

TRANSCRIPT

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

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

Melbourne—Tuesday, 11 August 2020

(via videoconference)

MEMBERS

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WITNESS

Professor Marylouise McLaws, Epidemiologist, University of New South Wales.

The CHAIR: Good afternoon and welcome to the second series of public hearings for the Public Accounts and Estimates Committee Inquiry into the Victorian Government's Response to the COVID-19 Pandemic. We welcome Professor Marylouise McLaws.

The committee will be reviewing and reporting to the Parliament on the responses taken by the Victorian government, including as part of the national cabinet, to manage the COVID-19 pandemic and any other matter related to the COVID-19 pandemic. Members are attending these hearings remotely from their home or from their electorate offices, so that we ask that people note that members are not required to wear a face covering if they are working by themselves in an office under the stay-at-home direction of 6 August, part 2, section (7)(i).

We advise that all evidence taken by this committee is protected by parliamentary privilege. Therefore you are protected against any action for what you say here today, but if you repeat the same things outside this forum, including on social media, those comments may not be protected by this privilege. As a witness you will be provided with a proof version of the transcript for you to check. Verified transcripts, presentations and handouts will be placed on the committee's website as soon as possible.

We invite you to make a brief 5-minute opening statement. We ask that you state your name, position and the organisation you represent for broadcasting purposes. This will be followed by members of the committee with questions. Thank you, Professor Marylouise.

Prof. McLAWS: Thank you for the invitation. I hope you can hear me okay.

I will just give a very brief overview of who I am, because I am not sure what information you have about me. I am an epidemiologist. I have a position as professor of epidemiology, hospital infection and infectious diseases control at the University of New South Wales. I am a member of the World Health Organization health emergencies program experts advisory panel for infection prevention and control preparedness, readiness and response to COVID-19. That then changed to the World Health Organization infection prevention and control guidance discussion group recently. I have been a WHO adviser to China and to Malaysia, and I was fortunate to review the SARS response in a SARS hospital in Hong Kong in 2003 during the outbreak, and Beijing, and I reviewed the pandemic influenza infection prevention and control guidelines for healthcare workers in 2010 on behalf of the then Chief Medical Officer. I am an honorary adviser to the New South Wales Clinical Excellence Commission, and I have supervised doctoral students who have participated in pandemics, including three Ebola missions.

Any of my comments are based on that experience or available public data and information. I have not been given any other information on which I have made evaluations of how Victoria has been handling this pandemic. Thank you.

Mr RICHARDSON: Thank you, Professor McLaws. It is a real privilege to have you join us this afternoon. Thank you very much for your time. Starting off with the statistical process of infection control, for the committee's purposes can you take us through what are the key analyses that should be undertaken in a pandemic?

Prof. McLAWS: Yes. Well, in this particular pandemic and in MERS there have been many mathematical models to predict how many beds may be needed and health service requirements—staff, medication, intensive care beds. Previous to this, modelling had not really been in charge of making decisions about what infection prevention and control or outbreak management there would be during an outbreak. But mainly when you look at the attack rate, how many people within a particular group such as aged-care facilities are infected, what the mortality rate is—and I have to remind everybody that the current mortality rates are usually a little bit unadjusted, because often patients have not had time to recover or die. So they can often be misleading, and at the beginning of any pandemic mortality rates are usually very high. You then have a look at the incidence every day and you plot it daily. However, looking at daily numbers, particularly in a state or in a city, can be very misleading. It does not give you a really good idea of how fast a pandemic is moving, because things can change daily because of simple things like the public not going for testing as soon as they should or pathology

not being able to keep up with the demand, and the numbers may be a bit slow to get to the authorities to put them up on the website.

I use an R just like anybody else, but I also look at a 14-day moving average. That is a classic outbreak approach: 14 days is a little more than twice the incubation period, and that is because we look for evidence that over two incubation periods you are getting close to elimination. I know this country has not gone for elimination, but it still gives me a good idea of how well you are doing, how well you are travelling. I also look at a seven-day, although seven days can give you a bit of a lumpy idea of how you are going because it is really only just over an incubation period.

Mr RICHARDSON: Elaborating a bit further on that, obviously Victoria got down to a very small number of cases, but we are seeing a second wave, like a number of other jurisdictions, Professor. Can you take us through our methods. Obviously at the federal level the COVIDSafe app has been complementary to some of the things that have been worked on—we have got contact tracing as well—but how do we stack up in our approach to other jurisdictions across the world?

