

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

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

Melbourne—Friday, 4 December 2020

MEMBERS

Ms Lizzie Blandthorn—Chair

Mr Richard Riordan—Deputy Chair

Mr Sam Hibbins

Mr David Limbrick

Mr Gary Maas

Mr Danny O'Brien

Ms Pauline Richards

Mr Tim Richardson

Ms Nina Taylor

Ms Bridget Vallenge

WITNESSES

Mr Martin Foley, MP, Minister for the Coordination of Health and Human Services: COVID-19,

Professor Euan Wallace, Secretary,

Mr Terry Symonds, Deputy Secretary, Health and Wellbeing,

Mr Argiri Alisandratos, Deputy Secretary, Children, Families, Communities and Disability, and Commander, Operation Beneserre,

Mr Ben Rimmer, Associate Secretary, and Deputy Secretary, Housing, and Chief Executive Officer, Homes Victoria,

Mr Greg Stenton, Deputy Secretary, Corporate Services,

Mr Chris Hotham, Deputy Secretary, Infrastructure,

Professor Brett Sutton, Chief Health Officer,

Professor Allen Cheng, Deputy Chief Health Officer,

Ms Sandy Pitcher, Deputy Secretary, COVID-19 Case Management, Contact and Outbreak, and

Mr Jeroen Weimar, Deputy Secretary, COVID-19 Community Engagement and Testing, and Commander, Operation Drasi, Department of Health and Human Services.

The CHAIR: I declare open this hearing of the Public Accounts and Estimates Committee.

I would like to begin by acknowledging the traditional Aboriginal owners of the land on which we are meeting. We pay our respects to them, their culture, their elders past, present and future and elders from other communities who may be here today.

Welcome to the third series of public hearings for the Public Accounts and Estimates Committee's Inquiry into the Victorian Government's Response to the COVID-19 Pandemic. The committee is reviewing and reporting to the Parliament on the responses taken by the Victorian government, including as part of the national cabinet, to manage the COVID-19 pandemic.

We note that witnesses and members may remove their masks when speaking to the committee but must replace them afterwards. Mobile telephones should be turned to silent.

All evidence taken by this committee is protected by parliamentary privilege. Comments repeated outside this hearing may not be protected by this privilege. Witnesses will be provided with a proof version of the transcript to check. Verified transcripts, presentations and handouts will be placed on the committee's website as soon as possible.

Welcome, Minister. Welcome to your officials. We invite you to make a brief opening statement of 8 minutes. We ask that you state your name, position and the department you represent for broadcasting purposes. This will be followed by questions from the committee.

Mr FOLEY: Thank you, Chair. I appreciate the opportunity to present to the committee on this very significant issue. When we get to our friends from the department I am sure they will introduce themselves accordingly.

Visual presentation.

Mr FOLEY: People may well have seen variations of this graph over recent times, but Victoria recorded its first case of COVID-19 on 25 January, and during March as the overseas case numbers returned and increased Victoria and indeed the rest of Australia recorded what we would now say was the first wave of cases, which largely resulted from large outbreaks in Iran, Italy, USA and the UK. In June 2020 after a period of relaxation

of restrictions the context changed dramatically as the result of an outbreak that emerged in relation to transmission from the hotel quarantine arrangements. The transmission at the start of the second wave included large family gatherings. Cases included people employed in casualised workforces with disincentives to engage with testing and potential isolation and real disincentives to reveal contacts who would have to therefore quarantine. Significant efforts and investments were made to drive down the numbers in Victoria. As we know, Victoria has now reached an extended period where zero cases have occurred following the success of these interventions.

In regard to investing to protect our health system—on slide 2—I think I might have commented earlier that there is really no opportunity for an economic recovery without building on a health recovery first, so this government has provided so far over \$2.9 billion in health initiatives to support the state's response to COVID-19. This has involved an early investment of some \$1.9 billion for new beds, new builds and critical care capacity. Our public health response has continued to evolve since the start of this pandemic. During the second wave of the pandemic we invested some \$14.7 million for medical research to fight the coronavirus as we grappled with understanding its evolution and its impact on communities.

As we continue to take careful steps out of restrictions we have also, amongst other things, released a \$9.8 million healthcare worker wellbeing package to support our healthcare workers, who have been working tirelessly to care for the Victorian community during the coronavirus pandemic and have been particularly disproportionately impacted by the spread of the virus. We have invested \$155 million towards establishing an Australian Institute for Infectious Diseases to lead the fight against future pandemics, and we are giving more patients the opportunity to recover from illness or surgery at home through programs such as I referred to earlier today—the delivery of hospital services in patients' homes.

In regard to beating the second wave and the strong focus that testing, tracing and isolation has had on the pandemic response, the three key tools are precisely that—to test, trace and isolate—and whilst they might well be three, they are in fact part of the one process. The government has built an extensive network of more than 200 testing sites across the state. Almost 3.6 million tests have been completed across the state, evolving and adapting as the needs and priorities of the community and the pattern of the virus that has spread across our community has changed.

Up until the weekend of 27 November, 89 per cent of tests were returned within 24 hours, and 99 per cent of tests were returned within 48 hours. As we continue to take steps on the road map to reopening, we have expanded the testing options to give industry the tools they need to reopen safely and to stay open. We have introduced surveillance testing in a range of high-risk industries to help keep our communities safe.

In response to beating the second wave, and again to expand on test, trace and isolating responses, contact tracing has been a critical part of our effort to slow the spread of coronavirus in Victoria. Our contact-tracing system has helped Victoria go from a high of over 700 cases a day to now 35 days in a row of zero cases. This is an outstanding achievement by any measure. We have continued to improve Victoria's testing and tracing capabilities, investing in over 2400 public response personnel in those teams of contact tracers to help stop the spread of the virus, cutting down the average time of test to quarantine to some 38 hours. We have established six metropolitan and six regional local public health units. These public health units strengthen the public health response more broadly and support engagement with the community, enable better integration of functions and improve the ability to respond to new cases and to outbreaks.

In regard to protecting our health system, our hospitals and local healthcare services have been the backbone, indeed the heart and soul, of our response to the pandemic. The government is protecting our health system by having ordered and having placed thousands of ventilators, significantly increasing the number of ICU beds and rapidly expanding innovative models of care, including new approaches to telehealth and Hospital in the Home to keep patients and healthcare workers safe. We secured an agreement with the state's major private hospital operators to ensure that they could continue to care for Victorians during the coronavirus pandemic. This agreement has meant that public and private hospitals have and will continue to work together to relieve pressure on public hospitals and ensure the entire health system is operating at full capacity.

In regard to protecting our healthcare workers, who have borne such a disproportionate load during the pandemic, a big part of the program of work was undertaken to drive down the coronavirus infections in our

healthcare workers. Research indicated that most cases acquired the virus at work. Every single health service in Victoria has been checked to make sure its COVID-safe plan is in place and up to scratch.

We have established a healthcare worker infection prevention and wellbeing task force that brings together infection control experts and workforce representatives to examine what may and can be done to stop the spread of the virus in our healthcare facilities. Based on its advice, we have released the *Protecting Our Healthcare Workers* plan, which has released a range of measures and helped to push policies, both in the state and across the commonwealth, to keep our workers safe. This has involved measures such as reducing patient density, reducing worker mobility across sites, daily staff attestations about wellness and increased PPE guidance and training. As part of the taskforce's additional recommendations, the government has worked with relevant stakeholders to assess every single health service, every aged-care facility, Aboriginal-controlled health organisations and GP clinics to ensure that workplaces are COVID-safe. Still in regard to protecting our healthcare workforce, in November we released a worker wellbeing package developed in consultation with hospitals, clinicians, peak bodies, unions and researchers. This \$9.8 million package complements additional measures to reduce healthcare worker infections and to increase support to those workers. This includes the development of a range of programs to assist—my time is done, I think, Chair.

The CHAIR: Thank you, Minister. Your time is done; thank you very much. I will pass to the Deputy Chair, Mr Richard Riordan, MP.

Mr RIORDAN: Thank you, Chair. Welcome back, everybody, and welcome to our guests. This is our third inquiry now into the state government's response to COVID, and as I sit here for the third time, I look across the table and presumably am looking at our six most experienced or knowledgeable people in the way the state is handling this, and of course the thing that springs to mind most is the fact that three of you have only just joined the ranks in recent months, and three of you—the minister, the department secretary and the assistant—are all replacements, which is a worrying thing to see—50 per cent turnover in management at a time of such crisis. I guess my question then is about a statement that was only published in the annual report in recent weeks from the person Secretary Wallace replaced, Kym Peake. She made the point that she felt:

... privileged to lead an organisation where I get to work with so many extraordinary, purpose-driven people, not only in the Department of Health and Human Services, but right across the state.

I guess many Victorians today are possibly wondering where that camaraderie and friendship and common purpose is when half the key people have been replaced. So my question to the Secretary, prior to your appointment you worked in various roles in the department—in your experience, has DHHS operated in a harmonious and collaborative manner?

Prof. WALLACE: Thanks, Mr Riordan. Yes, it is my belief we have. As you know, for four years now I have been CEO of Safer Care Victoria, an administrative office aligned with the department, so I have worked very closely with the department for four years. For the last six months of those, as you know, I have been working in public health—the COVID command—in a case contact and outbreak management team with Ms Pitcher, so I worked much more closely with the department than I had for the prior three and a half years and so I really saw the department very much close up. The senior leadership, the executive board of the department, the deputy secretaries, executive directors and directors reporting to us have all worked amazingly harmoniously. I mean, I think some of my deputy secretaries in recent weeks have commented that, as the state would hope, when faced with the huge challenges that the pandemic has presented not just for the Department of Health and Human Services but the state overall, the leadership has responded exactly as you would want them to—to pitch in and work very, very closely together. Necessarily we have all, from our various bits of the department, seamlessly shared staff. So as an example, Safer Care has an FTE equivalent of about 120; some 60 or 70 of those staff we moved out in service of the broader department's response to COVID. And that is replicated across the whole of the department, both in the health portfolios and in the human services portfolios.

Mr RIORDAN: So you do not think Victorians, particularly Victorians who have been badly affected by what has gone on here in the last seven months, would at all feel that, when they see a 50 per cent turnover of senior management, that is part of the problem?

Prof. WALLACE: No, I do not. In answering your question about, 'Have we worked harmoniously?', we have. Have we always had a shared view? No, we have not, but we have discussed and debated and come to a collective consensus view—

Mr RIORDAN: When you do not have a shared view, is that when someone gets turfed off the boat?

Prof. WALLACE: Not at all.

Mr RIORDAN: So we have not have a situation where we have had a minister steering the ship—

Mr FOLEY: If I could, Chair—

Mr RIORDAN: Excuse me, Minister—

Mr FOLEY: If the Secretary could be allowed to answer the question rather than have Mr Riordan continually interrupt his response, it might assist the smooth flowing of the committee.

Mr RIORDAN: I do not think I have. Put the mask back on.

The CHAIR: Deputy Chair, could you please refrain from such rude behaviour. Those who are asked a question have the right to be able to answer it. I would also remind the Deputy Chair that this is an inquiry into the government's response to managing the COVID pandemic. If you could keep your questions on task, that would be appreciated by the committee as a whole.

Mr RIORDAN: Chair, thank you for gobbling up my time once again. My question is quite simply: you have had a huge turnover—

The CHAIR: Deputy Chair, could you allow the Secretary to answer the question, please.

Prof. WALLACE: As I understand, your question is the turnover. You asked a specific question, 'Has the turnover of people reflected that people's opinions were not valued and they were moved?'. The resounding answer is absolutely not. I mean, Victorians should expect diversity of views, and of course views have changed over time. We have learned, as the rest of the world has, an enormous amount about how to handle and respond to this virus and the pandemic, and so of course as the pandemic has changed—and the minister showed the two waves, very, very different in nature requiring actually quite different responses—so we have moved with those responses.

Mr RIORDAN: Okay. So, Professor, it has been reported you contacted Professor Sutton as you had heard that there was a bit of tension. You had an email exchange with Professor Sutton where he raised grievances in line with I guess what you have been saying. Were you surprised when neither Ms Peake nor Professor Sutton raised these emails in evidence at the hotel inquiry?

Prof. WALLACE: I think the evidence that both Ms Peake and Professor Sutton raised and tabled at the inquiry was in response to questions asked of them. I do not think that there has been a characterisation that the department withheld evidence. I think that is a mischaracterisation. There was no purposeful withholding of evidence from the inquiry. In fact the response of the department to the board of inquiry was fulsome in its entirety. The email that you refer to was an email just exploring in the early phases of hotel quarantine the standing up and the delivery of the clinical pathways that underpinned the hotel quarantine program. And actually, as you know, I was a witness myself at the board of inquiry. I was asked exactly the same question by counsel assisting with regard to a very similar email to the deputy secretary in charge of RHPEM at the time. Again, it was an email that related conversations about the formulation—the very rapid formulation—of policy guidelines, patient flow and then the implementation of those guidelines.

Mr RIORDAN: So my next question is to Professor Sutton. It has been reported that you said not being consulted on hotel quarantine was a source of moral and legal unease, which I think we could assume is a pretty firm statement there. What did you mean by that?

Prof. SUTTON: I meant that the role of the Chief Health Officer is to hold a statutory position where the exercise of power is very substantial, and that includes authorising authorised officers to undertake powers, including of detention of individuals in quarantine and isolation. So that is a significant legal responsibility, and appropriate oversight of that is an important feature.

Mr RIORDAN: This was in relation to you not being involved in setting up the hotel quarantine and the protocols. So what further action did you take? At that time, as you have all year, you became an important part

of every Victorian's life in terms of tuning in to see what they can and cannot do for the next day, and even here in Parliament we have to wait to see whether you say we can sit in the chamber or not sit in the chamber. These are decisions that have affected every Victorian's life. What did you do with this? Clearly as a medical person you would have understood that quarantine, particularly international quarantine, was a really vital thing to get right. What did you do to progress the fact that you had moral and legal unease about something that you obviously would have known could have been catastrophic if it was wrong?

Prof. SUTTON: So I discussed it with my public health leadership team—the public health incident management team leadership—and engaged them in discussions with the emergency management colleagues around these issues to make sure that the policy inputs and that the oversight that they had over some of those critical functions was as strong as it could be.

Mr RIORDAN: And at that point when things were not happening as they should have, you, with this moral and legal unease, did not go above and go straight to the minister? You did not go straight to Kym Peake at the time? You did not maximise your capacity to influence what was going on?

Prof. SUTTON: Well, I did discuss it with Professor Wallace, as you saw in the email exchange. And we agreed that it was important to have a continued discussion and engagement with the emergency management branch of DHHS and with Emergency Management Victoria around those elements, and there was ongoing discussion and ongoing negotiation about how best those arrangements could be embedded.

