing on third-party payments, including other jurisdictions' departments, the Australian Defence Force and private contractors. Figure 9.2 shows third party expenditure versus other expenditure for contact tracing and testing in 2020–21.



180 Anthony Close, Parliamentary Budget Office, *Submission 35*, p. 7.

181 Ibid., p. 8.

**Figure 9.2** Third party expenditure, 2020–21 ($ million)




Source: Anthony Close, Parliamentary Budget Office, *Submission 35*, p. 8.

The above breakdown of third-party payments versus other expenditure shows that:

- 59% ($41.8 million) of actual contact tracing expenditure in 2020–21 was for third-party payments
- 98% ($123.9 million) of actual testing expenditure in 2020–21 was for third-party payments[182]

The Parliamentary Budget Officer determined that the following list of third-party agencies and employers were engaged by the Victorian Government as part of its COVID-19 response, however, noted that this list was not exhaustive:

- Australian Defence Force
- Australian Government
- Ambulance Victoria
- Cabrini Hospital
- Eastern Health
- Epworth
- Ernst & Young
- Hays
- HealthDirect
- Helloworld
- ACT Government

182 Ibid.

- NSW Government
- Queensland Government
- SA Government
- Tasmanian Government
- WA Government
- KPMG
- McArthur
- Melbourne Sexual Health Clinic
- NSW Health
- Queensland Health
- SA Health
- Stellar Australia
- Tasmania Health
- Victoria Police
- WorkWise
- Your Nursing Agency[183]

In a situation which affects the livelihood and wellbeing of every resident of Victoria, the Committee is of the opinion that the Victorian Government has a duty to maintain transparency and be forthcoming about the cost to taxpayers, the scope, development and tender process of contracts, and the eventual outcomes attributed to this expenditure. The information provided by the Parliamentary Budget Officer goes some way to assisting with our understanding of the funding and actual expenditure for contact tracing and testing. However, the Committee believes that more specific information about the costs of contact tracing and testing should be made available to the public by the Victorian Government; in particular costs and terms of contracts in relation to private contractors.

Funding should be published for:

- Costs to obtain and retain surge workforces in testing and contact tracing, including any contracts with third party service providers
- Costs to engage technology providers, including those partnerships that were later ceased
- Costs to engage and secure private pathology providers



183 Ibid., p. 10.

- Costs associated with community outreach programs to engage and communicate with CALD communities throughout Victoria
- Any other associated funds.

Further to this, the Committee is concerned by the significant contracts entered into by the Victorian Government with third-party contractors which represents a large portion of the funding allocated. The Committee believes that it should be determined whether these contracts yielded support for the system commensurate with the funds provided. The Committee is of the opinion that the outcome of these contracts should be communicated to the Victorian public.

**FINDING 33:** There was a lack of transparency from the Victorian Government in relation to the cost of the testing regime.

**FINDING 34:** The Committee was unable to determine if the system was cost-effective with the data supplied to the inquiry .

**RECOMMENDATION 13:** That the Victorian Government publish accurate records of financial commitments and costings involved with the testing regime and contact tracing system, including resourcing and staffing by third parties.



## 9.5 Why the contact tracing system was overwhelmed

One of the most prominent criticisms of the Victorian contact tracing system and testing regime was its inability to deal with a significant number of positive COVID-19 cases. In his submission, Dr Giuseppe Garra, General Practitioner, stated that:

> One of the early issues with contact tracing was laboratory capacity and non-prioritization of results. The testing blitz, while very appropriate, has the unintended consequence of delaying results. This has the potential to cause problems with front line workers and managing the pandemic.[184]

Dr Tim Read, Member of the Legislative Assembly, noted in his submission that:

> I'm concerned that Victorian decision-makers put too much faith in our "army of disease detectives" in June and July this year, when the epidemic had grown too large to suppress with contact tracing. We need to know when contact tracing is "out of its depth" and we need to institute community-wide measures.[185]

184 Dr Giuseppe Garra, *Submission 7*, p. 2.

185 Dr Tim Read, Member of the Legislative Assembly, Parliament of Victoria, *Submission 28*, p. 1.

A number of witnesses shared the view that the system was overwhelmed:

- … what was evident to us was the fact that this was also something that DHHS was not prepared for.[186]
- There is no doubt it seems Victoria's contact tracing system was not built to deal with such a large-scale pandemic. It was evident during the beginning of the second wave when nearly, from our vantage point, all facets of the system were overwhelmed. I doubt, though, that this was just a Victorian issue given the numbers. Similarly, the testing capacity within Victoria also struggled during the beginning of the second wave.[187]
- … there is no question that the Victorian system was overwhelmed, and cases just were not being managed end to end—some were lost, duplications occurred. It was difficult. If you have a system that is designed for a certain low case, measles and other infectious diseases, and then you are hit by a pandemic with large numbers that are doubling every four or five days, unless you are fully prepared for that and supported by an appropriate technology base—fully prepared in terms of training, anticipation and preventative measures to slow the rate of increase in the first place—it is easy to get overwhelmed. And yes, Victoria was overwhelmed.[188]
- The issue … with some of the blitzes was that the number of tests therefore increased dramatically, and the labs could not cope with the numbers, and so timelines for reporting blew up from two or three days to seven or eight days, which of course is understandable from a lab point of view, but if you are waiting for your result, you quite rightly are in need of your result.[189]

As noted in Chapter 5, the capacity for responsive and effective contact tracing is heavily reliant upon a fast turnaround once test samples have been received. This was an issue throughout Victoria's second wave and caused extended delays in notifying primary close contacts. Additionally, when the time from specimen being taken to positive test results being received was in excess of 24 hours, the non-compliance rate for isolation was assumed to be greater. Dr Finkel (Chief Scientist of Australia) said that:

> I would struggle as a responsible person to obey the instruction to self-isolate after a test if, when I went for the test, they told me it would be three, four, five days or thereabouts. But if they could tell me with confidence that it is 24 hours or less, then why wouldn't I be a compliant patient working within the system?[190]

The submission received by the Victorian Multicultural Commission supported this contention, stating that 'Improvements in the faster release of test results reduced stress of staying in isolation'.[191]



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186 Mr Tony Kairouz, General Manager and Owner, Cedar Meats, public hearing, via videoconference, 18 November 2020, *Transcript of evidence*, p. 13.

187 Mr Paul Guerra, *Transcript of evidence*, p. 77.

188 Dr Alan Finkel AO, *Transcript of evidence*, p. 2.

189 Dr Mukesh Haikerwal, *Transcript of evidence*, p. 46.

190 Dr Alan Finkel AO, *Transcript of evidence*, p. 3.

191 Victorian Multicultural Commission, *Submission 27*, p. 4.

Extended delays between testing, notification of individuals, and notification of close contacts were recorded in a number of submissions to the Committee. One submission recalled their experience when their daughter was identified as a close contact in early September 2020, noting that 'it took a whopping 5 full days to receive a miserable SMS from DHHS that [my daughter] has to isolate.'[192]

A similar experience was recorded by a patient who was notified of their positive test result on 28 July 2020:

> 5 days after being contacted by the doctor I was still yet to hear from the DHHS. Being extremely anxious … I called them to ask why I hadn't been contacted yet. Finally getting through the officer told me that the doctor gave the wrong phone number to the DHHS. After finally getting some information I was told to self-quarantine and was put on the system.
>
> I was told to wait for a phone call from the contact tracing team … This phone call came on the next day, they took all my contact details from 3 days prior of my test (work and social contacts I had seen). … I had informed all my close contacts that the DHHS will be in contact with them soon … All of which had already been tested and were self-isolating for 14 days without any instruction from the DHHS. Coming to the end of this 14-day period on day 13 most of my contacts finally received a text or phone call that they needed to self-isolate for 14 days.[193]

This experience was echoed by Dr Marina Malcolm, a general practitioner based in Richmond in her submission to the inquiry. Dr Malcolm explained that:

> At the height of the wave there were large delays between the test taking place, patients receiving their positive result, and contact tracers contacting those patients to initiate public health measures. In one of my patients cases it took 6 days from testing before the contact tracers made contact with my COVID positive patient. Those long delays risked people not isolating correctly and close contacts not being identified early; both scenarios increasing infection exposure to the community. It also meant that COVID positive household contacts often had to isolate a lot longer than necessary because the information and the process was initiated later.[194]

In the evidence given to the Committee, Mr Weimar (Department of Health and Human Services) noted that 'our testing capacity during the first wave was actually quite limited and quite small'[195] and outlined how the testing capacity affected the time taken to alert people of their results when Victoria experienced a greater number of cases:

> Back in July we were running with about half the tests taking longer than a day for people to get their results, and certainly we saw some of our lab test results taking two, three, four days sometimes to come back.[196]

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192 Name Withheld, *Submission 4*, p. 1.

193 Ibid.

194 Dr Marina Malcolm, General Practitioner, *Submission 14*, p. 2.

195 Mr Jeroen Weimar, *Transcript of evidence*, p. 4.

196 Ibid.

**FINDING 35:** The Victorian Government testing regime exceeded its capacity, both in public and private pathology labs, at the beginning of, and throughout, the second wave.

## 9.6 Testing criteria

A number of issues were raised about the Victorian testing regime in relation to the criteria for testing.

Dr Malcolm noted in her submission to the inquiry that:

> The everchanging criteria for testing in Victoria was extremely hard to stay up to date with, especially at the beginning of restrictions. We were bombarded daily with changes and new information, all while making many changes to our practices and trying to keep our patients, selves and staff safe, as well as source PPE … There were problems with the difference in Federal testing criteria vs State testing criteria. There needed to be more communication between the National and State guidelines so that patients were not turned away.[197]

Inability to access testing was a recurring issue throughout the evidence provided to the Committee by stakeholders, and several submissions stated that they had been turned away from testing sites or refused testing despite having symptoms; being in close contact with a confirmed positive case; having letters from DHHS explicitly identifying themselves as a close contact; or any combination of these. Public evidence supported these experiences of being turned away, or general practitioners being told they were unable to test members of the public:

- Person 2 had not been feeling well and was not at work since 17 April, 10 days earlier. He had been to the doctor's twice and on both occasions asked the doctor for a COVID test. As he was not presenting with all the symptoms that were deemed necessary at the time to warrant a COVID test, he was sent home. In all this time he stayed away from work. The third time he went to the doctor he insisted on a COVID test, to which the doctor then obliged. It turned out to be positive.[198]
- Early on in the first wave, a colleague caring for residents at a residential aged care facility (RACF) where there were two confirmed cases of COVID needed help from DHHS. She wished to screen all the other residents, obtain infection control advice, and help with communication to residents' distressed families (several of whom were wanting to move their loved ones). Other than the general phone line, there was no point of contact for urgent clinical advice. It took repeated calls and hours to get through to someone. Once she did it was an inexperienced person who advised here to follow the written guideline (which she explained she had read and felt was not appropriate) and was informed DHHS would not support her to test the other residents (telling her that she was not allowed to) or assist in any way. Despite this, the GP tested all 80 residents and received a further three positive cases.[199]

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197 Dr Marina Malcolm, *Submission 14*, p. 3.

198 Mr Tony Kairouz, *Transcript of evidence*, p. 13.

199 Dr Ines Rio, General Practitioner, *Submission 29*, p. 6.

Widening criteria for testing has been important in ensuring the community has access to the appropriate health services, but equally that the public health response is determined by an accurate understanding of the prevalence of COVID-19 in the community. Professor Mary-Louise McLaws noted the improvement in Victoria's testing regime in her appearance at the Public Accounts and Estimates Committee's inquiry into the Victorian Government's response to the COVID-19 pandemic:

> … Victoria, I think, leads the way with testing. Last month I looked at your testing numbers and I think you were up to something like 700 000 tests in July, which is very remarkable. I would congratulate the authorities but also the locals for going out and getting tested. You know, you have opened up the criteria so that people can get testing without being turned away. The offer of testing and the ability for your pathology practices to keep up with that is nothing more than remarkable.[200]

Further information about recommendations for communication lines between the Department and general practitioners is available at Section 9.8.2.

**FINDING 36:** A lack of clear communication and conflicting advice about testing criteria from Federal and State government agencies was an obstacle to Victorians accessing testing and prevented some healthcare providers delivering testing services.

**RECOMMENDATION 14:** That the Victorian Government engage in further consultation with other jurisdictions to ensure consistency of testing criteria.



## 9.7 Test Tracker

The Committee remains concerned about the systems in place to track testing turnaround times. In the data supplied by the Department of Health and Human Services at the request of the Committee, the Department notes that:

> … measuring the time taken from when sample was taken to when the Department is notified can only be done for tests that are in a certain digital tracing device (Test Tracker) meaning the person has scanned a QR code. We are not able to track the time taken to notify the Department of tests not going through Test Tracker.

The Committee found this to be a troubling assertion and put the question to the Department in their evidence. Professor Wallace explained that:

> … we did not have the data hooks that allowed us to extract all the time points, so we built those time points into our processes to allow us to report. So the reason that some of the data do not exist all the way back to January is the data simply were not collected in the manner.[201]

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200 Professor Mary-Louise McLaws, Epidemiologist, University of New South Wales, Public Accounts and Estimates Committee, public hearing, via videoconference, 11 August 2020, *Transcript of evidence*, p. 3.

201 Professor Euan Wallace, *Transcript of evidence*, p. 8.

As outlined in section 5.5.1, the Test Tracker was piloted in September and October 2020 and the Victorian Government submission noted that:

> ... it is now being used at an increasing range of testing sites (such as pop-up, drive-through and door-to-door) to record patient data, issue laboratory eRequests, and enable tracking of tests to the pathology labs.[202]

The Committee notes a lack of transparency in statements from the Department about how data from test times is collected. It is unclear to both the Committee and the Victorian public how this information was previously collected, and how the aggregate test time was determined given conflicting information from submissions and the evidence provided by the Government.

The discrepancy in information relating to test times was clarified in evidence received by the Public Accounts and Estimates Committee. In response to a question on notice, the Department explained that data before 15 August 2020 pertaining to the time between DHHS being notified of positive results and patients and contacts being notified 'is not available given changes in measurement methodology.'[203]

**FINDING 37:** The Victorian Government was significantly underprepared to effectively collect, manage and utilise the key data required to accurately understand the State's performance up to October 2020.

**FINDING 38:** Appropriate data capture systems are being rolled out throughout the state, however the time between the first COVID-19 test in Victoria and the rollout of a test tracking system is insufficient and inadequate.

**RECOMMENDATION 15:** That the Victorian Government mandate the use of Test Tracker for all test sites and develop real-time reporting between Test Tracker and the appropriate databases.

## 9.8 Where can information on Victoria's contact tracing system and testing regime be found?

Throughout the course of this inquiry the Committee has noticed that essential information about testing and contact tracing is too often difficult to find or spread across many sources. The Committee has compiled the following list of sources of information on testing and contact tracing:[204]

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202 Victorian Government, *Submission 23*, p. 18.

203 Department of Health and Human Services, Inquiry into the Victorian Government's Response to the COVID-19 pandemic hearings, response to questions on notice received 30 November 2020, p. 2.

204 Please note, this is not an exhaustive list of available resources.

- Coronavirus (COVID-19) Victoria:[205] this website is regularly updated by the Victorian Government to reflect the most current changes and updates to restrictions, positive case numbers, testing criteria and sites, and advice for specific industries.
  - The Committee notes that historical information which may be useful or of interest to Victorians is difficult to locate on the website. The Committee believes that transparency and accessibility in relation to provision of historical information to the public are essential to understanding the evolution of the Government's approach and to building trust in Government objectives.
- Latest news and data—coronavirus (COVID-19):[206] this website provides up-to-date data on case numbers, case averages, contact tracing, outbreaks, testing and wastewater monitoring.
- For health services and professionals—coronavirus (COVID-19):[207] includes guidelines and other materials outlining practices for testing and contact tracing, such as:
  - Victoria testing criteria
  - Case and contact management guidelines
  - Infection control guidelines
- National Guidelines for Public Health Units (Communicable Diseases Network Australia):[208] this includes recommendations for surveillance, infection control, laboratory testing and contact management for COVID-19.



### 9.8.1 What information is missing?

The Committee has noted throughout this report that there are significant gaps in information about Victoria's contact tracing system and testing regime, including the evidence gathering and decision-making processes that underpin the Government's approach and the governance of the testing regime and contact tracing system.

Professor Rait (Australian Medical Association, Victorian Council) noted that:

> Greater transparency is required around the state's contact tracing system. The community has a right to know as much as possible about its contact tracing system, including its resourcing, its staffing, its benchmarks and its performance.[209]

The Committee acknowledges the Victorian Government for its commitment to inform the Victorian public through press conferences and key statistics posted on websites. However, the Committee notes that there has been limited information communicated

205 <https://www.coronavirus.vic.gov.au>

206 <https://www.dhhs.vic.gov.au/latest-news-and-data-coronavirus-covid-19>

207 <https://www.dhhs.vic.gov.au/health-services-and-professionals-coronavirus-covid-19>

208 <https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm>

209 Professor Julian Rait, *Transcript of evidence*, p. 12.

to the Victorian public about the processes and systems of the contact tracing system. A number of third-party providers have been involved in Victoria's testing and contact tracing efforts but there is limited information on how these companies were chosen or the specific nature of their involvement. The primary goal of protecting public health in relation to the Victoria Government's COVID-19 response would be supported by greater transparency and openness in these areas.

**FINDING 39:** More transparency from the Victorian Government would increase public trust and confidence in the capacity of the testing regime and contact tracing system.

**RECOMMENDATION 16:** That the Victorian Government provide evidence to the Victorian public about the basis of its contact tracing and testing response to COVID-19 in relation to operational processes implemented and procurement decisions.

### 9.8.2 Need for greater involvement of General Practitioners

A repeated theme which arose at public hearings and was discussed in submissions was the lack of engagement by the Victorian Government with general practitioners in their implementation of public health measures. The decision not to involve general practitioners in assisting with local contact tracing and testing was heavily criticised by stakeholders. There was a consensus that general practitioners need to be involved in COVID-19 testing and contact tracing for several reasons:

- Involvement of general practitioners would lead to a more person-centred approach.
- Physicians and medical specialists are specialists in their field whilst general practitioners are specialists in their patient and should be informed about their health status and provided with an opportunity to be involved in their care.
- General practitioners are equipped to manage their patients in the context of the local community and to share targeted messages with that community through their patients and their practices.
- General practitioners often speak languages spoken by their community and can understand the diverse needs of the cohort.

Professor Rait outlined concerns identified by members of the Victorian branch of the Australian Medical Association:

> Another issue AMA Victoria would like to see resolved is better collaboration between DHHS and general practice. This has been a common theme throughout the pandemic and results from years of disconnect between general practice and the state government. It is a point we emphasised in our submission to the Public Accounts and Estimates Committee earlier this year—the state government must improve its collaboration with general practice. General practice is uniquely placed within communities to assist with contact tracing in the management of COVID-19

> cases. General practice has often been in local communities for decades and has expert local knowledge that can benefit the state's contact-tracing efforts, particularly in multicultural communities. If utilised effectively and worked with in partnership with general practice, it can speed up the process of informing possible new cases. But unfortunately, we still have a way to go before general practice is meaningfully included in contact tracing and case management. The state government is obviously working with community health centres and primary health networks but does not really recognise that these centres and networks represent only a small part of the general practice universe.[210]

Professor Rait noted another benefit of including general practitioners in the contact tracing process:

> The reason I think that is very important is that often while there may be contact with positive cases from the department, there might not be any follow-up and so people might become unwell and not know where to go or who to consult. But if there is an automatic notification to a GP and a follow-up that is organised so that the welfare of that particular patient is being monitored, we think that would be an advantage.[211]

Professor Rait described the impact that general practitioners would have in communicating information about contact tracing and testing to their patients and community. Professor Rait further discussed the lost opportunity that failing to involve general practitioners in testing, contact tracing and even outbreak management represented:

> If GPs were getting a text to say, 'Oh, well, there's an outbreak in your community at this location; you can expect to see employees from this particular location coming to see you', I think that would have been very helpful… I think that there was a lack of an opportunity to sort of engage with the local GPs, many of whom, if I could reinforce this, were linguistically capable—did not have to call a telephone interpreter service; spoke, I think it was, Burmese that was the main language involved with many of the [Cedar Meats] workers there. I think that those languages were spoken by some GPs in the local community, and if they had known about it they could have actually reached out to many of those employees who were already known to them and encouraged them to get tested. So it certainly seemed to me that there was again a lost opportunity to help or to inform GPs and make sure that they were engaged in the contact-tracing process early on.[212]

In his submission, Dr Giuseppe Garra, a General Practitioner in Werribee with over 30 years of experience discussed what he believed were the consequences of not involving local general practitioners in managing the Cedar Meats outbreak:

> The earliest warning that contact tracing wasn't working well was Cedar Meats. The first case was April 2. We knew from overseas that abattoirs are high risk workplaces. There should've been a blitz then. When the second worker tested positive the

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210 Ibid., p. 13.

211 Ibid., p. 15.

212 Ibid., p. 17.

> department denied there was a link. We were asked to believe there was just an extraordinary coincidence that two people at an abattoir tested positive 3 weeks apart. This demonstrated a total lack of community knowledge by the department. Any GP [General Practitioner] in Werribee could've told the department that these migrant workers spoke little English, lived in multi-generational homes and often lived very near other families. Contact tracing could not be adequately done by phone. It should have been done in person in conjunction with local government and community groups.[213]

Dr Garra recommended that, to improve the contact tracing process:

> DHHS has to go local, involve councils and GPs and be quickly adaptable. It is a health issue and flexibility and speed are essential... The current advisory committee for the suburban hubs has too many hospital specialists on it and only one GP. It should be the exact opposite, one specialist and 4–5 GPs from different regions and some local government representatives.[214]

A Richmond-based General Practitioner, Dr Marina Malcolm, also told the Committee that:

> The Victorian contract tracing system did not liaise or include the involvement of GPs. I did not know what the system or process involved, except that once a patient swabbed positive at a testing site they would be contacted by the contact tracing team. I did not know when my patients tested COVID 19 positive, unless I performed the swab, nor whether my patients were contacted by DHHS. I did not know what arrangements were put in place for them by DHHS. Later in the lockdown patient's GP's were recorded at testing sites so that we were informed and then could assist in the process.[215]

In her submission, Dr Anita Munoz, a General Practitioner based in Melbourne's central business district, made several recommendations on how to enhance the involvement of General Practitioners in contact tracing and testing processes:

> I believe best practice would be the following:
>
> 1. When a case is identified, their GP is one of the key pieces of info asked for by the contact tracer at the start of the interview
> 2. The GP is alerted early about the case
> 3. The GP is invited to help in the community medical management of the case
> 4. The GP has an opportunity to help the contact tracers with community/ cultural/ language etc sensitive issues
> 5. The GP is then used if appropriate as a conduit for alerting the medical community and wider community about the matter, spreading the urgent public health message in a rational and effective way.[216]

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**213** Dr Giuseppe Garra, *Submission 7*, p. 2.

**214** Ibid., p. 3.

**215** Dr Marina Malcolm, *Submission 14*, p. 2.

**216** Dr Anita Munoz, General Practitioner, *Submission 18*, pp. 2–3.

The benefit of involving general practitioners in local testing and contact tracing in Victoria was demonstrated in the approach by Colac Area Health. Colac Area Health is an integrated health care service that meets the needs of more than 30,000 people in the Corangamite, Colac, Otway, and Surf Coast Shires. The health service encompasses Aged Care, Hospital Care, Community Care and many other services. Colac Area Health covered the Colac Otway Shire which suffered two major outbreaks.

The first outbreak of COVID-19 in the region was linked to the town's largest employer, the Australian Lamb Company abattoir, which saw the number of active coronavirus cases peak at 92 on August 8. Two-and-a-half weeks later, the number had dropped to eight. Colac confronted a second coronavirus cluster days after controlling the outbreak from the Australian Lamb Company abattoir. After this incident, Colac Shire Mayor Jason Schram called for his region to enter a two-week lockdown.

In response to the outbreaks the Colac community experienced, Colac Area Health working with Barwon Health:

- was an early adopter of many infection control measures
- expanded testing services to meet increased demand for testing
- conducted local contact tracing led by Barwon Health
- engaged in widespread community engagement, such as the 'Keep Colac Safe' and 'Let's Get Back to None' campaigns.



Professor Eugene Athan, Director of the Department of Infectious Diseases at Barwon Health stated in his evidence to the Committee that Barwon Health's successfully integrated testing and contact tracing regime was largely independent:

> The contact-tracing hub was based at Barwon Health, so we provided an intensive program of contact tracing in the Colac area. As far as resources go, we used our own information technology systems, with access to the public health surveillance system, PHESS. In terms of additional redeployment of staff, that was covered within our health service human resources allocation, but we were able to expand if needed.[217]

Further to that, Professor Athan noted the measures undertaken by the Barwon Health team to incorporate local general practitioners and community health organisations:

> We worked closely with the primary health network, the Western Victoria Primary Health Network, PHN. Historically we have got good relationships in education, workforce and collaborative health promotion, including immunisation. So, we did collaborate with GPs in the local communities, and all GPs were advised about potential cases when they were confirmed through the health information system as part of the notification. In Colac particularly the GPs were instrumental in helping us with the clinical care, the triage and then the need for escalation to hospital, if that was required. But I agree, the GPs are a vital part of the workforce. We need to work with them

217 Professor Eugene Athan, *Transcript of evidence*, p. 39.

> collaboratively and also look after their health, because there was a lot of anxiety among healthcare workers about potential COVID transmission.[218]

Another example of the extraordinary contribution of local health workers to the COVID-19 response is the work done by Dr Mukesh Haikerwal, a General Practitioner based in Altona North. The Committee was able to discuss with Dr Haikerwal the processes he identified as needed and what he initiated within his community in relation to COVID-19 testing:

> One of the things we fundamentally brought here when we set up our clinic was the rigour of gathering the patient information and data to the extent that we deployed something called the national health identifier, which has to be very specific for the patient so we know we have got the right patient, right place, right time. That has been instrumental in being able to see who is actually coming and where they are coming from, especially when they turn out to be positive, and that information has led us to the next stage: what happens when somebody turns up positive? We started testing on site on 3 April and we had zero cases until 2 July. On 2 July we had our first case and up until now we are at about 110 cases. There have been luckily no cases since the middle of October, I am really pleased to say.

Dr Haikerwal described the personal nature of the approach that he and his colleagues took, as well as the academic evaluation they opened the process to:

> We have therefore interfaced with patients face to face prior to testing, during testing and after testing. We have written to every single one of their GPs electronically informing them of their results and about any outcomes of the consultations they will have had with us. We have had our services evaluated by the University of Melbourne—both the drive-through service, which is unique for Australia, and our respiratory clinic, which is one of over 140 across the country. We have made sure that we have given good service to the individuals by following them up, especially after they test positive, and that is how I know and feel the pain that they have gone through at each of the intervals that they have had.[219]

Dr Haikerwal explained how general practitioners' local knowledge is indispensable to contact tracing and broader outbreak management:

> I can see everybody here, I can see the postcodes, I can see where they are, and that is how I spotted the spikes in my area. That is the local knowledge: I can see the streets, I can see, walking out my gate, where it starts. I can see families, because I know them by name. Dr El-Khoury, my colleague in Complete Family Care in Newport, when I said to him, 'We've been asked, thank goodness, by the testing people, "Can you please help us with these mystery cases?"', I asked him and he said, 'This isn't two families; this is one family. This is husband and wife. It's the same family. Oh, and by the way they have got this many kids'. All of a sudden we unravelled another web that we could then address together as a community across a community.[220]

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218 Ibid., p. 42.

219 Dr Mukesh Haikerwal, *Transcript of evidence*, p. 42.

220 Ibid., p. 46.

In the Committee's view, it was an oversight of the Victorian Government not to call on local doctors and general practices to assist with supporting testing and contact tracing in their communities. It is clear to the Committee that Victoria's contact tracing system and testing regime would be more effective if it included measures to ensure general practices were made aware of positive cases amongst their patient cohort. The Committee recommends that the Victorian Government include general practitioners in the response to COVID-19.

It became clear to the Committee than many individuals such as Dr Haikerwal, and other general practitioners and health services simply took on the frontline work of supporting Victorians tirelessly throughout the COVID-19 pandemic in order to assist their communities.

**FINDING 40:** General practitioners were not consulted in the development of the contact tracing system and testing regime or formally involved in developing or supporting the official crisis response. Excluding general practitioners from the official system of contact tracing and the testing regime led to a less effective, less responsive and potentially more costly response to COVID-19.

**FINDING 41:** Because general practitioners were excluded from the official response to COVID-19 the system did not include effective measures to ensure general practices were made aware of positive cases amongst their patient cohort.



**RECOMMENDATION 17:** That the Victorian Government, through the Chief Medical Officer, embed general practitioners into the system of management of contact tracing and testing as part of a localised, collaborative and more person-centred approach.

### 9.8.3 Reaching culturally and linguistically diverse communities

The Committee believes that culturally and linguistically diverse residents of Victoria were neglected in the Victorian Government's response to the pandemic.

The Committee acknowledges that culturally diverse communities have suffered disproportionately throughout COVID-19, from those who have contracted the disease to those who have been left without support due to the inability to work. Further, the Committee notes that some members of diverse communities have been subjected to racism and xenophobia during some stages of the COVID-19 pandemic.

Members of the Committee have been affected by the adversity that their communities have experienced throughout 2020 and have been keenly aware of the difficulties that many constituents they have come into contact with have faced.

The Committee is grateful to Victoria's culturally and linguistically diverse community members for their contributions to this inquiry.

The Committee, in no uncertain terms, condemns vilification where that occurred.

The Committee encourages the Victorian Government to learn from the experiences of the COVID-19 pandemic to better tailor information, support, and policies to the diverse population of Victoria.