Prof. McLAWS: Well, I have to say that every country that has not had SARS or MERS, particularly—they are very big outbreaks—makes mistakes. They all do because they are learning. The countries that have done particularly well, such as China, for its containment, have had experience in having to do the hard lockdowns that were criticised initially. But people now are realising that you have got to go to level 3 and sometimes level 4. They went straight to those levels immediately, as did New Zealand. Australia is doing particularly well, even though Victoria is having a big challenge at the moment—but we have done well. There are mistakes that we can learn from, but every country and every leader make mistakes because leaders are only as good as the information that their chief medical officer is given. If their chief medical officer is not being given evidence from people that have had unpleasant experiences in SARS or MERS or Ebola or one of those, it is very hard for them to try to guess everything that possibly can go wrong. That is where you need a secondary viewpoint to walk through and say what went wrong that we thought we were getting right and that you could have headed off at the pass. I would say that this is a good thing you are doing, a parliamentary inquiry—it needs to be transparent, honest and depoliticised—but what could you have done differently at each moment but also what can you learn next time, because we are not going to get a vaccine anytime soon?

Mr RICHARDSON: We are obviously in the midst of the second wave now of the pandemic and testing as a mark of where the virus presents in the community and where it is at any given point. Can you take us through Victoria's approach to testing, the numbers [Zoom dropout] how far and how that is mapped and how important [Zoom dropout] the virus?

Prof. McLAWS: Yes. One of the most important public health approaches that WHO, of course, has been advising since the beginning of this has been, 'Testing, testing, testing', as Dr Tedros says. Victoria, I think, leads the way with testing. Last month I looked at your testing numbers and I think you were up to something like 700 000 tests in July, which is very remarkable. I would congratulate the authorities but also the locals for going out and getting tested. You know, you have opened up the criteria so that people can get testing without being turned away. The offer of testing and the ability for your pathology practices to keep up with that is nothing more than remarkable.

Mr RICHARDSON: Can I take you now, Professor, to infection control? I understand you have done quite an extensive amount of work on hand hygiene compliance in hospital-based physicians. What were the learnings of that work that you could detail to the committee, and are there any learnings from those environments that could be translated to a broader community viewpoint?

Prof. McLAWS: The work that I did with the World Health Organization was to develop—being led by Didier Pittet—a guideline for hand hygiene. It was a new work in 2005, and those guidelines were redeveloped in 2009. Then we trialled them in six sites around the world—

Interruption.

The CHAIR: Sorry, I think one of our members had turned off their mute. If you could continue.

Prof. McLAWS: Okay.

Mr RICHARDSON: That was not my young daughter sitting next to me, Professor.

Prof. McLAWS: No, I can tell! So we trialled those to see how well they were going in six sites around the world and looked to see how well hand hygiene reduced infection, and it significantly reduced infection and saved countless lives. But I did some more work in Australia, looking at our Australian healthcare workers, and found that our nurses and doctors who are highly trained—probably some of the best in the world; think high-order nursing and medicine—are not necessarily thinking hand hygiene. So it can be very difficult for them to put in place very simple infection prevention and control strategies, such as hand hygiene, particularly when they are thinking about this high-order work like, you know, ‘Have I done the meds properly? Does the patient have an infection, have a temperature?’. So they are not thinking low-order hand hygiene. I concluded that this was because we teach people hand hygiene around our own risk rather than around the risk for the patient when we are teaching young children how to hand hygiene during toilet years, and this has been the same for the findings that I did in Iran, Malaysia and many other countries—Turkey. It is all the same: we all bring up our children to protect themselves first and foremost, rather than everybody else as well. So it is not surprising when they accidentally make a mistake.

In 2003, during Hong Kong’s SARS outbreak, the woman that was charged with looking after the hospital had a champion on the ward to observe the healthcare workers, who were in all their personal protective equipment—very hot, working long hours—to remind them ‘don’t touch your face, hand hygiene now, change your gloves now’, so that they could continue to think about life-saving practices while not having to think about practices that save their own lives. My analysis of that hospital and the number of healthcare workers that acquired SARS identified that they were infected for one of two reasons: either they rushed in to save the life of a patient instead of putting their mask on first or they had worn their full PPE for many, many hours—8 hours—and they were exhausted. So the longer healthcare workers have to look after COVID patients, with full PPE, the greater the risk of an error.