Mr RIORDAN: But that is not really answering my question. My question goes to the essence that for every day and every week for seven months you have pretty much instructed Victorians on every element of their lives, and yet in an area that was clearly the most dangerous part of the whole experience for seven months, you were just happy to do the odd little email and have the odd conversation with people in your office, not to go straight to the top on it.

Prof. SUTTON: No. I think that is a mischaracterisation. Firstly, it was not the most important element of the response. The important elements of the response were—

Mr RIORDAN: Is it the most cataclysmic?

Prof. SUTTON: In terms of how it turned out, absolutely it was. But at the time, there were a number of challenges that related to everyone who was in isolation and quarantine across the state, not just in the hotel quarantine program. In terms of how we tried to progress it, we absolutely continued to work through how best to have public health leadership represented in the command and control conversations.

Mr RIORDAN: Getting back to the tendering of evidence to the hotel inquiry, did you look back through your own emails before tendering evidence to the hotel inquiry?

Prof. SUTTON: No, I did not.

Mr RIORDAN: You did not at all?

Prof. SUTTON: No.

Mr RIORDAN: No? Okay. And did Professor Wallace ever raise with you concerns about the accuracy of the evidence that you were giving to the hotel inquiry before he ordered a forensic—

Prof. SUTTON: Before he—

Mr RIORDAN: Before he ordered the forensic review of the further information that was given to the hotel. Did he discuss with you the accuracy of what you had tendered?

Prof. SUTTON: No, he did not.

Prof. WALLACE: Mr Riordan, remember that I was not Secretary when the further information was provided to the board of inquiry. So I have not triggered a further review.

Mr RIORDAN: And, Secretary, a further question—thank you, Dr Sutton—has your department and its lawyers, Minter Ellison, in appearing before the hotel quarantine inquiry, upheld the government’s model litigant guidelines and met all community expectations?

Prof. WALLACE: Yes, we have.

Mr RIORDAN: And can you give us an idea to date of what the cost to your department has been in its legal representation at the inquiry?

Prof. WALLACE: Not at the moment. As you know, the inquiry has not handed down its findings, and so the process has not finished. So we do not have a final cost.

Mr RIORDAN: Well, have you got a running tally? Presumably you have paid some bills.

Prof. WALLACE: I do not have that information today.

Mr RIORDAN: Would that be something you do have that you could provide to us?

Prof. WALLACE: I am not sure. I mean, I think it is something that will clearly be provided by the end of the litigation, by the end of the board of inquiry, but at the moment we do not have a—

Mr RIORDAN: You do not have—okay. Okay, so it is just getting paid out of petty cash, I guess. On behalf of your department, do you accept any responsibility for the delays and additional costs of the inquiry, given the fact that it was actually through media pressure that further and better information had to be supplied to the inquiry?

Prof. WALLACE: No. All of the witnesses provided fulsome responses to questions they were asked. If I give you just a sense, the department established a dedicated team to respond to the board of inquiry. Over half a million documents were extracted for review. In the first round we provided nearly 4500 documents, we responded to some 36 notices to produce, and all those documents amounted to almost 42 500 pages, with 31 witness statements themselves running to more than 600 pages—14 officials in the department collectively gave evidence for over 30 hours and then in the second round have reviewed another 20 000 documents. And all this was going on at a time that the department had a central role in protecting Victorians against this pandemic. So I think the department has been more than fulsome and cooperative, exactly as the people of Victoria would have expected.

Mr RIORDAN: Well, I guess we will soon find out, won’t we? Secretary, you made the point just before that you have not managed to tally up any legal costs for the inquiry that has been going since July. Presumably you have probably put a red line under the costs associated with former Minister Mikakos. Would you be able to tell us what costs were incurred with the former minister?

Prof. WALLACE: In terms of costs—

Mr RIORDAN: For the inquiry, yes.

Prof. WALLACE: to the inquiry? No.

Mr RIORDAN: Would you have those available?

Prof. WALLACE: No, I do not.

Mr RIORDAN: You do not have those either? Okay. Secretary, the Coate inquiry detailed that the cost of hotel quarantine was \$195 million. What portion of that did DHHS pay?

Prof. WALLACE: I do have that for you.

Mr RIORDAN: Are you able to provide that sort of information with a breakdown of expenditure that DHHS—

Prof. WALLACE: Yes, I do. Apologies; just bear with me.

Mr RIORDAN: Perhaps while you are searching for that, Secretary, could I just get a last question to the minister, if I may, Minister Foley? In evidence earlier today you said that a vaccine for COVID would not be compulsory but would be voluntary and that there would be incentives. What did you mean by, ‘There would be incentives’?

Mr FOLEY: Thank you, Mr Riordan. Thank you for your question. As you recall, I was relaying the position of the national cabinet. I was faithfully sharing with this committee and through it the people of Victoria the fact that the national cabinet has taken that position. That is what I meant—no more, no less.

Mr RIORDAN: Okay. Thank you.

Prof. WALLACE: Sorry, Mr Riordan. So in the last financial year, 2019–20, the cost was \$17.57 million and from 1 July to 16 September it was \$33.7 million.

Mr RIORDAN: Right. Can I ask, just on the legal costs question—you said you have not yet tallied up those for former Minister Mikakos. Can we assume that you have actually finished with her and we are not still paying ongoing costs for her representation? Are there ongoing costs still associated with the former minister’s position?

Prof. WALLACE: I am not aware that we have ongoing costs with the minister, but—

Mr RIORDAN: Could you get back to us—take that on notice?

Prof. WALLACE: I will.

Mr RIORDAN: Okay. Thank you very much. Now, back to the vaccine issue—and we are out of time.

The CHAIR: Sorry, Mr Riordan, your time has expired. I will pass the call to Mr Gary Maas, MP.

Mr MAAS: Thank you, Chair. And thank you, Minister and health officials, for your appearance at this inquiry. I would like to go to the substantial issue of contact tracing and a question for the minister. Throughout Victoria’s response to COVID-19 I think it would be fair to say that there has been a fair bit of attention that has been given to our contact-tracing system. At the last parliamentary hearing the DHHS witnesses talked about many changes and improvements that were indeed being made to the contact-tracing system. Indeed I think this morning most Victorians woke up to the news of the mystery-case tool that has been developed. Minister, I was hoping you would be able to take the committee through some of these improvements that have been made.

Mr FOLEY: Thank you, Mr Maas, and I am more than happy to do so. The Victorian Department of Health and Human Services, as a high-performance learning organisation, is always looking to how it can improve and respond to issues that are confronting it. There have been no more confronting issues than the global pandemic of 2020, and in that regard, looking at ways to continuously improve the way we fight that virus has been a significant focus for the department.

We know that test, trace and isolate is a key part of how we respond to this virus until such time as a suitable vaccine and treatment is in place—and, I suspect for some substantial time after that, until the virus is considered beaten. We need to make sure that the people who test positive, their contacts and increasingly, through the evolution of the model, the contacts of those close contacts are protected and isolated in the most timely and effective way. Internationally this performance is measured by how you contact all cases and place them in isolation within 24 hours of the original notification. It is all, then, the ability to make sure that you interview all cases within 24 hours of the notification to identify their close contacts and the ability to quarantine close contacts within 24 hours and within 48 hours of the case being notified.

Victoria, I am happy to report, clearly over the period of the last few months has exceeded these performance measures when it has had to respond to outbreaks. The result is now, for over a month now—35 days in fact—we have had zero community transmissions. I see this in part as a result of the continuous improvement and learning approach that a high-performance organisation like DHHS would expect of itself.

Following the first wave the department reviewed and implemented improvements across the test, trace and isolate process, including enhancement to the technologies and equally to the way in which it went about that, underpinning effective and efficient contact tracing. One of these achievements was the establishment of what

has been dubbed by the media the ‘mystery case tracker’. This was an innovation developed in-house by our epidemiologists and public health data team. This case tracker essentially—from what we understand the first of its kind created in-house—saves precious minutes if not hours in contact tracing investigation. And indeed we have seen its application more recently—in the past few days, in fact—in helping track down some issues around potential shedding contacts in the Colac area. One of these arrangements essentially was to make sure that, as a result of the aforementioned national contact-tracing review by Dr Finkel, this tool was highlighted, and it has been the subject of some interest by our interstate colleagues.

The mystery case tracker is a tool that supports the department’s epidemiologists in their investigations in linking together unknown sources of acquisitions, assisting them with real-time artificial information and augmented support to draw links that would take otherwise substantial periods of time for humans to go through, let alone existing IT systems to go through.

The mystery case tracker started being used in its initial forms in September and is now in place for potentially every single case that Victoria needs to deploy it for. And whilst we hope that we never have to deploy it again in terms of cases and contacts, the reality is, as we have seen in interstate jurisdictions in more recent times, that there is every expectation that whilst the past 35 days have been in the space that we want them to be—no new infections—we are working on the basis that this infection will come back and that we do need to be eternally vigilant in terms of how we respond if we want to stay safe and stay open.

This tool is an important part of the technological contribution to having the right people, the right systems, the right technology and the right community engagement in place to make sure that our public health response—that key component of it; testing tracing and isolating positive cases and their contacts—is at the heart of that response.

Mr MAAS: Thank you, Minister. If I could take you now to the establishment of regional and local public health units. The government recently announced these to support the response to the pandemic. Would you be able to outline for the committee how the use of these units will operate and, secondly, the role that they will play in containing future outbreaks?

Mr FOLEY: Thank you, and I am happy to do so. So, ensuring that local intelligence in every sense of ‘local’ and ‘intelligence’ applies in public health responses is critical now in response to the COVID-19 pandemic as well as ongoing engagement for future, wider public health responses. The local public health units have been a very important part of that civic, medical, community, rich pattern of bringing that localised appreciation of issues into decision-making and response, not just of the Department of Health and Human Services but indeed the wider primary health community, the health and hospital network and all the associated community groups associated with that, together with the central part of DHHS’s response across the state. Local public health units strengthen that public health response by making it more embedded in the community and able to respond in a more timely and effective way. We know that an enabled community is able to respond both in a public health sense as well as a care-providing response in ways that make sure that that public health need is nuanced to that community’s responses and application of how the virus presents differently in different communities is dealt with.

The six regional and six metropolitan public health units have now been operating across the board fully since 19 October. These local public health units have been established with the emergence of what has been a series of cooperative clusters—whether they be in the regions, based on the western, south-eastern and north-eastern hospital networks or equally within the Victorian Melbourne metropolitan area—and we have seen lead health services partner with the local public health units, with the primary health care networks, with the local GPs, with the specific diverse communities, with local government and with other agencies to make sure that the diversity of Victoria’s population is responded to and reflected in the localised public health units’ response to both this pandemic and I would hope a future of further public health measures into the future.

Each unit will progressively develop its own local, embedded primary care, local government and community partners. They have all been great, but the Barwon local public health unit has been, frankly, outstanding in its ability to get off and running and bring its substantial community intelligence into the public health response. We have seen that, as I say, most recently in its application of the community knowledge and the technology in just tracking down so quickly the response that we have managed to identify the likely source of the virus shedding in the Colac community this week—to a point where I was pleasantly surprised that my good friend

the federal Minister for Health gave the Victorian Department of Health and Human Services response a shout-out in his media conference yesterday with the Prime Minister on that particular response. And I sent the federal minister an acknowledgement that it was very good to be back on team Victoria when it came to recognising the important efforts that the Victorian government and this department had achieved in bringing together all of those critical elements of people, technology and community into an integrated public health response—and the local public health units I am confident will be an ongoing central pillar to that response.

Mr MAAS: Very good. Thank you, Minister. If the committee could hear some examples perhaps of an effective local response.

Mr FOLEY: Indeed. Staying on the work of the local public health unit in Barwon, I am sure the Deputy Chair would be strongly in support of the manner in which the Barwon local public health unit responded to the Colac abattoir outbreak earlier in the year, where some 88 cases were linked to the Australian Lamb Colac facility, which included 68 cases in staff, 17 household contacts, two social contacts and one visitor to the site. The way in which that Barwon-led local public health unit was able to engage with the community and with the response was a significant forerunner to continuous learning in responses to that. We then saw again in the Kilmore outbreak the same local teams—in this case Barwon assisted the Goulburn Valley team in responding to that—and we saw substantial development in how the community managed to provide really critical and quality information as to people who were in the Oddfellows Cafe at the time. That case remarkably, even though the virus had been circulating for some time, was able to be responded to to keep that to five cases. It was an extraordinary effort, again bringing together those localised supports and contacts and the wider response.

Indeed I would perhaps close by pointing out the Shepparton outbreak, where—even longer—the virus had been circulating for the best part of two weeks prior to it being diagnosed in that community, which was unfortunate on many levels but fortunate in that it showed again the Goulburn Valley team leading that response supported by other local public health units. But it brought together civic leadership, medical local primary health leadership, the Goulburn Valley Health team, other local public health units, the support from the ADF and the outstanding support of the Shepparton community, where we saw enormous amounts of that Goulburn Valley community in Shepparton in particular respond in an outstanding way. And it is a case that I think we should all reflect on when we think about the role that masks play—low-cost but high-impact arrangements. As a result of that community being able to wear masks for that two-week period, we will never know for sure, but every piece of advice that I have seen and every piece of local impact and response that I have heard places all of those different elements in an important continuum of response that saw that outbreak after two weeks of unchecked spread of the virus be restricted to three cases. I felt that was an outstanding example of all the different elements of the learnings of the Victorian community, particularly the officers of my department and the officers of the local public health units, and the support particularly that the Victorian community brought that can point to the successes.

Yes there have been many learnings, but there have been many important successes. No other health service—no other public health service—has been tested in this country like the Victorian response. I am extraordinarily proud of the efforts that my department and its partners have made, and I want to use this as an opportunity to acknowledge both the leadership of this department and the contribution from so many community partners in helping us get to the position where frankly the many sceptics have been proved wrong, that we can get to the amount of 35 days of continuous COVID-free status. We are not out of this process by a long shot, but the role that local public health units play in that response has been important and I think will only grow in importance.

Mr MAAS: Thank you, Minister. In the last couple of minutes that I have left, would you be able to outline for the committee the considerations that were taken into account as to where local public health units would be located?

Mr FOLEY: Like all things in the response that the government has dealt with during the course of this global pandemic, it has been based on the public health advice and the science and the data, and in this instance overlaid with the community engagement and the feedback from local communities as to where resources are best allocated and through the outstanding collaborations we have seen from both our health networks, our primary health providers and our community health providers. Those discussions, which I cannot claim credit for in that the former minister and the department at the time put them all in place, saw how the location of the data from the case contact and outbreak management team applied a series of criteria.

