

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

Ms Lizzie Blandthorn—Chair

Mr Richard Riordan—Deputy Chair

Mr Sam Hibbins

Mr David Limbrick

Mr Gary Maas

Mr Danny O'Brien

Ms Pauline Richards

Mr Tim Richardson

Ms Ingrid Stitt

Ms Bridget Vallence

WITNESSES

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

Professor Brett Sutton, Chief Health Officer,

Professor Allen Cheng, Deputy Chief Health Officer,

Ms Kym Peake, Secretary,

Mr Terry Symonds, Deputy Secretary, Health and Wellbeing,

Mr Greg Stenton, Deputy Secretary, Corporate Services, and

Professor Euan Wallace, Chief Executive Officer, Safer Care Victoria, Department of Health and Human Services.

The CHAIR: Good morning, Minister. Good morning, Chief Health Officer, Deputy Chief Health Officer and your officials. 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.

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 either from their homes or from their electorate offices. Please 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 directions of 6 August, part 2, section 7(i).

We also 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.

Minister, we invite you to make an opening statement and presentation of no more than 8 minutes. We ask that, for the record, you state your name, position and the organisation you represent. This will be followed by questions from the committee members. Thank you.

Visual presentation.

Ms MIKAKOS: I will just speak to some slides, and hopefully we will get the technology working. Victoria, like so many countries around the world, is currently experiencing a second wave of COVID-19. Just over a week ago we announced our toughest restrictions yet in order to slow the spread of this virus. The stage 4 restrictions that are currently in place in metropolitan Melbourne and the stage 3 restrictions in regional Victoria are based on the public health advice and are designed to limit people's movement and to slow the spread and reduce the transmission of the virus also in workplaces, which is where we have seen significant spread during the second wave.

I understand how challenging these restrictions are and the huge sacrifices that many Victorians are having to make. But, as we can see from this slide, we needed to take further action. Stage 3 restrictions in Melbourne and the introduction of mandatory masks were slowing the growth in case numbers, but we needed to do more to reduce the number of cases more quickly. This modelling shows where we were headed without stage 3 restrictions. As the Chief Health Officer has said, we were on track for close to 20 000 cases per day and more than 8000 people in hospital. The directions that we put in place to reduce movement and slow the spread have helped us avoid this scenario and in turn save lives.

But, Chair, we have not taken any chances. Since the start of the year we have invested more than \$1.9 billion in our health system, because we saw overseas what could happen with this global pandemic. Last time I

appeared before this committee I spoke about the work underway across the state to get ready, and today I can point to the outcomes of that work. We have delivered new projects that mean extra beds are ready for patients: 45 new beds at Bendigo Hospital; 84 new beds at St Vincent's on the Park, the former Peter Mac cancer centre; and 50 new beds and consulting rooms are open at Baxter House in Geelong. We accelerated projects that we had in our massive health pipeline of works so that the beds were ready in case we needed them during the pandemic, with 40 beds at Casey Hospital and a new inpatient tower at Shepparton hospital.

As well as building new beds we bought a significant amount of medical equipment to upgrade the beds in our system, enabling thousands of hospital beds to be used for critical care. To date 1556 ICU and critical care spaces have been prepared across public and private hospitals. There are another 1300 that come online as part of stage 2 and 1400 in stage 3 if these are required. We have ordered 5216 ventilators, 130 dialysis machines and 2945 patient monitors. We were the first state to sign an agreement with private hospitals so that our public and private hospitals could effectively work as one system during this pandemic. We have put this agreement to use and added significant capacity for a system-wide response. This has been particularly important recently to treat aged-care residents who have not been able to be looked after in their own facilities. We also worked to rapidly expand innovative models of care, including telehealth and hospital in the home, to keep patients and healthcare workers safe. Difficult but necessary decisions to reduce non-urgent elective surgery further ensure we have a surge capacity if needed and help protect both patients and staff.

Our government has always thought of our healthcare workers as our heroes, and that has never been more apparent than during this global pandemic. As well as investing in bricks and mortar and equipment, we have spent hundreds of millions of dollars purchasing personal protective equipment for our healthcare workers. To ensure supply lines when everyone across the globe was fighting for the same products, we reformed the procurement of PPE and introduced a centralised procurement and distribution function for the first time. We have also made investments to stimulate local PPE production to reduce the sovereign risk of only relying on international orders. So far we have ordered more than 805 million gloves, 154 million masks and 26 million gowns, and we will continue to make orders as long as the PPE is needed.