Mr RICHARDSON: Thank you, Professor. Taking you to, I guess, the broader fight against COVID, it is getting our communities on board, and human behaviour is a real, critical element of that. How important is educating our broader community, getting those messages out—the washing of hands, coughing into the elbow, mask usage—in driving and stopping the spread of respiratory diseases? And then could we have your feedback or comments on how you get a broader cohort on board.

Prof. McLAWS: Yes. So during SARS 2003 wherever you walked, post June when the outbreak was brought to a halt, you still found posters in walkways, in shops, everywhere—in fact I took photos of them; they were so cute—that taught people how to cough into their elbow, how to hand hygiene. So there was a lot of public discourse. There was a lot of advice given, particularly around the numbers of what we knew about SARS, which was good, and that is what Victoria does every morning, but there was also this addition of teaching the public how to best look after themselves and others, because the public like to feel in control of their destiny and you need to tell them—other than a lot of information about the outbreak, where the hotspots are et cetera—about how to protect themselves and others.

One important thing is to do it for targeted groups. So at the moment I think it is 36 per cent of your cases are between 20 and 34 years of age, and that is higher than their representation in the general population of Melbourne and Victoria. So they may not listen to your Premier in the morning or your Chief Medical Officer. They may need targeting through whatever they listen to or whatever media stream will work for them, because not only are they at risk themselves but they have the risk of transmitting it. Also, looking at what happened during your public housing outbreak, we know this country, including Melbourne, is basically a migrant country that we embrace, but we sometimes forget that our migrants have come from often war-torn countries or are lacking the opportunity to have secondary education. The literacy in their own language may be poor but of course orally they can understand messages very well. I think we need to embrace our communities to ensure that they hear as well the main message. They often work double shifts, and the young as well are often casually employed, and they may not take the opportunity to hear mainstream media or in English.

Mr RICHARDSON: Finally, Professor, in my section here I was keen to get your thoughts. Given the global pandemic is not going anywhere for years and your experience with SARS as well, do you think Australia would benefit from something like the American [inaudible]. What do you think of Australia’s experience and what we could be doing further?

Prof. McLAWS: I agree with you that I think we could benefit from some sort of CDC, but I would ask you—and this is from a strong, of course, WHO perspective—that we embrace the learnings and the amazing knowledge that our Asian neighbours have so that if we do have something like a CDC that we really do cross-cultural and cross-country knowledge sharing. After SARS I was quite surprised when the chief infection control officer, Wing Hong Seto, and the chief medical executive officer of the SARS hospital, Dr Lily Chiu, were not brought over to share their experiences. I had them record many lectures for my students because they just had the most amazing experience. Professor Liang, now from Beijing, from the bureau of health, I think was running the Wuhan experience. Really, we can learn an awful lot from our Asian neighbours, and it would be great to have an Asian bubble of experience, that we just do not focus on Australia but New Zealand and all our neighbours so that if this happens again, we have an area approach rather than just a country approach.

The CHAIR: Thank you very much. The member's time has expired. I will now pass to Mr Danny O'Brien, MP.

Mr D O'BRIEN: Thank you, Professor. That is really interesting testimony so far—evidence, sorry, not testimony. Just a broad question to start with—and I think I might head towards a 'What is the endgame?' type of question here—do you think the current stage 4 restrictions are (a) necessary and (b) will they do the job, and is there anything that could be done to change them to have a better impact?

Prof. McLAWS: Building on the questions that I have just been previously asked about bringing on board the public, I think that we should be doing more communication with the public and focusing targeted information to different groups. I think that the level 4 restrictions in Melbourne are going to result in excellent results, and it would be a great opportunity to try to go for what I call 'near elimination'—because you never get true eradication with this virus—so that you can open up and get back close to COVID-safe, normal behaviour and we open up our corridors with each other. And also it provides you with—it is cheaper. You are not running around trying to put out outbreak bushfires and using an enormous amount of human resources just trying to cope with outbreaks. So yes, I think your stage 4 was necessary. Yes, I think it will work. I thought that introducing masks was an excellent idea, and then following it with stage 4.

The only comment that I have about this is that an outbreak manager would be more pre-emptive rather than reactionary. Now, it is admirable that you have been reactionary, but I think that one now needs to learn from this and say, 'Where was it in this outbreak of this second wave that we had an opportunity to cut it off at the pass to prevent these large numbers from happening?'. And if you notice, most of these outbreaks have occurred indoors. And this is where the virus likes it—indoors, working conditions.