That criteria involved proximity to community; making sure that public health units could function in a sufficiently big enough population group to make sure that the skills and the backing and the resources were in local communities at those centres; the organisational capability of the lead partner organisations—to make sure that they were equipped with sufficient expertise, workforce and infrastructure—and how that needed to be supplemented quite substantially, but we needed a base level of organisational capacity; how to make sure that systems were in strategic alignment, between those services as lead organisations that were chosen, and how that could be consistent with a wider system of engagement and structures with both state and national bodies, and through their level of competency and their history, how engaged they in turn were in their local community, particularly when it comes to diverse communities and at-risk communities; and then of course the efficiency of the operation to make sure that local public health units and local health services could provide the range of services they needed to respond.

Mr MAAS: Thank you, Minister.

The CHAIR: Thank you. David Limbrick, MLC.

Mr LIMBRICK: Thank you, Chair, and thank you again, Minister and team, for appearing again today. I would like to direct my first question to Professor Sutton, and I imagine you already have an idea of what I am going to be talking about. But I will start with a bit of preamble. As part of my role as an MP, I go to witness some of the responses to the pandemic that the government has been doing, and on 3 November, Cup Day, there was a protest planned just outside, there. I would estimate there were probably between 1000 and 1500 people that turned up there. We have had a number of submissions to the inquiry that give an account of this protest. I realise you would not have read all of the submissions, so rather than hear my description of it, I would like to just quote a couple of paragraphs from this submission. This is submission 210a from a ‘name withheld’, and this person is describing the point at which the police surrounded people. I can personally attest to the accuracy of what this person is saying, because I witnessed nearly everything that they are talking about personally. And I will quote:

I also noticed that the hundreds of police officers began to slowly encircle us to a point where we were kettled in—
‘kettling’ is the name of the tactic used—

so tightly and then detained for up to 3 to 4 hours for no reason. While we were detained, women were having anxiety attacks and difficulty in breathing, some needed to go to the toilet as I could hear that they had women issues—

I might add that women were yelling out that they were having their period and needed to go to the toilet; I personally heard this—

but the police officers wouldn’t release us. It was a warm day and people within the circle requested water and eventually after an hour or more we were given some water from a bucket.

Which I later discovered was borrowed from the pub.

During that time an elderly man within the circle, approached the police officers encircling us asked to go to the toilet, immediately they head locked him and hauled him off in such a terrible manner it was horrifying to see, the elderly man needed to go to the toilet, he had been detained for more than 3 hours! I eventually saw him later sitting on a chair with his shirt unbuttoned with two police officers attending to him as he had two stickers on his chest with wire coming out of him, the brutal attack obviously affected him. Why would they drag and wrestle an elderly man for requesting to use the toilet??

Well, the answer to that is that the police were enforcing and giving out fines for breaching section 203 of the *Public Health and Wellbeing Act*, and the reason given, which seems quite crazy to me, was that they were congregating in groups of more than 10 people. My question to you, Professor Sutton, is: would not this type of enforcement of these public health directions increase the risk of disease transmission rather than reduce it?

Prof. SUTTON: I was not there. I accept your account as a direct witness and as someone who knows other individuals who were present. My advice in framing public health directions is around reducing the risk of transmission. That is why the public health directions have limited public gatherings to various sizes at different points in the epidemic. In terms of what the tactical or strategic responses of police are in managing that, I think it is for them to answer how best they do it. But it always remains the public health advice that the greater the distance that you can have between people, the lesser the risk of transmission of a virus should someone be infected, and of course the reduced amount of time that people are in close contact and the reduction in the number of people, especially those who do not know each other, who do not normally reside together, are all measures that reduce the risk of transmission. But how police tactically manage the dilemma, I guess, of people

gathering against the public health directions in terms of the limitations framed in those directions on gathering sizes is a matter for Victoria Police.

Mr LIMBRICK: Thank you, Professor Sutton. Did you have any consultation with police before this event—like, how they might go about managing these restrictions?

Prof. SUTTON: No, I did not. I was not aware that the event was taking place.

Mr LIMBRICK: Okay. One thing that we have spoken about before, and I brought this up with the Premier last week as well, is that we have two things here: one is the public health directions, and the other is the enforcement of those directions. We have discussed this before, that when your team is coming up with the public health directions, they have to be proportionate and the least restrictive of rights. What I do not understand, and what I think many people do not understand, is how can you be sure that the public health directions that are being issued are the least restrictive of rights, when the restrictions of those rights are actually handled by Victoria Police, which is totally separate apparently to the creation of those directions? How can you be certain that they are actually the least restrictive of rights, when you do not have any input into the enforcement?

Prof. SUTTON: The framing of ‘least restrictive’ is in terms of the threshold numbers, if you like, for the kind of directions that have been put in place, so on the size of gatherings, on the time that people are permitted to be engaged in a particular activity. Those public health directions are informed by that balancing of risk of transmission against the constraints on people’s movement and people’s assembly. One never knows in absolute terms if you could have had lesser constraints, because we do not have an alternative universe in which transmission has played out differently, but we are always mindful of the fact that we are trying to constrain to the smallest extent possible people’s individual rights and liberties, but still manage, really what I would regard as the most profound threat to liberty, which is an uncontrolled epidemic, where tens of thousands of people can contract illness and hundreds of people can die, including on a daily basis if you do not get control of that transmission.

Mr LIMBRICK: Thank you, Professor Sutton—

The CHAIR: Sorry, Mr Limbrick, can I just interrupt you for a moment. The submission that you have been referring to was published on the basis that the name was withheld. Can you just be careful not to say anything that might subsequently identify the name of the person?

Mr LIMBRICK: Yes. I do not know this person at all. It just happens to coincide with my experience, but I do not know who this actually is, and it was published on the website.

We have a situation, though, where in the creation of these directions, when you were formulating or when your team was formulating that direction, you imagined what rights might be limited by that, but clearly the enforcement of that has resulted in other rights being taken away from Victorians. As a direct result of the creation of that direction, it would appear that you did not imagine that people, by the gathering-of-more-than-10-people restriction, would not be deprived of their liberty for being in the city for a number of hours and pushed together like that and some of the other awful things that I described in this submission and I also witnessed. You know, what is the response here? Certainly there are more rights being restricted than are envisaged when the public health directions are being created. It is clear by the evidence, isn’t it?

Prof. SUTTON: I would say that it is true of any law that has a potential police response. Any law could have the potential for police requiring enforcement that, as you rightly point out, infringes people in other ways in order to enforce that law. It is a matter for Victoria Police to manage that in a way that they see as the most appropriate and proportionate, and should be cognisant of the rights of individuals under law.

Mr LIMBRICK: Thank you, Professor Sutton. The evidence for these directions and the human rights charter assessments—I believe that they are done for all these, but they have not been published. I spoke to the Premier about this last week. There has been a summary of advice in the statement of emergency extensions, which I provided my feedback on, and it was not particularly flattering. But these assessments are not public, so the public does not get to see these charter assessments. Are they sent to the Victorian Equal Opportunity and Human Rights Commission? Have they seen the evidence and the charter assessments? Is that something that they review?

Prof. SUTTON: Not that I am aware of, but those assessments are made for each and every direction and each iteration of every direction that is made. They must be considered by me, and the legal team provide that with any highlights of things that are of concern or need to be emphasised in terms of the difficult balancing of rights and liberties.

Mr LIMBRICK: Thank you, Professor Sutton. So if it turns out that the Victorian Equal Opportunity and Human Rights Commission does not have access to the evidence or the charter assessments, it would not be possible for them to independently determine if these restrictions were proportionate and the least restrictive of rights without seeing those assessments. Would that be correct?

Prof. SUTTON: It is a given to me if they cannot see them that they cannot make a determination in relation to them.

Mr LIMBRICK: Who can make that determination independently of your team?

Prof. SUTTON: Well, I know that any individual can challenge the public health directions—

Mr LIMBRICK: We have seen a court challenge, yes.

Prof. SUTTON: and that can come before the court in terms of a question of proportionality or legitimacy.

Mr LIMBRICK: But how could I as a member of Parliament? It is my job to scrutinise this. I want to independently verify that I am satisfied that this is proportionate and the least restrictive of rights. It is impossible for me to do that. In fact the only way that I can do that is to get out on the street and witness the results of the directions and make my own assessment, and I do not buy it basically. What is your response to that? How can anyone know that this is the least restrictive, outside of your team?

Prof. SUTTON: I am not a legal expert. I would leave it to somebody who—

Mr LIMBRICK: Well, it is not even a legal issue really. You could frame it as a legal issue, but I am not trying to frame it as a legal issue. I am trying to say: are there other options that your team could have come up with that would have been less restrictive of rights? I look at the results on the ground, and it seems like there might be.

Prof. SUTTON: I think it is a legal issue in terms of what the avenues are for individuals to examine laws made under the *Public Health and Wellbeing Act* and the emergency declarations under that.

Mr LIMBRICK: Okay, thank you. Another thing with the public health directions—and we have spoken about this before—is in the legislation you have got a couple of options: either you can base it on the best scientific evidence or you can base these directions on the precautionary principle if you do not have full evidence. I think we have spoken about this before. I know you will not know exactly off the top of your head, but as a guide, what proportion of these directions is relying on the precautionary principle rather than direct evidence?

Prof. SUTTON: They are not mutually exclusive considerations. You can have evidence and you still apply the precautionary principle, because the alternative has played out globally. We have seen countries take action at the height of transmission where an earlier intervention that can look excessive, is often accused of being excessive, is missed. That opportunity is missed because the actions are taken when the health system is under stress, when the numbers of people presenting for acute care or who are dying is actually peaking. So I would not say that you either have evidence or the precautionary principle, but the precautionary principle, as you rightly point out, says that in the absence of absolute clarity it should be a consideration. I would say that in probably the majority of considerations the precautionary principle is at play, because the alternative, as I say, is that it can get away from you whereby the cure, if you like, the response, is even harder, even longer, even more constraining of personal freedoms and rights than if you take an earlier and sometimes apparently more robust or more excessive response.

Mr LIMBRICK: Thank you, Professor Sutton. On the issue of a more excessive response, we have seen other countries take different responses to us, and I would say maybe they would have been more successful—we would have controlled it quicker here if we had had more restrictive things. You know, like in China we saw those images of people's apartment doors being welded shut and all this sort of thing, very, very shocking

things to a free society like Australia. But it sort of begs the question that if there is a more extreme response and there is a lesser response, how do Victorians know that the response that we have got is not excessive?

Prof. SUTTON: It is my obligation under the *Public Health and Wellbeing Act* to consider those principles as outlined in the Act. That is my statutory duty. I have to make a consideration of not being excessive, to consider in absolute terms the question of proportionality. I give my assurance that I have not taken actions that are more than is required to the best of my knowledge.

Mr LIMBRICK: Thank you, Professor Sutton. One of the things that is concerning me on top of this is because people do not see this evidence and these charter assessments, very soon we are going to be in a situation where if a vaccine becomes recognised as safe and effective, public health teams are going to have to communicate that to the public and say, 'You know, this is a safe and effective thing'. Minister Foley said that it will not be a mandatory thing, so it will be a matter of people trusting public health experts. What sort of actions do you think are going to be necessary to get that trust of people to believe that these medicines will be beneficial and not dangerous and that they are safe and effective?

Prof. SUTTON: Look, it is a really critical question. I think it will be the most important task ahead of us in lots of ways, to build the trust and rapport in the vaccine that will be, I am sure, going through the regulatory processes in Australia and getting to a point where it is approved. I think it involves all levels of government. I think we need to work with our academic partners and other experts in the field to be really clear about our understanding and any uncertainties that might remain, to hear the concerns, to respond to them rationally and scientifically and to be as engaged as we possibly can be with those who are supportive, those who are ambivalent and those who are vociferously against the idea of vaccination. I think that engagement is absolutely critical, and we should not shy away from it. I think the task begins now. I have no doubt that we will work with all of our jurisdictional counterparts and the commonwealth government around people building trust in the vaccine and all the information that is coming from independent public health experts around the country.

Mr LIMBRICK: Thank you very much, Professor Sutton.

The CHAIR: Thank you, Mr Limbrick. Mr Danny O'Brien.

Mr D O'BRIEN: Thank you, Chair. Good afternoon, Professor Sutton. Leave the mask off, which is pertinent. We have just gone past 35 days now of zero cases, seven days past the accepted definition of elimination. What is your current advice to government as at today on the need for masks?

Prof. SUTTON: We are clearly moving through a phase where the utility of masks becomes less and less, and we have changed the advice on masks from universal mask wearing indoors and outdoors to primarily focused on wearing indoors. That is the current state of advice, as well as where it is impossible or where one is unable to appropriately physically distance when outside. It is to be determined this weekend, but we will move to a phase where there is even more limited use of masks in public.

But the recommendation for mask wearing still exists around Australia, even in places where it has not been mandated at all, because it is a kind of insurance for all of us in Australia. We do not know where another incursion into the country might come from. We have seen incursions into hotel quarantine. They are intrinsically high-risk settings for transmission—and South Australia and Western Australia and New South Wales and New Zealand and Victoria have all had cases of transmission out of hotel quarantine—but first ports of entry, maritime crew and even frozen goods have been implicated as new incursions. So as an insurance policy, it is better to have masks worn when someone might be infectious than to have a very broad mandate after you find transmission in the local community.

Mr D O'BRIEN: Professor Sutton, I get all that, and I understand the nuance you were giving in your answer to Mr Limbrick. The question was: what is your advice to government as at today?

Prof. SUTTON: Well, it has not been framed definitively. There will be announcements on Sunday.

Mr D O'BRIEN: On Sunday. This is probably a good question that many of us have been wondering all this year: when do you give your advice that the government then provides? Is it written? Do you give it to them in verbal form? On all the restrictions, I mean?

Prof. SUTTON: All the above. So there is advice that is given formally in written form. There is an iterative process where there are further questions, clarifications through the considerations of CMC as it is currently, and previously through CCC, and verbal advice that is given around the many public health meetings that we have with cabinet or cabinet representatives.

Mr D O'BRIEN: And are we safe now to go to COVID normal?

Prof. SUTTON: Yes, I think so.

Mr D O'BRIEN: Why haven't we gone to it already, then? You know, if we eliminated a week ago, why didn't we go on Sunday?

Prof. SUTTON: There are policy questions, the details of which need to get worked up in detail. All of the legislation needs to be written in a way that is proportionate and that takes account of intended and unintended consequences, so there is a detailed bit of work to do around that.

Mr D O'BRIEN: Okay. And there is a policy question there, so I will throw this one to the minister: the state of emergency expires on Sunday. Will it be extended beyond Sunday?

Mr FOLEY: Yes.

Mr D O'BRIEN: Why?

Mr FOLEY: Because that is the advice of the public health team, and to not do so would see the establishment of the hotel quarantine arrangements collapse on Monday, and I do not think anyone wants to be responsible for that. The hotel quarantine powers are based on the declaration of the state of emergency.

Mr D O'BRIEN: Are there not some other powers that they could be undertaken under?

Mr FOLEY: No.