Our public health response has grown and evolved since the start of this pandemic, and it continues to do so. Victoria continues to have one of the highest rates of testing in the world. As of today there is an extensive network of 188 testing sites across Victoria. More than 1 700 000 tests have now been completed. We have adapted our testing strategy based on emerging needs and priorities. Just yesterday the Premier and I announced another tool in our testing tool bag, call-to-test and rapid response testing teams. We have also significantly adjusted our contact tracing efforts based on the data and the behaviour of Victorians. There are now more than 2600 people working on contact tracing. The ADF are assisting with the doorknocking of cases who cannot be reached by phone, and we have set up regional public health teams to assist with contact tracing activities in their local communities.

Chair, as you can see, the massive investment and activity that has been undertaken across our health system since this pandemic began has meant that thankfully our health system has not been overwhelmed like so many health systems across the world during their second waves. Whether this remains the case depends not only on the preparations that we are making but on whether Victorians continue to limit their movement, follow the chief health officer's directions and slow the spread. In recent days we have begun to see the slowing of our case numbers because of the restrictions that have been put in place, and I am so grateful to all Victorians who are doing the right thing, but we must all continue to adhere to the advice of the public health experts and persist with our efforts to bring down case numbers.

Thank you, Chair; thank you, committee members. I am very happy to take your questions.

Mr RIORDAN: Thank you, Minister. Before I ask my questions on behalf of the opposition I would very much like on the record to acknowledge the many thousands of health workers right across the state of Victoria, who I know have gone above and beyond at this time, and also the many community agencies, particularly in my own electorate of Polwarth in the town of Colac, where literally hundreds of people have been working together to support others. I think despite the robust discussions we will have today it is definitely acknowledged by certainly our side of politics and Parliament that we are very grateful to those that have gone above and beyond.

But, Minister, turning to the questions of the day, can I ask you: at what point did you become aware that Agriculture Victoria, Regional Roads Victoria, Global Victoria and the national gallery were running the Victorian hotel quarantine program?

Ms MIKAKOS: Well, thank you, Mr Riordan, for your question. Can I say firstly that the government has established an independent inquiry to get to the bottom of what happened and what went wrong with the hotel quarantine program. As I have said previously, this was a multi-agency response. There were many departments and many agencies involved in this program, and the respective roles of each of those organisations will be thoroughly examined by former Judge Coate in the process of her inquiry. In terms of the details that are in the newspaper today, I certainly read those with some interest, and certainly there were matters covered in that newspaper story that I was not aware of that detail and the individuals involved.

Mr RIORDAN: Are you saying, Minister, as Minister for Health in the state of Victoria in the worst pandemic in a lifetime, it is the first time today that you knew who was running your hotel quarantine program, designed to keep Victorians safe?

Ms MIKAKOS: No. What I am saying, Mr Riordan, is that what inevitably will happen is there will be new revelations in the media on a day-to-day basis, as there have been already to date, and that is why it is important that there is a thorough examination of what happened, how this program was run and what went wrong, because we all want answers. I want answers and Victorians want answers, and the inquiry will allow us to get to the bottom of it. But providing a running commentary based on what might be—

Mr RIORDAN: Minister, this is not a—

Ms MIKAKOS: based on a day-to-day—

The CHAIR: Mr Riordan, could you allow the minister to answer?

Ms MIKAKOS: really will not help us to get to the bottom of what went wrong. So the point that I am making is it was a multi-agency response. I am very happy to assist the judicial inquiry with that process, as is my department, and I am looking forward to all of us getting the answers that we want.

Mr RIORDAN: Okay. So we will take that as: that was the first time you knew who was running it.

Ms MIKAKOS: No, please do not put words into my mouth. I think that is not going to help us at all today.

Mr RIORDAN: Okay. Thank you, Minister. Can you please provide copies of the emails received by your department outlining concerns regarding hotel quarantine in late March?