Getting your experts—and you have many experts, even if they have not had outbreak experience—walking the corridors of workplaces such as Cedar Meats and places like that to say, 'How can we advise the employers to make it safe?', because employers do not know what they do not know. The experts in your ministry of health do know, so they can actually say simple things like, 'Ensure that you wear a mask while you're having lunch breaks'. That could have been done much earlier on given what we know about what happened in America—and in America they had something like 16 000 meatworkers infected. Sure, it was a 9 per cent attack rate, but nevertheless that is an awful lot. And it just goes to show that when you are in close confinements these things happen. So some more pre-emptive assistance and helping employers know what they do not know.

Mr D O'BRIEN: And on that point, and this is relevant for recommendations that we have already made but that we may look at going forward, we have heard previously evidence—and Cedar Meats was a good example, where Cedar Meats itself was not told—where the company was not told there had been a positive case there, because of health records acts and privacy concerns. Likewise, and this comes to inconsistent messages too, we had the Chief Health Officer say a few weeks ago people under quarantine who are positive must be allowed out to exercise because otherwise it breaches their human rights, yet two weeks later those human rights have actually been breached. Do we need to look at changing laws in that respect so that we can deal with this?

Prof. McLAWS: Yes. I cannot see how an individual's rights take priority over the greater good when it comes to an outbreak like this, and I think that most Australians really support and trust their government, and you have noted an enormous amount of support throughout Australia. So to alter those regulations, I think that

they would feel confident that you are doing it for the greater good if you communicate it in such a way. I do agree of course—in public health of course I would agree—that the greater good comes first.

Mr D O'BRIEN: Yes. Can I just ask on contact tracing, I think you mentioned you are jumping on small outbreaks. We heard earlier from the Minister for Health that through June there were, I think, 1891 contract tracers in the department at a time where we actually hit zero cases on a couple of occasions per day and then slowly went up—single digits, teens, 20s. Does it surprise you and it is a failing that with that many contact tracers we did not get on top of that outbreak and stop the second wave?

Prof. McLAWS: Look, as an epidemiologist I would have started being pre-emptive on 18 June. That is because 18 June was when you reached 102 cases over two incubation periods. It does not sound like a lot, but if you have got 10 cases every day and they have 10 contacts, that is 100 contacts that you have to get before day three or four because there is something called the serial interval, and that is the time between being exposed and the time that you become infectious to others. There is a newish paper out that says that that serial interval is somewhere between day three and day five. In other words, if you do not get all of those contacts by day three to day five—let us say just day three—then they can become a potential case and then cause secondary generation. So you are behind the clock all the time. You do need a lot of contact tracers, but you also need a lot of public health officers to go out and walk the corridors of places to find out how this virus can take the opportunity of people's behaviour—so when they forget to wear a mask, for example.

When you started to get the cases between, I think, 2 May and 22 May, that would have been the time to go out and walk the corridors to say, 'What's going on in Cedar and what's going on in some other places so that we can prevent it?'. A simple thing could have been face shields and face masks and, yes, an immediate call from the department of health to not just Cedar meatworks but all other meatworks, because you have now got lamb and pork and poultry. I mean, those built environments are perfect for COVID, partly because you are very close together; second, you are not wearing a mask; and, third, the airflow is very low. In a hospital airflow has to be somewhere—for COVID wards it should be—between 40 and 80 litres per second per patient. Now, in most public transport it is less than 3 litres, so it is very low. I would suggest in a lot of factories and wholesale meatworks it is also low for many reasons, so you have got a perfect storm and a perfect area. So getting back to being pre-emptive on 2 May, as soon as you get a case you go, 'What's going on here?'

I was stalking your data from May, and I started seeing it going up of course in June. But I also started noticing that you had hotel quarantine staff, and that rang alarm bells for me because that is very unusual. At first I thought it must have had something to do with a social event that may have brought people together, and then when you started to get more cases I was surprised. I was hoping, because I do not have any special insight into what has been happening in the ministry of health, that there was some pre-emptive work—going in, walking the corridors, finding out what is going on, and also protecting families as well. So how did the large public housing outbreak occur?

The CHAIR: I am sorry to have to interrupt you, Professor, but the member's time has expired.