Mr D O'BRIEN: But the *Public Health and Wellbeing Act* allows the CHO to issue directions without having to be a state of emergency, surely?

Mr FOLEY: This gets to precisely the questions that Mr Limbrick was touching on at a very high level. If we are to take the severe steps to restrain the movement of citizens, there has to be a really good reason. The introduction of a highly infectious, deadly virus that is rampaging across the globe in enormous proportions that we have hopefully managed to contain and suppress in this country, in this state—the relative risk of those two measures is a really significant issue. Essentially, the social contract that we have entered into as a community is reflected in the provisions of the *Public Health and Wellbeing Act*, and the extraordinary powers in extraordinary circumstances it gives us means that if you want to prevent that incursion of that virus into our state, then measures that the nation as a whole and its representative groups have decided through the national cabinet process, through the iteration of that at different state levels, where the powers reside, means that we have to take these steps. Those steps are based on the restraint of liberty to the extent that is necessary as reflected by the *Public Health and Wellbeing Act* as expressed in the hotel quarantine program.

Mr D O'BRIEN: So the natural extension of that, Minister, is that we are going to have the state of emergency declared until a vaccine gets this under control.

Mr FOLEY: Well, we will continue to operate on the best of advice, and Professor Sutton has just taken you through the processes as to how that develops in an iterative manner. I cannot predict the future, but what I can predict is—

Mr D O'BRIEN: No, but can you confirm, though, while ever there is hotel—

Mr FOLEY: I can predict the future of what is going to be needed on Monday if we want the hotel quarantine process to apply.

Mr D O'BRIEN: Righto. But while ever we have people coming from overseas and there is still virus at large, there will be hotel quarantine and we will require a state of emergency to continue that.

Mr FOLEY: We will require the hotel quarantine process for as long as needed. I can certainly predict that come Monday the strong recommendation that I expect I will have in the very near future from the public health team, and to therefore be expressed through the work of the newly established COVID-19 Quarantine Victoria, will require special powers as envisaged by the *Public Health and Wellbeing Act* to deliver that power.

Mr D O'BRIEN: Thank you, Minister. Can I go onto the vaccine, Professor Sutton? Which populations will be prioritised in the rollout of a vaccine if and when it comes?

Prof. SUTTON: It is a matter for the commonwealth government, on advice from the Australian Technical Advisory Group on Immunisation. Allen Cheng is represented there, so he may be even better placed, but my understanding is it will focus on the most vulnerable populations, including aged-care residents, but also those most likely to come into contact with a potentially infected individual, so healthcare workers, aged-care workers in particular.

Mr D O'BRIEN: So Victoria will follow a national program for that?

Prof. SUTTON: Yes, and I am not sure the extent to which there might be scope at a jurisdictional level to address different epidemiology. It may be that there are hotspots around the country where there is a specific jurisdictional response that is a little bit different in terms of managing an outbreak in a particular setting or a cohort of the population or a local government area. That might be a consideration as well.

Mr D O'BRIEN: Yes. Do you know—and Professor Cheng might be able to answer as well—if there is a time line as yet as to what the rollout will be?

Prof. CHENG: It is not clear at this stage. It is contingent on the regulatory approval of a vaccine. As you probably know, the United Kingdom have given emergency use authorisation for a vaccine. That is a different step to full approval and that is a step that is granted in the context of a public health emergency, so obviously the risks and the benefits of deploying it in the United Kingdom are very different to here. So we do not know at this stage, but I am aware that the Therapeutic Goods Administration have access to all the data that is coming out and there is still ongoing data to be submitted.

Mr D O'BRIEN: I know this is speculative. I think the Prime Minister has indicated possibly March we might start to see it. In your professional opinion, is that accurate? Could it be any earlier? Will it be likely later?

Prof. CHENG: I think that probably is a fairly good indicative time—possibly a little bit earlier but possibly a little bit later.

Mr D O'BRIEN: Okay. Thank you very much. Secretary, can I move on. On 1 April \$1.3 billion was announced for the establishment of an additional 4000 ICU beds. In the minister's presentation he indicated there are 1590 ICU spaces. My first question, I guess, is: what is a space as opposed to a bed? Is it the same thing?

Prof. WALLACE: Thank you. Not precisely. The allocation of funding for the 4000 spaces was around provisioning for both equipment, staff and physical spaces within our hospitals, in anticipation. Remember, this was, as you said, at the very beginning of this. As we looked overseas, particularly Italy but also other parts of western Europe, around what they were facing and then modelled what that meant for Victoria, the modelling at that time was there could be requirements for up to 4000 ICU beds. We have about 450, 500 beds—

Mr D O'BRIEN: Usually?

Prof. WALLACE: Usually, and so that funding was to commission equipment, staff and potential spaces in our hospitals to allow us to do that.

Mr D O'BRIEN: So a space is a space for a bed, the necessary plug-ins for gas and power and everything, and a staff member or more to deal with it?

Prof. WALLACE: Yes. It was done hospital by hospital, but some hospitals chose to potentially repurpose areas; for example, the admission areas in the theatres, which were perfectly ideal for an ICU space but would not normally be used.

Mr D O'BRIEN: Yes. The presentation also said—so 1590 we have now, ICU spaces—‘around 2500 available’. Is that on top of 1590 or 1590 plus whatever that is to get it to 2500?

Prof. WALLACE: We have functioning today about the 500 ICU beds, plus all the equipment and staff provisioning for 1590, plus additional equipment in terms of ventilators and potential surge staff for another 2000, to take us to nearly 4000.

Mr D O'BRIEN: Okay, so another 2500 potentially, righto. At the moment, though, still how many—490 did you say, literally operating at the moment?

Prof. WALLACE: About 500 beds we have operating at the moment.

Mr D O'BRIEN: Okay. And that 1590 does include staff?

Prof. WALLACE: Yes.

Mr D O'BRIEN: Okay. Can you tell me, of the \$1.3 billion, how much has actually been spent?

Prof. WALLACE: I cannot exactly tell you how much has been spent today, and clearly this is not finished. We continue to face changes and provisioning in all different components, as the minister outlined—staffing, equipment for staff, training for staff—and continue to adapt that and evolve it, as the Chief Health Officer has described in terms of the changing face of this pandemic for us.

Mr D O'BRIEN: Okay. And probably in the August hearings, Mr Symonds told us there were 426 ICU beds, so it has not changed much. Is that literally because the demand was not there?

Prof. WALLACE: Yes. Again, it is about preparedness, isn't it? So it is making sure—again, in the planning back at the beginning of the year—the system is able to cope with it, looking at our colleagues in Italy primarily and then other parts of Western Europe. So it was enabling the system to have enough beds to meet that. As we all know, and we discussed this morning in the health portfolio, there were changes to our hospitals—changes to the activity we did—in order to allow hospitals to free up space, free up staff, free up equipment. And because many of our surgeries have patients who then end up in ICU as part of their surgery—cardiothoracic surgery, for example, but not limited to that—it is about ceasing surgeries where safe to do so to create the space. Thankfully we have not had the ICU demands from the pandemic that our colleagues—

Mr D O'BRIEN: Overseas had.

Prof. WALLACE: in Western Europe had.

Mr D O'BRIEN: But bottom line, if all hell broke loose again next week—perish the thought—we could surge to 4000?

Prof. WALLACE: Well, we have 1590 beds—

Mr D O'BRIEN: Ready to go?

Prof. WALLACE: on tap, and we can surge very quickly another 2000.

Mr D O'BRIEN: Yes. And the answer on the \$1.3 billion, could we perhaps get that on notice if you are able to, on how much—

Prof. WALLACE: If I am able to.

Mr D O'BRIEN: has been spent and not. It was reported on 1 November that there was an audit underway into hospital ventilation. Can you advise whether that has been completed?

Prof. WALLACE: No, it has not. There is a review of modes of transmission of this virus. So again if we think back to the beginning of the year, the prevailing wisdom at the time was that this was a virus that was primarily transmitted through droplet transmission. So the preventative strategies, many of which we are using today in terms of cleaning benchtops and desktops, reflects that at the time, back at the beginning of the year, the understanding of this virus was that that was a principal mode of transmission. As the world has learned more about this virus over time, over the year, it has been widely accepted—not universally, but I would think widely accepted, and certainly Victoria has accepted—that there is now also aerosol transmission, hence the use of masks. Sorry, I have forgotten your question.

Mr D O'BRIEN: When is it going to be completed, the ventilation—

Prof. WALLACE: So one of the ongoing responses to the aerosol bit is 'What does that mean for our hospitals?', both for our PPE for our staff, for how we look after patients, distancing patients and also ventilation—negative pressure rooms. In this committee we talked about that I think back in May. So the review is not quite finished—we have not got the report—but we will hopefully have the report before the end of the year.

Mr D O'BRIEN: And has that looked at every acute hospital across the state?

Prof. WALLACE: Well—

Mr D O'BRIEN: Or is it just a general review?

Prof. WALLACE: There are two bits to it. One is just a sort of fundamental, 'Are ventilation and ventilation standards important?'. Common sense would say that it is related, hence our restrictions outside are different to those inside. But what does that mean then for our health services, if it means anything at all? Once we have that information and advice, the next step is 'Are our health services equipped to provide this infrastructure?'.

Mr D O'BRIEN: So it is actually not an audit of all our hospitals at this point?

Prof. WALLACE: Well, the other bit to this is—and again it just goes to the sort of breadth of our preparedness for anything else that might come in the future—an audit of what we have broadly called the COVID-safe plans for our health services, but it is not constrained to capital or ventilation or negative pressure rooms. It is also distancing of beds, training and equipment for the staff et cetera, visiting hours—the whole thing. So in those audits—and we have completed the audits of all of our hospitals—there are components that are related to these sort of items. But that is then going to be informed by the review of 'What do we think, what does the world'—

Mr D O'BRIEN: 'What does it need?', yes. And that will be—sorry, the timeline?

Prof. WALLACE: I am hoping by the end the year. I do not know if Mr Hotham might be able to—

Mr HOTHAM: By the end of the year.

Mr D O'BRIEN: End of the year. Okay, thank you. Moving on to fit-testing of masks—I am going to run out of time shortly—again the presentation mentioned 6670 priority workers had been fit-tested in, quote, 'the past few weeks', which I found a bit alarming. Is that the total of healthcare workers that have been fit-tested?

Prof. WALLACE: Yes. There are about 26 500 priority staff identified—

Mr D O'BRIEN: Right.

Prof. WALLACE: and as of the end of October, 6670, which represents about a quarter. The other staff are progressively being fit-tested. Again I think this responds to our evolving and changing understanding of the risks and the requirements to mitigate those risks. At the beginning of the pandemic, in a healthcare worker setting it was widely accepted that standard surgical masks were fit for purpose. Indeed there was a report from—

Mr D O'BRIEN: Can I quickly just ask: when do you expect that final 26 000 will be fully fit-tested?

Prof. WALLACE: I do not have an end date. I do not know if Mr Symonds has an end date for that.

Mr D O'BRIEN: Happy if you can investigate it, and if you can, provide it on notice.

Prof. WALLACE: Yes. I mean, the program was introduced in October and it is now December. By the beginning of November, it was 6500—about a quarter—so that gives you a sense of it being probably a couple of months away, two or three months away.

Mr D O'BRIEN: Okay. Thank you.

The CHAIR: Ms Pauline Richards.

Ms RICHARDS: Thank you, Chair. Thank you, Minister, for appearing, and to all of you as officials for appearing but also for your public service this year particularly. I am just going to explore a topic that was started by Mr Maas. The recent 2020–21 budget, I was just wondering if you can outline the funding that was provided for local public health units as part of that.

Mr FOLEY: Yes, I am happy to do so. As I think I referred to in the earlier conversation on the health budget arrangement, whether it is the asset review in BP3, page 78, where you will see the public health output with its contribution there, or perhaps more substantially in the same budget paper at page 64 in the public health output initiatives where you will see the substantial \$2.96 billion investment, they are essentially the output groupings that provide the support for the local public health unit funding. We hope that—or we more than hope, we know—the partnerships that we are able to deliver through engagement with councils, with local organisations, primary healthcare providers, community health organisations and the public health network funded by the commonwealth, as well as the partnerships from local health networks, all of those coming together will see the kind of collaboration that will place these local public health units at the heart of not just our public health response to the virus but, as Professor Sutton has touched on, one of those key partners in the next stage of our response, which we hope, subject to regulatory approval, will be very soon about how we continue to manage the virus but pivot to our response for vaccine distribution and treatment arrangements. Whilst that will be important, that is not in and of itself a golden bullet to the pandemic. The need to keep, whilst that is happening, the fundamental principles that both Professor Wallace and Professor Sutton have touched on around the social aspects of the response to the pandemic will be important, and it will be important in different ways in different communities, which is where the local public health units will be critical.

If I could point to perhaps an example of that, not in the regions but as an example of how nuanced that response needs to be. In the northern suburbs outbreak that we saw that targeted, disproportionately, large families in poor housing from culturally and linguistically diverse backgrounds in precarious employment, how that played out is a very different prospect to how that played out in the first wave, which, no disrespect to the Member for Prahran's constituents, was largely an overseas-returned community play-out with the famous Aspen links et cetera. Not too many people in the Heidelberg housing estate were coming back from Aspen; they got it from all sorts of other close, really important community, normal human engagement activities that we all value. How you then engage with communities in those disadvantaged settings in a way that is relevant to them and builds trust and cohesion in their response cannot come from 50 Lonsdale Street, it cannot come from Canberra. It has to come from trusted sources in those communities. And when those communities are led in diverse faith and diverse ethnic backgrounds, it is those grassroots organisations. I do not know how Minister Spence presented to the committee yesterday, but the work that Minister Spence and her multicultural team has led in close partnership with the outbreak team that Mr Weimar and others have been intimately involved in has been bringing together that diversity and engagement response in a really significant way.

So I would point to not just the developments in the technology and the community and the people capacity that this department has brought with it, but for a proper public health response those learnings about how the virus plays out and magnifies and amplifies. Social disadvantage and the weaknesses in our social community fabric have been a really important part of what I hope we never forget as a community: that it is the social application of disease and disadvantage and harm that disproportionately plays out in those parts of the community that are least able to respond to that. I think that our local public health units are going to be a critical part of sharing and extending that message well beyond this pandemic, and I would hope they will be an important part of improving the health, wellbeing and livelihoods of those communities.

Ms RICHARDS: Thank you, Minister. Putting things into context perhaps. Around the world and around Australia governments have all had to grapple with how to manage the spread of COVID-19 in communities and to keep people safe. Just reflecting on the experiences we have all lived through here in Victoria compared to other jurisdictions, how does Victoria's response compare?