A research article on 'Better engaging culturally diverse communities during COVID-19' published by the University of Melbourne noted that 'Across the world, CALD communities and poorer people have experienced higher COVID-19 infection rates and poorer health outcomes.'[221] In the context of Victoria, the article observed:

> COVID-19 has disproportionally affected disadvantaged and culturally and linguistically diverse (CALD) communities. However, the Victorian Government has released little disaggregated data on categories like ethnicity or socioeconomic status – perhaps trying to avoid discriminating along lines of wealth, race or religion.[222]

The article stated that:

> Although the Victorian Government hasn't released specific subgroup data, it is obvious from infection distribution maps that the COVID-19 hotspots are located in low socio-economic suburbs that are culturally and linguistically diverse and have large recent immigrant communities.[223]

This was supported by Mr Jeroen Weimar (Department of Health and Human Services) in his appearance before the Committee, who contended that COVID-19:

> … has disproportionately impacted people who are living in high-density households, who are working in less structured roles or in short-term, part-time or casualised employment and who sometimes face language and cultural barriers in engaging with the other support that is provided by the state. Fifty per cent of people who have contracted COVID in Victoria were born outside of Australia, and that is significantly more than the proportion they are of the population.[224]

The Victorian Government submission identified factors that led to CALD members potentially being at higher risk:

- low socio-economic status and low English or health literacy
- people born outside of Australia account for 50% of all cases, even though they make up 30% of the population. 29% of cases speak a language other than English at home

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221 Nathan Grills and Nicole Butcher, 'Better engaging culturally diverse communities during COVID-19', *Pursuit*, 4 September 2020, <https://pursuit.unimelb.edu.au/articles/better-engaging-culturally-diverse-communities-during-covid-19> accessed 29 November 2020.

222 Ibid.

223 Ibid.

224 Mr Jeroen Weimar, *Transcript of evidence*, p. 17.

- live or congregate in high density (at times with three to four adults in one dwelling), overcrowded dwellings or settings, or
- work in casualised, mobile, or high-risk industries.[225]

A number of witnesses who appeared before the Committee noted the importance of properly engaging with culturally and linguistically diverse communities:

- … I think clarity around communication generally and working with local communities to particularly address where there might be local cultural or social issues that require further understanding, further engagement, further support in order for people to be fully engaged and for the health response to be the most effective—I think they are quite critical elements going ahead.[226]
- I think communication is critical for it working well, and even though we have had glitches in communication, it still worked.[227]
- We are very fortunate—about 65 to 70 per cent of the staff at Western Health live in our catchment population. They are very multicultural as a group, and therefore we have been using the staff to put the messages of those preventative steps about washing hands and social and physical distancing out to communities in languages and in methods that are understood… I think that is another great learning that we will be harnessing for our public health unit—that that engagement with community is absolutely crucial.[228]
- Obviously the ability to address the culturally and linguistically diverse community through interpreters and community leaders and written material and infographics was absolutely critical. So there were diverse requirements in that phase because communication was critical at all levels.[229]
- … it is an important part of the public health response. We have worked both locally and in the region focusing on community engagement and working through CALD community leaders and community agencies like Diversitat to help us both to engage and to understand the needs of the CALD community, and that has been quite successful. [230]

The publication of translated resources to the Department's webpage is outlined in the following table (Table 9.3) which provides the language and when it was first made available.



225 Victorian Government, *Submission 23*, p. 36.

226 Professor Catherine Bennett, *Transcript of evidence*, p. 48.

227 Ibid., p. 52.

228 Adjunct Professor Russell Harrison, *Transcript of evidence*, p. 61.

229 Ms Fiona Brew, *Transcript of evidence*, p. 67.

230 Professor Eugene Athan, *Transcript of evidence*, p. 43.

## Table 9.3 Availability of translated COVID-19 resources on the Department of Health and Human Services website

| Date uploaded | Language | Date uploaded | Language |
|---|---|---|---|
| 5 March 2020 | Mandarin/Simplified Chinese | 21 March 2020 (continued) | Chaldean (Iraq) |
| | Vietnamese | | French |
| | Arabic | | Japanese |
| | Khmer (Cambodian) | | Karen |
| | Assyrian | | Maltese |
| 6 March | Farsi (Persian) | | Oromo |
| | Hazaragi | | Polish |
| 10 March 2020 | Italian | | Swahili (Kiswahili) |
| | Greek | | Tigrinya |
| | Cantonese/Traditional Chinese | | Zomi |
| | Turkish | 23 March 2020 | Urdu |
| | Punjabi | | Fiipino/Tagalog |
| | Hindi | | Nepali |
| | Dari | | Pashto |
| | Dinka | | Portuguese |
| | Macedonian | | Sinhalese |
| | Thai | 31 March 2020 | Chin (Hakha Chin) |
| | Tamil | | Nuer (Thok Nath) |
| | Indonesian | 7 April 2020 | Malay |
| | Croatian | 24 April 2020 | Rohingya |
| | Gujarati | 20 June 2020 | Samoan |
| 11 March 2020 | Korean | | Cook Island Maori (Rarotongan) |
| 12 March 2020 | Burmese | | Tongan |
| 20 March 2020 | Somali | | Fijian |
| 21 March 2020 | Spanish | 25 June 2020 | Niue (Niue - Vagahau Niue) |
| | Russian | 3 July 2020 | Bosnian |
| | Serbian | 13 July 2020 | Hakka |
| | Amharic | 24 September 2020 | Malayalam |
| | Bengali | | |

Source: Legislative Council Legal and Social Issues Committee. Information provided by Department of Health and Human Services, Inquiry into the Victorian Government's Response to the COVID-19 pandemic hearings, response to questions on notice received 30 November 2020, pp. 5–6.

The quality of translated resources from the Victorian Government is also a concern for the Committee. Multiple examples of errors in translation have undermined the community engagement work being undertaken by the Victorian Government.

Figure 9.3 shows translation errors in COVID-19 resources provided by the Victorian Government.

**Figure 9.3 Translated resources provided by the Department of Health and Human Services**


Source: Dalzell, Stephanie, 'Government coronavirus messages left 'nonsensical' after being translated into other languages', *ABC News,* 13 August 2020, <https://www.abc.net.au/news/2020-08-13/coronavirus-messages-translated-to-nonsense-in-other-languages/12550520> accessed 30 November 2020.

In late October, resources on the Department of Health and Human Services' Coronavirus website were examined by the ABC who noted their findings regarding the Indonesian, Traditional Chinese and Simplified Chinese pages:

> Those pages were out of date and didn't reflect the information on the English website. They also linked back to the English website for critical information, such as where to get tested and the reopening roadmap.
>
> In one instance, a key point on the Indonesian page was instead translated into Turkish.[231]

In a press conference delivered on 26 June 2020, Professor Sutton acknowledged that ensuring appropriate public health messaging was reaching culturally and linguistically diverse communities was a responsibility of the Victorian Government, stating that

231 Erwin Renaldi and Jason Fang, 'Victoria's coronavirus information mistranslated and outdated for migrant communities', *ABC News*, 27 October 2020, <https://www.abc.net.au/news/2020-10-27/victoria-migrants-concerned-covid-19-information/12815164> accessed 30 November 2020.

'It's our obligation as government to reach those people. It's not their fault if we're not going in with appropriate engagement.'[232]

Despite this, many of the communications throughout the COVID-19 pandemic failed to connect with culturally and linguistically diverse communities. Professor Julian Rait expressed the Australian Medical Association Victoria's view that the Victorian Government and the Department of Health and Human Services struggled to engage with these communities:

> COVID-19 has exposed issues with DHHS's capacity to engage on a micro level with various communities. In future it will need to build a communication framework that is more inclusive and finesse its engagement with culturally diverse communities across Victoria. There is evidence to suggest that there has been some improvement in this regard, which is of course encouraging, but DHHS needs to continue to work and develop this.[233]

Dr Giuseppe Garra, a General Practitioner in Werribee for over 30 years, explained the shortcomings of the Government's approach in the Cedar Meats outbreak:

> This demonstrated a total lack of community knowledge by the department. Any GP in Werribee could've told the department that these migrant workers spoke little English, lived in multi-generational homes and often lived very near other families. Contact tracing could not be adequately done by phone. It should have been done in person in conjunction with local government and community groups.[234]

The relationship between the Victorian Government and practitioners is further discussed in Section 9.8.2.

In their submission to the Public Accounts and Estimates Committee's Inquiry into the Victorian Government's COVID-19 Response, the Ethnic Communities Council of Victoria also observed a marked inability to properly engage with diverse communities:

> The overarching problem cited both by community members and multicultural organisations was the lack of coordination by the State Government of a taskforce including multicultural organisations and ethnic associations with long experience in working directly with ethnic communities. Failure to fully bring these bodies on board as active partners in the planning and implementation of Victoria's COVID-19 response meant that their dedicated expertise, and the learnings they have gained on a daily basis through their work in community, was under-utilised. One area in which this engagement gap had clearly negative repercussions was with regard to communications.[235]

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232 Elise Kinsella, 'Victoria's coronavirus case increase saw a horror week of new restrictions and a testing blitz', *ABC News*, 27 June 2020, <https://www.abc.net.au/news/2020-06-27/victorias-horror-coronavirus-week-testing-blitz-and-restrictions/12396324> accessed 30 November 2020.

233 Professor Julian Rait, *Transcript of evidence*, p. 13.

234 Dr Giuseppe Garra, *Submission 7*, p. 2.

235 Ethnic Communities Council of Victoria, *Submission 34*, submission to Parliament of Victoria, Public Accounts and Estimates Committee, Inquiry into the Victorian Government's COVID-19 response, 2020, p. 4.

The Multicultural Centre for Women's Health, who promote health education amongst refugee and migrant women throughout Victoria, reiterated this inability to effectively communicate in their submission to the Committee and provided examples of common issues that they encountered when engaging with migrant and refugee women:

> We were also engaged by the Victorian Office for Housing to make in-language phone calls to women and their families in public housing estates, informing about COVID-19 and encouraging them to get tested. During the course of this work we found out that migrant communities were not being reached by mainstream communications methods. The people we spoke with told us many examples of attempts by authorities and health services to communicate with them that did not effectively reach them. These instances included:
>
> - inadequate accessibility of messaging about COVID-19 prevention, testing and restrictions;
> - instructions after testing, and test results, provided in English language text messages. People did not have the means to understand their own test results, or to understand what their next steps should be;
> - misunderstandings and miscommunications about when and how to isolate, how long for, and where to access specific additional information;
> - hesitancy or inability, due to language barriers, to use the Coronavirus Hotline to access material support.[236]

The complexity within culturally and linguistically diverse communities was further noted by Professor Catherine Bennett, Chair in Epidemiology, Institute of Health Transformation, Faculty of Health, Deakin University, who stated that:

> … this is not about people who need translated information provided for them. This is about people who have fundamentally different understandings of health systems or government or compliance—what that means or even what a household means and how they interpret the information.[237]

The Committee received further evidence which demonstrated problems with how the Victorian Government engaged with culturally diverse groups:

- The nature of initial community engagement and mutual understanding between DHHS and communities proved challenging to facilitate important conversations and provide instructions on how to manage processes. This also extends to the adequacy of disclosure of close contacts or their movements.[238]
- Many temporary visa holders and for those in precarious working conditions had feared job loss or reprisal should they test positive to COVID-19, with some continuing to work with symptoms.[239]

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**236** Multicultural Centre for Women's Health, *Submission 33*, p. 1.

**237** Professor Catherine Bennett, *Transcript of evidence*.

**238** Victorian Multicultural Commission, *Submission 27*, p. 3.

**239** Ibid., p. 4.

- Concerns and barriers to testing included stigma around testing, initial delay in receiving test results (though this improved significantly over time), need for clearer and simpler translated information/resources and misinformation that was spreading through other mediums such as social media.[240]

The Committee notes that, while it is important to provide translated resources to linguistically diverse communities, the creation and distribution of these resources is ineffective without understanding the nuances of the community that is being targeted. A research article written by Ms Abigail Wild and Dr Brea Kunstler, who are both Research Fellows at BehaviourWorks Australia, Monash Sustainable Development Institute, collaborated with a range of experts and key stakeholders to investigate and make recommendations into communicating health information to culturally and linguistically diverse communities in the context of COVID-19. The article captured issues with engagement with diverse communities beyond translating and disseminating resources:

> It is often assumed that providing people with information and explaining why people should perform a behaviour will result in compliance. However, behavioural science has demonstrated that achieving desirable behaviours in a target population is accomplished by understanding the needs of the population, and the barriers and enablers to behaviour change.[241]

The lack of reliable in-language resources, both in public health messaging and through text messages in both testing and contact tracing systems, contributed to confusion and the inability for culturally and linguistically diverse communities to access important information. While the Committee commends efforts being made by the Department, especially regarding liaison with community and faith leaders and creative messaging platforms like videos and recorded messages, the Committee notes that appropriate connections and communications early in the pandemic may have prevented some of the more extreme lockdowns experienced in public housing towers and surrounding suburbs.

**FINDING 42:** By better engaging with trusted representatives throughout the community, the Government may have been able to prevent widespread transmission through vulnerable communities. The Government's approach to culturally and linguistically diverse communities was a failure to coordinate a system effective for all Victorians. Greater work needs to be done to ensure the testing regime and contact tracing system is fit for purpose to and makes genuine provisions for all Victorians.

Beyond engagement, communication throughout the contact tracing and testing program was inadequate for non-English speakers. As noted by the Multicultural Centre for Women's Health, providing test results and isolating instructions in English

240 Ibid.

241 Abigail Wild et al., 'Communicating COVID-19 Health Information to Culturally and Linguistically Diverse (CALD) Communities: The Importance of Partnership, Co-design, and Behavioural and Implementation Science', *MetaArXiv*, 2 August 2020, <https://osf.io/preprints/metaarxiv/85h93> accessed 29 November 2020.

only meant a number of people could not decipher their own results, nor could they adequately understand their obligations to isolate. An important inclusion into communication channels were community and faith leaders, who could communicate in-language to linguistically diverse communities. However, the Committee believes that this grassroots engagement was incorporated too late into the pandemic.

A key to bridging these challenges lies in collaboration with general practitioners. The Committee notes that the Victorian Government has introduced specialised public health outbreak teams which are 'dedicated to outbreak and complex case management'.[242] This includes a Priority Communities team which encompasses Aboriginal and multicultural community groups. In its submission, the Victorian Government explained the purpose of these specialised teams:

> These teams are focused on specific sensitive settings and are led by experienced Public Health, Occupational Health or Infectious Diseases Physicians.
>
> Industry experts and stakeholders are embedded in teams to expedite provision of public health advice to outbreak settings as well as facilitate rapid stakeholder engagement and response. This includes embedding physicians in areas closer to the outbreak settings, which allows the Victorian Government to leverage existing relationships and knowhow of local communities.[243]

On 13 August 2020, the Victorian Government established the CALD (Culturally and Linguistically Diverse) Communities Taskforce which, in partnership with community organisations, local governments, and the Victorian Multicultural Commission, is developing community-specific and locally delivered solutions for addressing COVID-19. This includes:

- Providing tailored health advice
- Direct engagement with multicultural and multifaith communities
- $11.3 million to support services assisting Victoria's multicultural and multifaith communities with social isolation, youth engagement and culturally specific family violence support
- $14.3 million to support multicultural organisations deliver emergency relief, health advice, and boost translation and interpreter services[244]

The Committee supports the establishment of specialised public health outbreak teams and the CALD community task force. The Committee believes that government agencies must remain vigilant in supporting Victoria's culturally and linguistically diverse communities so that they can understand the contact tracing system and testing regime and play their part in prevention. The Committee also takes the view that these responses were put in place too late in the process.

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242 Victorian Government, *Submission 23*, p. 32.

243 Ibid.

244 Victorian Government, *Supporting multicultural communities through coronavirus (COVID-19)*, September 2020, <https://www.vic.gov.au/supporting-multicultural-communities-through-coronavirus-covid-19> accessed 26 November 2020.

In their submission to the Committee, the Victorian Government said that they have developed their community engagement strategy to prioritise multicultural communities:

> Providing information for Victoria's multicultural communities about how to stay safe has been a significant focus of the Government's extensive public health advertising campaign. For instance, advertising has been translated and appears across multicultural print, radio and social media, and the Victorian Government hosted a series of roundtables with community leaders from multicultural communities.
>
> The roundtables are an opportunity for communities to get a detailed update on the virus, discuss their experience of the pandemic, explain what support their community needs and discuss the important role community leaders have in helping slow the spread of the virus. At these events, the Minister for Multicultural Affairs provided an opening address and the Chief Health Officer (or nominee) provided a COVID-19 update. There is also an opportunity for community questions and answers.
>
> Events have been held with Chinese, Vietnamese, Burmese, Afghani, South Sudanese, Somali and Indian communities, with plans to continue these engagements with additional communities.[245]

According to its submission, the Victorian Government has:

- Translated COVID-19 materials into 57 languages in partnership with local communities, governments and other organisations
- Recorded 20 videos, each in a different language, with community leaders that were distributed through community networks and social media
- Established a distribution list of over 600 contacts which received a pack of resources that can be used by community leaders, organisations and services.[246]

The Committee is hopeful that the work done by the Victorian Government to reach out to priority communities, such as culturally and linguistically diverse persons, will bridge some of the gaps evident in their approach during the first and second waves of the pandemic. Significant effort must continue to be made to ensure that all Victorians have an equal understanding of Victoria's COVID-19 response and the role testing and tracing plays within it. Their approach should incorporate observations made by the Victorian Multicultural Commission.

Alongside general practitioners, the Victorian Government should work with community leaders and organisations on developing tailored approaches to communicating with multicultural communities and should equip their leaders with information that they can use to support and educate their members. Community leaders are a trusted voice within their own communities and are best-placed to ensure that the message is getting across and that people understand expectations around testing, contact tracing and the broader COVID-19 response.

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**245** Ibid., p. 36.

**246** Ibid., pp. 36–7.

The need to work closely with community leaders has been acknowledged by the Department of Health and Human Services. Mr Weimar conceded that one of the lessons that has been learnt by the Department is a need to work with local leaders especially if there is an outbreak within the community:

> If we then get into individual outbreaks... one of the bits of feedback we have had as we found positive cases particularly within specific communities is that we have learned that we have to work far more closely with community leaders. So yes, there is information that we can provide and that our clinical teams can provide, but what we have started to do—and this goes back really to late July and early August—is work very closely with community leaders. In fact we started in June with the housing towers, working very closely with people who are trusted voices within their own communities and recognising that they can influence, direct and support people who are facing a very challenging situation. COVID may not just be a health issue for them; it may also have implications for their dependents. It may have issues for their employment, for basic income and for providing all the other needs that they have.[247]

In the Committee's view, it is vitally important that Victoria's culturally and linguistically diverse communities have easy access to detailed and up-to-date information about testing and contact tracing delivered in a suitable language or format. The Committee acknowledges the efforts by the Victorian Government to produce a range of materials for these communities but believes more works needs to be done, in collaboration with community leaders, to ensure that this information is targeted and accessible.

The Committee notes that the following challenges were also raised in evidence, but did not have sufficient opportunity to accurately address them:

- Mistrust of official communications
- Stigmas around getting tested and testing positive
- Unwillingness to disclose close contacts due to a lack of trust in government officials
- Unwillingness to answer calls from unidentified callers.

**FINDING 43:** The Victorian Government's CALD Community Task Force was established and includes multicultural and multifaith leaders.

**RECOMMENDATION 18:** That the Victorian Government's CALD Community Task Force include health workers such as general practitioners.

**FINDING 44:** Community leaders, including general practitioners, are trusted voices in their communities and can assist with ensuring their communities understand the processes of COVID-19 testing and contact tracing.

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247 Mr Jeroen Weimar, *Transcript of evidence*, p. 18.

## Aboriginal community-controlled health response

Evidence provided by the Victorian Government suggested that amongst Victoria's Aboriginal community, there have been:

- 75 positive cases of COVID-19
- 11 hospitalisations
- Zero fatalities.[248]

At a public hearing, the Department of Health and Human Services told the Committee that a tailored approach was put in place to support Aboriginal communities during the pandemic. Mr Weimar explained this approach to the Committee:

> We have had really quite a tailored approach to supporting Aboriginal communities across Victoria. We have had 14 different Aboriginal community-controlled health organisations providing COVID testing—so dedicated arrangements in place to provide them with additional support and to also ensure that we can provide that testing in a safe and controlled environment. What we have also dealt with is—and I think the Shepparton outbreak we had back in September was a pretty good example of this—that every time we saw those outbreaks coming we identified any particularly vulnerable communities and looked at how we could best support them in terms of handling that particular outbreak.[249]

Mr Weimar went on to discuss the strong existing health structures within Aboriginal communities that assisted in supporting a tailored response to COVID-19:

> The Aboriginal community are probably the most structured and best example of using the existing community health structures that are in place, using existing community leaders and working with the really strong local partnerships that already exist to ensure we have got good, relevant, localised information, really active engagement and really active work around COVID-safe practices. We have used a lot of the learnings in that space and applied them to other communities we see across Victoria, again recognising that the way you implement that has to reflect the dynamics of the community, who the influential people are and what the best way is to get information and support into those areas. And that work continues; we continue to provide lots of that localised, regionalised approach. It is a critically important part of not only getting through the second wave but also managing COVID safety going forward.[250]



248 Ibid., p. 27.

249 Ibid.

250 Ibid., pp. 27–8.

## 9.9 Data collection

### 9.9.1 What information is collected through contact tracing in Victoria?

During a contact tracing interview or when filling out a questionnaire personal information is collected to assist with contact tracing and ongoing communication (including COVID-19 test results). The information collected by contact tracers includes:

- First and Last Name
- Date of Birth
- Street Address
- Suburb
- Postcode
- Email
- Mobile phone number
- If the person identifies as Aboriginal and/or Torres Strait Islander
- Language spoken
- Date of the test
- Date of onset of symptoms
- Extensive detail of movements in the days prior to diagnosis
  - Locations visited, duration of stay at location
  - Contact with individuals

In its submission, the Victorian Government outlined the key aims of contact tracing interviews:

> Interviews with positive cases and close contacts are conducted by DHHS's Case, Contact and Outbreak Management team, with the aim to:
>
> - inform the individual about isolation requirements and provide support in relation to isolation
> - establish whether the case reports having had any recent symptoms consistent with COVID-19 preceding or since the positive test
> - identify close contacts and secondary close contacts (see below for contact definitions), inform them about requirements and provide support in relation to quarantine.[251]

251 Victorian Government, *Submission 23*, p. 19.

Effective contact tracing requires the collection of personal and sensitive data in order to properly identify and communicate with close contacts who may be at risk of contracting COVID-19. Providing this level of information can be a daunting experience for many people and there can be a sense of anxiety or vulnerability about providing private information to an unknown person during a telephone call. However, collecting this information is a critical part of case contact and outbreak management.

The *National Contact Tracing Review* report emphasised the importance of detailed case interviews in responding to a potential cluster or outbreak. The report stated:

> Immediate case isolation, detailed case interviews, and quarantine of close contacts helps prevent further spread downstream from the case. However, to eliminate an outbreak or cluster, it is often necessary to trace and confirm the upstream source of infection of the current case. The source case or cases may have been asymptomatic and not previously identified. Once identified, further downstream contact tracing from that source can help to prevent further infection. The upstream contact tracing process may be repeated multiple times if generations of cases have not been identified.[252]

This was explained by the World Health Organization in its *Joint Statement on Data Protection and Privacy in their COVID-19 Response* issued on 19 November 2020:

> Mounting evidence demonstrates that the collection, use, sharing and further processing of data can help limit the spread of the virus and aid in accelerating the recovery, especially through digital contact tracing. Mobility data derived from people's usage of mobile phones, emails, banking, social media, postal services, for instance, can assist in monitoring the spread of the virus…[253]

The Committee acknowledges the importance of detailed contact tracing interviews and data collection as a necessary part of Victoria's public health response to the COVID-19 pandemic. However, it is incumbent on agencies to ensure that the questions and information sought through contact tracing interviews or questionnaires does not overstep the threshold of what would be considered reasonably necessary for public health management. Any information outside of this scope should not be collected.

### What are the requirements for businesses in collecting data for contact tracing?

To assist with contact tracing efforts, Victorian workplaces and businesses have specific record-keeping obligations outlined by Victoria's Chief Health Officer's Workplace Directions (No 10).[254] Every Victorian employer is required to record the following information for any person who attended the work premises for longer than 15 minutes:

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252 National Contact Tracing Review, *National Contact Tracing Review*, p. 59.

253 World Health Organization, *Joint Statement on Data Protection and Privacy in the COVID-19 Response*, November 2020, <https://www.who.int/news/item/19-11-2020-joint-statement-on-data-protection-and-privacy-in-the-covid-19-response> accessed 24 November 2020.

254 Workplace Directions (No 10) was the directions in force at the time of writing this report. Section 200(1)(d) of the *Public Health and Wellbeing Act 2008* (Vic) allows the Victorian Chief Health Officer to 'give any other direction that the authorised officer considers is reasonably necessary to protect public health'.

- Person's first name
- Contact number
- Date and time they attended the work premises
- Areas of work premises attended.

This applies to staff, customers or outside contractors.[255]

Workplace Directions (No 10) also prescribes that an employer can comply with their record-keeping requirements by using a digital system. The Directions specify that the digital system can only be used if it is provided by the Service Victoria CEO or the Victorian Government specifically for contact tracing purposes.[256] On 1 December 2020, the Victorian Government released a universal QR-code to be used by a registered facility or venue for contact tracing purposes. The Victorian Government QR code app is outlined in the section below. The Committee notes that there was insufficient time to assess uptake and efficacy of the app.

The Direction outlines exemptions for certain employers who do not need to comply with recording requirements. Exemptions are in place for:

- Recording information about customers visiting a market or market stall, retail facility, or retail shopping centre if it is not practicable to do so.
- Recording information about members of the public using a commercial passenger vehicle service.
- The recording of information by an essential support group or health services if confidentiality requirements are in place. For example, an alcohol and drug or family violence support group.[257]

At a public hearing, Mr Sven Bluemmel, Commissioner, Office of the Victorian Information Commissioner, explained to the Committee that personal information collected by employers or businesses in compliance with the *Public Health and Wellbeing Act 2008* (Vic), can only be collected for contact tracing purposes:

> On the protections currently, there are protections not in the privacy legislation but in the *Workplace Directions (No 9)*—these are the ones issued by our chief health officer under the *Public Health and Wellbeing Act*. That Act basically provides that whoever collects that information needs to obviously only collect what is necessary and only use it for contact-tracing purposes and so on. So in that case this is one of those cases where you have the acute phase here, where something needs to be done, and the directions were issued under Victorian legislation and they just apply to anyone who plays in this space.[258]

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255 Workplace Directions (No 10), 22 November 2020, *Public Health and Wellbeing Act 2008* (Vic) s 200(1)(d).

256 Ibid.

257 Ibid.

258 Mr Sven Bluemmel, *Transcript of evidence*, pp. 27–8.

The Committee is satisfied that the *Public Health and Wellbeing Act 2008* (Vic) contains the necessary protections to prescribe that personal information should only be collected by employers or businesses for the purpose of contact tracing. However, the Committee is concerned that there is a risk that some businesses, particularly small businesses, may not be aware of their legislative obligations which could lead to mismanagement or unintended misuse of records.

Ms Judy O'Connell, Commissioner, Victorian Small Business Commission, explained to the Committee that some small businesses are not aware of their obligations because information was not readily available:

> What we found is that in terms of accessing information small businesses were using government websites. Some were relying on industry associations and their local business networks who were providing guidance. What we found was that compliance was high, although there were concerns around businesses who were not connected to perhaps an industry association not being aware of all of their obligations.
>
> ...
>
> We think there needs to be education on good record keeping practices but also the consequences of not complying. A large number of businesses did not really understand why they really needed to keep those records. There also needs to be education on that safe data handling and that disposal process, and there really needs to be some strategic engagement with those harder to reach businesses through the local networks, local councils or those highway traders' groups and also with the culturally and linguistically diverse community and using their business leaders and their communication channels to actually get things happening.[259]

Businesses, particularly small businesses not connected to strong industry groups or associations, have had trouble understanding the requirements for record keeping for contact tracing. Mr Paul Guerra, Chief Executive, Victorian Chamber of Commerce and Industry, recommended that visits be made to businesses to assist them to understand their obligations:

> the main our members are doing what is required, but there is a cohort of businesses that are not members of any industry association and it would appear that communication into that group has been difficult. So the idea of actually going out and visiting businesses to make sure that they understand what is needed to be put in place and pointing them to the resources that are available on the government websites or back through industry groups which they can get information from would be really useful.[260]

In the Committee's view, it is incumbent on the Victorian Government to produce clear guidance on what businesses are required to do to assist contact tracing efforts, particularly how businesses can go about supporting and implementing digitised

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259 Ms Judy O'Connell, Commissioner, Victorian Small Business Commission, public hearing, via videoconference, 16 November 2020, *Transcript of evidence*, p. 77.

260 Mr Paul Guerra, *Transcript of evidence*, p. 78.

contact tracing systems. The Committee believes that there should be a concerted effort to support businesses transitioning to a QR-code based contact tracing system now that the technology has moved out of the pilot phase. This can be achieved through ensuring that there is readily available information that clearly sets out a businesses' obligations and that relevant agencies work with industry groups to ensure that information is supplied to businesses that are traditionally harder to reach.

**FINDING 45:** Due to a lack of clear and accessible guidance from the Victorian Government some eligible small businesses are not aware of their legislative obligations to assist contact tracing by recording personal information of any persons on their premises for over 15 minutes.

**RECOMMENDATION 19:** That the Victorian Government work with unions, industry groups and associations to develop clear and accessible guidance for businesses on their obligations for contact tracing record keeping, particularly around setting up and using digital systems such as QR codes.

### Victorian Government QR code app

On 13 November 2020, the Victorian Government began pilot testing its QR code for contact tracing with select registered businesses. The pilot program concluded on 28 November 2020. The QR code app has since been made available to businesses on a voluntary basis.[261]

Material (such as posters, infographics and instructions) needed for a business to display the QR code on their premises, is free.

A business using the Victorian Government's QR code is unable to use another QR code service for contact tracing.

A list of responses to frequently asked questions can be found on the coronavirus.vic.gov.au website.