Prof. McLAWS: Certainly.

The CHAIR: I will pass the call to Mr David Limbrick, MLC.

Mr LIMBRICK: Thank you, Chair, and thank you very much, Professor, for appearing today. I would like to start with talking around education and some of the measures that the government has been talking about. Would you agree that from a public health perspective voluntary compliance is preferable to mandatory laws, and if so, what could the government have done better or do better in the future to get community buy-in and better voluntary compliance with some of these strategies for implementing public health measures?

Prof. McLAWS: Thank you very much—a nice and deep question. So public buy-in is always better than forcing people, and I think countries like China, Taiwan and Singapore have been able to have buy-in because they have experienced this. It is probably as difficult in all other countries without experience. I would first of all start by educating the public early on, before any outbreak, about how to behave. For example, maybe at the beginning of every winter season, 'It's important to care for yourself and your family with a vaccine, or if you're not going to do a vaccine, wear a mask'—engaging people with a lot of education. You did provide a lot of data on the website, but equally something like an app for people to see where they live, where the hotspots are, that comes up where they do not have to go into the website. I mean, I have been going into your website

regularly, but the public having an app on their phone so they can see and so they can really understand that this is real, it is not theoretical. More targeted education, more bringing them on and having the face of who they are—so for the young ones, having somebody giving them information that they look up to and that they trust, and for the middle-aged and the elderly, targeting that information and getting them ready for the next steps as well. Because there will be pandemic fatigue, and we will need to get them ready. I notice that you constantly congratulate the public, which is really very important because without them you would not have any success. But I think also you could educate them about ‘This is not going to be natural for a while’ and then ‘These are the things that may happen in the future, and we would really appreciate any thoughts’—get them involved.

Mr LIMBRICK: Thank you, and one of the things that I have found very concerning is that in many of these instances the government has just bypassed education and gone straight to mandatory compliance. I mean, masks is the obvious one. For a long time the government was saying, ‘You don’t need a mask, you don’t need a mask’, and then all of a sudden it was ‘You need a mask or you’re going to get a fine’. This was a very jarring thing for lots of people. And then, after the fact, people were educated about this—after it was already mandatory—even though they do not really have a choice and cannot make a decision. This has been the case with a lot of things. You mentioned just before about the idea of the public good and the individual rights. This is something very dear to my heart, and I would be interested to know: how far do you think we should go? I mean, we are already in a situation where we have a curfew, we have police arresting people on the street for walking with their mother, we have videos of people getting hurt by police for these sorts of things, we have massive fines and we have pretty much the worst situation for individual rights that we have pretty much seen in Victorian history. I mean, can it get worse on this?

Prof. McLAWS: Look, I think we are very fortunate in Australia that we are very peaceful and very cohesive normally. I think that what we are seeing is anxiety and anger. People go through grief in very different ways, and some people grieve with anger. And what you might be seeing is those that are grieving the fact that they do not have a job, they are underemployed and they are fearful. So I think we need to address those issues. How do we ensure that they can pay their rent and that they can pay a job and that we bring them on board? Back to the mask issue, one of the problems when leaders say ‘Definitely we don’t need X’ is that to walk back that rhetoric is very hard. And the sign of a good leader is when they can turn around and say, ‘We’ve got new science now, and this is the new evidence that we have’. So I think that that is one thing that we can learn from. For example, the World Health Organization put out the mask use on 5 June, but because we told Australians that they did not need to wear a mask at the beginning, which I was supportive of, we did not explain to them, ‘Look, you’re at home; you don’t need a mask. And by the time we lift the restrictions you still won’t need one, but we’ll let you know when you do’. But we failed to tell them that honestly, so by the time it came to ‘I think a mask is a very good idea; it is cheap and it is highly effective’, we had walked ourselves into a corner. I think one of the most important things is to be overtly honest with them and bring them on board and deal with their anxiety.

The CHAIR: Thank you very much. I am sorry to have to interrupt you, Mr Limbrick, but the time for your questions has expired. Thank you very much, Professor, for your time with the committee today. We appreciate your wisdom and knowledge. The committee will follow up on any questions taken on notice in writing, and responses will be required within five working days of the committee’s request. The committee will take a very short break before the consideration of its next witness. Thank you for your time today, and we declare this hearing adjourned. Thank you.

Prof. McLAWS: Thank you.

Witness withdrew.