Ms MIKAKOS: Firstly, can I say that I read that newspaper story about certain emails, and that was the first time I became aware of the matters canvassed in that newspaper story. Now, I understand that there have been—

Mr RIORDAN: Minister, sorry just to—

The CHAIR: Mr Riordan, could you let the minister answer the question?

Ms MIKAKOS: If you actually let me finish, Mr Riordan, you might be greatly enlightened. Firstly, can I say that my department has provided thousands and thousands of pages, including emails and other documents, to the inquiry. I have not had the time to read those thousands of pages because I am focused every day on responding to this pandemic. I have got to look forward. I do not have the luxury of looking backwards. That will be the role that the judge will play—to examine all of those thousands of documents, to hear from witnesses, including people who played a hands-on operational role on a day-to-day basis, to be able to give us the answers that we all want. I do not have those emails.

Mr RIORDAN: The answer is no. Okay.

Ms MIKAKOS: The answer is: I do not have the emails, Mr Riordan. I read about them in the newspaper, and what was contained in that newspaper story was something that I heard about for the first time.

Mr RIORDAN: Okay. So, Minister, I have got an email here sent to me on 11 May that was also sent to your department, clearly outlining deficiencies in hotel quarantine, by an experienced infection control nurse in hotel quarantine. You seem to be telling Victorians and this committee that you received no advice whatsoever over the last three or four months of any deficiencies in hotel quarantine. Is that what you are saying?

Ms MIKAKOS: I am not sure what that email is that you are referring to, Mr Riordan. Was that an email addressed to myself?

Mr RIORDAN: It was addressed to your department.

Ms MIKAKOS: Okay, so it was not addressed to me. So what I can say to you is what I said before, Mr Riordan: there may have been many hundreds or thousands of emails perhaps that have been exchanged by different departments, different agencies, different public servants, working on the pandemic response. I do not think anyone would expect that I have the ability to read all of those emails. If they are not addressed to me, there is no opportunity for me to read those emails. That is what the judge will do. She will be able to look at all the documentation and get to the bottom—

Mr RIORDAN: Minister, I do not need to hear what the judge is going to do. You have told us many times. My question quite simply was: I am trying to ascertain if you had received any advice that there were problems in hotel quarantine. You seem to be saying that you have not had enough time and you had received no advice in three months that there were issues in hotel quarantine: yes or no?

Ms MIKAKOS: Mr Riordan, I have actually said publicly previously, at a media conference on 3 July, that the first time I became aware of any infection control issues with this program was in fact about the day, perhaps the first day, where we had the first case at the first hotel, and that was I believe on 26 May, where we had the first security guard that was diagnosed with coronavirus at Rydges hotel. So I am not able to divine—

Mr RIORDAN: Minister—

Ms MIKAKOS: Perhaps let me finish. I am not able to divine if there are infection control problems before an infection breakout actually happens. So that was, to the best of my recollection, the first time that I became aware of an infection control issue at one of the quarantine hotels.

Mr RIORDAN: Okay. So we will put that on the record that you did not know until the end of May that there was a problem. My next question—

Ms MIKAKOS: And I said that previously publicly more than a month ago, Mr Riordan.

Mr RIORDAN: Okay. There seem to have been a lot of emails not read or passed on to you, Minister. Can I pose my next question to the Chief Health Officer, please?

Ms MIKAKOS: Professor Sutton is on this call. He is a witness. I am just making the point for the benefit of committee members all in different locations, so hopefully the technology will work.

Mr RIORDAN: Is Professor Sutton available?

Prof. SUTTON: Yes, I am here, Mr Riordan.

Mr RIORDAN: Professor Sutton, what advice to the government have you provided that they have not followed through with this pandemic?

Prof. SUTTON: There is no advice that I have provided to government that has not been followed through.

Mr RIORDAN: Okay. What decision has the government undertaken in relation to the COVID response that was not your advice or that went against your advice?

Prof. SUTTON: There are no actions that I can recall that are against my advice. There are a number of matters that are taken by cabinet that relate to details of engagement with the broader sector and the stakeholders within those sectors that are matters for ministers and the secretaries of those departments in which

my advice provides general principles but does not relate to the specifics of those particular recommendations that cabinet might make.