## 9.9.2 Where is data collected stored and who has access to this data?

The type of information obtained during testing and tracing is difficult to determine given a lack of transparency about data disclosures. The President of Liberty Victoria, Ms Julia Kretzenbacher, noted that investigations were fruitless when seeking this information:

> … when it comes to finding information about what happens to what you tell a contact tracer or how long that information is kept, there is nothing that can be readily found

261 Victorian Government, *Victorian Government QR Code Service*, December 2020, <https://www.coronavirus.vic.gov.au/qrcode> accessed 10 December 2020.

> online about that. We have tried, and we have not been able to find any readily available information.
>
> In preparation for appearing at this inquiry, we decided to look on the DHHS website and at other government resources and ask ourselves the question: 'If I were to test positive, or if I were a close contact, how does contact tracing work?'. Unfortunately we have not been able to find any information to clearly answer that question. We have not been able to find information, for example, which confirms that, firstly, the information that you tell a contact tracer will only be used by DHHS and will not be disseminated to other state or federal government agencies, in particular police or border force, and secondly, on how the information that you give to contact tracers is stored, how long it is stored for and really how securely it is stored as well, and on how and when that information is destroyed.[262]

The flow of data from testing to contact tracing was summarised by Dr Alan Finkel:

> So the data from the pathology labs comes into the Department of Health's new system in real time, and a positive case can be allocated to a case interview officer through that digital system, and then literally in real time the system prompts the case interview officer, who is a trained person but still needs to go through a formal interview process, and their results of that interview go straight back into that system and can be used by the outbreak management people.[263]

The Committee established that on testing, a paper slip with an individual's details is provided to the pathology laboratory. Using the Test Tracker system, people getting tested can use a QR code to put their own details into the test to ensure the information is captured accurately; similarly, this information can be entered by a healthcare worker on the patient's behalf.

Representatives from Salesforce confirmed that the company had no ownership of the data that was collected by the CRM and could not use it for any purposes outside of contact tracing. They explained that 'The department only ever owns that customer data; we do not have access to it. It is solely the Department's.'[264] This was reiterated by Mr Andrew Burnes, who explained that no data used by Helloworld was retained by the company: 'We have no data at all, no.'[265]

Evidence provided to the Committee by Stellar Asia Pacific was that the paper slips used contain the following information:

- Name
- Address
- Quarantine location

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262 Ms Julia Kretzenbacher, President, Liberty Victoria, public hearing, via videoconference, 18 November 2020, *Transcript of evidence*, p. 75.

263 Dr Alan Finkel AO, *Transcript of evidence*, pp. 3–4.

264 Mr Michael Bonaddio, *Transcript of evidence*, p. 9.

265 Mr Andrew Burnes, *Transcript of evidence*, p. 57.

- Household occupants
- Mobile phone number
- Preferred language
- Working arrangements (including financial assistance, sick leave, income).

For those with children, the slips capture

- Childcare, school or higher education attended by child
- Date of last attendance at institution.

The Committee notes that this information is personal and is concerned about how this information is being stored and shared. Ms Rachel O'Loughlin, Chief Customer Officer at Stellar Asia Pacific, noted that the information captured by Stellar was encapsulated in a single telephony system:

> … we are actually managing a very specific piece of work, and that specific piece of work is all contained within Genesys. Certainly, the conversation we had with the department during the initial scoping of the solution was that it was very important to us to ensure that data was captured, and information was captured within a system and other systems were not used, so that is all done within Genesys.[266]

In hearings before the Committee, Mr Andrew Burnes explained that separate systems were used by the staff at Helloworld to manage information:

> Well, our systems here internally, we have a lot of different systems. We have 1200 personnel in Australia, and through the cloud—we use the DHHS PureCloud system—we were able to connect directly, in Melbourne initially and in some of the other centres as well, into the DHHS cloud system, so all of the data that we collected and that was passed onto DHHS went straight into their system. None of this data was ever exposed or entered into any system of Helloworld's. Obviously connectivity is in the pipelines that we have in here, but it got straight into the DHHS system.[267]

Issues with multiple officers accessing the data were raised by Liberty Victoria, who noted:

> Another concerning aspect of the contact-tracing system that we have become aware of through media reports is that it seems that a person being contact traced might be speaking to a number of different people in the process. And they might have to repeat information that they have already divulged. Where there is little information available about what happens to what you tell a contact tracer, this process might hamper the building of rapport and trust between contact tracers and individuals.[268]

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266 Ms Rachel O'Loughlin, Chief Customer Officer, Stellar Asia Pacific, public hearing, via videoconference, 18 November 2020, *Transcript of evidence*, p. 35.

267 Mr Andrew Burnes, *Transcript of evidence*, p. 57.

268 Ms Julia Kretzenbacher, *Transcript of evidence*, p. 75.

Further to this, the data collected by Whispir Communications is retained indefinitely for audit purposes:

> … we do store data so that DHHS can come back and audit communications in the future—who said what to whom and when, for example, what was the thing that they were provided, did they say yes or no. So to the extent that data is retained, we retain it, but obviously it is the data of DHHS; it is not ours.[269]

The Committee notes that, as a contracted service provider, Whispir's obligations to manage and destroy data are the same as those applicable to the contracting public sector body; as a provider under state contract, it is the responsibility of the relevant public sector body to ensure that Whispir adhere to the appropriate privacy principals.[270]

As far as the Committee is able to ascertain, the data obtained during testing and contact tracing process is collected and stored in the following systems:

- Public Health Event Surveillance System (PHESS)

  DHHS' database for communicable diseases and is also used by certain other jurisdictions. PHESS is the existing communicable diseases track and tracing system is the central database being used to manage COVID-19. At this start of the pandemic, PHESS was managing an unprecedented volume of data, which affected system performance and reporting timeliness.[271]

- Case and Contact Management Portal

  The Case and Contact Management Portal system provides real time PHESS integration and fully digital functionality for internal and external contact tracing teams to interview positive cases and collect close contact information…

  The system automatically categorises and allocates cases to contact tracing teams based on configurable business rules (e.g. Postcode, Aged Care resident, Healthcare worker).The system has over 800 users, comprising staff from DHHS, outsourced call centre providers (e.g. HealthDirect, Stellar Asia and Helloworld) and all local public health units. Over 3,000 cases have been processed using the system.[272]

- Rapid Tracer—Salesforce CRM

  It will cover the whole program of contact tracing – from positive result coming in, the interviews, follow up phone calls and coordination of Operation Vestige to the clearance of cases and contacts to be managed all within the one system.

  An important feature of the CRM is the ability to provide simultaneous users contact tracing across DHHS' CCOM team and local public health units. This will help synchronise



269 Mr Jeromy Wells, *Transcript of evidence*, p. 68.

270 Dr Alan Finkel AO, *Transcript of evidence*, pp. 3–4.

271 Victorian Government, *Submission 23*, p. 23.

272 Ibid., pp. 23–4.

> all local public health units and central DHHS teams to monitor and rapidly contain future transmissions of COVID-19.[273]

Where the data is held for the Salesforce CRM was outlined by Mr Michael Bonaddio at his appearance before the Committee:

> The data is held securely in Amazon Web Services cloud infrastructure in Australia, so that is all onshore. Amazon Web Services is a trusted partner of Salesforce, and they provide services to a range of other federal and state governments in Australia.[274]

Dr Alan Finkel commented on the security of the data residency and the use of the Amazon Web Services:

> … what level of security and comfort should we have, or what level of comfort should we have, in the integrity and reliability of a system that is built on a cloud-based platform from an American company and actually using an interface and database platform from another American company. Well, Amazon Web Services, Salesforce—the word 'ubiquitous' is probably too strong, but they are everywhere. Big companies and governments are using them.[275]
>
> Similarly, Amazon Web Services, even more so, is the cloud-based service, alongside the Microsoft Office offering and the Google offering and others, that—I do not know the numbers, but I would guess—more than half of the big companies in the world, between those three cloud-based services, would be totally dependent on their proper operation. The Department of Defense in America is using cloud-based services. You cannot not have a concern, but at some stage you have to say it is a managed risk to accept that, for example, our telephone system will stay up in the middle of a crisis. It is not always the case, if there is a bushfire or mobile phone towers are being destroyed by the intense heat. But fundamentally we run our systems based on backbones such as the internet and the telephone service and nowadays backbones such as cloud-based servers. With my vote of one, I would say I am comfortable using those two technology bases.[276]



### 9.9.3 How long is the data stored?

The Committee found it difficult to obtain information on how long data is stored in the Salesforce Rapid Trace CRM. The data retention policy for contact tracing and testing information is the decision of the Department rather than Salesforce:

> In terms of the retention period for that data … that is obviously a policy for the department, so whether the department intends to keep that long term or medium term, that would be up to them, but we have obviously got mechanisms to be able to store it for whatever period that the department requires.[277]

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273 Ibid., p. 24.

274 Mr Michael Bonaddio, *Transcript of evidence*, p. 9.

275 Dr Alan Finkel AO, *Transcript of evidence*, pp. 5–6.

276 Ibid.

277 Mr Michael Bonaddio, *Transcript of evidence*, p. 9.

Businesses that are required to record information for contact tracing are also required to keep all the information collected for at least 28 days, unless a statutory requirement requires or permits retaining the information. Beyond 28 days, the business should destroy these records as soon as practicable.[278]

**FINDING 46:** Businesses that record personal information for contact tracing must store the information for 28 days, unless another statutory requirement requires it to be retained. After 28 days, this information must be destroyed as soon as practicable.

### 9.9.4 What impact will the development of the universal QR code for contact tracing have on data security and privacy?

A state-wide QR code was, at the time of writing, recently rolled out across industries in Victoria to manage the collection and storage of information to staff and visitors within businesses:

> This digital registration solution will allow users to check in to venues using QR (quick response) codes and provide an interface that connects third party check-in apps with the Victorian Government's contact tracing systems.[279]

While the Committee acknowledges that the development of a QR is outside the scope of the inquiry, the Committee would like to briefly explore the implications of the data security and privacy issues raised in evidence.

Professor Euan Wallace confirmed that 'the QR again is being used in progressive pilot and implementation phase now' throughout businesses in Victoria.[280] The benefit of the code was explained by Ms Sandy Pitcher (Department of Health and Human Services):

> Really the QR code is very simple in many ways. It provides the name, phone number and contact details of the person but also the time that they were in a venue, and that is really what we need. We need what time they were there and we need what time other patrons were there. We are very alive to the security concerns of not all of those businesses holding that data more than they need, but we are also very alive that we do not need other things than that ourselves to be able to have a very effective contact-tracing system that businesses and government are working in partnership with. I think we reflected on the COVIDSafe app not perhaps providing what we had all hoped for in some ways at the start of the pandemic in terms of lots of different contact information.[281]

In her appearance before the Committee, Dr Monique Mann noted that the use of a universal QR code with specific protections in place was preferable to a range of third-party systems:

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278 Workplace Directions (No 10), 22 November 2020.

279 Victorian Government, *Submission 23*, p. 25.

280 Professor Euan Wallace, *Transcript of evidence*, p. 14.

281 Ms Sandy Pitcher, *Transcript of evidence*, p. 29.

> … if it is necessary for the purposes of contact tracing and we have appropriate safeguards in place—it is time bound, the data is deleted after a period of days, whether that be 21 or otherwise—that would be an avenue to explore. And that would probably be a preferred approach than having a number of different third-party QR providers collecting a whole range of information that is not necessarily required for the purposes of contact tracing, such as email address or date of birth.[282]

The assurance of a reliable system which is supported by the Victorian Government was a key element in creating buy-in and compliance from business and patrons alike:

> Going into the contact-tracing phase that we are now in with organisations, the sorts of things I would be concerned about are—and government is taking these concerns on board—you can imagine going to your local cafe and being asked to scan a QR code, and if you ask the person at the front desk, 'Well, why do I need to do that?' the person says, 'It's a government COVID thing'. Okay. So a person might think, 'Well, it's government. I might not like the government, but it's the government; it's not a social media company, and it's not a marketing company. Okay, I'll provide my information'. Now, of course, if that app is then actually provided by a private sector organisation—and of course there are several that provide these sorts of services for loyalty programs, for table bookings—if they then integrate the contact tracing into that, you can easily see a scenario where you go into the cafe, you sign in and you scan and then you start getting spam from the restaurant, from a company, from whatever, saying, 'You might also enjoy this'. In your mind you are going, 'I gave this to the government, and now I'm getting spammed'. These are the sorts of nuances where trust can break down.[283]

To ensure the appropriate use and management of a universal QR code, the Committee notes the following safeguards should be considered:

- Data is collected at the lowest requirement—name and a method of contacting the user
- Data is destroyed after a certain period (21 days or otherwise)
- Data is held by the individual until such time as it becomes relevant to the contact tracing process.

The Committee also notes that there are additional implications with a mandatory system being put in place, and that a range of privacy obligations can be circumvented by obtaining an individual's consent. This is reflected on the Victorian Government's website, which notes that businesses 'should encourage visitors to check-in via the QR code displayed at your business or venue.'[284]

**FINDING 47:** There is a lack of clear, publicly available information on the collection, storage and usage of information gathered by contact tracers.

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282 Dr Monique Mann, Vice-President, Liberty Victoria, public hearing, via videoconference, 18 November 2020, *Transcript of evidence*, pp. 76–7.

283 Mr Sven Bluemmel, *Transcript of evidence*, p. 26.

284 Victorian Government, *Victorian Government QR Code Service*.

# Appendix 1
# About the inquiry

## A1.1 Submissions

| | |
|---|---|
| 1 | Karl Chlebowczyk |
| 2 | Dr Vanessa Teague |
| 3 | Geoff Daly |
| 4 | Name Withheld |
| 5 | Name Withheld |
| 6 | Name Withheld |
| 7 | Dr Guiseppe Garra |
| 8 | Salesforce |
| 9. | Cedar Meats |
| 10. | Lynn Nash |
| 11. | Dr Michael Baron |
| 12 | Name Withheld |
| 13 | Tom Voigt |
| 14 | Dr Marina Malcolm |
| 15 | Name Withheld |
| 16 | Office of the Victorian Information Commissioner |
| 17 | Name Withheld |
| 18 | Dr Anita Munoz |
| 19 | Confidential |
| 20 | William Albon |
| 21 | Public Health Association of Australia |
| 22 | Parousya Technologies Pty Ltd |
| 23 | Department of Health and Human Services |
| 24 | Yvonne Hrusak |
| 25 | Name Withheld |
| 26 | AMA Victoria Limited |
| 27 | Victorian Multicultural Commission |
| 28 | Dr Tim Read |
| 29 | Dr Ines Rio |
| 30 | Brimbank City Council |

A1

| | |
|---|---|
| 31 | Name Withheld |
| 32 | Community and Public Sector Union – Victorian branch |
| 33 | Multicultural Centre for Women's Health |
| 34 | Brent Allan |
| 35 | Parliamentary Budget Officer |
| 36 | Australian Government Department of Health |

## A1.2 Public Hearings

### Monday, 23 November 2020

Via video link

| Name | Title | Organisation |
|---|---|---|
| Professor Euan Wallace AM | Secretary | Department of Health and Human Services |
| Jeroen Weimar | Commander of Testing and Community Engagement | |
| Sandy Pitcher | Deputy Secretary, Case Management, Contact Tracing and Outbreak | |
| Professor Andrew Wilson | Chief Medical Officer, Safer Care Victoria | |
| Professor Brett Sutton | Chief Health Officer | |
| Dr Simon Crouch | COVID-19 Deputy Public Health Commander, Case Management, Contact Tracing and Outbreak | |
| Dr Clare Looker | COVID-19 Deputy Public Health Commander, Case Management, Contact Tracing and Outbreak | |
| Dr Annaliese van Diemen | Deputy Chief Health Officer, Communicable Diseases | |

## Wednesday, 18 November 2020

Via video link

| Name | Title | Organisation |
|---|---|---|
| Dr Alan Finkel AO | Chief Scientist | Office of the Chief Scientist Australia |
| Tony Kairouz | General Manager & Owner | Cedar Meats |
| Professor Mary-Louise McLaws | Professor in Epidemiology, Hospital Infection and Infectious Diseases Control, School of Population Health, University of New South Wales<br>WHO Health Emergencies Program Ad-hoc COVID-19 Infection Prevention and Control Guidance Development Group<br>Focal Point WHO Global Outbreak Alert and Response Network (GOARN) | University of NSW |
| Adjunct Professor George Rubin | Public Health University of Sydney<br>Conjoint Professor Public Health, University of New South Wales<br>Consultant in Public Health and Clinical Practice Improvement | |
| Ms Rachel O'Loughlin | Chief Customer Officer | Stellar Asia Pacific |
| Dr Mukesh Haikerwal GP | – | – |
| Felicity Topp | Chief Executive Officer | Peninsula Health |
| Dr Shyaman Menon | Executive Director of Medical Services and Clinical Governance | |
| Adjunct Professor Russell Harrison | Chief Executive Officer | Western Health |
| Dr Clare White | Clinical Services Director, Geriatric Medicine | |
| Fiona Brew | Chief Executive | Colac Area Health |
| Associate Professor Daniel O'Brien | Deputy Director | Department of Infectious Diseases, Barwon Health |
| Julia Kretzenbacher | President | Liberty Victoria |
| Dr Monique Mann | Vice President | |
| Charles Agee | General Manager, Global Technology Services Australia/ New Zealand | IBM Services |
| Ralph Klaassen | Solution Architect | |

A1

## Monday, 16 November 2020

Via video link

| Name | Title | Organisation |
|---|---|---|
| Pip Marlow | Chief Executive Officer, ANZ | Salesforce |
| Michael Bonaddio | Principal Architect | |
| Professor Julian Rait OAM | – | Australian Medical Association Victorian Council |
| Sven Bluemmel | Commissioner | Office of the Victorian Information Commissioner |
| Rachel Dixon | Privacy and Data Collection Deputy Commissioner | |
| Professor Eugene Athan | Director | Department of Infectious Diseases, Barwon Health |
| Professor Catherine Bennett | Chair in Epidemiology, Institute of Health Transformation | Faculty of Health, Deakin University |
| Andrew Burnes | Chief Executive Officer and Managing Director | Helloworld Travel Ltd |
| Jeromy Wells | Chief Executive Officer | Whispir |
| Paul Guerra | Chief Executive | Victorian Chamber of Commerce and Industry |
| Judy O'Connell | Commissioner | Victorian Small Business Commission |
| Tim Piper | Director, Victoria | Australian Industry Group |

# Appendix 2
# Information provided by the Department of Health and Human Services

Secretary

Department of Health and Human Services

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Ms Fiona Patten
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Legislative Council, Legal and Social Issues Committee
Parliament House, Spring Street
EAST MELBOURNE VIC 3002

Dear Ms Patten

**Inquiry into the Victorian Government's COVID-19 Contact Tracing System and Testing Regime**

I write in response to your letter sent to the Commander of Testing and Community Engagement, requesting data for the Parliamentary Inquiry into the Victorian Government's COVID-19 Contact Tracing System and Testing Regime.

Provided with this letter are the data requested and a summary document that sets out:

- a summary of the status of the data requested and further information
- data definitions, description of any data limitations and further information
- an indexing reference to assist with locating the data

Every effort was made to provide the data requested by close of business yesterday, but I am afraid it was not possible within the timeframe. Thank you for your understanding on this matter.

Should you or the Legal and Social Issues Committee have any queries, please direct them to [redacted], Operational Policy and Planning; Case, Contact, and Outbreak Management at [redacted].

Yours sincerely

**Professor Euan Wallace**
Deputy Secretary, Case, Contact and Outbreak Management
13 /11/2020

**Parliamentary Inquiry into Contact Tracing and Testing – Data Summary and Explanation**

| Contact Tracing Request | **Status** | **Index** | **Further explanation if needed** |
|---|---|---|---|
| 1. Disaggregated information pertaining to contact tracing interactions in Victoria since 1 January 2020. Please provide for all positive cases:<br>a. the average weekly sequence of timing (in hours) from tests being taken, results received by the Department, the initial contact being made with the positive case, and the conclusion of the contact tracing process for that case. | Provided | CT1a (testing to notification)<br>CT1a_2 (timing of contacts)<br>CT1a and CT3c (av timing test) | • The elapsed time to interview confirmed cases and notify close contacts is measured from the time that a sample is taken at a testing site.<br>• The end-to-end analysis is based on measuring the time taken to complete several different milestones between the test, the interview and the notification of a close contact.<br>• In some instances the data collected to assess the time taken between milestones is a sample. For example, for measuring the time taken from when sample was taken to when the Department is notified can only be done for tests that are in a certain digital tracing device (Test Tracker) meaning the person has scanned a QR code. We are not able to track the time taken to notify the Department of tests not going through Test Tracker.<br>• The methodology is designed to collate the maximum number of data points, however in some instances this can only be a sample of the full data. |
| b. The communication mode used to notify:<br>I. the patient<br>II. primary close contacts<br>III. secondary close contacts (if applicable) | Provided | CT1b (communication notification modes) | • The list provided outlines the communication types that DHHS uses to communicate with a confirmed case/patient once a positive result has been established and the patient and department have been notified of the positive result.<br>• DHHS teams do not typically notify a patient/case of their COVID-19 test result. That is the responsibility of the health service/medical practitioner.<br>• However, where DHHS does organise testing for potential cases (e.g close contacts or individuals identified as part of an outbreak) the department notifies the individual directly of their result. |
| c. the number of mandatory tests carried out on primary and secondary close contacts. | Provided | No attachment required | • Mandatory testing at Day 11 or an extension of quarantine for 10 days for primary close contacts was introduced on the 10th October 2020. |

| Contact Tracing Request | **Status** | **Index** | **Further explanation if needed** |
|---|---|---|---|
| | | | • Since the introduction of mandatory testing, there have been 482 primary close contacts and only 9 Primary close contacts have refused a day 11 test and had their quarantine extended.<br>• Testing of secondary close contacts is not mandatory so not provided.<br>• There are 94,320 primary close contacts recorded in Public Health Event Surveillance System (PHESS). Since the 1st of August 2020 all Negative Test Results have been stored in a separate database outside of PHESS. This requires a predominantly manual search on key individual identifiers to link negative test results to individual close contacts. |
| 2. The weekly number of people employed in COVID-19 related contact tracing roles for Victoria since 1 January 2020. Please provide:<br>a. Qualifications of each employee | Partly provided | CT2a (workforce data)<br>CT2a_1 (CCOM job cards)<br>CT2a_2 (CCOM PDs)<br>CT2a_3 (departmental response) | • The department employs suitably qualified epidemiologists, case, contact and outbreak management staff, senior medical advice officers and specialist medical officers (including the Chief and Deputy Chief Health Officers) to support the department's ongoing response to the COVID-19 pandemic.<br>• Job Card and Position Descriptions have been provided for relevant contact tracing related roles within the Case, Contact and Outbreak Management function within the Department of Health and Human Services.<br>• DHHS does not hold the qualifications of each employee, once an employee has commenced their employment with the department.<br>• Qualifications, experience and skills are vetted through the recruitment process.<br>• Each role recruited for the COVID 19 response is done via a Job Card or a Position Description. The Job Card and Position Description outlines the skills, expertise and qualifications expected for each role. The person is selected on the basis of their qualifications, skill, expertise and fit for the role.<br>• Job Cards and Position Descriptions are provided for most roles within the COVID response. |

| Contact Tracing Request | Status | Index | Further explanation if needed |
|---|---|---|---|
| | | | • During the initial stages of the Emergency Response some staff were reassigned to COVID duties based on an expression of interest (EOI) or recruitment process where the skills, experience, and preferences of the employee were taken into account and the deployment period was for weeks or months, not exceeding six months.<br>• To provide individual qualifications would require retrieving the resume of each staff member and would not meet timelines.<br>• Please note, DHHS is investing in a whole of government end-to-end human resource system (Human Capital Management System) that will capture this data in the future. There is significant work occurring in DHHS Workforce Readiness Centre that will also assist with the collection of this information |
| b. The employer of each employee (Helloworld, Stellar Pty Ltd, DHHS etc.) | Provided | CT2a (workforce data) | • A list of agencies and organisations that employ staff has been provided |
| c. The weekly average hours worked since 1 January 2020 | Not provided | CT2a – (workforce data) | • This data is unable to be provided for the Case, Contact and Outbreak Management function within the Department of Health and Human Services. This is due to the composition of the sources of the workforce that comprise the Case, Contact Outbreak Management function within the department.<br>• Please note that many of the employees within the Case, Contact and Outbreak Management function are paid by external organisations and the collection of this information may not be available for all employees, including staff who were not required to be rostered on shift patterns while engaged by DHHS. When this occurs, only the headcount of the employee will be recorded.<br>• Under the VPS Industrial Relations Framework, several seconded staff from other VPS departments remained on their home |

| Contact Tracing Request | **Status** | **Index** | **Further explanation if needed** |
|---|---|---|---|
| | | | department's payroll system and therefore the department does not have access to this data within the timeframes requested.<br>• Some employees who were seconded from other organisations (including health organisations) have remained on their home organisations payroll system. The Department does not have access to this data within the timeframe requested. The Department will need to submit a formal request to these organisations for the relevant payroll data.<br>• For staff engaged via labour hire arrangements or through commercial contracts with the department, the department has procured the contract details for these staff. However, this will not necessarily outline each employees' weekly average hours nor FTE as requested in 2) c) and d). The department would need additional time to provide this data.<br>• Case and contact staff work 24/7, with outreach for case and contact management with members of the Victorian public occurring between 8am and 10pm. |
| d. FTE for each employee. | Headcount provided | CT2a – (workforce data) | • Headcount has been provided due to the sources of the workforce that comprises the Case, Contact Outbreak Management function within the department.<br>• Many of the employees within the Case, Contact and Outbreak Management function are paid by external organisations and the collection of this information is not be available for all employees.<br>• On 29 January the Health Protection Branch identified the need to establish an Incident Management Team to respond to the emerging threat of COVID-19 Cases within Australia.<br>• The initial public health response team from the Health Protection Branch comprised approximately 57 people. |

| Contact Tracing Request | **Status** | **Index** | **Further explanation if needed** |
|---|---|---|---|
| | | | • There were 255 people working in the Case, Contact and Outbreak Management function on the 1 May 2020.<br>• On the 23 June 2020, the Public Health Emergency Operations and Coordination Division was established within the department. As a result of this division being established the department began to formalise structures and reporting arrangements in its HR systems.<br>• The department has provided the headcount of staff engaged specifically within the Case, Contact and Outbreak Management function from June to 24 October, which is used to inform part of the department's overall Public Health workforce figures.<br>• The data has been provided in a deidentified manner to protect the privacy of individual employees.<br>• The headcount provided is based on fortnightly payroll data for DHHS employees.<br>• Please note that many of the employees within the COVID-19 Response are paid by external organisations and the collection of this information may not be available for all employees, including staff who were not required to be rostered on shift patterns while engaged by DHHS. |
| 3. Weekly metrics for people employed in COVID-19 related contact tracing roles for Victoria since 1 January 2020. Please provide:<br>a. Inbound call numbers per week, including calls connected and calls that were not answered | Provided | CT3a and b (contact tracing call data) | • Data provided from the Genesys (telephony) database.<br>• Data relates predominantly to the following call service:<br>o DHHS Hotline: The Department of Health and Human Services operates a 24-hour communicable diseases hotline (1300 651 160). This number receives urgent communicable disease notifications from clinicians, including notifications for COVID-19.<br>• Please note that the Inbound / Outbound category relates to calls that were either received or made that required an additional party to be included, for example, a translator service. |

| Contact Tracing Request | Status | Index | Further explanation if needed |
|---|---|---|---|
| b. Outbound call numbers per week, including calls connected and calls that were not answered | Provided | CT3a and b (contact tracing call data) | • Data provided from the Genesys database.<br>• Data relates predominantly to the following call services:<br>  ○ Helloworld and Stella calls: calls made by external contractors to close contacts.<br>  ○ HealthDirect: external contractor that has supported CCOM in making calls to confirmed cases.<br>• Please note that the Inbound / Outbound category relates to calls that were either received or made that required an additional party to be included, for example, a translator service. |
| c. Outbound text messages sent per week (if applicable) | Provided | CT3 (sms messages sent) | • Data provided from the WHISPIR database for SMS sent to confirmed cases and close contacts. |
| d. Outbound email messages sent per week | Not provided | | • Not able to provide as not recorded and too onerous |
| e. Inbound email messages sent per week. | Not provided | | • Not able to provide as not recorded and too onerous |

| Testing Request | Status | Index | Further explanation if needed |
|---|---|---|---|
| **4. Please provide daily test numbers carried out in Victoria since 1 January 2020, broken down by:**<br>**a. testing site by Local Government Area (i.e. surge pop-up, fixed location, drive through, or at home)** | Partly provided | T3 and 4 (testing) | • List of current test sites by local government area (LGA) provided.<br>• Breakdown by testing modalities by LGA to date for polymerase chain reaction ("PCR") and Serology tests provided. Other modalities are in pilot and have not been provided.<br>(PCR tests are generally considered better at detecting the presence of the SARS-CoV-2 virus and are currently the gold standard for diagnosis of COVID-19. Serology-based tests detect antibodies that develop in response to coronavirus (COVID-19) infection).<br>• Daily aggregate level testing data by local government area provided.<br>Gaps and context:<br>• DHHS currently has two methods of monitoring activity around its testing regime:<br>1) collection of data relating to the number of tests processed at the lab, which provides the most complete and accurate picture of all testing activity in the State<br>2) the samples collected at the point of testing which does not have a complete picture due to:<br>o Sample collection numbers by site cannot offer site-level detail reliably due to how the data is provided currently, eg some data is provided at an organisation level (aggregate level) but not at a site level<br>o Several sample collection activities arranged outside of the department such as aged care testing, private commercial testing etc. do not provide sample collection data.<br>• All testing activity is reflected through results of tests reported through pathology testing numbers; however, these do not report from which site the samples have come from. |

| | | | |
|---|---|---|---|
| | | | • For the number of tests processed by labs, these can be broken down by LGA, but this is for patient's place of residence and not where they undertook their test.<br>• We have limited historical site data prior to end of June 2020. |
| **b. testing method.** | | T3 and 4 (testing) | • Provided breakdown by testing modalities by LGA to date for PCR and Serology tests. Others are in pilot. |
| **5. Please provide specific locations of each testing site in Victoria, and the date each site was established.** | Partly provided | T3 and 4 (testing) | • List of current test sites by LGA and location provided<br>• Some sites will not have commencement dates<br>• Data is not available prior to September 2020 as data was captured inconsistently. |
| **6. In regard to at-home, self-administered COVID-19 tests, please provide:**<br>**a. The total number of at-home, self-administered COVID-19 tests** | Partly provided | | • The department does not provide at-home, self-administered testing.<br>• A small pilot was undertaken in June/July 2020; it was discontinued. |
| **b. The total number of positive results from these tests** | Not provided | | This data is not available |
| **c. Any connections to known clusters identified from at-home, self-administered tests.** | Not provided | | This data is not available |
| **7. In regard to employee testing in high-risk industries (such as aged care, abattoirs, meat and poultry processing, and supermarket distribution centres), please provide:**<br>**a. The dates that mandated testing in high-risk industries commenced;** | Provided | T3 and 4 (testing) | |
| **b. The number of tests completed in high-risk industries, broken down by industry type** | Provided | T3 and 4 (testing) | |

| | | | |
|---|---|---|---|
| **c. The number of mandated tests completed in the health care sector, excluding aged care** | Partly provided | T3 and 4 (testing) | • Data is limited to 2 weeks starting October 25th, 2020 |

| Date (Week ending) | Time from Testing to Notification to Positive Case (completion of Case Interview) (Hours : minutes) | Time from Testing of Positive Case to Notification to Close Contacts (sending of SMS) (Hours : minutes) |
|---|---|---|
| 28/08/2020 | 62:45 | 81:30 |
| 4/09/2020 | 38:00 | 58:15 |
| 11/09/2020 | 32:05 | 47:10 |
| 18/09/2020 | 27:44 | 42:54 |
| 25/09/2020 | 27:05 | 42:15 |
| 2/10/2020 | 29:18 | 38:41 |
| 9/10/2020 | 28:35 | 38:32 |
| 16/10/2020 | 27:07 | 36:31 |
| 22/10/2020 | 26:24 | 37:35 |
| 30/10/2020 | 25:26 | 36:35 |