Mr FOLEY: Well, I will start off, but I will perhaps ask Professor Sutton and of course our recently arrived—well, not that recently, a few decades—Secretary, who brings his experience from Scotland here, to reflect on these issues, because they are much more intimately involved in that. But there are no jurisdictions in Australia that have been tested to the effect and to the extent that the state of Victoria has been tested, and there are a few jurisdictions around the world that have managed to get to this position of 35 days straight from an equivalent position in June and July, when indeed the United Kingdom was at almost precisely the level of infections that the state of Victoria was at. To compare and contrast the differences now, where that jurisdiction is having to use emergency powers to respond to what we hope are successful vaccines as—not my phrase; well, it is my phrase—a desperate attempt to try to haul back some of the devastating impacts that that has had is cause, I think, for quite a substantial sense of achievement. At a terrible cost—nobody underestimates the awful price that Victorians have paid as a community and in particular families and with 820 deaths and the devastation that that has caused to so many families.

But at the same time, building on the conversation between Mr Limbrick and Professor Sutton, that response about how Victoria has responded has been particularly outstanding. I will ask Professor Sutton to perhaps expand, but just one anecdote. I received a call from the Australian ambassador to Ireland in regard to Victoria's response. He essentially was looking for assistance from the Australian government's relationship with the Republic of Ireland's response as to how they could look to the Victorian example as a model, and I know that Professor Sutton followed that up with extensive discussions with his Irish counterparts. That is but one example of how the world has looked to Victoria's example of how to respond.

That should not be taken as hubris. That should not be taken as anything other than the collegiate nature of the public health community globally in sharing and learning and seeking to make sure that this awful pandemic and its learnings are dealt with in a way that gets us out of this as quickly as possible with the minimum impact and loss of life and the maximum application of the shared knowledge of that journey. With your indulgence, I might ask Professor Sutton, who is much more closely aligned with where we sit globally on these issues, to expand.

Prof. SUTTON: Thanks, Minister. I would also like to recognise that Victoria has suffered enormously through a second wave that has challenged us all and that has led to tragic deaths and 20 000 tragic cases of illness. But again, having gone through a second wave, there were alternative pathways that Victoria might have gone down, and there have been many jurisdictions globally that again have gotten to very small numbers of cases—single figures in Switzerland, single figures in the Republic of Ireland—that have then had waves where there were literally 10 000 or more cases per day played out over a month or two months, leading to hundreds of deaths. And we do not know the long-term consequences of what it means to have hundreds of thousands of individuals—now in some countries in Europe over 1 million, over 2 million cases for those countries—and what long COVID might mean or the chronic after-effects of COVID might mean. It is awful to have had 20 000 cases having occurred in Victoria, but it is much, much better than to have had 500 000 cases.

To again get to a point where we have had effective elimination—35 days without a single case—means that we can have much, much greater confidence that whatever challenges might come over the next few months we will be in a position to maintain that until a vaccine is broadly rolled out and avoid any further waves, even as countries across the Northern Hemisphere are going into winter with currently thousands of cases per day. They are going to be challenged by even more cases and more deaths. There are probably only a handful of jurisdictions that have gone from the levels of transmission that we have had, and maybe not with the same level of complexity and rapid transmission that we saw in our second wave. Singapore comes to mind. It had hundreds of cases, but it still has community transmission ongoing. It has not gotten to elimination. It has had its own challenges with control and with explosive outbreaks. But I think we have done pretty well on the global scale.

Mr FOLEY: Which is not an invitation for the people of Victoria to relax their vigilance and for governments and community organisations to do anything other than be eternally vigilant to make sure that we stay where we are.

Ms RICHARDS: Thank you, Professor Sutton, and thank you, Minister. So the Victorian experience of a second wave has provided some significant knowledge and lessons. How has this experience been able to benefit and support the responses in other jurisdictions? You have just spoken about Ireland. Do you have any other examples of where you have been able to see our insights be able to be shared?

Mr FOLEY: In many spaces, not the least being our interstate colleagues. I have only held this portfolio for a very short period of time, but I can reflect on, prior to that through the mental health portfolio, the learnings that we all brought to the commonwealth national cabinet's mental health plan. The Victorian and New South Wales mental health ministers worked incredibly cooperatively together, together with the National Mental Health Commission through the forums that national cabinet established, to share some of the learnings that we were all seeing at the time, and that saw the normal, if you like, political divisions put aside in response to that national cabinet's mental health plan, which has been quite important in dealing with the range of the demands that we have seen, particularly in youth mental health. And I was very pleased to see both the Productivity Commission's final report and the National Mental Health Commission's report to the Prime Minister on suicide prevention closely align with the work that the states and territories had done in May and, perhaps more importantly, acknowledge that the next step in that process will be the work of the Victorian mental health royal commission due to report by 5 February.

In the short time that I have had this portfolio I have been even more impressed by the collegiate way in which the states and the territories and the commonwealth have engaged in how shared learnings can be applied across jurisdictions and how, perhaps more importantly, shared resources can be thrown at problems, whether that be the support that other jurisdictions brought Victoria but equally the support that all jurisdictions—New South Wales, the commonwealth, Victoria and Western Australia—brought and are still providing, not to the extent that was unfortunately required in Victoria, to our colleagues in South Australia in response to the Parafield outbreak, where Victoria brought its learnings in contact tracing and particularly took on board the responsibility of dealing with the state school-related aspects of that outbreak. That was a highly successful collegiate effort. But even more significantly, the learnings of the Victorian example of the test have been reflected in, to refer to it again, Dr Finkel's national contact-tracing review, and that contribution has been important. The aspirations of both applying technology, as central as it was to the national contact-tracing review, but applying that in a human and community setting have been really significant. The other jurisdictions have been collegiate in how they have assisted but equally they have received back from Victoria the support of how this plays out in a real-world environment. That shared knowledge that particularly Professor Sutton and Professor Cheng have been part of, playing out through the AHPPC and its various working groups, has been really significant. The work in which that has been able to play out, I think, has been a success story of how the federation at its best operates.

Now, yes, there might well have been some opportunities for gratuitous piling in along the way, but we ignore those and move on. I do reflect again that only yesterday the commonwealth health minister called out Victoria's contact-tracing and outbreak response team and the public health team more generally for the impressive effort of being able to bring that combination of local engagement, technology and community understanding to the very rapid way in which it resolved the issues around the Colac testing of sewage, in what was almost certainly a case of shedding of the virus from a previous case. So I think that the learnings that we have managed to establish throughout the course of this pandemic from a Victorian point of view have been important globally, across the commonwealth and perhaps most importantly of all, at a local level.

Ms RICHARDS: Thank you, Minister.

The CHAIR: Thank you, Minister. Thank you, Ms Richards. At this point I think it is appropriate for us to adjourn for our afternoon break, and we will resume at 4 o'clock.

We welcome you back, Minister and your team, and Mr Sam Hibbins, MP, has the call.

Mr HIBBINS: Great. Thanks, Chair, and thank you, Minister and your team, for appearing before us this afternoon. My first question is for Mr Sutton and it follows on from the questions around public protest. We have had a few protests occur despite there being restrictions, so it is clear that people are going to protest, and it is an important part of democracy to have people being able to protest. Would you consider publishing rules or guidelines for people to follow so people who do want to protest are able to actually do so or actually have an understanding of what rules they need to follow when they protest?

Prof. SUTTON: Yes, I think it is not unreasonable. In a sense the public health directions have communications pieces around them, each and every one of them, in terms of what one is able or not able to do. The COVID directions team within the department will respond to any queries around what people are entitled to or able to do, and I think the same should be applied with respect to people's questions around protesting. There is nothing philosophical in the public health directions that excludes the possibility of protest. You can go out—even when we were in stage 4 restrictions one was able to leave home and walk. There was nothing that explicitly said that you could not protest as an individual leaving your home during that time. So I think to the extent that people want guidance around what they are able or not able to do, we have got an obligation to frame that appropriately for all our directions.

Mr HIBBINS: Yes, great. Thanks. Yes, I think it would be helpful. Some of the protests I agreed with, some of them I did not. I will leave it up to others to figure out which ones are which, but I think—

Mr D O'BRIEN: Can I have a go now?

Mr HIBBINS: Look, it is good to hear, because I think it is an important right for people to have, and for people who want to do the right thing I think it would be of great assistance.

My next question is probably best for Mr Cheng in terms of your experience or your knowledge, and it is about the long-term effects. We have now a lot of non-fatal complications from people who have contracted COVID. Do you have any indication of just how many Victorians have got significant non-fatal complications from COVID?

Prof. CHENG: At this stage we really do not know, and I think, just to emphasise, there is quite a broad spectrum of illness after COVID. Some people clearly recover fully and do not have any sequelae. Unfortunately one of the deaths that was reported recently was an unfortunate person who had fibrosis of the lungs after having COVID—had recovered in terms of the acute illness but then was not able to get off a ventilator, and she succumbed to complications of COVID. But I think it is probably not uncommon that maybe 10 or 20 per cent of people have some sort of organ dysfunction or some sort of sequelae.

I think what is difficult with that is that if you look at people that do not have illness, sometimes you find organ dysfunction. I think that is one of the things that is a little bit difficult about studying COVID: if you find something—particularly in older people that might have had pre-existing illness—is that finding due to the infection or was it there before? I think that is not well defined at this stage, but I think there is certainly an indication that long COVID or chronic complications of COVID is a clinical entity but is not yet well defined, and that requires more study.

Mr HIBBINS: Okay. And is the government's response to that at the moment just more study in terms of what it actually entails?

Prof. CHENG: Yes. Certainly the government has sponsored a number of studies to look at the sequelae of infection, both at a state level but also at a national level, and we will await those with interest and look at what the needs of those people are in the longer term and what might be able to be done to help or to mitigate against their effects.

Mr HIBBINS: Yes, great. Thank you. Next question is probably to the minister. I mean, essentially the testing system that we have set up has been a state-run testing system instead of, you know, people going to their GP. Is the testing system going to continue or do you see a transfer of that to GPs?

Mr FOLEY: It is not an either-or situation now, actually. Whilst the state established at its peak over 200—and around 200 now—testing facilities, the commonwealth-backed respiratory clinics are largely GP-driven, and they are in existence now. So the two have coincided. We have also established, besides the fixed-location facilities, a range of pop-up testing facilities and we have also established an 'if you can't come to us, we'll come to you' call-out system—people with disabilities, people with acute injuries and other things and just people who are immobile. As it happens, the two deputy secretaries here at the table have both been intimately involved in the delivery process.

I do not think that we have got, nor does the commonwealth have, any plans to move away from the existing arrangements. The existing arrangements will have to continue to evolve in the face of the changing patterns of

the pandemic. The existing arrangements might well—although this has not yet been established—also be a pivot point as we move into a COVID-safe summer and have to change as the patterns of Victoria's movements across the state change over the holiday period. And then, subject to when the vaccine or vaccines may become available, they may in turn provide further infrastructure support for what will be a substantial—well beyond just that sort of infrastructure, but that might well form a component of it—huge logistical exercise. Perhaps Deputy Secretary Weimar might be able to assist us as to what those conversations with particularly the commonwealth respiratory clinics might be.

Mr WEIMAR: Yes, sure. Thank you, Minister, and good afternoon. As the minister said, we currently have 196 testing centres across the state. Certainly everybody within the wider metropolitan Melbourne area is within no more than 10 kilometres of a testing facility, and there is a huge range of options: 89 respiratory clinics across community health hospitals and GPs, some of it funded by the commonwealth; 37 drive-throughs; 14 walk-ups; and I think actually particularly importantly 16 Aboriginal community controlled health organisations also providing COVID testing. So the strategy was to ensure that everybody was able to not only physically access a testing facility but also that we provided through a whole range of different providers, because we know that some people are heavily connected into their community health and hospital health systems, we know many people are not, and we need to ensure that people have different access points to get easy and effective COVID testing.

The network has moved around a bit over the last three or four months in line with the pandemic, but also the most significant change we have made in the last four or five weeks has been with a number of our big drive-through sites being based in big shopping centres. Not surprisingly, shopping centres were keen to get some of their car parking spaces back as restrictions eased, so we have moved them into some of the council properties and other sites. But certainly our intention is to maintain that density and that visibility of the network. We have over 1600 clinical staff involved who are providing critical clinical resource around those sites, and we will continue to maintain that. The challenge for us going forward is: how do we now ensure that symptomatic presentations, people who are not feeling well, continue to come and get COVID tested? Having a good, visible network is an important part of that.

Mr HIBBINS: Thanks. Would you be able to provide—and I appreciate if you do not have this information on hand, but on notice if need be—the percentage of tests coming from the various different facilities?

Mr WEIMAR: Yes, I can give you an indication now, and I am happy to take the details on notice. If you look at the drive-through retail sites that we cover, that probably accounts for around 20 or 25 per cent of the testing volume. Again, those numbers fluctuate depending on the overall testing demand that we see. Certainly GP respiratory clinics are a fairly significant source of demand—probably another 20 per cent or so—and then the other clinics provide the numbers in between. I would say that we rely on the drive-through sites to also provide that surge capacity, particularly when we see outbreaks. It is able to stand up, and as the minister has indicated, what we also do when we see, particularly when we are pushing for testing in certain areas, is that mobile testing resource. We have 11 rapid response testing teams around the state. We deploy them in surge capacity. We did it with the outbreaks—so in Shepparton we added about I think a dozen or so testing sites in the space of three days. When we did the northern metro outbreak we set up a whole number of community testing sites, and we will do it again over the summer as we look to support particularly smaller regional community holiday towns et cetera to make sure they have got access to testing facility to reflect their summertime population.

Mr HIBBINS: Great, thank you. I want to now ask about the rollout of the vaccine when it is available. My understanding is that Queensland and Tasmania have indicated that pharmacies will be able to dispense the vaccine. Is that on the cards for Victoria?

Mr FOLEY: At a high level, yes. Fortunately Professor Cheng is the co-chair, I think, of the technical advisory group for the nation as to how this will roll out, but Victoria has an extraordinarily successful set of infrastructure arrangements to deliver vaccines—nothing like the scale that we are going to be expected to be calling on in 2021—and some of the peculiar elements that set the Victorian system apart are the supports from pharmacists, the supports from local government, the support from the Victorian iterations of what community health centres look like and of course linking into the wider GP and other networks. Fortunately Allen is infinitely better qualified than me and is intimately involved in the detail, so I might defer to Allen.

Prof. CHENG: Thank you, Minister. It is going to be an extraordinarily complicated vaccination campaign. As an example, you probably know that the first vaccine that is being deployed in the United Kingdom needs to be stored at minus 70 degrees, which is colder than your average fridge, and this sort of infrastructure is not available in a lot of places. It is likely but not inevitable that the first vaccines may not be deployed widely through community outlets. They will probably have to be at a relatively smaller number of locations where that infrastructure can be deployed. That said, there are other vaccines that are closely following along. The AstraZeneca vaccine can be held at an ordinary fridge temperature of 2 degrees to 8 degrees, and that one will probably be able to be more widely distributed. What that really goes to is that the way that the vaccine will be deployed into the community will depend very much on which of the vaccines and what their properties are and who is going to get them first and all those sorts of things, so those decisions have not been made yet. There is a negotiation between the commonwealth and each of the jurisdictions about what is available, what are the normal ways and what is successful in each of the jurisdictions. So an example is aged-care facilities. Different jurisdictions have different ways of getting vaccines out to them and so where they work very well, then those mechanisms could be used. But again, it really depends on the properties of the vaccine and particularly things like cold chain storage.