# Time from Testing to Notification to Positive Case (completion of Case Interview) Time from Testing of Positive Case to Notification to Close Contacts

| Week ending | Time from Testing to Notification to Positive Case (completion of Case Interview) [Hours : minutes] | Time from Testing of Positive Case to Notification to Close Contacts (sending of SMS) [Hours : minutes] |
|---|---|---|
| 28/08/2020 | 62:45 | 81:30 |
| 4/09/2020 | 38:00 | 58:15 |
| 11/09/2020 | 32:05 | 47:10 |
| 18/09/2020 | 27:44 | 42:54 |
| 25/09/2020 | 27:05 | 42:15 |
| 2/10/2020 | 29:18 | 38:41 |
| 9/10/2020 | 28:35 | 38:32 |
| 16/10/2020 | 27:07 | 36:31 |
| 22/10/2020 | 26:24 | 37:35 |
| 30/10/2020 | 25:26 | 36:35 |

# Percent of cases contacted within 24 hours
# Percent of cases interviewed within 24 hours
# Percent of contact notified within 48 hours

| Date From | Date to | Percent of cases contacted within 24 hours | Percent of cases interviewed within 24 hours | Percent of contacts notified within 48 hours |
|---|---|---|---|---|
| 15-Aug | 21-Aug | 100.00% | 75.44% | 99.26% |
| 22-Aug | 28-Aug | 100.00% | 74.81% | 98.81% |
| 29-Aug | 04-Sep | 100.00% | 88.49% | 99.28% |
| 05-Sep | 11-Sep | 100.00% | 95.36% | 98.22% |
| 12-Sep | 18-Sep | 100.00% | 98.82% | 99.46% |
| 19-Sep | 25-Sep | 100.00% | 99.06% | 99.05% |
| 26-Sep | 02-Oct | 100.00% | 98.65% | 99.41% |
| 03-Oct | 09-Oct | 100.00% | 100.00% | 99.67% |
| 17-Oct | 27-Oct | 100.00% | 100.00% | 98.80% |
| 18-Oct | 24-Oct | 100.00% | 100.00% | 98.87% |
| 25-Oct | 31-Oct | 100.00% | 100.00% | 100.00% |
| 1-Nov | 7-Nov | 100.00% | 100.00% | 100.00% |

# Total number of SMS sent

| Date From | Date to | Total Number of SMS Sent |
|---|---|---|
| 29-Jun-20 | 05-Jul-20 | 15,270 |
| 06-Jul-20 | 12-Jul-20 | 28,209 |
| 13-Jul-20 | 19-Jul-20 | 35,868 |
| 20-Jul-20 | 26-Jul-20 | 69,109 |
| 27-Jul-20 | 02-Aug-20 | 74,760 |
| 03-Aug-20 | 09-Aug-20 | 104,973 |
| 10-Aug-20 | 16-Aug-20 | 94,756 |
| 17-Aug-20 | 23-Aug-20 | 63,661 |
| 24-Aug-20 | 30-Aug-20 | 39,601 |
| 31-Aug-20 | 06-Sep-20 | 26,722 |
| 07-Sep-20 | 13-Sep-20 | 15,771 |
| 14-Sep-20 | 20-Sep-20 | 10,325 |
| 21-Sep-20 | 27-Sep-20 | 5,352 |
| 28-Sep-20 | 04-Oct-20 | 3,412 |
| 05-Oct-20 | 11-Oct-20 | 3,018 |
| 12-Oct-20 | 18-Oct-20 | 2,458 |
| 19-Oct-20 | 25-Oct-20 | 1,607 |
| 26-Oct-20 | 01-Nov-20 | 1,841 |
| 02-Nov-20 | 08-Nov-20 | 834 |

*Timing of contacts*

| Date From | Date to | Confirmed cases attempted to contact | | | Confirmed cases interviewed | | | Close contacts notified | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Number of new confirmed cases to contact | Number of new confirmed cases attempted to contact | Percent of cases contacted within 24 hours | Number of new confirmed cases to interview | Number of new confirmed cases interviewed | Percent of cases interviewed within 24 hours | Number of new known close contacts to notify | Number of new known close contacts notified | Percent of known contacts notified within 48 hours |
| 15-Aug | 21-Aug | 1,600 | 1,600 | 100% | 1,600 | 1,207 | 75.44% | 5,521 | 5,480 | 99.26% |
| 22-Aug | 28-Aug | 941 | 941 | 100% | 941 | 704 | 74.81% | 3,628 | 3,585 | 98.81% |
| 29-Aug | 4-Sep | 617 | 617 | 100% | 617 | 543 | 88.49% | 1,932 | 1,918 | 99.28% |
| 5-Sep | 11-Sep | 366 | 366 | 100% | 366 | 349 | 95.36% | 956 | 939 | 98.22% |
| 12-Sep | 18-Sep | 254 | 254 | 100% | 254 | 251 | 98.82% | 734 | 730 | 99.46% |
| 19-Sep | 25-Sep | 106 | 106 | 100% | 106 | 106 | 100% | 316 | 313 | 99.05% |
| 26-Sep | 2-Oct | 74 | 74 | 100% | 74 | 73 | 98.65% | 503 | 500 | 99.40% |
| 3-Oct | 9-Oct | 78 | 78 | 100% | 78 | 78 | 100% | 287 | 286 | 99.65% |
| 10-Oct | 16-Oct | 55 | 55 | 100% | 55 | 55 | 100% | 192 | 192 | 100% |
| 17-Oct | 23-Oct | 23 | 23 | 100% | 23 | 23 | 100% | 178 | 177 | 99.44% |
| 24-Oct | 30-Oct | 16 | 16 | 100% | 16 | 16 | 100% | 177 | 175 | 98.87% |
| 31-Oct | 6-Nov | 0 | 0 | N/A | 0 | 0 | N/A | 18 | 18 | 100% |
| 7-Nov | 13-Nov | 0 | 0 | N/A | 0 | 0 | N/A | 0 | 0 | N/A |

# Communication modes used to notify:
# I. The patient
# ii. Primary close contacts
# iii. Secondary close contacts

| Channel | Confirmed cases *(referred to as the Patient)* | Primary close contacts | Secondary close contacts |
|---|---|---|---|
| SMS | ✓ | ✓ | |
| Phone call | ✓ | ✓ | ✓ |
| Email | ✓ (e.g. Clearance email) | ✓ (e.g. Clearance email) | ✓ (e.g. Clearance email) |
| Door knock | ✓ | ✓ | ✓ (households) |
| Face-to-face interaction | ✓ | ✓ | ✓ |

Note:

- The above list outlines the communication types that the Department uses to communicate with a confirmed case/patient once a positive result has been established and the patient and department have been notified of the positive result.
- Case contact and outbreak management (CCOM) does not typically notify a patient/case of their COVID-19 test result. That is the responsibility of the health service/medical practitioner.
- However, when CCOM has been the requestor then there has been a process through our Path Cell. Negative results were via text and positive results was subcontracted to Medibank Solutions up until last week. This is now being coordinated through Community Engagement and Testing Division and the rapid testing program.

✓ Channel used

Table 2 - Case, Contact and Outbreak Management Fortnightly Headcount

| Start of Pay Period | 11.10.2020 | 27.09.2020 | 13.09.2020 | 30.08.2020 | 16.08.2020 | 02.08.2020 | 19.07.2020 | 05.07.2020 | 21.06.2020 | 07.06.2020 |
|---|---|---|---|---|---|---|---|---|---|---|
| End of Pay Period | 24.10.2020 | 10.10.2020 | 26.09.2020 | 12.09.2020 | 29.08.2020 | 15.08.2020 | 01.08.2020 | 18.07.2020 | 04.07.2020 | 20.06.2020 |
| Australian Defence Force | 24 | 68 | 68 | 68 | 183 | 183 | 183 | | | |
| Case, Contact and Outbreak Management | 529 | 480 | 484 | 473 | 603 | 444 | 377 | 358 | 329 | 286 |
| Commonwealth and other states | 113 | 81 | 76 | 243 | 244 | 360 | 6 | 6 | 6 | 6 |
| Health Direct | 200 | 200 | 200 | 200 | 150 | 150 | 150 | | | |
| Helloworld | 28 | 39 | 34 | 36 | 37 | 37 | 62 | 31 | 22 | 22 |
| Local Public Health Units | 209 | 212 | 212 | 212 | 212 | 102 | 77 | | | |
| Office of Deputy Secretary CCOM | 7 | 7 | 6 | 6 | 7 | 6 | 6 | 5 | 5 | 4 |
| Operational Policy and Planning | 12 | 12 | 12 | 12 | 9 | 10 | 10 | 10 | 10 | 8 |
| Outbreak Squads | 49 | 44 | 42 | 41 | 41 | 40 | 39 | 37 | 37 | 33 |
| Senior Medical Adviser Office of CHO | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| Stella | 34 | 34 | 34 | 48 | 48 | 48 | 24 | | | |
| Grand Total | 1210 | 1182 | 1173 | 1344 | 1539 | 1385 | 939 | 452 | 414 | 364 |

## Question Two:

The weekly number of people employed in COVID-19 related contact tracing roles for Victoria since 1 January 2020. Please provide:

a) Qualifications of each employee
b) The employer of each employee (Helloworld, Stellar Pty Ltd, DHHS etc.)
c) The weekly average hours worked since 1 January 2020
d) FTE for each employee.

# Item A - Qualifications of each employee

**Department response:**

- The department employs suitably qualified epidemiologists, case, contact and outbreak management staff, senior medical advice officers and specialist medical officers (including the Chief and Deputy Chief Health Officers) to support the department's ongoing response to the COVID-19 pandemic.
- Job Card and Position Descriptions have been provided for relevant contact tracing related roles within the Case, Contact and Outbreak Management function within the Department of Health and Human Services.
- DHHS does not hold a copy of the qualifications of each employee, once an employee has commenced their employment with the department.
- Qualifications, experience and skills are vetted through the recruitment process.
- Each role recruited for the COVID 19 response is done via a Job Card or a Position Description. The Job Card and Position Description outlines the skills, expertise and qualifications expected for each role. The person is selected on the basis of their qualifications, skill, expertise and fit for the role. (ZIP file will be provided)
- Job Cards and Position Descriptions will be provided for most roles within the COVID response.
- During the initial stages of the Emergency Response some staff were reassigned to COVID duties based on an expression of interest (EOI) or recruitment process where the skills, experience, and preferences of the employee were taken into account and the deployment period was for weeks or months, not exceeding six months.
- To provide individual qualifications would require retrieving the resume of each staff member and would not meet timelines.
- Please note, DHHS is investing in a whole of government end-to-end human resource system (Human Capital Management System) as part of the One VPS, that will capture these data in the future. There is significant work occurring in DHHS Workforce Readiness Centre that will also assist with the collection of this information

# Item B - List of Agencies and Organisations that employ staff to contact tracing related roles

**Department Response - Provided**

**The below table lists the Agencies and Employers**

**Supporting Data – TAB 1 – Agencies and Employers**

| |
|---|
| Australian Defence Force |
| Ambulance Victoria |
| Births, Deaths and Marriages |
| Cabrini Hospital |
| Department of Health and Human Services |
| Eastern Health |
| Epworth Hospital |
| Fines Victoria |
| Hays |
| Interstate Seconded ACT Government Employees |
| Interstate Seconded NSW Government Employees |
| Interstate Seconded QLD Government Employees |
| Interstate Seconded SA Government Employees |
| Interstate Seconded TAS Government Employees |
| Interstate Seconded WA Government Employees |
| KPMG |
| McArthur |
| Melbourne Sexual Health Clinic |
| Victoria Police |
| Other Victorian Government Departments |
| WorkWise |
| Your Nursing Agency (YNA) |
| Commonwealth Government |
| HealthDirect |
| Helloworld |
| Ernst & Young |
| Stella Australia |
| NSW Health |
| QLD Health |
| SA Health |
| Tasmania Health |
| Other |

# Item c: The weekly average hours worked since 1 January 2020

**Department Response – Not Provided**

**Supporting Data - NIL**

- It is not possible to provide these data for the Case, Contact and Outbreak Management function within the Department of Health and Human Services. This is due to the composition of the sources of the workforce that comprise the Case, Contact Outbreak Management function within the department.

- Please note that many of the employees within the Case, Contact and Outbreak Management function are paid by external organisations and the collection of this information may not be available for all employees, including staff who were not required to be rostered on shift patterns while engaged by DHHS. When this occurs, only the headcount of the employee will be recorded.

- Under the VPS Industrial Relations Framework, several seconded staff from other VPS departments remained on their home department's payroll system and therefore the department does not have access to this data within the timeframes requested.

- Some employees who were seconded from other organisation (including health organisations) have remained on their home organisations payroll system. The Department does not have access to this data within the timeframe requested. The Department will need to submit a formal request to these organisations for the relevant payroll data.

- For staff engaged via labour hire arrangements or through commercial contracts with the department, the department has procured the contract details for these staff. However, this will not necessarily outline each employees' weekly average hours nor FTE as requested in 2) c) and d). The department would need additional time to provide this data.

- Case and contact staff work 24/7, with outreach for case and contact management with members of the Victorian public occurring between 8am and 10pm.

# Item d. FTE for each employee.

**Department Response**

- Headcount provided

**Supporting Data**

**Attachment 1 – TAB 2 – Headcount**

- Headcount has been provided due to the sources of the workforce that comprises the Case, Contact Outbreak Management function within the department.

- Many of the employees within the Case, Contact and Outbreak Management function are paid by external organisations and the collection of this information is not be available for all employees.

- On 29 January the Health Protection Branch identified the need to establish an Incident Management Team to respond to the emerging threat of COVID-19 Cases within Australia.

- The initial public health response team from the Health Protection Branch comprised approximately 57 people.

- There were 255 people working in the Case, Contact and Outbreak Management function on the 1 May 2020.

- On the 23 June 2020, the Public Health Emergency Operations and Coordination Division was established within the department. As a result of this division being established the department began to formalise structures and reporting arrangements in its HR systems.

- The department has provided the headcount of staff engaged specifically within the Case, Contact and Outbreak Management function from June to 24 October, which is used to inform part of the department's overall Public Health workforce figures.

- The data has been provided in a deidentified manner to protect the privacy of individual employees. The data is provided as a unique identifier.

- The headcount provided is based on fortnightly payroll data for DHHS employees.

- Please note that many of the employees within the COVID-19 Response are paid by external organisations and the collection of this information may not be available for all employees, including staff who were not required to be rostered on shift patterns while engaged by DHHS.

| Call type | Month | Total Attempted |
|---|---|---|
| Outbound | July | 7,157 |
| | August | 41,554 |
| | September | 9,378 |
| | October | 1,196 |
| | November | 9 |
| | **Total** | **59,294** |

| | |
|---|---|
| Calls attempted | 59,294 |
| Contact connected | 51,116 |

**Notes:**

Policy is for unsuccessful call attempts to be escalated to the Department to complete.
HealthDirect makes multiple call attempts and only then escalate.
HealthDirect is an external contractor that has supported CCOM in making calls to confirmed cases.

| Date From | Date To | Total Number of SMS Sent |
|---|---|---|
| 29-Jun-20 | 05-Jul-20 | 15,270 |
| 06-Jul-20 | 12-Jul-20 | 28,209 |
| 13-Jul-20 | 19-Jul-20 | 35,868 |
| 20-Jul-20 | 26-Jul-20 | 69,109 |
| 27-Jul-20 | 02-Aug-20 | 74,760 |
| 03-Aug-20 | 09-Aug-20 | 104,973 |
| 10-Aug-20 | 16-Aug-20 | 94,756 |
| 17-Aug-20 | 23-Aug-20 | 63,661 |
| 24-Aug-20 | 30-Aug-20 | 39,601 |
| 31-Aug-20 | 06-Sep-20 | 26,722 |
| 07-Sep-20 | 13-Sep-20 | 15,771 |
| 14-Sep-20 | 20-Sep-20 | 10,325 |
| 21-Sep-20 | 27-Sep-20 | 5,352 |
| 28-Sep-20 | 04-Oct-20 | 3,412 |
| 05-Oct-20 | 11-Oct-20 | 3,018 |
| 12-Oct-20 | 18-Oct-20 | 2,458 |
| 19-Oct-20 | 25-Oct-20 | 1,607 |
| 26-Oct-20 | 01-Nov-20 | 1,841 |
| 02-Nov-20 | 08-Nov-20 | 834 |

# Appendix 3
# Submission from Parliamentary Budget Officer

4 December 2020

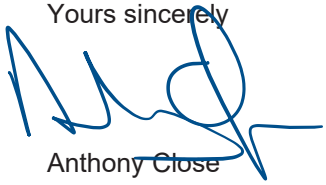
Fiona Patten MLC
Chair
Legislative Council Legal and Social Issues Committee
Parliament House
Spring Street
East Melbourne, VIC, 3002

**RE: COVID-19 — Contact tracing and testing**

Dear Fiona

Thank you for your request to provide a submission to the *Inquiry into the Victorian Government's COVID-19 Contact Tracing System and Testing Regime for the* Legislative Council Legal and Social Issues Committee.

Yours sincerely



Anthony Close
Parliamentary Budget Officer

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Parliament House Spring Street East Melbourne 3002
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Parliamentary Budget Office

# COVID-19

## Contact tracing and testing

Parliamentary Budget Office

**Parliamentary Budget Office**

We provide independent fiscal, economic and financial advice to all members of the Parliament of Victoria. Our objective is to inform policy development and public debate in parliament and the community.

| | |
|---|---|
| Postal address | Parliament House Spring Street East Melbourne Victoria Australia 3002 |
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# Contents

# Context

## Request

On 24 November 2020, Fiona Patten MLC, Chair, Legislative Council Legal and Social Issues Committee, asked the Parliamentary Budget Officer to provide advice in relation to the *Inquiry into the Victorian Government's COVID-19 Contact Tracing System and Testing Regime*.

Ms Patten requested that the advice provide information on budgetary figures for government expenditure in relation to COVD-19 contact tracing and testing within Victoria, including payments made to third parties.

## Scope

In this advice, we consider Department of Health and Human Services (DHHS) funding and spending on the Victorian Government's COVID-19 contact tracing and testing.

## Limitations

Due to the availability of data, we have only identified payments to third party service providers in 2020-21.

Due to the availability of data, the list of third parties that DHHS engaged as part of its response (Appendix B) is not exhaustive.

We prepared this advice on 3 December 2020.

## Background

DHHS is the lead agency for Victoria's COVID-19 public health response.

**Figure 1 –Contact tracing and testing costs**

| Contact tracing costs include: | Testing costs include: |
|---|---|
| ▪ Outbreak squads<br>▪ Local public health units<br>▪ Case management<br>▪ Contact tracing and outbreak management<br>▪ Operational policy and planning<br>▪ Operation Vestige<br>▪ Contact tracing support costs. | ▪ Testing delivery<br>▪ Testing data and intelligence<br>▪ Pathology<br>▪ Community engagement<br>▪ Prioritisation and response<br>▪ Testing support costs |

Note: Operation Vestige refers to home-visits to positive cases and close contacts, conducted by Australian Defence Force personnel and Department of Health and Human Services authorised officers.

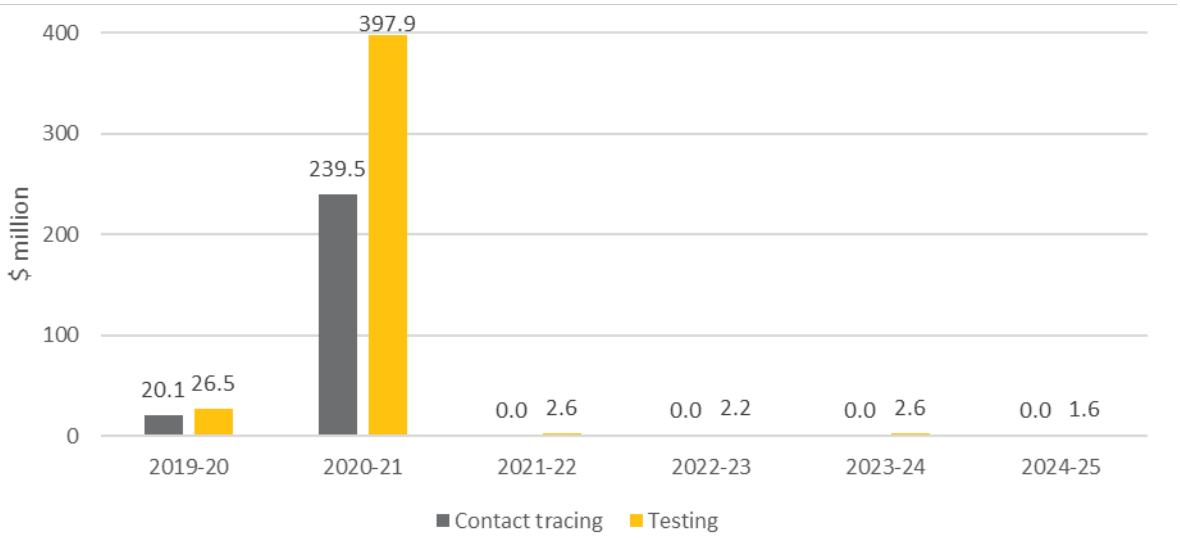
Source: Department of Health and Human Services.

The PBO monitored the government's policy response to the COVID-19 pandemic between March and October 2020, which is located at Victorian COVID-19 Policy Tracker.

# Contact tracing and testing expenditure

Across 2019-20 to 2024-25, the government, through DHHS, has budgeted $693.1 million for COVID-19 contact tracing and testing.

**Figure 2 – COVID-19 contact tracing and testing budget allocation**




Source: Parliamentary Budget Office.

It has budgeted:

- 92 per cent of funding in 2020-21 across contact tracing and testing
- 67 per cent more funding for testing than contact tracing.

**Figure 3 – COVID-19 contact tracing and testing expenditure ($ million)**

| | 2019-20 | 2020-21 | 2021-22 | 2022-23 | 2023-24 | 2024-25 | Ongoing | Total |
|---|---|---|---|---|---|---|---|---|
| Budgeted – contact tracing | 20.1 | 239.5 | - | - | - | - | - | 259.7 |
| Budgeted - testing | 26.5 | 397.9 | 2.6 | 2.2 | 2.6 | 1.6 | 1.4 | 433.4 |
| **Total budgeted** | **46.7** | **637.4** | **2.6** | **2.2** | **2.6** | **1.6** | **1.4** | **693.1** |
| Actual expenditure – contact tracing | 20.1 | 70.4 | - | - | - | - | - | 90.5 |
| Actual expenditure - testing | 31.7 | 127.1 | - | - | - | - | - | 158.8 |
| **Total actual expenditure** | **51.9** | **197.4** | **-** | **-** | **-** | **-** | **-** | **249.3** |

Notes: Actual and third party figures are at 26 November 2020. Total is for period across 2019-20 to 2024-25 (excluding ongoing funding). Figures may not sum to totals due to rounding.

Source: Parliamentary Budget Office.

The government, through DHHS, has budgeted funding for COVID-19 testing on an ongoing basis.

It has not budgeted any funding for contact tracing beyond 30 June 2021.

## Contact tracing

The government, through DHHS, has allocated funding for COVID-19 contact tracing in 2019-20 and 2020-21 only.

It has budgeted a total of $259.7 million for contact tracing. Of this, DHHS has spent $90.5 million to date (35 per cent). In 2019-20, DHHS spent exactly its budget for contact tracing.

## Testing

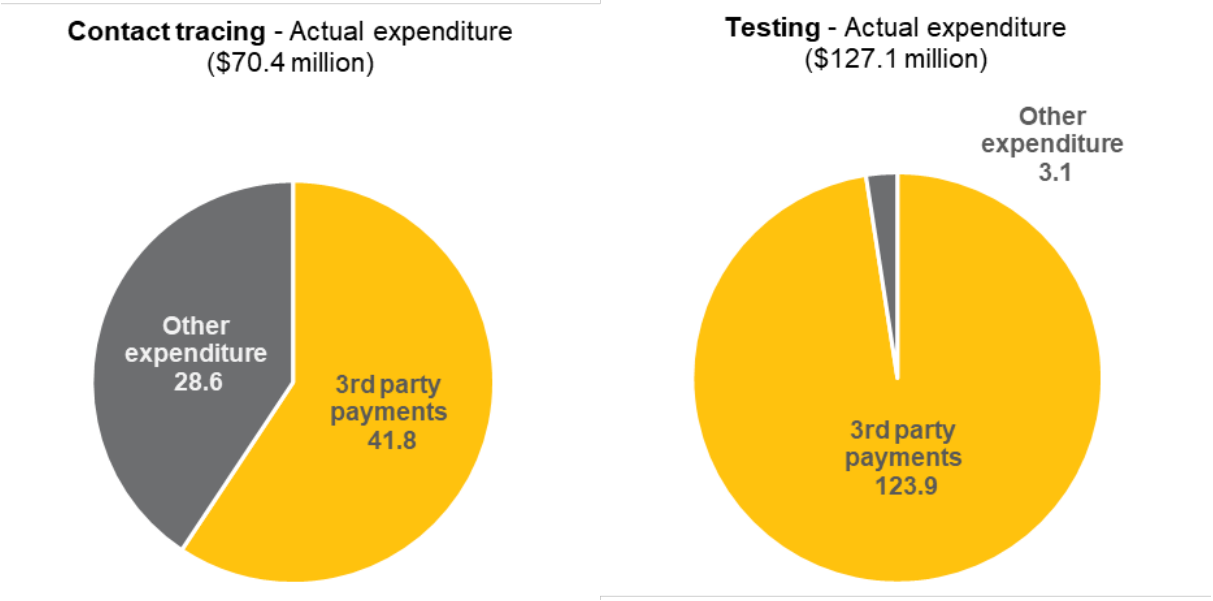
The government, through DHHS, has allocated funding for COVID-19 testing every year to 2024-25 and on an ongoing basis.

It has budgeted a total of $433.4 million to 2024-25. Of this, DHHS has spent $158.8 million to date (37 per cent). In 2019-20, DHHS spent $5.2 million (20 per cent) more than its budget for testing.

## Third party expenditure

DHHS spent most of its COVID-19 contact tracing and testing funding through third parties, which we list in Appendix B. Third parties include other jurisdictions' departments, the Australian Defence Force, and private contractors.

**Figure 4 – Third party expenditure, 2020-21 ($ million)**




Note: Figures are at 26 November 2020.

Source: Parliamentary Budget Office.

Of the $70.4 million of actual contact tracing expenditure in 2020-21, DHHS provided 59 per cent of it to third parties ($41.8 million).

Of the $127.1 million of actual testing expenditure in 2020-21, DHHS provided 98 per cent of it to third parties ($123.9 million).

DHHS made a higher proportion of payments to third parties for testing than it did for contact tracing.

# Appendix A — Data sources


- Information from the Department of Health and Human Services
- Parliament of Victoria. 2020. *Inquiry into the 2020-21 Budget Estimates, DHHS 2020-21 Budget Estimates Questionnaire response*, [ONLINE]. Available at: Public Accounts and Estimates (parliament.vic.gov.au) [Accessed 30 November 2020]
- Parliament of Victoria. 2020. *Inquiry into the Victorian Government's COVID-19 Contact Tracing System and Testing Regime – Department of Health and Human Services Data CT2a*, [ONLINE]. Available at: Legal and Social Issues (parliament.vic.gov.au) [Accessed 30 November 2020]
- Premier of Victoria. 2020. *Stay Home: New Crackdown on Isolation Breaches,* [ONLINE]. Available at: Stay Home: New Crackdown On Isolation Breaches | Premier of Victoria [Accessed 30 November 2020]

# Appendix B — Third parties

**Figure 5 – Third parties**

| The Department of Health and Human Services engaged staff from the following agencies and employers as part of its COVID-19 response |
|---|
| Australian Defence Force |
| Australian Government |
| Ambulance Victoria |
| Cabrini Hospital |
| Eastern Health |
| Epworth |
| Ernst & Young |
| Hays |
| HealthDirect |
| Helloworld |
| ACT Government |
| NSW Government |
| QLD Government |
| SA Government |
| TAS Government |
| WA Government |
| KPMG |
| McArthur |
| Melbourne Sexual Health Clinic |
| NSW Health |
| QLD Health |
| SA Health |
| Stella Australia |
| Tasmania Health |
| Victorian Police |
| WorkWise |
| Your Nursing Agency (YNA) |

Notes: This list is not exhaustive, referring to agencies and employers that the department sourced staff from for the Case Contact and Outbreak Management work function. It does not include all third parties that the government may have procured goods and services from.

Source: Department of Health and Human Services.

# Appendix 4
# Submission from Australian Government Department of Health

A4

Australian Government

Department of Health

# Parliament of Victoria – Inquiry into the Victorian Government Contact Tracing System and Testing Regime

# AUSTRALIAN GOVERNMENT DEPARTMENT OF HEALTH SUBMISSION

# 5 DECEMBER 2020

# Australian Government Support to Victoria – Detail of Actions by Theme

In early 2020, the Australian Government responded rapidly to the emerging COVID-19 global pandemic and, working closely with all jurisdictions through the National Cabinet, the National Coordination Mechanism and the Australian Health Protection Principal Committee (AHPPC), established a framework to support a national response to COVID-19. This national approach included specific support for rapid response to outbreaks.

In this context, the Australian Government has provided to Victoria a comprehensive range of direct assistance to support outbreak response.

## Department of Health

From the onset of the outbreak in Victoria, the Commonwealth Department of Health (the department) consistently and frequently made offers of support to the Victorian Chief Health Officer through the daily meetings of the AHPPC, and directly through both the Secretary and the Acting Chief Medical Officer to the Department of Health and Human Services (DHHS) and the Victorian Chief Health Officer.

### Contact Tracing

#### General Support

State and Territory public health authorities are responsible for managing infectious disease cases and contacts in Australia, including COVID-19.

When a public health authority in a state or territory (or another country under the *International Health Regulations 2005*) identifies that a person has travelled on a flight/vessel while infectious, the National Incident Room, within the Department of Health, provides a central support role to identify passengers (and crew) at risk.

- **25 January onwards -** The Australian National Focal Point (NFP) team has actioned more than 130 requests for assistance relating to flights, both domestic and international, arriving into Victoria. These requests for assistance included:
    - the provision of manifests (sought from the operating airline), and/or
    - the provision of passenger contact details (sought from Australian Border Force (ABF) by way of Incoming Passenger Card requests, or from domestic carriers), and
    - the collection of information from other countries on Australians diagnosed overseas.

- **20 – 22 March 2020** - The National Incident Room (NIR) received the passenger list for the Ruby Princess from NSW Health (containing 2647 passengers).

  - **20 March 2020** - the NIR provided the details of all close contacts to 21 jurisdictions (domestic and international), including Victoria, for the purposes of public health follow-up and contact tracing in their specific jurisdiction.
  - **22 March 2020** - The department asked the ABF for options to prevent onward travel boarding of Ruby Princess passengers. The ABF placed Ruby Princess passengers on an alert system so that if a person attempted to board an outgoing international flight, including from Melbourne Airport, the airline would be notified that the person was a passenger on board the Ruby Princess and required to quarantine for 14 days.

- **26 April 2020** - the Australian Government launched the COVIDSafe app, to provide a new tool to assist state and territory health authorities to undertake contact tracing of people exposed to COVID-19. The app is voluntary and uses Bluetooth signals to record encrypted data about close contacts with other users.
- The launch was supported with a national communications campaign across television, radio and social media platforms.
- As at **4 December 2020**, there have been **7,202,362** registrations for the COVIDSafe App. As at **30 November** the number of registrations by Victorians was 2,021,394.
- As at **3 December 2020**, Victoria had reported that more than 1,800 people diagnosed with COVID-19 said they have downloaded the COVIDSafe app.
- 89 Victorian health officials have undertaken training in the use of COVID app data.

- **9 October 2020** - DHHS requested the NFP assist in obtaining contact details for individuals who had quarantined in Victoria, who DHHS identified as being at risk of exposure to a Blood Borne Virus through the use of blood glucose monitors while in quarantine. This included seeking 631 incoming passenger cards from ABF. A timeline of this request is at Attachment A.

## Commonwealth Contact Tracing Taskforce to assist Victoria

- **9 July 2020 -** DHHS sought contact tracing surge capacity from the Commonwealth.

- **11 July 2020** – A Memorandum of Understanding (MoU) was negotiated between Victoria and the Commonwealth to allow Commonwealth Officers to operate "in the service of" the Victorian Government. The department responded with the establishment of a Victorian Contact Tracing Taskforce (the Taskforce).

- **12 July – 13 July** – the Department liaised with DHHS to developed phone scripts and other relevant materials.

- **13 July – 1 September** – The Taskforce operated seven days per week with over two shifts per day. The Taskforce received daily allocations from DHHS and undertook the management of over 1,400 allocated cases. Taskforce personnel were trained by DHHS in the use of COVIDSafe app data, if required. This service was never requested. Daily reports were provided to DHHS, and the department regularly notified DHHS when spare capacity was available to manage additional cases.

- **15 July 2020** –Additional Australian Defence Force (ADF) personnel were deployed to Victoria to assist with contract tracing efforts through door-knocking and administrative support.
- **4 September 2020** - the Taskforce was officially scaled down with capability and capacity being retained within the Department to ensure the timely re-activation of the Taskforce if required by Victoria or other jurisdictions.

A full timeline is at Attachment B.

## Leadership and Coordination

The department, through the AHPPC and the NIR, has coordinated the national health response to the COVID-19 pandemic. The NIR commenced monitoring what would become the COVID-19 pandemic on **1 January 2020**.

During the first wave of the pandemic, the Commonwealth provided ongoing support to all states and territories as requested.

In response to the Victorian outbreak, the department proposed and facilitated direct on-ground assistance to Victoria by many of Australia's leading public health experts and practitioners. The Australian Government facilitated hands-on support of a former Chief Health Officer of Western Australia, a current Deputy Chief Health Officer of Queensland and the Commonwealth Chief Nursing and Midwifery Officer (see below for further detail), together with several senior epidemiologists and experienced Defence crisis management and logistics personnel.

### Co-ordination of Clinical Staff Deployment to Victoria

- **30 June 2020 -** [redacted], emailed all jurisdictions advising that the Australian Government would deploy 600 clinical staff, including ADF personnel, to support Victoria to conduct SARS-CoV-2 testing, and requested other jurisdictions contribute an additional 200 clinical staff.
- **30 June 2020** - SA Health confirmed it would provide 30 clinical staff.
- **1 July 2020** - QLD Health confirmed 31-33 Registered Nurses had nominated to assist, and additional nominations were being sought.
- **3 July 2020** - NSW Health confirmed 58 staff had nominated to assist.

### Australian Health Protection Principal Committee (AHPPC) Support

- As at 3 December 2020, AHPPC has met 214 times since January, with 213 of these being COVID-19 specific meetings.
- The Victorian Chief Health Officer is a member of AHPPC.
- AHPPC has advised the National Cabinet since its establishment in **March 2020**. Outcomes of AHPPC are cabinet-in-confidence.

- For the duration of the COVID-19 outbreak in Victoria (**June – November 2020**), AHPPC met at least several times a week and many weekends to provide coordinated national support and advice to Victoria.

## Communicable Diseases Network Australia (CDNA) Support

- CDNA has met 179 times since January.
- CDNA is a subcommittee of AHPPC. Outcomes of CNDA are committee-in-confidence.
- Victoria is represented on CDNA.
- **June – November 2020** - CDNA regularly considered the Victorian situation.

## Public Health Laboratory Network (PHLN) Support

- PHLN has met 39 times since January.
- PHLN is a subcommittee of the AHPPC. Outcomes of PHLN are committee-in-confidence.
- Victoria is represented on PHLN.
- **15 July 2020** - [redacted] Royal Melbourne Hospital, wrote to the PHLN Secretariat requesting information on the process for accessing one of the 14 TECAN EVO liquid handling platforms that was procured for the National Medical Stockpile (NMS) in collaboration with the Department of Industry, Science, Energy and Resources. Information was provided, but no official request from Victoria to access a TECAN EVO platform has been received to date.
- The Department continues to provide details on TECAN, with the most recent update sent on **21 November 2020**.
- **August 2020** - The Commonwealth offered BGI equipment to Victoria. This offer was also not taken up.

## Australian Government Chief Nursing and Midwifery Officer Assistance

- **4 July 2020** - The Deputy Chief Health Officer of Victoria asked the acting Chief Medical Officer of the Australian Government for assistance. The Australian Government Chief Nursing and Midwifery Officer, Professor (Practice) Alison McMillan, agreed to assist.
- **5 to 23 July 2020** - Prof McMillan was seconded to DHHS as a Public Health Officer in the Victorian Public Health Unit. Prof McMillan provided expert advice and leadership on outbreak response with specific focus on infection prevention and control.
- **24 July to 7 August 2020** - Prof McMillan was deployed to support the Victorian Aged Care Response Centre (VACRC). Whilst at VACRC, Prof McMillan provided clinical leadership and advice. Further information regarding the VACRC can be found under Aged Care in this document. Prof McMillan was required to quarantine for 14 days upon her return to the ACT.

## Epidemiology

- From the commencement of the pandemic the department's National Incident Room (NIR) produced detailed national epidemiological reporting for both internal and external stakeholders on a daily basis.
- **1 July 2020 –** daily reporting shows the emerging outbreak in Victoria. In order to provide more detailed epidemiological reporting on the emerging situation in Victoria, a detailed epidemiological assessment was undertaken.
- **2 July – 18 September 2020** – In response to the serious outbreak in Victoria, the NIR produced Victoria-specific epidemiological reporting. A total of 55 reports were produced and distributed to all states and territories through the AHPPC.
- 25 July 2020 - Epidemiological expertise was also provided to support the VACRC both on the ground and remotely, including two senior epidemiologists and three departmental epidemiologists. Further information regarding the VACRC can be found under Aged Care in this document.

## Australian Medical Assistance Teams (AUSMAT) and clinical deployments

- Since 31 January 2020 , 145 AUSMAT personnel has been deployed nationally in support of outbreaks, including:
    - **31 January – 6 March 2020** - 108 AUSMAT personnel were deployed across quarantine facilities in Christmas Island and Howard Springs to assist with quarantining of repatriation of Australians from Wuhan, China as well as from the Diamond Princess cruise ship ahead of onward travel to their home jurisdictions.
    - **October 2020 – present** – 25 AUSMAT personnel deployed to Howard Springs to facilitate quarantine arrangements for the increased international arrivals ahead of onward travel to home jurisdictions.
    - **4 December 2020** – 5 AUSMAT personnel deployed to Hobart to assist with quarantine arrangements for the international arrivals.
- **Late July to mid-September 2020**, the Australian Government deployed an AUSMAT of 40 personnel to support the VACRC.
- AUSMAT provided **five** 'strike teams' to rapidly deploy to residential aged care facilities in active outbreak to assess and enhance personal protection and infection prevention and control measures in the facilities. Further detail is under Aged Care in this document.
- The ADF deployed clinically trained personnel to support Victoria's enhanced community swab-testing. Further detail is under Emergency Management Australia in this document.

## National Medical Stockpile (NMS)

The NMS has provided record quantities of Personal Protective Equipment (PPE) to Victoria. To date, through **4,447** disbursements, approximately **28 million** masks, **5 million** gowns and **3 million** face shields and a range of other PPE have been provided to Victoria to:

- support frontline acute health service and primary care staff, especially those performing aerosolising procedures;
- GPs, pharmacists and Aboriginal Community Controlled Health Organisations; and
- Aged care and disability workers in the event of an outbreak of COVID-19.

Further detail on NMS deployments is under Aged Care and Primary Care in this document. A detailed list of PPE provided to Victoria is provided at Attachment C.

## Aged care

The Australian Government provided significant and sustained support for aged care facilities and residents in Victoria.

All impacted aged care services in Victoria received assistance from the Australian Government including a dedicated case manager, personal protective equipment (PPE), testing support in residential aged care facilities, and workforce support.

### Workforce

- Since **March 2020** – surge workforce supports were established by the Australian Government and have been expanded as demand for workforce support increased.
- **25 July 2020** to present - some **1,000** Australian Government funded surge staff have been deployed to Victorian aged care services to support the standing workforce and replace staff who had been furloughed, quarantined or isolated.
- **September 2020** - the Australian Government established the National Aged Care Emergency Response (NACER) which provided a pool of staff from areas outside Victoria to assist Victorian aged care services with confirmed cases of COVID-19:
    - Twelve teams with **76** personnel (QLD, WA, SA teams) were deployed under the NACER arrangements.
    - This support was provided in addition to the teams of clinical personnel provided by TAS, WA and SA governments deployed to Victorian residential aged care facilities.
- **15 November 2020** - workforce surge staff filled in excess of **36,800** shifts in around **160** Australian aged care facilities impacted by COVID-19 and deployed over **4,500** individual workers, including GPs, nurses, care workers, allied health workers, executive and ancillary staff.

### Victorian Aged Care Response Centre (VACRC)

In response to unprecedented outbreak in Victoria, the Australian and Victorian governments established the VACRC in Melbourne to support aged care providers experiencing a COVID-19 outbreak in Victoria.

- **25 July 2020** - the VACRC brought together a workforce of more than **150** staff from **28** agencies, including clinical specialists and a number of hospitals and health services. The VACRC continues to work with the health services hub network, the Victorian DHHS Public Health Unit, the Aged Care Quality and Safety Commission, the Older Persons Advocacy Network and residential aged care facilities to meet the ongoing needs and requirements of residents, staff, families and associated communities.

Under the administration of VACRC, AUSMAT were deployed to support impacted aged care facilities and minimise risk associated with the management of COVID-19.

- AUSMAT personnel completed **174** visits to **80** Victorian aged care facilities.
- AUSMAT provided strong leadership in nursing, clinical care, infection prevention and control, and use of PPE for impacted aged care facilities to reassure returning staff and minimise cross contamination risk associated with COVID-19 management.
- More than **170** ADF personnel have supported the work of VACRC.
    - Teams of ADF personnel attended **593** residential aged care facilities to conduct clinical screens and assess IPC practices.
    - ADF teams conducted **679** preventative support visits, which included follow-up visits. Preventative support visits by the ADF ceased on **15 October 2020**.
- VACRC has partnered with the aviation industry to develop an innovative Residential Aged Care Assistant role to support care delivery in aged care facilities across Victoria.
    - **54** Residential Aged Care Assistants (RACAs) completed **832** shifts across **six** facilities.
- **47** Residential Aged Care Safety Observers (RACSO) completed **1,346** shifts across **18** facilities. RACSOs monitored IPC protocols and implemented corrective actions where required. RACSO deployments ceased on **4 November 2020**.
- The VACRC has deployed Residential Aged Care Visitation Assistants (RACVAs) to assist residents with visitation and basic care and support.
    - **55** RACVAs have completed **484** shifts across **25** Victorian residential aged care facilities.

### Support for Aged Care Workers

- In **August 2020**, the Australian Government established the Aged Care Workers in COVID-19 Grant to assist residential aged care providers by reimbursing workers for any potential lost entitlements due to working at a single site.
    - The grant was open to residential aged care services located in Greater Melbourne and Mitchell Shire until **30 November 2020**.
    - Approved providers can apply for funding up until **30 June 2021** to cover the costs of supporting eligible workers during the period to **30 November 2020**.

- The Australian Government also supported the establishment of the Guiding Principles Support Hub to provide access to specialist employment relations advice, clinical support and practical resources for providers in the sector.

### Aged Care Support Program

- **March 2020** - The Australian Government announced the establishment of the Aged Care Support Program, which reimburses eligible providers for eligible expenditure incurred on managing direct impacts of COVID-19. The grant is open until **31 May 2021**.

### Travel and accommodation support

- **July 2020** - The Australian Government provided travel and accommodation support for aged care workers from interstate or regional areas to work in designated COVID-19 areas in Victoria (metropolitan Melbourne and Mitchell Shire) or for local workers in these areas to minimise their exposure to the community or on public transport.

### Testing

- **22 April 2020 -** The Australian Government engaged Sonic Healthcare to provide a dedicated pathology service for the testing of suspected cases of COVID-19 in residential aged care facilities. As at **17 November 2020**, Sonic has conducted 196,116 COVID-19 tests at 669 unique residential aged care facilities in Victoria.

- **16 July 2020 -** The Government deployed five COVID-19 testing teams to test staff and residents in residential aged care services in metropolitan Melbourne and the Mitchell Shire.

- **30 September 2020** - The Government announced asymptomatic testing of aged care workers will continue in Victoria.

### PPE to Support Aged Care

**24 March 2020** - To fast track supplies of PPE to aged care services, the department established a dedicated process for aged care providers to request and receive PPE.

- More than **13 million** masks and approximately **3.8 million** goggles and face shields have been dispatched to support aged care services in Victoria to date. This includes dispatches from the NMS to individual aged care facilities and from the NMS to the Victorian Government to dispatch.

The Australian Government has bolstered the supply of PPE throughout residential aged care facilities across Melbourne and Mitchell shire.

- **13 July 2020** – **four million** face masks for all aged care workers in Melbourne hotspots announced.
- **17 July 2020** – **two million** face masks for Victorian aged care and disability workers announced.
- **19 July 2020** – additional **one million** face masks for Victorian aged care workers announced.
- **28 July 2020** – **500,000** face shields and an additional **5 million** face masks to Victorian aged care providers announced.

- **30 September 2020** – **seven million** P2/N95 respirator face masks for providers in Melbourne and Mitchell Shire announced.

### Clinical Waste

- **August 2020** - VACRC coordinated a cross government effort to manage a 100-fold increase in clinical waste bring produced at aged care facilities with outbreaks. The VACRC continues to support facilities that require urgent clinical waste assistance.

## Mental Health

The Australian Government recognises the restrictions brought in place to stop the spread of the virus in Victoria have a significant impact on the mental health of individuals and communities.

The people of Victoria have borne the brunt of the second wave of the COVID-19 pandemic and the Australian Government has continued to invest in services to increase their access to mental health care throughout the response to the pandemic.

The Australian Government, through the department, has worked with the Victorian Government and the relevant Primary Health Networks to respond quickly, and in a connected way, to support the mental health and wellbeing of the affected communities in Victoria by getting services on the ground that are appropriate to their needs.

### National Announcements

**March 2020** - The Government has made available more than **$500 million** in direct supports and telehealth services to respond to the mental health impacts of the COVID-19 pandemic, including a number of national supports that are also available to individuals in Victoria, such as:

- Changes to the Medicare Benefits Schedule to implement a telehealth whole-of-population model of care including mental health, and **$100.8** million to double the number of Medicare-funded psychological services from 10 to 20 per calendar year through the Better Access Initiative.
- A free 24/7 Coronavirus Mental Wellbeing Support Service available via phone on 1800 512 348 or at coronavirus.beyondblue.org.au. This service is specifically designed to help people through the COVID-19 pandemic.
- Additional funding to boost the capacity of key digital mental health services and supports including both preventative mental health and crisis support services such as Head to Health, Lifeline, Kids Helpline, SANE, Independent Community Living Australia [ICLA], Blue Knot, QLife, Mindspot, On the Line, ReachOut Australia and the Satellite Foundation.
- Funding to ensure vulnerable populations experiencing significant challenges during the pandemic continue to have access to vital mental health services, including young Australians, older Australians, culturally and linguistically diverse Australians, Indigenous Australians, carers and our frontline health workers.

## Victoria Specific Announcements

In response to the unprecedented outbreak in Victoria:

- **2 August 2020** - The Australia Government announced **$7.3 million** to provide an additional ten Medicare-subsidised psychological therapy sessions for Australians subject to further restrictions or who are in quarantine or required to self-isolate, and have used their existing 10 sessions.
- **6 August 2020** - The Australian Government announced **$12 million** to ensure service surge capacity for people in Victoria through access to 24/7 digital and telephone mental health support.
    - This included additional funding for Beyond Blue, Lifeline and Kids Helpline to meet additional demand and for headspace to increase their outreach services.
    - The organisations commenced activity immediately to ensure individuals could access support through existing arrangements while funding arrangements were put in place.
- **6 August 2020** - The Prime Minister and Minister for Health asked [redacted] the National Mental Health Commission, to provide advice on what additional mental health support in Victoria was needed.
- **12 August 2020** - The advice [redacted] was delivered to the Prime Minister.
- **17 August 2020** - The Australian Government announced **$26.9 million** to establish **15** dedicated *HeadtoHelp* mental health clinics across Victoria.
    - **14 September 2020** - Victorians have had access to the additional mental health support through the clinics, which are making mental health services more accessible and are staffed by multidisciplinary teams of mental health professionals.
    - The HeadtoHelp clinics are being delivered by the Victorian PHNs and are linking in with services already commissioned by the PHNs and services offered by the Victorian Government and the not for profit sector.
    - The Commonwealth established the Victorian Mental Health Pandemic Response Taskforce to oversee the rapid implementation of the mental health clinics. The Taskforce is co-chaired by [redacted] Mental Health Reform Victoria, and [redacted] Mental Health.
    - The Taskforce recognises the joint commitment between the Australian and Victorian Governments to support the mental health and wellbeing of Victorians through the pandemic in a more connected mental health system.
- **17 August 2020** - The Australian Government also announced an additional **$5 million** to support digital and telephone services for vulnerable populations including **$0.5 million** for the Victorian Aboriginal Health Services' Yarning

SafeNStrong helpline to provide culturally safe mental health support for Victorian Aboriginal and Torres Strait Islander communities.

- The Australian Government worked with Kids Helpline to prioritise calls and webchats from children in Victorian lockdown affected areas (focusing on those in Greater Melbourne) for the duration of the lockdown and to ensure the service continued to be made available to other priority groups.
- The Australian Government also worked with Beyond Blue to amplify the visibility of the Beyond Blue Coronavirus Mental Wellbeing Support Service through multiple communication channels, including providing assistance translating Beyond Blue advice into **63** languages.
- **8 July 2020** - The Australian Government provided a flyer to Primary Health Networks with information on the free 24/7 Coronavirus Mental Wellbeing Support Service which was designed specifically to help people manage the pandemic for distribution and use as needed across the region.
- **6 October 2020** - as part of the 2020-21 Budget this measure was expanded to double the number Medicare-funded psychological therapy sessions from 10 to 20 per calendar year through the Better Access Initiative for all Australians with an existing Mental Health Treatment Plan.

## Primary Care

The Australian Government has provided significant support to all jurisdictions – including Victoria – during the COVID-19 pandemic. At a national level, the Government's primary care response has provided dedicated investment in:

- telehealth;
- expansion of the National Triage phone line (healthdirect);
- the establishment of 150 General Practitioner led Respiratory Clinics;
- remote community preparedness and retrieval;
- infection prevention and control education, training and support;
- indigenous health;
- E-Prescribing and home medicine support;
- COVID-19 pathology testing;
- anti-viral and respiratory medicine research;
- aged care;
- support for people with disability; and
- mental health support.

### General Practitioner led Respiratory Clinics (GPRCs)

The Australian Government has funded the establishment of 28 GPRCs across Victoria, with:

- **1 April 2020 –** opening of first Victorian GPRC opening (see Attachment D for locations and opening dates); and
- two GPRCs run by Aboriginal Community Controlled Health Services (ACHHS) ensuring the availability of culturally safe care.

**1 April 2020** - **22 November 2020 -** The Victorian GPRCs have undertaken more than **220,000** assessments and have conducted over **199,800** tests.

- Approximately **480** positive cases have been detected through the Victorian GPRCs.
- The GPRCs averaged around **500** assessments per week during June and July when the second wave of infections were detected.

### Shepparton support

- **12 October 2020** - **23 October 2020** - The Australian Government worked closely with the Murray PHN and the Incident Management Team (led by DHHS), to assist with the response to the Shepparton Outbreak.
    - The Shepparton GPRC conducted a total of **954** assessments and **884** tests during this period. This is an almost tenfold increase when compared to previous two weeks.

### PPE support to the primary care sector

- **January 2020 onwards** - The Australian Government has provided the Victorian primary care sector with PPE, via PHNs.
- **17 July 2020** - The NMS released gowns to Victorian General Practices in response to increased requests for PPE.
- **8 August 2020** - DHHS announced that it recommended eye protection (goggles and face shields) for all patient care, regardless of whether there was a risk of exposure to blood or body fluids, secretions or excretions. The Victorian Government did not consult with the Australian Government on this change or on the availability of eye protection within the NMS. In support of Victoria, however, the Australian Government changed its policy on the release of PPE from the NMS.
- **12 August 2020** - The Department informed Victorian PHNs that the Australian Government would provide them with a one-off distribution of reusable goggles for use by eligible primary care sector providers.

### Primary Health Network support

- **March 2020 onwards** - The PHNs have:
    - identified, and assisted with the establishment of the GPRCs, including assistance to integrate within local clinical pathways and liaise with DHHS; and
    - taken on a new role to distribute PPE to primary care providers, including GPRCs, GPs, ACCHS and other eligible health care providers.
- 8 July **2020 onwards -** The Department has held a total of **27** Teleconferences with Victorian PHN CEOs in support of the Victorian outbreak. During the peak of the Victorian outbreak these meetings were scheduled biweekly. Teleconferences focussed on PPE supply and use, Telehealth, COVID-19 resources and the role of the PHNs supporting their communities.

### Meetings with DHHS and other stakeholders

- **8 April 2020 - 17 September 2020** - The Department's COVID-19 Primary Care Response team met on at least 12 occasions with DHHS, the Victorian Department of

Premier and Cabinet, the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and various Victorian PHNs.

- These meetings covered a range of issues including GPRC funding and operations, data sharing and analysis, and support for the Victorian Aged Care Response Centre.
- Additional meetings occurred at Assistant Secretary and officer level as required. Department staff are in regular contact with the GPRCs and PHNs.

### Data access

- **4 June 2020 onwards -** The Australian Government sent to all jurisdictions have received detailed weekly reports showing the number of tests and results for the previous week and since the first GPRC was opened. Prior to this data was provided on an ad hoc basis.
- **14 August 2020** - DHHS asked for ongoing daily assessment data broken down by geography, and demographics (age, sex, Indigeneity) to be provided to assist with their response planning.
    - **15 August 2020 –** first daily report on assessments by geography was sent; ongoing.
    - **2 September 2020** – weekly summaries of assessments by geography, demographics and symptoms commenced.
    - **29 September 2020** – DHHS given access to GovTeams for report access.
    - From **6 October 2020**, these reports reduced to monthly by agreement with DHHS.

### Aboriginal and Torres Strait Islander support

- The Australian Government set up the Aboriginal and Torres Strait Islander Advisory Group on COVID-19 to advise on health issues related to COVID-19. This advisory group developed the Management Plan for Aboriginal and Torres Strait Islander populations. This plan was endorsed by AHPPC in **March 2020**.
- Victoria is represented on the Aboriginal and Torres Strait Islander Advisory Group on COVID-19 by DHSS and the Victorian Aboriginal Community Controlled Health Organisation (VACCHO).
- VACCHO and its members also convened a fortnightly Victorian Aboriginal Health Sector Forum. The Australian Government is represented by the department and the National Indigenous Australians Agency.
- Two of the Victorian GPRCs are Aboriginal and Torres Strait Islander community-controlled.
- In addition to the GPRCs, there are two point-of-care testing sites in Victoria:
    - **29 June 2020** - Mildura opened and has tested **181** patients to-date.
    - **3 August 2020** 0 Mooroopna opened and has tested **204** patients to-date.

## Response for People with Disability

People with disability are generally at greater risk of more serious illness if infected by COVID-19. This can be due to a high prevalence of comorbidities including chronic conditions or a weakened immune system.

The National Disability Insurance Agency (NDIA) rapidly implemented a range of temporary measures to support National Disability Insurance Scheme (NDIS) participants, such as providing low-cost assistive technology, including smart devices, so participants could access telehealth services; the ability to claim for the cost of PPE; and greater plan flexibility. In Victoria, the NDIA and the Government were able to be agile to ensure the health and wellbeing of NDIS participants by turning on these temporary measures.

- **18 February 2020** - The Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19) was released, which expressly addresses the needs of vulnerable groups (chapter 6).
- **5 March 2020** - Minister Robert wrote to NDIA and Services Australia to request planning for COVID response.
- **5 March 2020** - Disability COVID taskforce setup in NDIA.
- **11 March 2020** - Prime Minister Scott Morrison announces a comprehensive $2.4 billion health package to protect all Australians, including vulnerable groups and people with a disability, from COVID-19.
- **13 March 2020** - Residential aged care facilities guidelines were released. This supports young people living in residential aged care facilities.
- **13 March 2020** - The Commonwealth Government implements a dedicated MBS item for pathology tests for COVID-19. This is to ensure access to rapid COVID testing. MBS funded pathology tests for COVID-19 can be requested by all medical practitioners and must be bulk billed, that is provided at no cost to the patient.
- **16 March 2020** - Minister Ruston and the Department of Social Services held a round table with about 10 Disability Representative Organisations (DROs) to discuss responses to COVID-19.
- **16 March 2020** - Online COVID-19 infection prevention and control training for care workers, including disability care workers, went live.
- **18 March 2020** - Extraordinary meeting of DRC (Disability Ministers) to discuss COVID 19 response (Also met on 9 April 2020, 11 May 2020 and 24 July 2020). Health officials attended 18 March meeting to outline current guidance and access to infection prevention control training and National Medical Stockpile.
- **19 March 2020** - Minister Ruston held a Carer Gateway Service Providers COVID-19 Update with the CEOs from 10 peak organisations.
- **29 March 2020** - Australian Government announces a range of mental health supports to help Australians through COVID including:
    - $14M to bolster the capacity of digital and telephone mental health services to provide additional support to vulnerable populations including people with complex mental health needs.
    - $28.4M to allow an additional year for people with a psychosocial disability to transition to the NDIS.
- **30 March 2020** - Minister Ruston held a COVID-19 roundtable with about a dozen Australian Disability Enterprises.