Mr HIBBINS: I want to ask now about Victoria's contact-tracing system, and just following on, we had the Premier earlier. Obviously there have been publicly raised some issues with where Victoria's contact tracing was at at the beginning of the pandemic, and so my question now goes to what our contact-tracing system will look like after the pandemic. Obviously it still needs to be used for other diseases—but in the hypothetical situation that something occurs again, what will the difference be between Victoria's contact-tracing system after the pandemic and what it was like before the pandemic?

Mr FOLEY: I might start, and I might seek assistance from Deputy Secretary Pitcher, whose particular responsibilities encompass that area. In terms of the question that you ended up with, I think they will be unrecognisable in comparison between what it was at the start of the pandemic and what it will be and will continue to be post the pandemic. I would hope that that would be the case: that an organisation that is committed to high performance and learning from experience has learned so much during the course of the pandemic—hard-earned lessons, but lessons that have, I think, been reflected in Dr Finkel's national contact-tracing review and the extraordinarily collegiate manner in which all states and jurisdictions have partnered through that area.

Whether it is technology, whether it is systems or whether it is people and the interface between the often referred to local public health units, the primary health providers—particularly community organisations—and the expertise of academics and researchers and public health officials centrally, I think all of those come together to inform a national contact-tracing set of minimum arrangements. Victoria now absolutely meets the benchmark and in many respects indeed could arguably be said to do particularly well if not lead, certainly in terms of—as you would expect after 35 days of zero cases—meeting all the national benchmarks. But certainly after we were coming off the peak of the pandemic in the second wave of infections, the improvements of technology, people, systems and intelligence all came together to see the Victorian system perform in a very high-performance manner. And if it is okay with you, Chair, I might ask Deputy Secretary Pitcher to perhaps put a bit more context to that.

Ms PITCHER: Thank you, Minister. Thanks for the question. I guess the thing I would add to the minister's answer is that, along with having capacity improvements in workforce and technology, we are actually really at the forefront of having increasing speed, increasing effectiveness and I would also highlight diversity as well. So when I am talking about diversity, Mr Weimar here mentioned earlier things like specialist Aboriginal-controlled clinics who are working with Aboriginal populations in terms of testing and working with us in terms of contact-tracing ability. We have also highlighted throughout questions today about the local public health units, and that is taking that contact-tracing ability to be locally spread all around Victoria. And in one sense not only do we have increases in diversity; the size and scale of the number of people that we can call on who understand contact tracing and who are plugged into that system—both in a human resources way but also in a technology way—is a really dramatic legacy that I think we will have for the people of Victoria going forward, not just in COVID contact tracing but in so many other aspects of public health and public health delivery in our communities.

So there are a lot of lessons, as the minister has said, but there are also a lot of ways that we have been able to build new and different ways. I think also it is worth really highlighting the important role that employers and

businesses have played in our contact-tracing effort as well as school communities and other groups who have taken on that sense of collective responsibility for fighting COVID and being part of information provision for all of us in that effort. Those lessons, I think, are ones that we have learned and they are ones that we are sharing, but it also does mean that the capacity, if you like, of both systems and people is a real improvement measure for us.

Mr HIBBINS: Thank you.

The CHAIR: Thank you. Mr Tim Richardson, MP.

Mr RICHARDSON: Thanks, Chair. And thank you, Minister and department representatives, for a marathon day today and this afternoon. We are nearly there. But I want to take you now, Minister, to pathology and testing. The rapid turnaround of COVID-19 tests has been identified as an important factor in ensuring that test results remain high—those received from the community—so that we know how the virus is circulating in our community and can take those appropriate steps forward to stop the spread. Minister, how is Victoria's pathology system ensuring that we know if and where the virus is at any time in our community?

Mr FOLEY: Thank you, Mr Richardson. Building on the comments from the two deputy secretaries just now: how do we know? Through testing. Testing is the forward eyes and ears of the public health system into where the virus is or may be, and as the presentation of the virus has changed and evolved, the testing has changed and evolved in location and emphasis. And in the very near future, once the public health team provides government and myself and cabinet the final provisions as to what a COVID-safe summer looks like, we would imagine that that would evolve yet again. But we know that testing wherever it is—whether it is in those higher risk settings, like hotel quarantine as was indicated earlier, or international points of contact of maritime, air or freight—is all part and parcel of how the exposures that people have in those contexts is an important part of testing, but so too is the fact that people then are part of their wider community. And as we have seen in Sydney just yesterday and in Adelaide and in New Zealand and in Western Australia and indeed in Victoria, we know that there is no such thing as a risk-free environment in those facilities.

So making sure that testing is available in the community is an equal part of sustaining the message that this is not over by a long shot. So Mr Weimar touched on the almost some 200 testing facilities that are so important, but so too is the speed and the accuracy and the nature of how the different types of testing occurs. Whilst we have the PCR nasal testing that is considered to be the highest standard, we also are increasingly—as indeed is the globe—looking at other types of testing, whether it be saliva testing, antigen testing and arrangements in that regard. Equally important, as we have touched on briefly, is sewage testing, and whilst we continue to hope that a number of the sewage testing reports of the virus are shedding cases, the longer that we go without community outbreaks, the advice I have from the public health team is that proportionally once you do find outbreaks in sewage it is an increasingly important tool to monitor where not so much shedding but real-life live cases of the virus might be in the local population. So we are growing that and making that an increasing part of the program.

To reflect that since 1 January some 3.5 million tests have been conducted, that places us in terms of the per 100 000 per head of population measure amongst the leading test communities globally and, given the way the virus has presented in this state, certainly the leading arrangement in the commonwealth. Of course in more recent weeks, as we have seen with the community outbreak in South Australia, not unsurprisingly the South Australian community has over the last few weeks, over that period of time, increased it substantially. But in terms of how the infrastructure, the presentation and the importance of different types of testings have played out over the course of the pandemic, it is fundamentally such a key part of how we respond.

I know you have all heard it many times, but—just in case there is anyone out there who has not heard—if you show even the most mild form of symptoms it is important for you to go and get tested immediately and to isolate until that test result is provided to you. And it is every piece of the expectation—the learnings, the technology, the people and the systems that we have in place—that we will not just support you but we will get that to you in world-class times and certainly within the space of 24 hours.

Mr RICHARDSON: That is a great message, Minister Foley. I was just checking the stats about local government areas and their testing rates, and today Kingston council area did just below 4000 but consistently

does 5000–6000 tests a fortnight. It shows with Victorians more broadly their commitment to testing and keeping this up and sharing in what we have all built together as Victorians.

I want to take you to improvements in testing and pathology. What improvements have been made to the pathology system to ensure it is able to cope with sustained high numbers of testing into the future?

Mr FOLEY: At a high level I can start that response, and then again I will perhaps defer to Jeroen in terms of a more detailed appreciation of that. The pathology in the test, trace and isolate system is such an important component of how that system operates. To get that effective, accurate and fast is so critical in driving down the times for notifying people who have tested that they are positive—or indeed if they are not positive—and therefore to get them into isolation to clamp down on any potential outbreaks. The constant review, the interrogation of processes and systems, including how the pathology area works, has been really significant in closing increasingly the times, with the learnings that we have brought both from the initial wave of the pandemic and the second wave, as well as the shared knowledge from right across the state, from right across the country and from right across the globe, and as Jeroen has touched on in many different ways, how that is applied. So in terms of the specific issues around how we cope with sustained high testing levels, it is by increasing investment, increasing technology and increasing better systems—all of which Mr Weimar is much more closely acquainted with, so I might ask him to supplement.

Mr WEIMAR: Thank you, Minister. Thank you for the question. Yes, I think pathology is at the centre of ensuring the community retains and increases its confidence in the overall testing system and goes out and gets tested. We have seen over the last six months a significant investment—around a \$36 million investment—in Victoria's pathology system. We have 16 laboratories across the public hospital sector, the reference labs and the private sector, and a significant part of that improvement of performance over the last six months has been around improving the logistics of how we move the samples around and how we manage capacity at the different laboratories but also investing in equipment and investing in staff and 24/7 operations. We now have more labs working around the clock. We have five high-volume analysers that have been audited and have been deployed into the system, and that means we can now run up to 25 000 tests a day and still deliver that next-day result that we are doing at the moment. The results for the last couple of weeks are that we are delivering 99.9 per cent of our test results by the next day. That is important for two reasons. One, it means that people who get tested yesterday have their results the next day—they have their results today—so they can make their decisions about whether they need to isolate or whether they can go back to work or school or all those other activities. But it also means that from a contact-tracing point of view and the work that Ms Pitcher leads it actually gives us that really fast start to identifying any positive cases and the close contact work, and it is a critical part to shortening that period.

We also see it in terms of people's willingness to come out and get tested. We saw from the beginning of August through to the end of October—the bulk of that second wave—a progressive increase in the willingness of Victorians to come and get tested if they had symptoms. We would still like more and, as the minister said, we need to maintain that message that says it is important that people get tested, but if you go and get a test, you will have your result the next day and you will be able to make an informed decision about how you isolate effectively or you can go about and carry on your business with confidence.

We are also looking at different testing modalities—some fantastic work by the Peter Doherty Institute over the last three months that has been funded by the department and worked on by colleagues in our teams. What that has allowed us to do is to also introduce saliva-based testing. We know that particularly for people who are tested on a very frequent basis because they are in critical, vulnerable, high-risk roles, they are in COVID-facing roles, we ask them to go through surveillance testing very frequently and having lots of nasal swabs may not be everybody's favourite thing to do, so the saliva testing—we have been working it through with a series of pilot studies in the food industry, with the police and other agencies, and we will now be deploying that as of Monday as a standard modality. So every single employee in the hotel quarantine system will be tested every single shift using a saliva-based methodology and then once a week they will get the nasal swab. That really gives us both a frequency of understanding and it also gives us a really solid database to ensure we protect those frontline workers. It is a testament to our pathology system and the thousands of people working in our pathology system that we can now run that and actively deploy that on such a consistent basis in a way which, frankly, very few other countries are able to do at this point in time.

We are also exploring—we have done a series of works with the Doherty around alternative testing platforms, so these rapid tests that everyone is very keen to have, and we are in late-stage trials now of the antigen testing platform. We know that antigen, the beauty of it is it will give us a result within 20 or 30 minutes. The downside is it is not as accurate as the PCR. So in our environment, where we have no community transmission, we will not be using the antigen test for day-to-day testing, because frankly there is no need to do it—we have a huge pathology system that can now run the very accurate tests more efficiently—but we will be looking at using it for some of our screening applications, particularly where we are dealing with known populations of high-risk populations coming into the state.

And a final comment, Mr Richardson: we do have access within Victoria to some rapid PCR testing, so PCR tests that we can turn around results with within about 2 hours. They are a limited supply nationally, so we get a monthly allocation, which we are very grateful for, and we have used those very proactively. We used them with some of our most sensitive communities, and if I think back to Shepparton and the Rumbalara Aboriginal community, we deployed those rapid tests there because we wanted to make sure we knew immediately whether there was any risk of exposure. So that proactive use of rapid testing as part of a coordinated strategy has been a critical part of managing the outbreak and will be a key part of managing the current low levels of transmission as we go forward.

Mr RICHARDSON: Thank you for that answer, for that overview. Minister, I want to take you now to the topic of health workers. There will be many stories through this pandemic, but one will be the efforts of those in our health workforce and the extraordinary work that they have done this year. They have been the backbone of our community efforts. Our health workers have been tireless through 2020 to protect the health of the community. What support has the government provided to not only keep our health workers safe from the coronavirus but ensure their wellbeing throughout a very difficult year?

Mr FOLEY: Thank you, Mr Richardson. In regard to our healthcare workers, I am sure I speak for all Victorians in saying that we all express our gratitude and thanks for those who have cared for us during that period of time. The advice I have is that some 3573 Victorian healthcare workers contracted the virus. That is 3573 too many, and we know that some will still be, as a proportion of that, like the wider population, dealing with the consequences of that.

The Department of Health and Human Services and Safer Care Victoria are currently analysing all of those cases of COVID-19 in healthcare workers, including the sources of infections, the patterns of transmissions and the manner in which they have played out in healthcare settings. As that data has increasingly come to hand it has been increasingly released, and a lot of it is already on the department's website. But we know that the sources of healthcare worker infections were very different in the first wave and how the virus played out in the community, and different again in the second wave. The majority of cases in the first wave, as we have indicated, were acquired from overseas or from some form of community transmission associated with the returned traveller community. The second wave was very different. Particularly with the interplay between private residential aged-care outbreaks and the crossover of those vulnerable populations and healthcare settings—not just the workforce in private residential aged care but the introduction of the virus into healthcare settings, be they aged care or our health network systems—we saw the transmission play a much larger role in those healthcare systems.

Of healthcare workers diagnosed in wave 1—and the cut-off date for the purposes of debate is 30 June—3 per cent of that first wave of infections from healthcare workers were in aged care, 42 per cent worked in hospital and 55 per cent worked in other healthcare settings, and 23 per cent of the healthcare workers were infected at work. Of healthcare workers diagnosed in wave 2—and for the sake of debate we have dated that from 1 July to 21 October—some 51.8 per cent worked in aged care, 29.7 per cent worked in hospitals and 18.5 per cent worked in other healthcare settings, and at least 69 per cent of healthcare worker infections in the second wave across all of those settings were acquired at work. So in total, across both waves, some 2604 healthcare workers acquired the virus in the workplace.

Making sure that the really brutal lessons that that has taught us, through some of the items that Mr Symonds described in earlier conversations, is really a significant part of how we have shared that with our workforce, who rightly, particularly at a shopfloor level and an industrial level, see this as perhaps one of the most significant issues that we still need to both learn from and resolve and which we are all committed to. How that plays out in learnings around personal protective equipment training, how we deal with the issues of PPE

spotters, how some of the issues that Professor Wallace was describing in some of the learnings around patient density in COVID wards and how we ensure that staff work in a COVID-safe surveillance testing and high-risk facilities is going to be important. Establishing the respiratory protection program, the fit-testing arrangements and the significant work that is going on around air conditioning and aerosol potential spread, together with other forms of how the virus presents, are really significant in how we are going to have to deal with the strong commitment that we are not going to place our healthcare workers in the risky situation that particularly the second wave found them to be in.