- **31 March 2020** - Minister Ruston met with Disability Discrimination Commissioner Ben Gauntlett.
- **2 April 2020** - The Advisory Committee on the Health Emergency Response to Coronavirus (COVID-19) for People with Disability was established.
- **3 April 2020** - Ministers Hunt, Roberts and Ruston announced that the Australian Government would urgently develop a response plan to focus on people with disability during coronavirus.
- **5 April 2020** - NDIS participants to receive priority home delivery from some of Australia's leading supermarkets.
- **9 April 2020** - $90.7 million announced to support people with disability as part of a broader community support package, including the establishment of a dedicated phone line for people with disability.
- **9 April 2020** - DRC meeting (Disability Ministers) met to discuss response to COVID
- **16 April 2020** - National Cabinet agreed to release the COVID-19 Management and Operational Plan for People with Disability.
- **17 April 2020** - The Australian Government's Management and Operational Plan for COVID-19 for People with Disability (the Plan) was released.
- **23 April 2020** - Announced changes to student visa work conditions to ensure continuity of health workforce, including in the disability sector.
- **27 April 2020** - New support items available for SIL providers where an NDIS participant is diagnosed with COVID-19, flexibility to purchase of low cost AT and downloadable access request forms to ensure eligible Australians can continue to apply for access to the NDIS.
- **1 May 2020** - Minister Ruston and the Department of Social Services held a round table with about 10 Disability Representative Organisations (DROs) to discuss responses to COVID-19.
- **11 May 2020** - Disability Ministers Meetings (all State and Territory ministers) to coordinate COVID response.
- **15 May 2020** - National Mental Health and Wellbeing Pandemic Response Plan announced with specific funding to support vulnerable groups including mental health and wellbeing of carers.
- **12 June 2020** - The NDIS moved to a post-pandemic phase from 1 July 2020, including the conclusion of some temporary measures.
- **17 July 2020** - Minister Hunt announces 1 million masks from National Medical Stockpile for disability care workers in Victoria.
- **24 July 2020** - DRC – Disability Ministers met to discuss response to COVID.
- **29 July 2020** - Allowing participants and providers in NSW and Victoria to claim the cost of PPE and access additional cleaning supports.
- **11 August 2020** - Proactive outreach to NDIS providers, measures to ensure workforce supply and mechanism for a clinical first response for cases or outbreaks amongst providers and/or residential care settings.
- **19 August 2020** - Daily publication of data on COVID-19 infection rates for NDIS participants and workers commenced.
- **21 August 2020** - NDIS providers in Victoria and NSW can directly claim the costs of PPE from the NDIA through an hourly allowance. Victorian Government announced the

establishment of the Disability Response Centre to coordinate and manage outbreaks and keep residents safe.

- **22 August 2020** - Participant and provider access to PPE extended to restricted areas of Queensland.
- **4 September 2020** - Australian and Victorian Government provide $15 million Mobility Reduction Payment for NDIS providers to reduce the movement of support workers between residential disability facilities.
- **8 September 2020** - The third iteration of the Disability Operational and Management Plan was endorsed by the Australian Health Protection Principal Committee.A substantial number of actions have been implemented under the Plan, including:
    - publishing the Coronavirus: Outbreak preparedness, prevention and management guidelines for National Disability Insurance Scheme (NDIS) providers;
    - producing COVID-19 infection control training for care workers across all health care settings, including disability;
    - publishing guidance materials on testing, returning to school and individual COVID 19 health plans as well as guidance for in-home providers, health professionals, carers and support workers; and
    - establishing the COVID-19 Health Professionals Disability Advisory Service helpline.
- **2 October 2020** - Minister Robert announced extension of temporary COVID measures until 28 February 2021.

As at **30 November -** the Department of Health, through the National Medical Stockpile, has dispatched approximately 600,000 masks, 40,000 gloves, 10,000 gowns, 45,000 goggles and face shields to the NDIA and to individual NDIS participants.

### Virtual Working Group

- Due to a limited national supply of SARS-CoV-2 test cartridges for point-of-care testing on GeneXpert platforms, the AHPPC agreed to the importance of having visibility of available stock across the various point-of-care testing programs.
- The AHPPC and the Australian Government supported the convening of a virtual working group to provide an ongoing assessment of allocation based on need at a national and jurisdictional level.
- **16 June 2020** - **24 November 2020 -** Through the virtual working groupan additional **7,240** test cartridges have been reallocated to Victoria from various programs.

### NACCHO and Sector Support Organisations

- **$8.3 million** has been allocated to NACCHO, its Sector Support Network and member organisations to coordinate and facilitate culturally-safe access to COVID-19 testing (as part of the broader GPRC funding).
- Of the original **$6.9 million** funding allocated in **March 2020**, **17** ACCHOs in Victoria received a total of **$787,500** under the COVID-19 culturally-safe accessibility grant. VACCHO also received **$140,000**.

### Remote Community Grants

- A small part of East Gippsland in Victoria is considered a remote area under the Modified Monash Model (considered a MM6 area). Moogji Aboriginal Council East Gippsland Inc. was offered **$40,000** under tranche 2 of the remote community preparedness grants.

## Communications Support

The national COVID-19 communication activities began in early 2020. The campaign ran across all media channels and included topics on COVID-19 symptoms, physical distancing, respiratory and hand hygiene, testing and self-isolation requirements, support for older Australians, movement and other restrictions, mental health support and the COVIDSafe app. Weekly communication commenced with all jurisdictions as part of a COVID-19 Communications working group from the start of the pandemic.

In addition to activities such as daily updates of information on health.gov.au and associated social media platforms, regular media updates, webinars and bulletins to health and aged care professionals. The campaign continues to emphasise the behaviours required to 'be COVIDSafe' in order to reduce the risk of outbreaks, encouraging this behaviour as the new social norm, particularly during summer and the Christmas/holiday season and until we have the added protection of a vaccine.

In support of Victoria:

- **22 June 2020** - The Department contacted Victoria's Department of Premier and Cabinet (DPC) to offer communications support. Victoria advised the Premier's Office. Regular phone calls and emails occurred over next few weeks until regular teleconferences commenced.
- **23 June 2020** - The Department provided DPC with social posts for review prior to posting.
- **24 June 2020** - A meeting was held with DHHS offering support, particularly with social posts.
- From the week commencing **25 June 2020** the department's national advertising campaign responded to the outbreak in Victoria by adapting the advertising materials in market.
- The department held a number of webinars for GPs, Primary Care and Allied Health providers and Mental Health providers which had a focus on the situation in Victoria and support available.
    - **30 September and 28 October** - webinars for Primary Care and Allied Health providers included Professor Donna Markham, Chief Allied Health Officer for Safer Care Victoria, as a guest panellist who provided information around what services could be provided during lockdown.
- **6 July 2020** - A joint teleconference with DHHS, DPC and NSW (NSW Health, Customer Service) was held.

- **7 July 2020** - The department commenced liaising with Community Broadcasting Association of Australia (CBAA) and ABC Emergency Broadcast radio regarding live reads for Vic/NSW border towns. This liaison was ongoing as new messages were required.
- **8 July 2020** - A joint teleconference with Vic and NSW governments was held.
- **14 -19 July 2020** - The department received a request from DHHS to adapt our mask infographic. Working files were provided. The adapted materials were received and approved
- **14 July - 15 October 2020** - Weekly joint teleconference with Vic and NSW governments were held.
- **3 November 2020** - The regular teleconferences with NSW and Vic were incorporated into fortnightly State and Territory Government teleconferences.
- The department also contacted VACCHO to offer support for Indigenous communities, however did not receive a response.

### Multicultural Communications Support for Victorian Outbreaks

In parallel, messages and materials have also been adapted for Aboriginal and Torres Strait Islander people, culturally and linguistically diverse (CALD) audiences and people living with a disability. Multicultural community engagement strategies have been used to engage with communities at a local level through information resources, video and social media content and ensuring information is provided in-language where required. This activity predominantly targeted 31 language groups via advertising. Additional activities included translated print editorials disseminated across ethnic press, in-language radio announcements and videos developed in partnership with SBS, translated factsheets, and information is available on the department's website in up to 63 languages. Topics covered include wearing masks, testing, the COVIDSafe app, medical and telehealth appointments and border closures, mental health, hygiene, physical distancing, aged care support and other emerging issues.

The Australian Government actively provided assistance for the Victorian outbreaks (Casey, Shepparton and North Melbourne) by sharing translated resources (fact sheets, posters, social assets, video and audio files) locally through the department's networks.

In summary:

- **15 September 2020 -** The department offered assistance to Victoria for Casey outbreak.
- **21 September 2020 -** Victoria responded to the department's request for resources to share through the department's multicultural networks.
- **28 September 2020 –** The department provided Victoria Health with contacts to liaise with CALD community
- **16 October 2020 -** The department offered assistance to Victoria for the Shepparton outbreak. The offer was accepted on **17 October**.
- **22 October 2020 -** DSS sent the department's translated resources to Victorian government contacts at the request of the department to assist the Shepparton outbreak

A complete timeline is at Attachment E.

### Support for Multicultural Communications on Border Closures between Victoria and NSW

- **10 - 21 July 2020 -** The department translated two border scripts into 37 languages and sent in-language recordings to Home Affairs to disseminate through Victorian Community Liaison Officers (VIC CLOs).
- **17 July 2020,** in-language audio commenced on SBS community radio in VIC and NSW for 2 weeks.
- **24 July 2020 -** DPC provided CALD stakeholder a kit regarding hygiene and face coverings, with the department distributing it to the Federation of Ethnic Communities Councils of Australia (FECCA) and Home Affairs.
- **30 July – 5 August 2020 -** The department reached out to DHHS regarding priority CALD audiences that are challenging (ie. reaching them, achieving compliance, etc).
- **5 – 8 August 2020 -** The department translated three border scripts into the top 6 languages in VIC and NSW (Arabic, Italian, Greek, Vietnamese, Cantonese, and Mandarin).
- **8 August 2020 -** Scripts aired on SBS community radio in VIC and NSW.
- **3 – 8 September 2020 -** The department translated three border scripts into the top 9 languages in VIC and NSW (Arabic, Italian, Greek, Vietnamese, Cantonese, Mandarin, Assyrian, Hindi, Bangla). Scripts also sent to Home Affairs to disseminate to VIC CLOs.
- **6 – 20 September 2020** - scripts aired for two weeks in VIC and NSW.

Multicultural Communications Support for Mental Health during the Victorian Lockdown

- **July 2020** - The department translated the beyond blue flyer that was developed to support Victorians through lockdown into 63 languages.
- The department disseminated the flyer to VIC PHNs, VIC CLOs through Home Affairs, Ethnic Community Council Victoria, FECCA and the Victorian Multicultural Commission.

## Summary of Support led by other Australian Government Agencies

## Emergency Management Australia

**16 March 2020 onwards -** Emergency Management Australia has facilitated 34 Requests for Australian Government Assistance from Victoria (see **Attachment F**) including:

- **32** requests submitted to the Australian Defence Force
  - **31** requests accepted
  - **one** accepted request was cancelled by the Emergency Management Victoria Commissioner for the provision of **850** Defence personnel to support hotel quarantine
  - **one** request was not accepted for the provision of remotely piloted aerial systems (Victorian Police Operation Hawkeye)
- **one** request accepted by the Australian Public Service Commission

- **one** request accepted by the department.

In addition, Emergency Management Australia facilitated **11** Requests for Australian Government Assistance for VACRC, including:

- **nine** requests accepted by the Australian Defence Force
- **one** request accepted by the department for the provision of Australian Medical Assistance Teams
- **one** request accepted by Services Australia.

**14 July 2020** – request for assistance covered contact tracing data management and analysis as well as planning, logistics and intelligence, public health, testing and call centre support, compliance support (in partnership with Victoria Police) to assist in the enforcement of the CHO's directions and provision of surge capacity for vehicle check points, humanitarian supply and logistics, community awareness support and pre-hospital health response.

**24 November 2020** - 50 ADF personnel are deployed to Victoria to directly support the COVID-19 response.

## Supermarkets Taskforce

- The Australian Government, through the Department of Home Affairs, convenes a Supermarket Taskforce that includes representatives from government departments, supermarkets and the grocery supply chain.
- During the Victorian lockdown, the Supermarkets Taskforce convened regularly to support the safe continuation of services for supermarkets and distribution centres in Victoria.
- **1 July 2020 -** The A/g CMO briefed Supermarket CEOs and the department provided advice to support the containment of the outbreak and continuation of the Coles Laverton distribution centre.

## Freight Movement Protocol and Code for the Domestic Border Controls

- **24 July 2020 -** National Cabinet agreed to the Freight Movements Protocol.
- **7 August 2020 -** National Cabinet agreed to the Freight Movement Code
- The Protocol complements existing WHS, fatigue management, health directives and COVIDSafe workplan requirements. The enforceable measures in the Freight Movement Code delivered greater consistency between states and territories when implementing their border controls, while allowing for the critical movement of goods to ensure supply chains could continue to operate.

## International Borders and Travellers

- **1 July 2020** - The Australian Government immediately responded to the Victoria outbreak to relieve the pressure on Victoria's public health workforce by diverting incoming international passenger arrivals of Victorians to quarantine in other jurisdictions. This became a sustained effort by the Australian Government and other jurisdictions providing for the quarantine of international arrivals intended to return home to Victoria.

## The COVID-19 National Partnership Agreement

- **13 March 2020 -** the National Partnership Agreement on COVID-19 Response was signed. The Australian Government continues to support Victoria, like all Australian states and territories through the agreement. This agreement is providing Australian Government funding to ensure all Australians receive the very best care of state and territory health services.
- **$1.483 billion** provided for specific COVID-19 health costs in Victoria. This funding arrangement has been critical in enabling Victoria, like other jurisdictions, to prepare its health services, increase resourcing and implement enhanced health measures to counter the threat of COVID-19 to the community.

Australian Government

Department of Health

**Secretary**

Ms Fiona Patten
Chair, Legislative Council Legal and Social Issues Committee
Parliament of Victoria
Parliament House
Spring Street
EAST MELBOURNE VIC 3002

Dear Chair

Thank you for your correspondence of 24 November 2020 requesting the Department of Health provide a submission outlining the assistance the Commonwealth has provided to Victoria in relation to Victoria's COVID-19 contact tracing system and testing regime and associated activities, since 1 January 2020.

Please find enclosed a summary of Australian Government COVID-19 outbreak related support to Victoria. Please also find enclosed the following attachments to the summary:

- Attachment A outlines the timeline of the Commonwealth support for contact tracing of individuals who were identified as being at risk of blood borne virus through the use of blood glucose monitors while in quarantine in Victoria;
- Attachment B outlines the timeline the Commonwealth's support for COVID-19 contact tracing;
- Attachment C details National Medical Stockpile deployments to Victoria;
- Attachment D lists all GP respiratory clinics established by the Commonwealth in Victoria;
- Attachment E details multicultural communications support; and
- Attachment F outlines requests for Australian Government assistance fielded via Emergency Management Australia at the Department of Home Affairs.

If you would like further clarification regarding this request, please contact [redacted] Public Health Response, Office of Health Protection and Response Division on [redacted]

Yours sincerely

[redacted]

Dr Brendan Murphy

5 December 2020

**Attachment A - Timeline of Blood Borne Virus Contact Tracing**

| Received – Health Ops | | Time Actioned (NIR) | | Respondent | Details of request | Health Ops Action |
|---|---|---|---|---|---|---|
| **Tranche 1**<br>30 contacts | | | | | | |
| 09.10.20 Fri | 16:13 | (refer duty to | phone<br>) | DHHS: A. Van Diemen | Request for contact details – no password | Requested Password |
| 09.10.20 Fri | 18:00 | 09.10.20 Fri | 18:57 | DHHS: [redacted] | Password for close contacts | IPC request #2321-02 |
| | | 09.10.20 Fri | 19:11 | | | IPC request #2321-03 |
| | | 09.10.20 Fri | 19:17 | | | IPC request #2321-04 |
| 09.10.20 Fri | 19:45 | 10.10.20 Sat | 10:29 | Converga: Immi Support | Provided IPCs #2321-02 | Dispatched IPCs |
| | 20:01 | 10.10.20 Sat | 10:29 | Converga: Immi Support | Provided IPCs #2321-03 | Dispatched IPCs |
| | 20:36 | 10.10.20 Sat | 10:29 | Converga: Immi Support | Provided IPCs #2321-04 (missing 1 contact) | Dispatched IPCs |
| 10.10.20 Sat | 16:22 | 10.10.20 Sat | 16:34 | DHHS: [redacted] | Requested second page of IPCs | Advised how to view 2nd page |
| 11.10.20 Sun | 17:24 | 11.10.20 Sun | 17:55 | DHHS: [redacted] | Phone call: advising correct details of missing contact | IPC Request #2321-05 |
| 11.10.20 Sun | 21:16 | 12.10.20 Mon | 06:28 | ICC One | Provided IPC #2321-05 | Dispatched IPC |
| | | | | | | |
| **Tranche 2**<br>32 contacts | | | | | | |
| 14.10.20 Wed | 22:17 | 15.10.20 Thu | 06:44 | DHHS: [redacted] | Request for IPCs for 32 contacts | IPC request #2321-07 |
| | | 15.10.20 Thu | 06:56 | | | IPC request #2321-08 |
| | | 15.10.20 Thu | 07:07 | | | IPC request #2321-09 |
| | | 15.10.20 Thu | 07:13 | | | IPC request #2321-10 |
| 15.10.20 Thu | 07:59 | 15.10.20 Thu | 08:57 | Converga: Immi Support | Provided IPCs #2321-10 | Dispatched IPCs |
| | 08:12 | 15.10.20 Thu | 08:57 | Converga: Immi Support | Provided IPCs #2321-09 | Dispatched IPCs |
| | 08:21 | 15.10.20 Thu | 08:57 | Converga: Immi Support | Provided IPCs #2321-07 (missing 1 contact) | Dispatched IPCs - requested correct details for missing contact |
| | 09:04 | 15.10.20 Thu | 09:13 | Converga: Immi Support | Provided IPCs #2321-08 (missing 1 contact) | Dispatched IPCs – requested correct details for missing contact |

| Received – Health Ops | | Time Actioned (NIR) | | Respondent | Details of request | Health Ops Action |
|---|---|---|---|---|---|---|
| 15.10.20 Thu | 10:50 | 15.10.20 Thu | 12:05 | DHHS: [redacted] | Provided updates for missing client from #2321-09 | IPC request #2321-12 |
| | 10:59 | 15.10.20 Thu | 12:05 | DHHS: [redacted] | Provided updates for missing client from #2321-07 | IPC request #2321-12 |
| | 13:24 | 15.10.20 Thu | 13:56 | Converga: Immi Support | Immi Support - Provided one of the IPCs from the two errors (#2321-12) | Dispatched to DHHS |
| **Tranche 3**<br>295 contacts | | | | | | |
| 15.10.20 Thu | 08:37 | 15.10.20 Thu | 09:14 | DHHS: [redacted] | List of 295 contacts for IPC request. | IPC request #2321-11 |
| 15.10.20 Thu | 13:12<br>13:13<br>13:13 | 15.10.20 Thu | 13:33<br>13:40<br>13:45 | Converga: Immi Support | Provided IPCs for 295 contacts. Divided into 3 emails. | Dispatched IPCs in 3 emails. |
| 19.10.20 Mon | 09:59 | 19.10.20 Mon | 10:31 | DHHS: [redacted] | Query as to whereabouts of this request. | Responded stating they were sent last Thursday in 3 batches. Provided email times and subject headings |
| 19.10.20 Mon | 10:40 | | | DHHS: [redacted] | Confirmed receipt of the afore mentioned emails | Nil |
| **Tranche 4**<br>**10 contacts** | | | | | | |
| 16.10.20 Fri | 15:09 | 16.10.20 Fri | 15:54 | DHHS: [redacted] | List of 10 contacts for IPC, noted there are some repeats from previous requests | IPC request #2321-13 |
| 16.10.20 Fri | 17:04 | 16.10.20 Fri | 17:18 | Immi Support | Provide 8 of the 10 IPCs requested | Forwarded to DHHS |
| | | | | | | |
| **Tranche 5**<br>**133 contacts** | | | | | | |
| 16.10.20 Fri | 18:02 | 16.10.20 Fri | 18:14 | DHHS: [redacted] | List of 133 individuals for IPC request. Sent to ABF for processing | IPC Request 2313-14 |
| 19.10.20 Mon | 10:55 | 19.10.20 Mon | 11.23 | Immi Support | Replied with 123 IPC, could not provide a match on 10 individuals | Forwarded to DHHS ([redacted] |

| Received – Health Ops | | Time Actioned (NIR) | | Respondent | Details of request | Health Ops Action |
|---|---|---|---|---|---|---|
| | | | | | | |
| **Tranche 6<br>10 contacts** | | | | | | |
| 19.10.20 Mon | 12:25 | 19.10.20 Mon | 13:23 | DHHS: [redacted] | List of 10 Contacts for IPCs sent to ABF for processing. | IPC Request #2313-15 |
| 19.10.20 Mon | 16:56 | 19.10.20 Mon | 16:48 | Immi Support | Replied with 10 IPCs | Forwarded to DHHS. |
| **Tranche 7<br>121 contacts** | | | | | | |
| 19.10.20 Mon | 17:57 | 19.10.20 Mon | 19:20 | DHHS: [redacted] | List of 121 Contacts for IPCs sent to ABF for processing. | IPC Request #2313-16 |
| 20.10.20 | 01:04 | 20.10.20 | 06:35 | Immi Support | IPC's returned to Health for distribution to DHHS | Forwarded to DHHS. |

### 1.1.1 Contact Tracing Taskforce

DHHS sought contact tracing surge capacity from the Commonwealth on **9 July 2020**. The Department of Health responded with the establishment of a Contact Tracing Taskforce (the Taskforce) in support of DHHS on **11 July 2020**. The Taskforce operated seven days per week with over two shifts per day and undertook the management of over 1,400 allocated cases from DHHS.

The Taskforce comprised a core team of 97 staff from across the Department, supplemented by 17 staff from the Department of Foreign Affairs and Trade. ACT Health facilitated training specifically for the Taskforce to ensure consistency; all core Commonwealth Officers were thus trained.

In addition, 90 departmental staff were registered as surge capacity to meet greater demand as required. A number of other jurisdictions provided support to Victoria including New South Wales and South Australia. The Australian Defence Force was also deployed to assist with contract tracing efforts through door-knocking and administrative support.

A Memorandum of Understanding (MoU) was negotiated between both parties to allow Commonwealth Officers to operate "in the service of" the Victorian Government. To ensure the MoU remained viable, it was updated with relevant staffing information as required. This MoU was updated on **20 August 2020** to enable Commonwealth Officers to access COVID-Safe App data. Commonwealth Officers attended training delivered by DHHS in order to support the Victorian contact tracing efforts using COVID-Safe App data. With decreased infection rates, however, this service was not fully utilised.

The Taskforce was officially scaled down on **4 September 2020** with capability and capacity being retained within the Department to ensure the timely re-activation of the Taskforce if required by Victoria or other jurisdictions.

**Timeline of the Contact Tracing Taskforce**

| Date | Method | From | To | Details | Commonwealth Response |
|---|---|---|---|---|---|
| 9-Jul-20 | Email | DHHS | Health | Victorian Government Department of Health and Human Services (DHHS) sought Commonwealth support to undertake contact tracing | Received, responded and actioned as directed with officers assiting with courtesy calls and contract tracing interviews |
| 10-Jul-20 | Email | DHHS | Health | DHHS seek commonwealth officer details in order to grant access to DHHS Communicable Dieases Data Hub (CDDH) sharepoint website | Received, responded and actioned as directed with officers added to the sharepoint approx. weekly as required, and daily allocations provided from DHHS to Health |
| 10-Jul-20 | Email | Health | DHHS | Offer of assistance to accept allocation of 75-100 cases<br>DHHS allocated cases via the CDDH sharepoint | Allocation accepted and complete |
| 11-Jul-20 | Email | Health | DHHS | Offer of assistance to accept allocation of 30 cases<br>Memorandum of Understanding (MoU) established for Commonwealth officers to work in the service of the Victorian Government | Allocation accepted and complete<br>MoU signed and agreed by both parties and updated with relevant staffing information as required |
| 12-Jul-20 | Email | Health | DHHS | Multiple emails re: clarification of script for phone calls | Received, responded and actioned as directed |
| 13-Jul-20 | Email | DHHS | Health | Allocation of 30 cases | Allocation accepted and complete |

| Date | Method | From | To | Details | Commonwealth Response |
|---|---|---|---|---|---|
| 13-Jul-20 | Email | DHHS | Health | Multiple emails re: script amendments | Received, responded and actioned as directed |
| 13-Jul-20 | Email | DHHS | Health | Multiple emails re: Aged Care, do not call advice | Received, responded and actioned as directed |
| 13-Jul-20 | Email | Health | DHHS | Provided a daily summary report to DHHS<br>Offer assistance to accept allocation of 70 cases | Allocation accepted and complete |
| 14-Jul-20 | Email | Health | DHHS | Provided a daily summary report to DHHS<br>Offer assistance to accept allocation of additional cases | DHHS did not respond |
| 15-Jul-20 | Email | Health | DHHS | Provided a daily summary report to DHHS<br>Offer assistance to accept allocation of additional cases | Allocation accepted and complete |
| 16-Jul-20 | Email | DHHS | Health | Multiple emails re: clarifying allocation of cases | Email clarification of 22 allocated cases |
| 17-Jul-20 | Email | Health | DHHS | Provided interview script updates and daily summary report to DHHS<br>Offer assitance to accept allocation of 60 cases | Allocation accepted and complete |
| 18-Jul-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation accepted and complete |
| 19-Jul-20 | Email and hardcopy | Health | DHHS | Provided interview script updates, daily summary report and hard copy interview transcripts to DHHS | Allocation accepted and complete |

| Date | Method | From | To | Details | Commonwealth Response |
|---|---|---|---|---|---|
| | | | | Offer assitance to accept allocation of 30 cases | |
| 20-Jul-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation accepted and complete |
| 21-Jul-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 35 cases | Allocation accepted and complete |
| 22-Jul-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 35 cases | DHHS provided no allocation - Health contacted DHHS Duty Officer to confirm |
| 23-Jul-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | DHHS provided no allocation - Health contacted DHHS Duty Officer to confirm |
| 24-Jul-20 | Email | Health | DHHS | Health contacted DHHS to confirm no allocation<br>Offer assitance to accept allocation | DHHS provided no allocation - Health contacted DHHS Duty Officer to confirm |
| 25-Jul-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 20 cases | Allocation accepted and complete |
| 26-Jul-20 | EMail | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 40 cases | Allocation accepted and complete |
| 27-Jul-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30-35 cases | Allocation accepted and complete |

| Date | Method | From | To | Details | Commonwealth Response |
|---|---|---|---|---|---|
| | | | | Offer of ability to scale up Contact Tracing Taskforce if required | |
| 27-Jul-20 | Email | DHHS | Health | Multiple emails re: allocation delays | Advice noted by Contact Tracing Taskforce officers |
| 28-Jul-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation accepted and complete |
| 29-Jul-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation accepted and complete |
| 30-Jul-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases<br>At request of VIC - daily reporting table commenced | Allocation accepted and complete, with 1 additional close contact complete and included in daily reporting table |
| 31-Jul-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 20 cases | Allocation of 30 accepted and complete, with 1 additional close contact complete and included in daily reporting table |
| 1-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 20 cases | Allocation of 33 accepted and complete, with 21 additional close contact complete and included in daily reporting table |
| 2-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 20 accepted and complete, with 10 additional close contact complete and included in daily reporting table |

| Date | Method | From | To | Details | Commonwealth Response |
|---|---|---|---|---|---|
| 3-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30-35 cases | Allocation of 30 accepted and complete, with 43 additional close contact complete and included in daily reporting table |
| 4-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 33 accepted and complete, with 59 additional close contact complete and included in daily reporting table |
| 5-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 30 accepted and complete, with 35 additional close contact complete and included in daily reporting table |
| 6-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 30 accepted and complete, with 46 additional close contact complete and included in daily reporting table |
| 7-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 30 accepted and complete, with 47 additional close contact complete and included in daily reporting table |
| 8-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 30 accepted and complete, with 61 additional close contact complete and included in daily reporting table |
| 9-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 35 cases | Allocation of 30 accepted and complete, with 44 additional close contact complete and included in daily reporting table |
| 10-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 35 cases | Allocation of 7 accepted and complete, with 1 additional close contact complete and included in daily reporting table |
| 11-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 25 accepted and complete, with 30 additional close contact complete and included in daily reporting table |

| Date | Method | From | To | Details | Commonwealth Response |
|---|---|---|---|---|---|
| 12-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 35 cases | Allocation of 30 accepted and complete, with 40 additional close contact complete and included in daily reporting table |
| 13-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 55 accepted and complete, with 101 additional close contact complete and included in daily reporting table |
| 14-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 30 accepted and complete, with 89 additional close contact complete and included in daily reporting table |
| 15-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 30 accepted and complete, with 69 additional close contact complete and included in daily reporting table |
| 16-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 26 accepted and complete, with 35 additional close contact complete and included in daily reporting table |
| 17-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 12 accepted and complete, with 21 additional close contact complete and included in daily reporting table |
| 18-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 22 accepted and complete, with 53 additional close contact complete and included in daily reporting table |
| 19-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 30 accepted and complete |
| 20-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 33 accepted and complete, with 44 additional close contact complete and included in daily reporting table |

| Date | Method | From | To | Details | Commonwealth Response |
|---|---|---|---|---|---|
| 20-Aug-20 | Email | DHHS | Health | Request for Commonwealth officers to access COVID-Safe App data to assist with contact tracing | Memorandum of Understanding updated to enable Commonwealth Officers to access COVID-Safe App data |
| 21-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 22 accepted and complete, with 31 additional close contact complete and included in daily reporting table |
| 22-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 25 accepted and complete, with 26 additional close contact complete and included in daily reporting table |
| 23-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 25 accepted and complete, with 73 additional close contact complete and included in daily reporting table |
| 24-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 11 accepted and complete, with 11 additional close contact complete and included in daily reporting table |
| 25-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 9 accepted and complete, with 8 additional close contact complete and included in daily reporting table |
| 25-Aug-20 | Email | DHHS | Health | Email re: request to not proceed with allocation of aged care residents | Advice received and actioned as directed |
| 26-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | DHHS provided no allocation - Health contacted DHHS Duty Officer to confirm |
| 27-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 18 accepted and complete, with 45 additional close contact complete and included in daily reporting table |

| Date | Method | From | To | Details | Commonwealth Response |
|---|---|---|---|---|---|
| 28-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 11 accepted and complete, with 2 additional close contact complete and included in daily reporting table |
| 29-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 18 accepted and complete, with 45 additional close contact complete and included in daily reporting table |
| 30-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to upscale Contact Tracing Taskforce if required | Allocation of 11 accepted and complete, with 14 additional close contact complete and included in daily reporting table |
| 1-Sep-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to upscale Contact Tracing Taskforce if required | Allocation of 1 accepted and complete, with 14 additional close contact complete and included in daily reporting table |
| 2-Sep-20 | Email | Health | DHHS | Provided daily summary report to DHHS | DHHS provided no allocation - Health contacted DHHS Duty Officer to confirm |
| 4-Sep-20 | Email | Health | DHHS | Victorian Government Department of Health and Human Services ceases Memorandum of Understanding with the Commonwealth Department of Health | The Contract Tracing Taskforce is officially scaled down |