The CHAIR: Thank you, Minister. I will pass the call to Ms Bridget Vallence, MP.

Ms VALLENCE: Thank you, Chair. My questions firstly are to you, Dr Sutton. Many times you have given evidence that your public health directives include the detention of people, including returned travellers, and given the previous hotel quarantine program was developed without, as you wrote, your approval or even input, and you have described in documents your moral and legal unease in relation to that, I know that the new COVID Quarantine Victoria is coordinated by Corrections, but have you advised or inputted into that process at all, into that new model?

Prof. SUTTON: I have, very substantially. There are a number of elements that would fall under the health and wellbeing portfolio for quarantine in the new system, one of which is infection prevention and control. So the public health infection prevention and control experts and others have developed a very comprehensive set of policies and procedures to mitigate risk to the fullest extent possible. That has had my sign-off, and the team have spent a great deal of time putting that together. There is a dedicated function of case contact and outbreak management that applies to any infections that might occur within the quarantine system outside of those who are in quarantine. There is the broader health and wellbeing support to those who are in quarantine. Healthcare Australia are engaged in a kind of primary care sense in that regard and they have a reporting line. All of these elements of the portfolio have a reporting line to a deputy chief health officer position reporting to Emma Cassar as the commissioner and effective head of CQV.

Ms VALLENCE: So that deputy chief health officer is from your team but reporting into Dr Cassar?

Prof. SUTTON: Yes, that is right, so a direct accountability to the head of the program but can call upon all of the resources of my office and the public health team as required, including for new policy development, for procedural review, for peer review, for evidence review as required.

Ms VALLENCE: You mentioned just then outbreak management. Is that the same outbreak management set-up that Professor Wallace and Ms Pitcher managed—that you told us at the August hearings that they managed?

Prof. SUTTON: It is using some of the same workforce, but it is a—

Ms VALLENCE: But in terms of, I guess, that outbreak management unit and what it was set out to achieve and its structure and obligations, is that the same? Has that changed at all?

Prof. SUTTON: It is bespoke for the quarantine program, so it is going to be a dedicated team, again kind of seconded to CQV in order to have all of its attention and have all of its capability applied to quarantine as required.

Ms VALLENCE: Okay. And in terms of the second wave period—or probably ahead of that more likely—when did you provide advice to the government about instituting the stage 3 restrictions?

Prof. SUTTON: I would have to take that on notice in terms of the exact date. Let me try and call up—

Ms VALLENCE: If it is something you cannot find—

Prof. SUTTON: So stage 3 restrictions, the postcode lockdown, which was limited to a specific number of postcodes—it was a kind of stage 3 just for those postcode areas, that was in June.

Ms VALLENCE: So when?

Prof. SUTTON: On 30 June.

Ms VALLENCE: On 30 June you provided that about the postcodes. And what date did you provide advice to the government about, I guess, the metro Melbourne and Mitchell shire stage 3 restrictions?

Prof. SUTTON: On 7 July.

Ms VALLENCE: On 7 July. You have given evidence there was a significant increase in cases in late May this year. Why weren't stage 3 restrictions implemented across metro Melbourne until 9 July?

Prof. SUTTON: Well, the postcode restriction was the first effort to control it. Again it was trying to find that balance between a precautionary approach and a proportionate approach. The—

Ms VALLENCE: But, Dr Sutton, you mentioned that you gave advice to go into postcode lockdowns on 30 June—

Prof. SUTTON: That is right.

Ms VALLENCE: yet you have also provided evidence that there was a significant increase in cases in May. Can you describe to me that gap? What happened in that time elapsing there from you knowing that cases—and you were the only one, and you have given evidence to this committee before that you were the one closest to the data, that you knew cases were increasing in May, which you have said, but you did not give advice to go into stage 3 restrictions until at first 30 June, and that was only for postcodes. Can you take us through that time frame?

Prof. SUTTON: Well, the overall numbers in May were not significantly increased. There were some households and there were some outbreaks that occurred in May where there was an increase in transmission—

Ms VALLENCE: Could you just repeat that? Did you just say 'not a significant increase'?

Prof. SUTTON: So overall in May—the overall numbers were not that significant in May.

Ms VALLENCE: In late May were they significant?

Prof. SUTTON: So there were some outbreaks that occurred in May, but again the overall numbers, even in late May, were not enormous. There was a decrease into the early June period from late May, so—

Ms VALLENCE: The reason I am asking this is because just very, very recently also to this Parliament, to the inquiry into the government's contact tracing, you said, and I quote:

... there was a significant increase in cases towards late May—
and it took off quickly.

Prof. SUTTON: Yes, so—

Ms VALLENCE: So I am trying to understand why then the advice to government was not to bring in restrictions. Why wouldn't we have brought in restrictions earlier to protect a number of Victorians, you know, perhaps have less cases and potentially less tragic deaths?

Prof. SUTTON: As I say, the increasing transmission was in a really specified geographic and other cohorts in the late May period. Overall there was still a decrease in numbers into June, right into the middle of June. It was towards the end of June that there was an increase in cases. Again we were working to manage those individual outbreaks and those individual cases with our contact-tracing system. The postcode restrictions came in when we were getting to a significant increase in those numbers; that was in late June.

Ms VALLENCE: Can you appreciate how I think from the Parliament's perspective and the Victorian public's perspective it seems rather confusing? Now what we know, the terrible circumstance that we have had in Victoria, the terrible outcome, and we did not have that in New South Wales or Queensland or other similar jurisdictions, why, if you knew that cases were increasing—and you described to the Parliament—in late May, early June, we did not go into restrictions until July.

Prof. SUTTON: So again, I cannot say it any more clearly: there was a decrease in overall numbers from late May, including into the middle of June. What was not visible to us in some respects was that there was an outbreak within the overall epidemiology in Victoria. There was a high level of transmission within a small number of households that was about to take off. If we had had a period of a month with no transmission, like we have got now, and we saw that emerge, we would have responded much like South Australia has responded. We would have seen a new emergence of cases, and we would have seen that take off. The unfortunate situation for Victoria, and it is a matter of deep regret to me that it was not visible, that we did not respond earlier—because knowing everything that Victoria has gone through, it has always been in my mind: what could have been done differently, could this have been avoided?

Ms VALLENCE: For example, the contact tracing? You know, the failures in contact tracing to manage those outbreaks?

Prof. SUTTON: No, largely I am concerned about the fact that we did not identify this rapid transmission within a small number of households. Contact tracing was doing its job. As we saw in South Australia, even with 30-odd cases you generate 4500 contacts and contacts of contacts when you can see that new cluster emerging. When it is hidden in the tail of the first wave, as was exactly the case with what we saw—a superspreading event hidden amongst a small number of other cases overall—it is very difficult to say, ‘Oh, here’s a newly emergent and rapidly spreading outbreak’. That was hidden in the tail end of Victoria’s first wave, and when saw the uptick in cases in late June, that is when my recommendations around restrictions were made to government.

Ms VALLENCE: Secretary Wallace, the Hotels for Heroes program—were private security guards used to protect those sites at all?

Prof. WALLACE: I do not have that information. I do not know.

Mr FOLEY: I might be able to assist. The program for hotel quarantine was transferred to the Department of Justice and Community Safety.

Ms VALLENCE: Sorry, Minister, much prior to that. So Hotels for Heroes was a program that was established first—

Mr FOLEY: Established early.

Ms VALLENCE: Early. So I am not talking about now; I am talking about earlier on. So I guess March, April time frame—were private security guards used?

Mr FOLEY: I think it is established on the public record that hotel quarantine certainly did have private sector security guards.

Ms VALLENCE: Not hotel quarantine; the Hotels for Heroes. We have heard evidence that the hotels were different in that there were Hotels for Heroes hotels and that there were hotel quarantine hotels. So in the Hotels for Heroes hotels were private security guards used?

Mr FOLEY: I am not in a position to assist the committee with that, but I am certain that we can establish—

Ms VALLENCE: There are a lot of people from the department here. Is there any one of the 12 or so officials here who could answer that?

Mr FOLEY: Why don’t we take that on notice and make sure that we get you an appropriate answer, particularly as to the specifics that you have asked, Ms Vallence.

Ms VALLENCE: Thank you. And really I am interested in that from March through all months and particularly, I guess, in the June–July–August months. I would like advice on that. That would be great.

Prof. WALLACE: Ms Vallence, I can provide you the answer now.

Ms VALLENCE: You could?

Prof. WALLACE: Apologies. There were no security guards used in the Hotels for Heroes program at all throughout its entirety. This was of course a voluntary program. They were not quarantined—detained quarantine—so there were no security guards used.

Ms VALLENCE: No security guards. So I understand—I mean, in fact I know people in my electorate who used it because they could not quarantine at home. So there was no-one securing those sites?

Prof. WALLACE: No, because, again, the basis of that quarantine is different from the mandatory quarantine for overseas returning passengers. I am advised that we had no security guards. There was no need for security guards for our Hotels for Heroes program.

Mr FOLEY: These are people that are willingly seeking the support and assistance of the state to protect either themselves or their family. They are not detained under the circumstances of the *Public Health and Wellbeing Act* and therefore, by extrapolation, are free citizens and therefore able to—

Ms VALLENCE: Yes, it is not a suggestion that they are being detained; it was just more: on that program were they used? Because evidence has been heard by this committee from Minister Pakula and the department of jobs that private security guards were used for Hotels for Heroes. So I am—

Prof. WALLACE: I will follow up. But I am advised that we did not, and it makes sense that we did not.

Ms VALLENCE: So this committee is hearing conflicting information.

Prof. WALLACE: We will resolve that contradiction for the committee. It makes sense that they were not, because they are equivalent to people quarantining at home.

Ms VALLENCE: Yes. No, I understand they are not being detained. But perhaps, you know, they just might have been protecting their belongings, I suppose, or making sure no-one else is coming in, I think is more to the point. But we have heard conflicting evidence now that private security guards were used, and—

Mr FOLEY: So you assert. We have not seen the evidence of Minister Pakula, and with greatest respect, some members of this committee tend to give particular nuances that might not necessarily be reflected in reality. So whilst we agree that that is your view—

Ms VALLENCE: It is not a view; it is evidence that has been—

Mr FOLEY: you would respect our ability to perhaps interrogate the record to the degree necessary to make sure that your assertions are at least vaguely related to reality.

The CHAIR: Thank you, Minister. Ms Vallence, also for the record I am not sure that the representation you have made here today does reflect what Minister Pakula said here—

Ms VALLENCE: Go and read the transcript.

The CHAIR: And I think the Hansard record will speak for itself.

Mr D O'BRIEN: Just a point of order, Chair.

The CHAIR: Point of order, Mr O'Brien?

Mr D O'BRIEN: I asked the questions. DJPR clearly said private security was used for Hotels for Heroes, and the Premier actually said in August that that is where it started.

The CHAIR: Mr O'Brien, Ms Vallence, that is your recollection. The Hansard record will speak for itself.

Ms VALLENCE: Yes, and I—

Mr FOLEY: And as I have indicated, we are more than happy to interrogate the record and establish whether your interpretation of what was said was accurate, but either way Professor Wallace has made it clear that he is more than prepared to make sure that the evidence that he has given is backed up by an interrogation of our department's—

Ms VALLENCE: Records.

Mr FOLEY: approach to this matter and resolve the issue on notice.

Ms VALLENCE: Thank you.

Mr FOLEY: I think that is an eminently sensible solution to the issue that Ms Vallence has presented to us.

The CHAIR: Thank you, Minister.

Ms VALLENCE: Thank you. And in doing so, if you could also provide all time frames as to which private security was used—

Prof. WALLACE: If—

Ms VALLENCE: if that is the case—

Prof. WALLACE: Yes.

Ms VALLENCE: and what time they were utilised and also if—if so—any of the same security companies were used that were also used in the hotel quarantine program simultaneously. That would be great.

Secretary, in terms of legal costs for the Coate inquiry—I know that was discussed earlier and you said that you would take that on notice—I am just wanting to confirm that you are looking at the legal costs for the Coate inquiry for the Department of Health and Human Services. Will you take that on notice to provide the total cost, or at least the cost to date?

Prof. WALLACE: I said that we do not have total costs because the process is ongoing and that we would provide costs when—

Ms VALLENCE: On that basis, then, have no invoices been provided by your legal representation? I presume that they would want to get paid.

Prof. WALLACE: Well, it is about the proper auditing of our accounts that we do periodically. We will be reporting on costs of aspects of the hotel quarantine program, including board, in due course.

Ms VALLENCE: So would you make that available to the committee, please, in terms of current costs?

Prof. WALLACE: Yes, we will make available the costs when they are ready.

Ms VALLENCE: Thank you. And in terms of that, would you also be so kind as to provide a breakdown of those costs in relation to, say, former Minister Mikakos, Dr Sutton and so on and so forth?

Prof. WALLACE: I am not sure whether that is going to be possible. I guess we will have to have a look at how those costs are—

Ms VALLENCE: I know from a business perspective that that should absolutely be something that is possible.

The CHAIR: Ms Vallence, you can make your request. It is not your position—

Mr FOLEY: So given that you are clearly well connected to the Victorian government's legal representations, we will take it as read that you have got the inside running on that, but we will await the outcomes from the Victorian government-appointed solicitors, and when those accounts are available, as Professor Wallace has indicated, we will provide the support that the committee has requested should that detail be available in the form that the honourable member of the committee has asked for.

The CHAIR: Thank you, Minister. The honourable member's time has expired. I will hand the call to Ms Nina Taylor, MLC.

Ms TAYLOR: Minister and department officials, thank you for your ongoing service to community. I would like to explore aerosol transmission a little further in light of evolving evidence in this domain. What is the current scientific evidence and medical advice on aerosol transmission, and can we be sure that healthcare workers are receiving the best possible PPE and other resources to keep them safe from COVID-19?

Mr FOLEY: Again, I might start, and given that you have asked for scientific aspects in your question, Ms Taylor, I think I might quickly defer to either the Chief Health Officer or the Deputy Chief Health Officer. But in terms of the general process that I touched on on the unacceptably high level of health worker infection that was reported in my earlier response, part of the process that we have put in place seeks to encompass all of the aspects of how the virus has presented in healthcare settings, understanding that there are a variety of healthcare settings in those figures—aged care, primary health, mental health, community health, and fortunately community controlled organisations, which have done spectacularly well, as well as acute hospital settings in COVID specialist wards. These areas are around making sure that the healthcare infection prevention and wellbeing taskforce, which has driven, not just from a shopfloor level, health service and government policy responses but has also informed, through the work of the chief medical officer, the work that he has led in conjunction with that work around healthcare responses. All of those have gone to and indeed then informed national considerations about how, amongst other things, airborne aerosol issues are dealt with.