Attachment B

Timeline for Commonwealth Contact Tracing Taskforce

| Date | Method | From | To | Details | Commonwealth Response |
|---|---|---|---|---|---|
| 9-Jul-20 | Email | DHHS | Health | Victorian Government Department of Health and Human Services (DHHS) sought Commonwealth support to undertake contact tracing | Received, responded and actioned as directed with officers assiting with courtesy calls and contract tracing interviews |
| 10-Jul-20 | Email | DHHS | Health | DHHS seek commonwealth officer details in order to grant access to DHHS Communicable Dieases Data Hub (CDDH) sharepoint website | Received, responded and actioned as directed with officers added to the sharepoint approx. weekly as required, and daily allocations provided from DHHS to Health |
| 10-Jul-20 | Email | Health | DHHS | Offer of assistance to accept allocation of 75-100 cases<br>DHHS allocated cases via the CDDH sharepoint | Allocation accepted and complete |
| 11-Jul-20 | Email | Health | DHHS | Offer of assistance to accept allocation of 30 cases<br>Memorandum of Understanding (MoU) established for Commonwealth officers to work in the service of the Victorian Government | Allocation accepted and complete<br>MoU signed and agreed by both parties and updated with relevant staffing information as required |
| 12-Jul-20 | Email | Health | DHHS | Multiple emails re: clarification of script for phone calls | Received, responded and actioned as directed |
| 13-Jul-20 | Email | DHHS | Health | Allocation of 30 cases | Allocation accepted and complete |
| 13-Jul-20 | Email | DHHS | Health | Multiple emails re: script amendments | Received, responded and actioned as directed |
| 13-Jul-20 | Email | DHHS | Health | Multiple emails re: Aged Care, do not call advice | Received, responded and actioned as directed |
| 13-Jul-20 | Email | Health | DHHS | Provided a daily summary report to DHHS<br>Offer assistance to accept allocation of 70 cases | Allocation accepted and complete |
| 14-Jul-20 | Email | Health | DHHS | Provided a daily summary report to DHHS<br>Offer assistance to accept allocation of additional cases | DHHS did not respond |
| 15-Jul-20 | Email | Health | DHHS | Provided a daily summary report to DHHS<br>Offer assistance to accept allocation of additional cases | Allocation accepted and complete |
| 16-Jul-20 | Email | DHHS | Health | Multiple emails re: clarifying allocation of cases | Email clarification of 22 allocated cases |
| 17-Jul-20 | Email | Health | DHHS | Provided interview script updates and daily summary report to DHHS<br>Offer assitance to accept allocation of 60 cases | Allocation accepted and complete |
| 18-Jul-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation accepted and complete |
| 19-Jul-20 | Email and hardcopy | Health | DHHS | Provided interview script updates, daily summary report and hard copy interview transcripts to DHHS<br>Offer assitance to accept allocation of 30 cases | Allocation accepted and complete |
| 20-Jul-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation accepted and complete |
| 21-Jul-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 35 cases | Allocation accepted and complete |
| 22-Jul-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 35 cases | DHHS provided no allocation - Health contacted DHHS Duty Officer to confirm |
| 23-Jul-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | DHHS provided no allocation - Health contacted DHHS Duty Officer to confirm |
| 24-Jul-20 | Email | Health | DHHS | Health contacted DHHS to confirm no allocation<br>Offer assitance to accept allocation | DHHS provided no allocation - Health contacted DHHS Duty Officer to confirm |
| 25-Jul-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 20 cases | Allocation accepted and complete |
| 26-Jul-20 | EMail | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 40 cases | Allocation accepted and complete |
| 27-Jul-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30-35 cases<br>Offer of ability to scale up Contact Tracing Taskforce if required | Allocation accepted and complete |
| 27-Jul-20 | Email | DHHS | Health | Multiple emails re: allocation delays | Advice noted by Contact Tracing Taskforce officers |

| | | | | | |
|---|---|---|---|---|---|
| 28-Jul-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation accepted and complete |
| 29-Jul-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation accepted and complete |
| 30-Jul-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases<br>At request of VIC - daily reporting table commenced | Allocation accepted and complete, with 1 additional close contact complete and included in daily reporting table |
| 31-Jul-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 20 cases | Allocation of 30 accepted and complete, with 1 additional close contact complete and included in daily reporting table |
| 1-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 20 cases | Allocation of 33 accepted and complete, with 21 additional close contact complete and included in daily reporting table |
| 2-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 20 accepted and complete, with 10 additional close contact complete and included in daily reporting table |
| 3-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30-35 cases | Allocation of 30 accepted and complete, with 43 additional close contact complete and included in daily reporting table |
| 4-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 33 accepted and complete, with 59 additional close contact complete and included in daily reporting table |
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| 7-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 30 accepted and complete, with 47 additional close contact complete and included in daily reporting table |
| 8-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 30 accepted and complete, with 61 additional close contact complete and included in daily reporting table |
| 9-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 35 cases | Allocation of 30 accepted and complete, with 44 additional close contact complete and included in daily reporting table |
| 10-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 35 cases | Allocation of 7 accepted and complete, with 1 additional close contact complete and included in daily reporting table |
| 11-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 25 accepted and complete, with 30 additional close contact complete and included in daily reporting table |
| 12-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 35 cases | Allocation of 30 accepted and complete, with 40 additional close contact complete and included in daily reporting table |
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| 14-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 30 accepted and complete, with 89 additional close contact complete and included in daily reporting table |
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| 19-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 30 accepted and complete |
| 20-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 33 accepted and complete, with 44 additional close contact complete and included in daily reporting table |
| 20-Aug-20 | Email | DHHS | Health | Request for Commonwealth officers to access COVID-Safe App data to assist with contact tracing | Memorandum of Understanding updated to enable Commonwealth Officers to access COVID-Safe App data |
| 21-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 22 accepted and complete, with 31 additional close contact complete and included in daily reporting table |

Attachment B

Timeline for Commonwealth Contact Tracing Taskforce

| | | | | | |
|---|---|---|---|---|---|
| 22-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 25 accepted and complete, with 26 additional close contact complete and included in daily reporting table |
| 23-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 25 accepted and complete, with 73 additional close contact complete and included in daily reporting table |
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| 25-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 9 accepted and complete, with 8 additional close contact complete and included in daily reporting table |
| 25-Aug-20 | Email | DHHS | Health | Email re: request to not proceed with allocation of aged care residents | Advice received and actioned as directed |
| 26-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | DHHS provided no allocation - Health contacted DHHS Duty Officer to confirm |
| 27-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 18 accepted and complete, with 45 additional close contact complete and included in daily reporting table |
| 28-Aug-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to accept allocation of 30 cases | Allocation of 11 accepted and complete, with 2 additional close contact complete and included in daily reporting table |
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| 1-Sep-20 | Email | Health | DHHS | Provided daily summary report to DHHS<br>Offer assistance to upscale Contact Tracing Taskforce if required | Allocation of 1 accepted and complete, with 14 additional close contact complete and included in daily reporting table |
| 2-Sep-20 | Email | Health | DHHS | Provided daily summary report to DHHS | DHHS provided no allocation - Health contacted DHHS Duty Officer to confirm |
| 4-Sep-20 | Email | Health | DHHS | Victorian Government Department of Health and Human Services ceases Memorandum of Understanding with the Commonwealth Department of Health | The Contract Tracing Taskforce is officially scaled down |

| | Number of dispatches from the NMS | P2/N95 respirators | Surgical masks | *Masks Total* | Gowns | Goggles | Face shields | Gloves | Hand sanitiser (bottles) |
|---|---|---|---|---|---|---|---|---|---|
| **Vic DHHS - acute care** | **21 dispatches** | **7,522,000** | **3,218,500** | ***10,740,500*** | **10,000** | | | | |
| Mar | 2 | 892,200 | 501,000 | *1,393,200* | | | | | |
| Apr | 2 | 140,400 | 1,260,000 | *1,400,400* | 10,000 | | | | |
| May | 4 | 638,640 | 1,457,500 | *2,096,140* | | | | | |
| Jun | 8 | 1,349,760 | | *1,349,760* | | | | | |
| Jul | 3 | 2,249,000 | | *2,249,000* | | | | | |
| Aug | 1 | 2,000,000 | | *2,000,000* | | | | | |
| Sep | 1 | 252,000 | | *252,000* | | | | | |
| **Vic DHHS - aged care*** | **9 dispatches** | **769,000** | **3,096,250** | ***3,865,250*** | **488,550** | **240** | **2,000** | **4,000** | **720** |
| Apr | 1 | 200 | 469,500 | *469,700* | | | | | |
| Jun | 3 | | 750 | *750* | 2,950 | 240 | 2,000 | 4,000 | 720 |
| Jul | 1 | | 2,626,000 | *2,626,000* | | | | | |
| Aug | 3 | 768,800 | | *768,800* | | | | | |
| Sep | 1 | | | *0* | 485,600 | | | | |
| **Aged care - facilities**** | **4170 dispatches** | **3,708,308** | **5,934,070** | ***9,642,378*** | **4,217,080** | **636,110** | **3,195,115** | **11,316,620** | **88,498** |
| May | 11 | 240 | 43,800 | *44,040* | 36,500 | | | 45,900 | |
| Jun | 11 | 350 | 32,200 | *32,550* | 30,880 | 1,060 | 4,400 | 54,500 | 120 |
| Jul | 960 | 124,780 | 2,350,650 | *2,475,430* | 959,580 | 282,020 | 468,350 | 2,793,620 | 22,680 |
| Aug | 1951 | 1,464,218 | 3,138,060 | *4,602,278* | 2,247,640 | 285,580 | 2,165,765 | 5,511,000 | 49,306 |
| Sep | 968 | 717,580 | 329,100 | *1,046,680* | 888,630 | 63,450 | 500,500 | 2,757,600 | 16,176 |
| Oct | 243 | 1,254,640 | 30,000 | *1,284,640* | 53,850 | 4,000 | 45,300 | 154,000 | 216 |
| Nov | 26 | 146,500 | 10,260 | *156,760* | | | 10,800 | | |
| **National Disability Insurance Scheme Participants ***** | **146 dispatches** | **6,740** | **119,300** | ***126,040*** | **8,830** | **1,570** | **20,320** | **31,200** | **312** |
| Apr | 3 | | 3,200 | *3,200* | | | | | |
| May | 1 | | | *0* | 10 | | | 100 | |
| Jul | 52 | 1,870 | 53,950 | *55,820* | 640 | | 350 | 10,000 | 72 |
| Aug | 68 | 3,770 | 41,300 | *45,070* | 6,580 | 1,570 | 15,650 | 12,900 | 192 |
| Sep | 10 | 100 | 3,150 | *3,250* | 700 | | 3,420 | 6,200 | 24 |
| Oct | 10 | 1,000 | 15,300 | *16,300* | 900 | | 900 | 2,000 | 24 |
| Nov | 2 | | 2,400 | *2,400* | | | | | |
| **Primary Health Networks** | **101 dispatches** | **293,900** | **3,606,100** | ***3,900,000*** | **204,000** | **189,600** | | **6,000** | |
| Jan | 4 | | 106,500 | *106,500* | | | | | |
| Feb | 13 | 4,320 | 61,500 | *65,820* | | | | | |
| Mar | 18 | 22,000 | 288,000 | *310,000* | | | | | |
| Apr | 18 | 82,440 | 1,204,500 | *1,286,940* | 7,200 | | | | |
| May | 6 | 31,920 | 346,500 | *378,420* | | | | | |
| Jun | 6 | | | *0* | 15,200 | | | | |
| Jul | 10 | 80,760 | 797,500 | *878,260* | 60,800 | | | 6,000 | |
| Aug | 15 | 53,460 | 504,000 | *557,460* | 115,700 | 189,600 | | | |
| Sep | 1 | 7,000 | 150,000 | *157,000* | | | | | |
| Oct | 2 | 12,000 | 6,000 | *18,000* | | | | | |
| Nov | 8 | | 141,600 | *141,600* | 5,100 | | | | |
| **Total dispatched to Victoria** | **4447 dispatches** | **12,299,948** | **15,974,220** | ***28,274,168*** | **4,928,460** | **827,520** | **3,217,435** | **11,357,820** | **89,530** |

* For distribution to the aged care sector on the NMS' behalf.

** Includes dispatches to help the Victorian Aged Care Response Coordinators support individual aged care facilities.

*** Not inclusive of products dispatched by the National Disability Insurance Agency on the NMS' behalf.

| Date of announcement | Announced by | Item | Quantity | Recipient - Category | Victorian-specific recipients | Announcement URL |
|---|---|---|---|---|---|---|
| 29/01/2020 | Prime Minister | Masks | 1,000,000 | Primary Care | PHNs | https://www.pm.gov.au/media/press-conference-australian-parliament-house-act-3 |
| 9/04/2020 | Minister Hunt | Masks | 7,000,000 | S&T | Vic DHHS | https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/doorstop-interview-in-canberra-about-coronavirus-covid-19-0 |
| 9/04/2020 | Minister Hunt | Masks | 2,300,000 | Primary Care | PHNs | https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/doorstop-interview-in-canberra-about-coronavirus-covid-19-0 |
| 9/04/2020 | Minister Hunt | Masks | 1,700,000 | Aged care | RACFs | https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/doorstop-interview-in-canberra-about-coronavirus-covid-19-0 |
| 19/04/2020 | Minister Hunt | Masks | 7,000,000 | S&T | Vic DHHS | https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/doorstop-interview-about-australias-measures-to-combat-covid-19 |
| 19/04/2020 | Minister Hunt | Masks | 2,800,000 | Primary Care | Primary Care (incl. allied health) | https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/doorstop-interview-about-australias-measures-to-combat-covid-19 |
| 19/04/2020 | Minister Hunt | Masks | 1,700,000 | Aged care | RACFs | https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/doorstop-interview-about-australias-measures-to-combat-covid-19 |
| 7/05/2020 | Minister Hunt | Masks | 35,000,000 | S&T | Vic DHHS | https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/doorstop-interview-in-melbourne-about-coronavirus-covid-19-1 |
| 7/05/2020 | Minister Hunt | Masks | 1,500,000 | Aged care | RACFs | https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/doorstop-interview-in-melbourne-about-coronavirus-covid-19-1 |
| 7/05/2020 | Minister Hunt | Masks | 3,500,000 | Primary Care | Primary Care (incl. allied health) | https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/doorstop-interview-in-melbourne-about-coronavirus-covid-19-1 |
| 9/06/2020 | Minister Hunt | Masks | 5,000,000 | Primary Care | Primary Care (incl. allied health) | https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/doorstop-interview-in-queanbeyan |
| 25/06/2020 | Minister Hunt | Various | Unspecified | Primary Care | Primary Care (GPs near VIC ski fields) | https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/ppe-for-gps-near-the-ski-fields |
| 13/07/2020 | Minister Hunt | Masks | 1,000,000 | Primary Care | PHNs | https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/press-conference-in-melbourne-about-coronavirus-covid-19-0 |
| 13/07/2020 | Minister Hunt | Masks | 4,000,000 | Aged care | RACFs | https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/press-conference-in-melbourne-about-coronavirus-covid-19-0 |
| 17/07/2020 | Minister Hunt | Masks | 1,000,000 | Aged care | RACFs | https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/two-million-more-face-masks-for-victorian-aged-care-and-disability-workers |
| 17/07/2020 | Minister Hunt | Masks | 1,000,000 | NDIS | Vic NDIS | https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/two-million-more-face-masks-for-victorian-aged-care-and-disability-workers |
| 28/07/2020 | Minister Hunt | Masks | 5,000,000 | Aged care | RACFs | https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/greater-virus-protection-for-aged-care-workers |
| 28/07/2020 | Minister Hunt | Face shield | 500,000 | Aged care | RACFs | https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/greater-virus-protection-for-aged-care-workers |
| 30/09/2020 | Minister Hunt | Masks | 7,000,000 | Aged care | RACFs | https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/additional-protection-for-victorian-aged-care-services-0 |

**Attachment B - Victorian GP Respiratory Clinics and opening dates**

| Clinic Name | Date Opened |
|---|---|
| Prahran Respiratory Clinic | 1/04/2020 |
| Altona North Respiratory Clinic | 2/04/2020 |
| Laverton Respiratory Clinic | 7/04/2020 |
| Mildura Respiratory Clinic | 7/04/2020 |
| Ringwood Respiratory Clinic | 7/04/2020 |
| Geelong Respiratory Clinic | 9/04/2020 |
| Ballarat UFS Respiratory clinic | 14/04/2020 |
| Bendigo Respiratory Clinic | 21/04/2020 |
| Carrum Downs Respiratory Clinic | 22/04/2020 |
| Rosebud Respiratory Clinic | 27/04/2020 |
| Warragul Respiratory Clinic | 27/04/2020 |
| Port Melbourne Respiratory Clinic | 30/04/2020 |
| Foster Respiratory Clinic | 4/05/2020 |
| Sale Respiratory Clinic | 4/05/2020 |
| Wonthaggi Respiratory Clinic | 4/05/2020 |
| Bellarine Respiratory Clinic | 8/05/2020 |
| Wodonga Respiratory Clinic | 13/05/2020 |
| Fitzroy (Victorian Aboriginal Health Service) Respiratory Clinic | 14/05/2020 |
| Bairnsdale Respiratory Clinic | 18/05/2020 |
| Morwell Respiratory Clinic | 18/05/2020 |
| Rowville Respiratory Clinic | 19/05/2020 |
| Coolaroo Respiratory Clinic | 25/05/2020 |
| Shepparton Respiratory Clinic | 28/05/2020 |
| Swan Hill Respiratory Clinic | 1/06/2020 |
| Wallan Respiratory Clinic | 1/06/2020 |
| Horsham Respiratory Clinic | 3/06/2020 |
| Thomastown Respiratory Clinic | 10/06/2020 |
| Warrnambool (Great South Coast) Respiratory Clinic | 1/07/2020 |

Attachment – E

Multicultural Communications Support for Victorian Outbreaks

| Date and time | Action | Who | Activity | Response |
|---|---|---|---|---|
| 15.09.20 morning | Phone call | DoH **TO** Victoria | Offered assistance to Victoria for Casey outbreak | Response received |
| 15.09.20 10:58 | Email | DoH **TO** Victoria | Offered assistance to Victoria for Casey outbreak. Asked for details on communications already conducted for Casey | Response received |
| 15.09.20 13:40 | Email | Victoria **TO** DoH | Replying to offer of assistance (email above). Victoria sent back their community engagement plan for the Casey outbreak | Offer accepted |
| 15.09.20 15:03 | Email | DoH **TO** Victoria | Offered assistance to Victoria for Casey outbreak | Response received |
| 21.09.20 12:24 | Email | DoH **TO** Victoria | Offered assistance to Victoria for Casey outbreak | Response received |
| 21.09.20 12:27 | Email | Victoria **TO** DoH | Victoria responded to DoH's request for resources to share through DoH's multicultural networks | |
| 23.09.20 17:41 | Email | DoH **TO** Victoria | Offered to connect Victoria Health to CALD stakeholder networks | Response received on 26 Sept |
| 28.09.20 14:00 | Email | DoH **TO** Victoria | Provided Victoria Health with contacts to liaise with CALD community | Offer accepted |
| 06.10.20 17:33 | Email | DoH **TO** Victoria | Followed up on activity and offered assistance | Response received |
| 16.10.20 14:04 | Email | DoH **TO** Victoria | Offered assistance to Victoria for the Shepparton outbreak | No response |
| 16.10.20 18:18 | Email | DoH **TO** Victoria | Offered assistance to Victoria for the Shepparton outbreak | No response |
| 17.10.20 10:27 | Email | Victoria **TO** DoH | Victoria accepted help for the Shepparton outbreak | Offer accepted |
| 19.10.20 16:24 | Email | DoH **TO** Victoria | Offered assistance to Victoria for the Shepparton outbreak | No response |
| 19.10.20 16:30 | Email | DoH **TO** Victoria | Offered assistance to Victoria for the Shepparton outbreak | No response |
| 22.10.20 13:38 | Email | DSS CLO **TO** Victoria | DSS CLO sent DoH translated resources to Victorian government contacts at the request of DoH to assist the Shepparton outbreak | Unknown |

# Victorian Requests for Australian Government non-financial assistance (RFA)

| Item | Request | Victorian RFA ID | Timeline detail |
|---|---|---|---|
| 1 | **Defence** personnel.<br>Personnel augmentation and assistance to enable effective and relevant State-level planning and/or execution of EMV/SCC-VIC Emergency Response efforts relating to COVID-19 - an ADF planning team experienced in Humanitarian Relief / Disaster Response operations be provided to ensure synchronisation and orchestration of inter-agency planning, testing of Response Options and ensure all potential planning options are considered. | EMV 001 | This DACC 4 was a duplicate and has now been updated to reflect one DACC only.<br>S/T advised by JOSS 18/3/20<br>**ADF accepted** |

| | | | |
|---|---|---|---|
| 2 | **Defence** personnel.<br>Personnel augmentation and assistance to enable effective and relevant State-level planning and/or execution of EMV/SCC-VIC Emergency Response efforts relating to COVID-19 - augmentation to the Victorian state emergency management agencies in planning and conducting the response to the COVID-19 pandemic, in order to meet both the humanitarian and basic needs of the community. | EMV 003 | 29/03/2020 @ 1708hrs - SCCVIC to EMA - RFA request<br>29/03/2020 @ 1807hrs - MSC to EMA - **RFA accepted**<br>29/03/2020 @ 1944hrs - EMA to SCCVIC - Advise MSC acceptance |
| 3 | **Defence** personnel.<br>An initial team of 5 personnel from the ADF Defence will augment Victorian Police Operation Sentinel, to enhance the Victorian State Government efforts.<br><br>These personnel will be required to proactively contact members of the public by phone and/or IT applications to confirm Quarantine Compliance in accordance with the Victorian Chief Health Officer's Directions. | Not provided by requestor<br>**Note added 14/08/2020**<br>This is likely to be EMV002. EMV006 (below) brings all DHHS support together under one RFA. This is one of three RFAs seeking support for DHHS that were submitted prior to 27/04/2020. | 01/04/2020 @ 0911hrs - VICPOL to EMA & MSC - RFA<br>01/04/2020 @ 2037hrs - MSC to VICPOL & EMA - **RFA accepted**<br><br>JOSS VIC SITREP061 (18/05/2020) states DACC3265010420 concluded on 17 May 2020 - SJM 20 May 2020<br>UPDATE ENTRY on 14/08/2020<br>Copy of DACC 6 request nominally authorised by AC Murphy, VICOPOL on 01/04/2020 |

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|---|---|---|---|
| 4 | **Defence** personnel.<br>Provision of 1 planning advisor to DHHS specifically focused on Construction Engineering and Contract Management of specified tasks (Exhibition Centre).<br><br>This advisor will initially work direct to DHHS Building Authority Project Director, on this task specifically and scope any further involvement for future action. | EMV004CV | 04/04/2020 @ 0856hrs - SCCVIC to EMA - RFA<br>04/04/2020 @ 0943hrs - EMA to MSC - RFA request<br>04/04/2020 @ 1432hrs - MSC to EMA - **RFA accepted**<br>04/04/2020 @ 1528hrs - EMA to VICPOL - Advise of acceptance |
| 5 | **Defence** personnel.<br>Provision of approximately 15 personnel to support Victoria Police Operation Hawkeye over Easter weekend to provide aerial vision of public places across Victoria for enforcement of social gathering restrictions. | EMV-VP01 | 05/04/2020 @ 1015hrs - SCCVIC to EMA - EMV-VP01 and EMV-VP02 RFAs<br>05/04/2020 @ 1252hrs - EMA to MSC - EMV-VP01 and EMV-VP02 RFAs<br>06/04/2020 @ 1238hrs - MSC to EMA - EMV-VP01 advise that MSC does not accept request<br>06/04/2020 @ 1439hrs - EMA to SCCVIC - Advise of RFA **not accepted** |
| 6 | **Defence** personnel.<br>Provision of 6 personnel working across two shift to support PAL supervisors to triage list of calls received from members of the public reporting quarantine compliance breaches and action in accordance with Victoria Police SOPs. | EMV-VP02 | 05/04/2020 @ 1015hrs - SCCVIC to EMA - EMV-VP01 and EMV-VP02 RFAs<br>05/04/2020 @ 1252hrs - EMA to MSC - EMV-VP01 and EMV-VP02 RFAs<br>05/04/2020 @ 1621hrs - MSC to EMA - EMV-VP02 **RFA accepted**<br>05/04/2020 @ 1658hrs - EMA to SCCVIC - EMV-VP02 RFA acceptance advice |

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|---|---|---|---|
| 7 | **Defence** Personnel.<br>Extension to RFA 4. Extension to the provision of 1 planning officer, modified to work under the supervision and direction of the Victorian DHHS Public Health Commander in the role of Deputy Public Health Commander. | EMV005CV | 14/04/2020 @ 1343hrs - SCCVIC to EMA<br>15/04/2020 @ 2007hrs - MSC to EMA - **RFA accepted**<br>16/04/2020 @ 1034hrs - EMA to SCCVIC - Advise MSC acceptance |
| 8 | **Defence** personnel.<br>Provision of up to 13 personnel to allow for sustained operations, rotations, working across two shifts to support PAL supervisors to triage a list of calls received from members of the public reporting quarantine compliance breaches and action in accordance with Victoria Police SOPs. Defence personnel will work under technical direction of Victoria Police sworn supervisors but remain under Defence command. | EMV-VP02B | Word doc RFA<br>18/04/2020 @ 1431hrs - EMA to MSC - Forward RFA<br>18/04/2020 @ 1415hrs - EMA to SCCVIC<br>18/04/2020 @1529hrs - MSC to EMA - **RFA accepted** (Only for two weeks)<br>18/04/2020 @ 1545hrs - EMA to SCCVIC - Advise defence acceptance |
| 9 | **Defence** Personnel.<br>Extension to RFA 3, 4 & 7.<br>Provision of support to assist DHHS efforts in the following areas: DHHS SEMC and lead agency operations such as health planning and operations assistance, Deputy Public Health Commander and operations centre support. | EMV006CV | 27/04/2020 - RFA PDF<br>27/04/2020 @ 1406hrs - EMA to MSC - Forward RFAs to MSC<br>28/04/2020 @ 1728hrs - MSC to EMA - **RFA accepted** with further info required<br>28/04/2020 @ 1756hrs - EMA to SCCVIC - Inform of acceptance with caveats<br>This is an extension of EMV002, EMV004CV, EMB005CV and one new effect - extension (EMV 009) until 31 May 2020 approved (Item 57) - Status changed to COMPLETE on 21/05/2020. |

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|---|---|---|---|
| 10 | **Defence** Personnel.<br>Extension to RFA 1 & 2<br>Extension request for augmentation to the Victorian state emergency management agencies in planning and conducting the response to the COVID-19 pandemic, in order to meet both the humanitarian and basic needs of the community. | EMV007CV | 27/04/2020 - RFA PDF<br>27/04/2020 @ 1406hrs - EMA to MSC - Forward RFAs to MSC<br>28/04/2020 @ 1728hrs - MSC to EMA - **RFA accepted** with further info required<br>28/04/2020 @ 1756hrs - EMA to SCCVIC - Inform of acceptance with caveats<br>29/04/2020 @ 1304hrs - EMA to SCCVIC - Previously not accepted, now ok due to it being an extension of EMV003<br>This is an extension of EMV001, EMV002 and EMV003 - request for another extension (EMV 010) until 31 May approved (Item 58) - Status changed to COMPLETE on 21/05/2020 |
| 11 | **Defence** Personnel.<br>Extension to RFA 8.<br>Extension to the provision of up to 13 personnel to allow for sustained operations, rotations, working across two shifts to support PAL supervisors to triage a list of calls received from members of the public reporting quarantine compliance breaches and action in accordance with Victoria Police SOPs. Defence personnel will work under technical direction of Victoria Police sworn supervisors but remain under Defence command. | EMV PO3 | 30/04/2020 @ 0911hrs - SCCVIC to EMA - RFA<br>30/04/2020 @ 1129hrs - EMA to MSC - Advise of the request<br>30/04/2020 @ 1545hrs - MSC acceptance - **RFA accepted**<br>21/05/2020 - email from EMV confirmed expiry on 17 May 2020 status changed to COMPLETED<br>30/04/2020 - MSC to EMA - Extension accepted |