But as we have heard, as that has emerged and learnings in that space have developed, we have also seen that it is but one of a range of technological and human and spatial responses to making sure that we protect our healthcare workers and take the learnings from that. But in regard to particularly the aerosol issues, I am happy to be guided by either the Chief Health Officer or the Deputy Chief Health Officer, whoever you think is best placed to respond.

Prof. CHENG: Yes, so there are three ways that we think that COVID is transmitted: there is contact, either by direct contact or contact via contaminated surface; there is droplet, which is, to use a technical term, the splattery bits that come out; and then there are aerosols, which are smaller particles that can hang around in the air. So we have always recognised that aerosol transmission, for example, for tuberculosis is something—that people can contract tuberculosis well after the other person, the case, has left the room. In the case of SARS 2, what has been difficult is that probably all three are contributing to some extent and in different circumstances. Right from the beginning it has always been recognised that there are what we call aerosol-generating procedures—so when you intubate a patient and you are very close to the airway, that generates aerosols, and they can hang around in the air, and that requires additional protection. There has been droplet protection, so the surgical masks that we use protect to some degree against those, and in the first wave there were certainly a lot of people using surgical masks and there was not a large number of healthcare infections.

In the second wave what we did start to realise was that where there were poorly ventilated settings, where there were particularly people that were exhibiting what we call aerosol-generating behaviours—so people that were shouting, singing; they were confused and there was a large number of them—that seemed to increase the aerosol transmission. So around that time many hospitals started to move to a different setting with respirators, so filter masks rather than surgical masks, but we also understood that there probably were a number of other things that needed to be put in place, in particular trying to improve the ventilation. So there are minimum standards of hospital ventilation—obviously in much older hospitals the ventilation is not quite as good, so by reducing the density, the crowding, of patients, by improving the ventilation and by using respirator filter masks instead of surgical masks, that seemed to reduce infections. So it is a range of things that are required to be put in place to help mitigate infection in that setting. Certainly in Victoria we were fairly early movers in that, and now we have respiratory protection plans, there are 6000 people who have been fit-tested, and that work will be ongoing.

Prof. SUTTON: And if I may add just briefly, what should not be controversial and what we are definitely focusing on in Victoria is that a systems approach is essential and that there should not be an overwhelming focus on fit testing and PPE to the exclusion of consideration of ventilation and there should not be consideration of ventilation without understanding that there are a whole series of risk mitigation controls that need to be in place to appropriately protect any worker. It is getting the balance right and ensuring that each and every one of those elements is addressed systematically.

Ms TAYLOR: Okay, thank you. So we know there have been 596 cases of COVID-19 in non-clinical staff in healthcare settings, including aged care settings, with 343 of these infections acquired in the workplace.

What supports have been offered to these workers to ensure their health and wellbeing and the safety of the broader community?

Mr FOLEY: Thank you for that question. The non-clinical staff are really the unsung heroes of how the Victorian health system has always operated but particularly how it has operated during the course of the pandemic. The fact that they are amongst the lowest paid workforce and from, generally speaking, diverse backgrounds further makes their important contribution more significant, and I want to thank them specifically. The non-clinical workforce in healthcare facilities are the people that feed, that clean, that secure the workplaces and therefore are at particular risk as a result of where they physically work across the healthcare facility.

Of the 596 non-clinical staff who have contracted coronavirus, 343 are understood to have contracted the virus at work—so the majority; a significant majority. Two hundred and forty-eight of those people—again, so overall, almost precisely half of that infection of non-clinical workforce—picked up the virus in aged-care facilities, and that continues to be a significant issue of concern to Victoria and the fact that overwhelmingly the private residential aged-care system represented almost the entirety of the infections in that group, let alone of the residents who call those places home and the devastating over-600 deaths that accompanied that.

Some 58 non-clinical staff in a hospital setting picked up the virus and some 37 staff in healthcare settings more broadly, not in community health settings—they have done extraordinarily well; the community health sector has been an extraordinary proponent of safe workplaces for its staff—but in general practice and other primary healthcare settings. This data was further broken down as a result of the forensic work that the public health team have done in interrogating the data, and that can be found on the DHHS website. But whilst it is pleasing to see that so many of those 500-plus people have now recovered, there will still be significant work to be done with them in terms of some of the ongoing implications and the so-called ‘long COVID’ assessments as to their wellbeing. We want to make sure that that non-clinical workforce continues to get the sort of support it needs. Fortunately that workforce now has no outbreaks, and with some of the supports that were available during the peak of particularly the second wave, they were amongst some of the significant participants in the aforementioned Hotels for Heroes programs—because they also came from large families, were in poor housing, in low-income occupations and more at-risk socio-economic groups where the spread of the virus could well have been disproportionately at play. So that has been one aspect.

Equally the support that has been brought from the VACRC—the joint commonwealth-state response centre for that sector—has been important, and I do want to take this opportunity to stress that the cooperation with the commonwealth in establishing VACRC as a response during the height of the second wave was really significant. What I perhaps might take slight issue with is how that has evolved and how the support for particularly those non-clinical workers in private residential aged care has played out. This risk in private residential aged care, let alone the risk in non-clinical settings, has not disappeared. Yes, there has been no community transmission for 35 days, and we will do everything in our power to continue that significant streak, but we are working on the basis that this is not over and that we know, through the process of the testing that both Jeroen and Professor Sutton referred to as in high-risk industries, continues on in that residential aged-care sector. The state, for its part, is approaching its significant contribution in residential aged care and state-provided services as meeting an important part of how we need to work on the basis that what we do is preventative measures. That involves some of the measures that were established during the second wave—supporting workers to work in one location, supporting workers to make up the pay that they forgo if they only work in one location—and I am pleased to see the Victorian government’s position is to continue that until the end of February, I think. It might be until March. I was a little bit disappointed that the commonwealth took the view that it was withdrawing its support for that measure from private residential aged care as of the start of December, and despite both the workforce’s and our concerns have gone ahead with that measure.

The commonwealth take a different view; they see that measure as a response to an outbreak as opposed to a preventative measure. Victoria and indeed the other jurisdictions, regardless of political flavour I might add, take the view that it should be—given the high-risk nature of those facilities—ensuring that we minimise risk by minimising the movement between facilities and restricting it wherever we possibly can, no matter how much it costs. To keep workers to one site is so critical, particularly in those non-clinical workforce groups. It is a measure that we hope the commonwealth will reconsider and we hope that as we move into a COVID-safe summer the lessons that we have all learned, but particularly Victoria and to a lesser degree New South Wales,

will be reflected in the support of what is primarily a regulatory responsibility and a funding responsibility of the commonwealth.

Given the fact that there is looming into 2021 a royal commission into that sector, we are hopeful that the royal commission in addition to the interim report that it has made will make some significant contributions to helping us all resolve this issue. If we have learned anything during the course of the pandemic, in healthcare settings more broadly but non-clinical healthcare settings especially in private residential aged care, it is there where the devastation, the illness and the consequences are most lethal. Anything that we can do collectively to make sure that we minimise that, including—relatively speaking—the small step of assisting casual, poorly paid, at-risk, non-clinical workers to be supported to minimise their risk by being part of a preventative strategy to stay in one location, we think is a very small investment to minimise a risk, and it is one that we continue to raise with our friends at the commonwealth, as indeed do other jurisdictions, to include that as a preventative measure going into 2021.

Prof. WALLACE: If I may add to the minister's comments, those 596 non-clinical-facing healthcare workers also had access to the Hotel for Heroes program in the same way that their clinical colleagues did. This is a healthcare worker workforce, whether you are patient facing or not patient facing, and they had the same access to the same support.

Ms TAYLOR: Thank you. In the time we have remaining, keeping on the subject of residential aged-care facilities, can you just flesh out a little bit more about how our health services assisted in managing the outbreaks? I am thinking of things like the aged-care hubs and so forth.

Mr FOLEY: Could you just repeat that?

Ms TAYLOR: Yes. How have our health services assisted in managing the outbreaks in residential aged-care facilities? I just wanted to flesh it out a little bit.

Mr FOLEY: At the height of the outbreaks in residential—particularly private residential—aged care, the role of our state-run services was critical. The commonwealth asked for assistance, of course because it is a sector regulated and funded by them, but these are Victorians who are in these facilities and the Victorian government's response was immediate. But more particularly, both the private and the public healthcare systems in Victoria in the hospital settings were outstanding in their response. At some significant risk to themselves and to their operations, they walked into settings that were hugely problematic—in fact traumatic.

Having spoken to some of the frontline nursing, ambulance and other staff, when the history of this outbreak is written, they will be amongst the true heroes of the response in terms of what they dealt with and how they dealt with it at a professional level. The Victorian healthcare system, through the cooperative clusters that were established, was at the heart of establishing an appropriate infection, prevention and control system that was fundamentally not there in the private residential aged-care sector. It will be an ongoing responsibility, regardless of the commonwealth's—relatively speaking—failures to fill this space, that the Victorian government will have to continue to shoulder the burden of to protect those facilities in so many ways. I want to thank the Victorian healthcare workforce and the healthcare networks for stepping into an area at some substantial risk for a responsibility that technically is not there, but these are fellow members of our community, aged members of our community, and our fellow citizens, our family and our connections, and we just cannot sit by and allow the commonwealth's relative dereliction of duty to go unchallenged.

Ms TAYLOR: Thank you.

The CHAIR: Thank you, Ms Taylor, and that concludes Ms Taylor's time for questions this afternoon. As Chair, I am concerned about the misrepresentation of the evidence given yesterday and during that interaction between Ms Taylor and the minister. I have consulted the draft Hansard record. For the record, I will just read out the section that Mr Phemister gave evidence to. That might assist the Secretary when providing further information on notice. But I think it is important for those watching that the record show what Mr Phemister said yesterday, and this is in relation to the line of questioning in relation to how private security may or may not have been used, both in relation to the Hotels for Heroes program and also in relation to hotel quarantine. And yes, Mr O'Brien was the person asking the questions, but Mr Phemister replied:

Indeed, and this is important context for the question. How private security was utilised became the ... issue. The fact that private security was on stream was moot to me from the 4.30 meeting, because I was asked to commission it and at that point in time I commissioned it. That was the first time that we engaged any security firm across any of these programs—that night—which is pretty evident throughout the evidence.

I just want that to sit on the record, and to assist you, Secretary, in your further deliberations and the information you might provide on notice.

Mr FOLEY: Thank you for clarifying that matter, Chair—very appropriate of you.

Mr RIORDAN: On a point of order, I think it is also relevant, and Mr O'Brien might correct me here, but when the Premier was asked in our hearings in August—the Premier on 11 August—Mr O'Brien asked him:

... why did you choose private security guards?

And the Premier himself answered:

It was essentially an extension of a program that we had already stood up, nothing more, nothing less.

The CHAIR: Deputy Chair—

Mr FOLEY: Was the reference to Hotels for Heroes or the wider program?

Mr RIORDAN: Yes.

Mr FOLEY: You know, you can seek to verbal people all you like, or you can seek for the evidence to speak for itself.

The CHAIR: Thank you.

Mr RIORDAN: Well, I think—

The CHAIR: Deputy Chair, there is no point of order. I have ruled on the point of order. The reference discussed before was in relation to—

Mr Riordan interjected.

The CHAIR: That you have no point of order.

Mr RIORDAN: Are you saying that the Premier did not say that?

The CHAIR: No, I am saying that you do not have a point of order. This is a procedural matter.

Mr FOLEY: No, you are trying to verbal the Premier, and you need to desist.

Mr D O'BRIEN: Excuse me, Minister.

Mr FOLEY: If you spent your time trying to answer questions rather than be a ratbag you might have a better deal in this.

Mr RIORDAN: Can you call the witness to order?

The CHAIR: Yes, I will call everyone to order.

Mr RIORDAN: I mean, just because you are, you know, [inaudible] on everything else for the day, it does not mean you—

The CHAIR: Deputy Chair! Minister! Mr O'Brien! What was said before was that Minister Pakula and Secretary Phemister gave evidence here yesterday contrary to the evidence that the Minister and the Secretary were providing today. All I have done is consult the Hansard record from yesterday so that this record of today's proceedings fully reflects the conversations that have been had across this hearing.

Ms VALLENCE: All you have done is try to editorialise.

The CHAIR: Ms Vallence—

Mr D O'BRIEN: Sorry, Chair—

The CHAIR: Sorry, Mr O'Brien?

Mr D O'BRIEN: Can I just get a clarification? I actually could not hear you properly then, Chair. What was the bit that you read out that you are saying is relevant?

The CHAIR: The bit that clarifies the conversation and might assist the Secretary in the information that we have requested on notice is that Mr Phemister said yesterday:

How private security was utilised became the key issue. The fact that private security was on stream was moot to me from the 4.30 meeting, because I was asked to commission it and at that point in time I commissioned it. That was the first time that we engaged any security firm across any of these programs—that night—which is pretty evident throughout the evidence.

Mr D O'BRIEN: Okay. For the record, on a point of order, Chair, there was further evidence presented before the bit that you have just read out.

The CHAIR: I could read out the whole lot, if you like.

Mr D O'BRIEN: Quite a bit before, because I distinctly recall—and as the Secretary has just alluded to—Secretary Phemister made it clear that it was different security, because security for people who were in a vulnerable situation was to protect them, not to protect the rest of the community. So I think we do need to see the full record, which we will do as we present this report. And frankly, Minister, telling us we are verballing people when you were not here—

The CHAIR: Mr O'Brien, you are out of order.

Mr D O'BRIEN: Well, the minister is out of order.

The CHAIR: Mr O'Brien, I gave you the opportunity to seek a point of clarification from the Chair. I did not give you the opportunity to re-engage with the witnesses. The Hansard record is the—

Mr D O'BRIEN: Well, did you call him to order, Chair?

The CHAIR: Mr O'Brien.

Mr D O'BRIEN: He engaged with us.

The CHAIR: Mr O'Brien!

Mr D O'BRIEN: It is all one way.

The CHAIR: Mr O'Brien, I have called everybody to order. I have provided this information for the assistance of the witnesses at the table and for the good of the Hansard record accurately reflecting discussions that this committee may have. Secretary, did you have a final question before we move on?

Prof. WALLACE: Yes, thank you, Chair. It was just in response to a question Mr Hibbins asked earlier about medical research into COVID-positive patients. This portfolio is now held by DJPR, but we have confirmed with them, Mr Hibbins, that in the first half of this year there was \$14.56 million for 15 projects and in the second half of this year \$16.5 million for research specifically into COVID patients.

Mr HIBBINS: Terrific, thank you.

The CHAIR: Thank you, Secretary. On that note we will formally conclude the proceedings. The committee will follow up on any questions and information taken on notice in writing, and responses will be required within five working days of the committee's request. We thank all witnesses who have given evidence to the committee today, and many of you have been with us all day. Thank you.

We also thank Hansard, the secretariat, the cleaning staff and the catering staff, and I declare this hearing adjourned. Thank you.

Committee adjourned.