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|---|---|---|---|
| 12 | **Defence** Personnel.<br>Provision of personnel to support Victoria's Department of Health and Human Services emergency Operations Cell functions for operation Soteria. | EMV008 | 30/04/2020 @ 0911hrs - SCCVIC to EMA - RFA<br>30/04/2020 @ 1131 hrs - EMA to MSC - RFA for consideration<br>30/04/2020 @ 1711hrs - MSC to EMA - **RFA accepted**<br>30/04/2020 @1711hrs - EMA to SCCVIC - RFA Acceptance<br>Request end date changed from 17/05/2020 to 15/05/2020 to align with MSC acceptance email ADD2020/2326653 21/05/2020.<br>Extended until 30 May 2020 (Item 57) - Status changed to COMPLETED - SJM 21/05/2020 |
| 13 | **Defence** Personnel.<br>Extension to RFA 9 & 12.<br>Continued provision of ADF support to assist DHHS efforts in the following areas:<br>1. DHHS State Emergency Management Centre and Lead Agency Operations<br>2. Operations Centre Support to Operation Soteria. | EMV009CV | Extension of Item 53.<br>RFA PDF<br>11/05/2020 @ 1417 hrs - EMA to MSC - RFA for consideration<br>11/05/2020 @ 1911 hrs - MSC to EMA<br>12/05/2020 @ 1151 hrs - MSC to EMA - **RFA accepted**<br>12/05/2020 @ 1214 hrs - EMA to SCCVIC - Advise of acceptance |
| 14 | **Defence** Personnel.<br>Extension to RFA 10.<br>Extension request for augmentation to the Victorian state emergency management agencies in planning and conducting the response to the COVID-19 pandemic, in order to meet both the humanitarian and basic needs of the community. | EMV010CV | Extension of Item 52.<br>11/05/2020 @ 1417 hrs - EMA to MSC - RFA for consideration<br>11/05/2020 @ 1911 hrs - MSC to EMA<br>12/05/2020 @ 1151 hrs - MSC to EMA - **RFA accepted**<br>12/05/2020 @ 1214 hrs - EMA to SCCVIC - Advise of acceptance |

| | | | |
|---|---|---|---|
| 15 | **Defence** Personnel.<br>Extension to RFA 13.<br>Continued provision of ADF support to assist DHHS efforts in the following areas:<br>1. DHHS State Emergency Management Centre and Lead Agency Operations<br>2. Operations Centre Support to Operation Soteria. | EMV011CV (Extension) | Extension of Item 57<br>28/05/2020 @ 1049 hrs - EMA to MSC - RFA extension request for consideration<br>28/05/2020 @ 1749 hrs - MSC to EMA - **RFA accepted**<br>29/05/2020 @ 0845 hrs - EMA to SCCVIC - Defence acceptance to Vic<br>No further extensions anticipated. |
| 16 | **Defence** Personnel.<br>Extension of RFA 14.<br>Extension request for augmentation to the Victorian state emergency management agencies in planning and conducting the response to the COVID-19 pandemic, in order to meet both the humanitarian and basic needs of the community. | EMV012CV (Extension) | Extension of Item 58<br>28/05/2020 @ 1049 hrs - EMA to MSC - RFA extension request for consideration<br>28/05/2020 @ 1749 hrs - MSC to EMA - **RFA accepted**<br>29/05/2020 @ 0845 hrs - EMA to SCCVIC - Defence acceptance to Vic<br>No further extensions anticipated. |
| 17 | **Defence** Personnel.<br>Extension to RFAs 1, 2, 10, 14 and 16<br>Extension request for augmentation to the Victorian state emergency management agencies in planning and conducting the response to the COVID-19 pandemic, in order to meet both the humanitarian and basic needs of the community. | EMV013CV (Extension) | 24/06/2020 @ 2003 hrs - SCCVIC to EMA - RFA request<br>24/06/2020 @ 2023 hrs - EMA to SCCVIC - Acknowledgement of receipt of request for EMVRFA013, EMVRFA014, EMVRFA015<br>24/06/2020 @ 2038 hrs - EMA to MSC - RFAs for consideration<br>24/06/2020 @ 2047 hrs - MSC to EMA - **RFA accepted** EMV-RFA-013, EMV-RFA-014, EMV-RFA-015<br>24/06/2020 @ 2052 hrs - EMA to SCCVIC - notified of acceptance |

| | | | |
|---|---|---|---|
| 18 | **Defence** Personnel.<br>Extension to RFAs 1, 2, 10, 14 and 16<br>Extension request for augmentation to the Victorian state emergency management agencies in planning and conducting the response to the COVID-19 pandemic, in order to meet both the humanitarian and basic needs of the community. | EMV014CV (Extension) | RFA request received by CCC 24/06/2020 @ 2003 hrs<br>Acknowledgement of receipt of request for EMVRFA013, EMVRFA014, EMVRFA015 24/06/20 @ 2023 hrs<br>Request to MSC 24/06/2020 @ 2038 hrs<br>**RFA accepted** -EMV-RFA-013, EMV-RFA-014, EMV-RFA-015 - 24/06/2020 @ 2045 hrs<br>SCC-Vic notified of acceptance 24/06/2020 2052 hrs |
| 19 | **Defence** Personnel.<br>Provision of up to 850 personnel to provide compliance and monitoring support to Department of Health and Human Services (DHHS) at the designated hotels being used for mandatory quarantine. | EMV015CV | RFA request received by CCC 24/06/2020 @2003 hrs<br>Acknowledgement of receipt of request for EMVRFA013, EMVRFA014, EMVRFA015 24/06/20 @ 2023 hrs<br>Request to MSC 24/06/2020 @ 2038 hrs<br>**RFA accepted** - EMV-RFA-013, EMV-RFA-014, EMV-RFA-015 - 24/06/2020 @ 2045 hrs<br>EMA to SCC advising Defence acceptance of EMV-RFA-013, EMV-RFA-014, EMV-RFA-015 - 24/06/2020 @ 2052 hrs<br>Victorian SCC **CANCELLING** RFA - email from Andrew S Crisp on 25/06/2020 @ 1252<br>RFA request CANCELLED email from MSC 25/06/20 @ 1606 hrs<br>RFA request CANCELLED email from EMV 25/06/20 @ 1231 hrs<br>EMA acknowledgement of the withdrawal of EMV015CV 25/06/20 @ 1253 hrs<br>Email to MSC advising of the CANCELLATION of EMV015CV 25/06/20 @ 1249 hrs |

| | | | |
|---|---|---|---|
| 20 | **Defence** Personnel.<br>Provision of up to 200 personnel to provide support to the Victorian Department of Health and Human Services (DHHS) to undertake medical testing in the community. | EMV016CV | RFA request received by the CCC on 25/06/2020 @1751 hrs<br>Request sent to MSC 25/06/20 @ 1759 hrs<br>Acknowledgement to SCC-Vic on 25/06/2020 @ 1758 hrs<br>Clarification email sent from SCC-Vic 25/06/2020 @ 2235 hrs hrs<br>MSC email received 25/06/20 @ 1813 hrs - **RFA accepted**<br>SCC-Vic advised 25/06/2020 @ 1901 hrs<br>Further to advice to SCC-Vic 26/06/20 @ 1346 hrs |
| 21 | **Defence** Personnel.<br>Provision of personnel for surge capabilities to support the increase in the testing of COVID-19 across Victoria. The task is for the support for the transportation of samples from temporary testing sites. | EMV017CV | RFA request received by the CCC on 25/06/2020 @ 1751 hrs<br>Request sent to MSC 25/06/20 @ 1759 hrs<br>Acknowledgement to SCC-Vic on 25/06/2020 @ 1758 hrs<br>Clarification email from SCC-Vic 25/06/20 @ 2235 hrs<br>MSC email received 25/06/20 @ 1813 hrs - **RFA accepted**<br>SCC-Vic advised 25/06/2020 @ 1901 hrs<br>Further to advice to SCC-Vic 26/06/20 @ 1346 hrs |
| 22 | **Defence** Personnel.<br>Provision of ADF Advisory, Operations and Planning Support to assist EMV, through the provision of 5 personnel to work shift rotation in the SCC planning team. | EMV018CV | PDF RFA22 (EMV018CV) from SCC to EMA 08/07/2020 @ 1727 hrs<br>Initial correspondence from MSC<br>Email from SCC-Vic to EMA- RFA 22 - 26 - 08/07/20 (EMV018CV - EMV022CV)<br>EMA acknowledgment of RFA22-26 from SCC-Vic 08/07/20 @ 1739 hrs<br>EMA email to MSC - RFA requests from SCC-Vic 08/07/20 @1738 hrs<br>**RFA accepted** - 22, 23, 24, 26 (EMV018, 019, 020 and 021) - not RFA25 (EMV021) unit further scoping is conducted with VICPOL on 08/07/20 @ 1845 hrs<br>EMA advising SCC-Vic of Defence acceptance of RFA 22, 23, 24, 26 (EMV 018, 019, 020, 022) 08/07/20 @ 1855 hrs |

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| 23 | **Defence** Personnel.<br>Provision of 6 Defence personnel, to support PAL supervisors to triage list of calls received from members of the public reporting quarantine compliance breaches and action in accordance with Victoria Police Standard Operating Procedures. | EMV019CV | PDF RFA23 (EMV019CV) from SCC to EMA 08/07/2020 @ 1727 hrs<br>Email from SCC-Vic to EMA- RFA 22 - 26 - 08/07/20 (EMV018CV - EMV022CV)<br>EMA acknowledgment of RFA22-26 from SCC-Vic 08/07/20 @ 1739 hrs<br>EMA email to MSC - RFA requests from SCC-Vic 08/07/20 @1738 hrs<br>**RFA accepted** - 22, 23, 24, 26 (EMV018, 019, 020 and 021) - not RFA25 (EMV021) unit further scoping is conducted with VICPOL on 08/07/20 @ 1845 hrs<br>EMA advising SCC-Vic of Defence acceptance of RFA 22, 23, 24, 26 (EMV 018, 019, 020, 022) 08/07/20 @ 1855 hrs |
| 24 | **Defence** Personnel.<br>Provision of ADF Advisory, Plsanning and Logistics support to assist Victoria Police through the provision of:<br>1. Four (4) Planning Officers<br>2. Four (4) Logistics Officers | EMV020CV | PDF RFA24 (EMV020CV) from SCC to EMA 08/07/20 @1727 hrs<br>Email from SCC-Vic to EMA- RFA 22 - 26 - 08/07/20 (EMV018CV - EMV022CV)<br>EMA acknowledgment of RFA22-26 from SCC-Vic 08/07/20 @ 1739 hrs<br>EMA email to MSC - RFA requests from SCC-Vic 08/07/20 @1738 hrs<br>**RFA accepted** - 22, 23, 24, 26 (EMV018, 019, 020 and 021) - not RFA25 (EMV021) unit further scoping is conducted with VICPOL on 08/07/20 @ 1845 hrs<br>EMA advising SCC-Vic of Defence acceptance of RFA 22, 23, 24, 26 (EMV 018, 019, 020, 022) 08/07/20 @ 1855 hrs |

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| 25 | **Defence** personnel.<br>Cancelled due to resourcing needs of Victoria Police have been pick up in subsequent RFAs.<br>The effect of this request is for the deployment of 150 personnel to augment Victoria Police in the planning and conducting the response to the COVID-19 Pandemic. | EMV021CV | Not yet accepted by Defence - further discussions with VicPol<br>PDF RFA25 (EMV021CV) from SCC to EMA 08/07/20 @1727 hrs<br>Email from SCC-Vic to EMA- RFA 22 - 26 - 08/07/20 (EMV018CV - EMV022CV)<br>EMA acknowledgment of RFA22-26 from SCC-Vic 08/07/20 @ 1739 hrs<br>EMA email to MSC - RFA requests from SCC-Vic 08/07/20 @1738 hrs<br>**RFA accepted** - 22, 23, 24, 26 (EMV018, 019, 020 and 021) - not RFA25 (EMV021) unit further scoping is conducted with VICPOL on 08/07/20 @ 1845 hrs<br>14/07/20 - SCC advise withdrawal of RFA 21 @ 1930 hrs<br>14/07/20 - EMA to MSC re cancellation of RFA 21 @ 1959 hrs<br>15/07/20 - MSC to EMA Ack of cancellation of RFA 25 (EMV021CV) @ 0942 hrs |
| 26 | **Defence** personnel.<br>Provision of 100 personnel to partner with Victoria police members to support the establishment and management of roadblocks within the Greater Melbourne and Mitchell Shire Council. | EMV022CV | PDF RFA24 (EMV022CV) from SCC to EMA 08/07/20 @1727 hrs<br>Email from SCC-Vic to EMA- RFA 22 - 26 - 08/07/20 (EMV018CV - EMV022CV)<br>EMA acknowledgment of RFA22-26 from SCC-Vic 08/07/20 @ 1739 hrs<br>EMA email to MSC - RFA requests from SCC-Vic 08/07/20 @1738 hrs<br>**RFA accepted** - 22, 23, 24, 26 (EMV018, 019, 020 and 021) - not RFA25 (EMV021) unit further scoping is conducted with VICPOL on 08/07/20 @ 1845 hrs<br>EMA advising SCC-Vic of Defence acceptance of RFA 22, 23, 24, 26 (EMV 018, 019, 020, 022) 08/07/20 @ 1855 hrs |

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| 27 | **Defence** personnel.<br>Provision of personnel to support COVID-19 operations. The tasking will include support to the functions of<br>1. Public health command liaison with the state controller health and other state control functions; and<br>2. intelligence support to the Vic. DHHS intelligence unit | EMV023CV | EMV-RFA-023 request VicGov - CCC received 10/07/20 @1108 hrs<br>EMA to SCCVic acknowledgement 10/07/20 @1132 hrs<br>EMA to MSC 10/08/20 @ 1143 hrs<br>MSC to EMA accepting RFA - 10/07/2020 @ 1405 hrs - **RFA accepted**<br>EMA to SCCVic advising of acceptance - 10/07/20 @ 1429 hrs |
| 28 | **Defence** personnel.<br>RFA 17, RFA 18, RFA 20, RFA 21, RFA 22, RFA 23, RFA 24, RFA 26, and RFA 27 have been included as part of RFA 28.<br><br>EMV024CV has been extended by EMV027CV and EMV028CV.<br>This overarching request includes all current requests (as at 14 July 2020) for assistance and covers planning, logistics and intelligence, public health, contact tracing data management and analysis, testing and call centre support, compliance support- in partnership with VicPol assist in the enforcement of the CHO's directions and provision of surge capacity for vehicle check points, humanitarian supply and logistics, community awareness support and pre-hospital health response. | EMV024CV | SCC to EMA Request for assistance - 14/07/20 @ 2139 hrs<br>EMA to MSC advice of RFA - 14/07/20 @ 2202 hrs<br>EMA to SCC acknowledging RFA - 14/07/20 @ 2205 hrs<br>MSC to EMA Defence - 15/07/20 @1607 hrs - **RFA accepted**<br>EMA to SCC Defence acceptance of RFA - 15/07/20 @1615 hrs<br>Note: All tasks have been accepted except for the 10 ADF Clinicians and 130 AHPRA registered ADF clinicians. Defence is investigating its medical resources and will advise as soon as possible about its ability to meet these aspects of the RFAs. |

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| 29 | Clinical personnel.<br>226 medical and clinical personnel to deploy in the Victorian Acute care settings to support existing health services. | EMV025CV | 02/08/2020 - SCC to EMA @1438 hrs - Initial request<br>02/08/2020 - signed RFA<br>02/08/2020 - EMA to DoH @ - 1537 hrs - advice of RFA<br>02/08/2020 - EMA to SCC - acknowledgment of receipt<br>02/08/2020 - EMA to MSC - supplementary request to Defence<br>08/09/2020 @ 0912 hrs - Health to EMA - advice on "completion" of RFA from 2/09/2020<br>**noting EMA did not receive the correspondence between Health Ops and DHHS that occurred on 2 September to advise of completion<br>08/09/2020 @ 1109 hrs - SCCVIC to Health, DHHS and EMA - requesting confirmation that RFA is not yet complete, but rather is in "STANDBY" mode until its original completion date of 30 September 2020<br>08/09/2020 @ 1117 hrs - DHHS to health, SCC and EMA - advice that RFA is in 'STANDBY' mode<br>NOTE: 25/09/2020: Advice from RIXON - Advised by EO to Commissioner EMV that this item will not be further extended.<br><br>**Forwarded to Department of Health for action** |
| 30 | **Defence** personnel.<br>Provision of 2x principal advisers and 2x senior advisors plus 75 data entry personnel to assist with DHHS inter-jurisdiction workforce relations and data entry support/surveillance officers to work with DHHS. | EMV026 | 05/08/2020 - Signed RFA<br>05/08/2020 @0816 hrs - EMV to EMA - initial request<br>05/08/2020 @ EMA to EMV acknowledgment of receipt<br>05/08/2020 @0931 hrs EMA to Services Australia - request for consideration of the request<br>06/08/2020 @ Notice by Defence to not accept<br>06/08/2020 @1824 - EMA to APSC - request for consideration of RFA<br>06/08/2020 @2102 hrs - APSC acknowledgment of receipt<br>11/08/2020 @ 1700 hrs - EMA to EMV - Advise that APSC had accepted the request<br>NOTE: 25/09/2020: Advice from RIXON - Advised by EO to Commissioner EMV that this item will not be further extended.<br><br>**APSC accepted RFA and provided personnel** |

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| 31 | **Defence** personnel. Items 31 and 32 replace item 28 (EMV024CV)<br>Personnel for Ambulance Victoria surge capacity now in EMV028CV<br>This overarching request includes all current requests (as at 26 August 2020) for assistance and covers state control support, public health, contact tracing data management and analysis, testing and call centre support, compliance support- in partnership with VicPol assist in the enforcement of the CHO's directions and provision of surge capacity for vehicle check points, humanitarian supply and logistics - support the distribution coordination of relief care packages such as essential supplies, community engagement support - assisting relevant agencies in delivery of community engagement and ooutreach, particularly for high risk and vulnerable communities, regional workplaces, high risk industries and critical infrastructure. | EMV027CV | 26/08/2020 - Signed RFA - ADD2020/4733271 plus appendix A<br>26/08/2020 @ 0907hrs - EMV ro EMA - initial request<br>26/08/2020 @ 0951hrs - EMA to EMV - acknowledgement of receipt<br>26/08/2020 @ 0946hrs - EMA to MSC - request for consideration<br>27/08/2020 @ 1028hrs - MSC to EMA - **RFA accepted**<br>27/08/2020 @ 1053hrs - EMA to EMV - Advise acceptance of RFA<br><br>The following precis identifies the support Defence will provide:<br><br>- Up to 8 ADF advisors to the SCC across various areas<br>- Up to 5 ADF to assist the SCC with coordination activities with a surge of 10 ADF pers at 7 days notice to effect (new task)<br>- Up to 60 ADF pers to assist DHHS with public health data management with a surge of 50 ADF pers at 7 days notice to effect<br>- Up to 260 ADF pers to assist DHHS with contact tracing (mix of 200 AHPRA clinicians and medics as currently agreed by DHHS and 60 support pers) with a surge of 20 ADF pers (log and ops) at 7 days notice to effect<br>- Up to 17 ADF pers (planning, ops) to assist with SCC intelligence functions<br>- Up to 2 ADF pers to assist SCC with off-site intelligence functions (new task)<br>- Up to 4 ADF pers to assist SCC with lessons capture and analysis (new task)<br>- Up to 12 ADF pers to assist VICPOL with the police assistance line<br>- Up to 5 ADF pers to assist VICPOL with planning and logistics<br>- Up to 200 ADF pers to assist VICPOL with check point operations (SENTINAL Phase II)<br>- Up to 50 ADF pers to assist VICPOL with community patrols (SENTINAL Phase I)<br>- Up to 60 ADF pers to assist DHHS with logistic planning and coordination<br>- Up to 100 ADF pers to assist DHHS with community engagement activities with a surge of 50 ADF pers at 7 days notice to effect<br>- Up to 30 ADF pers to assist VICPOL with QCM activities (VICPOL QCM data centre)<br>NOTE: 25/09/2020: Advice from EMA- Advised by EO to Commissioner EMV that an extension for a reduced scope of effort will be sought. MSC advised. |

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| 32 | **Defence** personnel. Items 31 and 32 replace item 28 (EMV024CV)<br>Previously included in EMV024CV<br>3 x teams of 20 (60) personnel for provision of surge capacity in partnering with Ambulance Victoria (AV) staff, in the pre-hospital health response. Each team to remain available for 60 days from each team's activation date. Dates are: 18/08, 21/08, 14/09. | EMV028CV | 26/08/2020 - Signed RFA<br>26/08/2020 @ 0907hrs - EMV to EMA - initial request<br>26/08/2020 @ 0952hrs - EMA to EMV - acknowledgement of receipt<br>26/08/2020 @ 0949hrs - EMA to MSC - request for consideration<br>27/08/2020 @ 0938hrs - MSC to EMA - **RFA accepted**<br>27/08/2020 @ 1011hrs - EMA to EMV - Advise acceptance of RFA<br>20/09/2020 @ 2029 hrs - EMA to MSC - Request for confirmation of RFA end date<br>29/09/2020 @ 2034 - EMA to SCC - confirmation of receipt of query re RFA EMV028CV<br>30/09/2020 @ 0922 - MSC to EMA - confirmation that EMV028CV will continue until 14/11/2020<br>30/09/2020 @ 1003 - EMA to VIC - Confirmation that RFA EMV028CV would continue until 14 /11/2020<br>10/11/2020 @ 1724 hrs - VIC to EMA - RFA not being extended |
| 33 | **Defence** personnel<br>Extension of Item 31, EMV027CV<br>This overarching request includes the following assistance:<br>+state control support<br>+ public health testing and call centre support<br>+ compliance support - in partnership with VicPol assist in the enforcement of the CHO's directions and provision of surge capacity for vehicle check points<br>+ Community Engagement Support - assisting relevant agencies in delivery of community engagement and outreach, particularly for high risk and vulnerable communities, regional workplaces, high risk industries and critical infrastructure. | EMV029CV | 29/09/2020 @ 1905 hrs - VIC to EMA - initial request<br>29/09/2020 @ 2024 hrs - EMA to MSC - RFA for consideration<br>29/09/2020 @ 2026 hrs - EMA to VIC - acknowledgement of receipt<br>30/09/2020 @ 0836 - EMA to VIC - Notice of a query from Defence about EMV029CV<br>30/09/2020 @ 1029 hrs - MSC to EMA - **RFA accepted**<br>30/09/2020 @ 1104 hrs - EMA to VIC - advice of defence acceptance with caveats<br>30/09/2020 @ 1109 - EMA to MSC - Copy of Victorian response to their query re EMV029CV<br>16102020 - VIC to EMA - Updated RFA<br>18102020 @ 0745 hrs - ABF to EMA - EMV-RFA029CV - Formal acceptance of RFA<br>18102020 @ 1529 hrs - EMA to VIC - EMV-RFA029CV - RFA APPROVED |

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| 34 | **Defence** personnel<br>Extension of Item 33, EMV029CV<br>This overarching request includes the following assistance:<br>+state control support<br>+ compliance support - in partnership with VicPol assist in the enforcement of the CHO's directions and provision of surge capacity for vehicle check points | EMA030CV | 28/10/2020 @ 0831 hrs - VIC to EMA - initial request<br>28/10/2020 @ 1024 hrs - EMA to MSC - RFA for consideration<br>28/10/2020 @ 1021 hrs - EMA to VIC - acknowledgement of receipt<br>30/10/2020 @ 2011 hrs - MSC to EMA - **RFA accepted**<br>30/10/2020 @ 2105 hrs - EMA to Vic - Acceptance |

## ASSISTANCE TO THE VICTORIAN AGED CARE RESPONSE

| Item | Request | Timeline detail |
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| 1 | **Defence** personnel.<br>Provision of 40 personnel to assist other agencies in providing medical support in aged care centres across Melbourne and also seeking capability, when not responding to emergency tasks to provide PPE training. | RFA received from VACRC to EMA 27/07/2020 @ 1945 hrs<br>EMA acknowledgment of request and sent to MSC for approval 27/07/2020 @2147 hrs<br>MSC approval of request 27/07/2020 @2245 hrs – **RFA accepted**<br>EMA advice of defence acceptance 28/07/2020 @0925 hrs<br>MSC to EMA - RFA PDF 28/07/2020 @1125 hrs |
| 2 | **Defence** personnel.<br>Develop and manage a complex headquarters involving mulitple commonwealth and support agencies, covering extended daily operating hours. | PDF RFA<br>30/07/2020 - 1350 hrs - VACRC to EMA - RFA<br>MSC was a recipient of this request message. Receipt was confirmed verbally with MSC (BUCKHAM) at around 1628 on 30 July 2020. PB, TL, 30/07/2020.<br>31/07/2020 - 0850hrs - MSC to EMA - **RFA accepted**<br>31/07/2020 - 0915hrs - EMA to VACRC - Advise acceptance<br>31/07/2020 - 0917hrs - VACRC to EMA - Acknowledgement |
| 3 | **Services Australia**<br>Facilitation of a 1800 number for the Aged Care Response Centre phone line to provide efficient dial-in access to the VACRC. | 05/08/2020 @ 0837 - VACRC to EMA - Initial request<br>05/08/2020 @0937 hrs - EMA to VACRC - acknowledgment of receipt – **Request forwarded to Services Australia** |
| 4 | **Defence** personnel.<br>Seeking to maintain the ongoing effect of 40 suitably qualified ADF medical staff, able to provide medical support to other agencies (such as AUSMAT, Clinical staff from assigned Hospitals) in emergency medical responses in aged care centres across greater metropolitan Melbourne and regional Victoria. | Signed RFA<br>6/08/2020 - VACRC to EMA initial request<br>6/08/2020 - EMA to VACRC - acknowledgement of receipt<br>06/08/2020 - EMA to MSC – **RFA accepted**<br>06/08/2020 @336 hrs - VA CRC to EMA - changes to RFA<br>07/08/2020 @0835 hrs - MSC/EMA to VACRC - acceptance/acknowledgment of RFA changes<br>07/08/2020 @1330 hrs - MSC to EMA - advice of formal acceptance |

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| 5 | **Medical** Personnel.<br>Seeking to establish suitably qualified AUSMAT (Department of Health) teams, able to provide medical and logistic support to emergency responses in aged care centres across greater metropolitan Melbourne and regional Victoria. | 20200807 - VACRC to EMA - Initial request<br>20200807 @1655 hrs - EMA to VACRC - acknowledgment of receipt<br>20200807 @ 1721 hrs - EMA to Health - RFA for approval<br>Note: RFA considered completed based on reporting contained in VACRC SITREP at 0800 on 06/10/2020<br>**Request forwarded to Department of Health for actioning** |
| 6 | **Defence** personnel.<br>VACRC request 100 Defence personnel who will, following training, be able to provide supplementary training to reinforce COVID-19 preventative protocols to staff in aged care facilities. | 20200810 @ 1208hrs - VACRC to EMA - initial request<br>20200810 @ 1226 hrs - EMA to MSC - advice of RFA approval<br>20200810 @ 1228 hrs - EMA to VACRC - Acknowledgement of receipt<br>20200813 @ 0951 hrs - MSC to EMA - advice on partial acceptance<br>20200817 @ 1341 hrs VACRC to EMA - advice on RFA amendment<br>20200817 @ 1524 hrs - EMA to MSC - RFA amendments for consideration<br>20200817 @ 1525 hrs -EMA to VACRC - acknowledgment of receipt<br>20200818 - @ 1818 hrs - MSC to EMA – **RFA accepted**<br>20200818 @ 1954 hrs - EMA to VACRC - advice on defence acceptance |
| 7 | **Defence** personnel.<br>Develop and manage a complex headquarters involving multiple commonwealth and support agencies, covering extended daily operating hours. | 13/08/2020 - VACRC to EMA - request for extension<br>13/08/2020 - EMA to VACRC - Ack of request<br>13/08/2020 - EMA to MSC - Advise of extension request<br>13/08/2020 - MSC to EMA – **RFA accepted** |
| 8 | **Defence** personnel.<br>VACRC to continue to use 100 Defence personnel to conduct Residual Aged Care Facility (RACF) site visits to reinforce COVID-19 preventative protocols to staff. | 02/09/2020 @ 1913 hrs - VACRC to EMA - request for extension<br>02/09/2020 @ 1930 hrs - EMA to MSC - advise extension request<br>02/09/2020 @ 1933 hrs - EMA to VACRC - acknowledgement of receipt<br>02/09/2020 @ 2004 hrs - MSC to EMA - acknowledgement of receipt<br>03/09/2020 @ 0826 hrs - MSC to EMA - acceptance advice<br>03/09/2020 @ 0859 hrs - EMA to VACRC – **RFA accepted**<br>03/09/2020 @ 0924 hrs - EMA to VACRC - advice of acceptance (mistaken resending of acceptance advice) |

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| 9 | **Defence** personnel.<br>Extension to the provision of ADF operational support staff to enable effective management of current and future operational effects to stem the spread of COIVD-19 infections throughout RACF. | 18/09/2020 @ 1010 hrs - VACRC to EMA - RFA extensions x2 - for consideration<br>18/09/2020 @ 1022 hrs EMA to MSC - RFA for consideration<br>18/09/2020 @ 1026 hrs - EMA to VACRC - acknowledgment of receipt<br>18/09/2020 @ 1533 hrs - MSC to EMA – **RFA accepted**<br>18/09/2020 @ 1539 hrs - EMA to VACRC - advice on defence acceptance |
| 10 | **Defence** personnel.<br>Seeking to maintain the ongoing effect of 40 suitably qualified ADF medical staff, able to provide medical support to other agencies (such as AUSMAT, Clinical staff from assigned Hospitals) in emergency medical responses in aged care centres across greater metropolitan Melbourne and regional Victoria.<br>MSC have agreed to provide a total of 30 personnel. | 18/09/2020 @ 1010 hrs - VACRC to EMA - RFA extensions x2 - for consideration<br>18/09/2020 @ 1026 hrs - EMA to VACRC - Acknowledgment of receipt<br>18/09/2020 @ 1022 hrs - EMA to MSC - RFA for consideration<br>22/09/2020 @ 1149 hrs - MSC to EMA – **RFA accepted** (with caveats)<br>22/09/2020 @ 1225 hrs - EMA to VACRC - advice on defence acceptance (with caveats) |
| 11 | **Defence** personnel.<br>Modification of extension to the provision of ADF operational support staff to enable effective management of current and future operational effects to stem the spread of COIVD-19 infections throughout RACF. | Modified RFA<br>18102020 @ 1807hrs - MSC to EMA – **RFA accepted**<br>19102020 @ 0928hrs - VIC to MSC - Signed RFA |