Mr RIORDAN: During our first hearing your department or your area presented to the committee that ‘if we did not take those initial actions with the first wave, we could have expected up to 57 000 cases a day being reported’ to yourself. The report that we have seen both from the Premier and from the health minister today has a figure of 20 000 under what are clearly much, much more serious circumstances than we faced early on. Could you provide to us that changed scenarioing that you have done so that we can understand how we have sort of got less than half the projected cases under what are clearly far worse circumstances?

Prof. SUTTON: Yes, of course. Very happy to provide that. The issue with modelling is that the earlier modelling is obviously more uncertain around some of the parameters. When we were doing modelling really prior to the first wave that we had in Victoria it was based on more limited understanding of transmission of the virus globally and what its effects might be and also what some of the population responses are that really can mitigate transmission. They are based on assumptions. Modelling is not a crystal ball into the future, but it does try and make some mathematical predictions, if you like, around how transmission occurs and the case numbers that we see. As we have gone into the second wave, we have had updated modelling. It does not relate to the severity of what we are going through right now. It is a measure of what could happen should we not take steps to mitigate transmission and get on top of the infectiousness of this virus by virtue of the physical distancing and other restrictions that have been put in place.

Mr RIORDAN: So with this updated advice then, presumably you have best-case scenarios and worst-case scenarios. Can you also provide that to the committee?

Prof. SUTTON: They are really best-guess scenarios. There are uncertainty parameters within that, but yes, we can provide the kind of range of scenarios that the modelling predicts.

Mr RIORDAN: And presumably that modelling takes into account the consequences of stage 4 restrictions?

Prof. SUTTON: I am not aware of modelling that already incorporates stage 4 restrictions. One of the things about modelling is that it needs to be informed by the actions and activities that are a consequence of a policy change. We will look at the mobility data. We will look at the actual transmission data over the next days and weeks, and that will help to give us a better picture of what the forward predictions might be.

Mr RIORDAN: So are you telling us that in order to advise and enforce stage 4 restrictions, you have no modelling on what that would mean for the outcome?

Prof. SUTTON: We do not have exact modelling. What we did see is the effect of what the stage 3 restrictions showed us in terms of the effective reproduction number. What that demonstrated was that it was driving transmission down and that numbers were expected to plateau. The addition of masks was also modelled to a degree with respect to driving transmission down further. But you cannot do exact modelling for stage 4 without really knowing what the effects might be and all of the uncertainties around how human behaviour responds to those changes in public health directions and policy guidance.

Mr RIORDAN: Okay. Well, we will move on. What date did you first know about the outbreaks of COVID-19 in hotel quarantine? We know you and the Premier talked about it. Is that the first you knew of outbreaks in hotel quarantine?

Prof. SUTTON: No, I would have been informed very early on in those outbreaks of the initial cases. I can go to the specifics.

Mr RIORDAN: I am happy for you to take that on notice—if you can supply us with the date that you were first aware.

Prof. SUTTON: Of course.

Mr RIORDAN: The minister previously has outlined that despite there being much public evidence of emails and notices sent to her department about breakdowns in hotel quarantine—did you likewise never

receive any notification? As I said, I have an email here sent to me back on May 11. That is nearly a month earlier than the minister. Were you aware of problems in hotel quarantine?

Prof. SUTTON: Prior to the outbreaks, the only issues that had been raised with respect to hotel quarantine were not about the staffing of security staff and were not about infection prevention and control measures, but issues had been raised with me around the coordination of data, the coordination of welfare support from medical and nursing staff and some of the issues that subcontracting health services were challenged by in the very early days of that quarantine program. They were referred, as appropriate, to the quarantine command structure, of which I was not a part. They had come to me because I think a lot of emails come to me with a sense that I am responsible for overarching elements of the government response, but the hotel quarantine program was under a separate command and Operation Soteria, with an appropriate agency or the appropriate command structure to receive that information.

Mr RIORDAN: So what we are hearing this morning is: both the health minister and the person responsible for the overall operation of the pandemic were never advised of any weaknesses in hotel quarantine.

Prof. SUTTON: As I say, I was made aware of some elements, but otherwise the operational team, including the physical distancing unit within our public health command structure, were engaged with Operation Soteria staff around those issues. But it is for the operations area of the public health incident management team that were appropriately engaged on those matters.

Mr RIORDAN: And so did you support the use of private security guards who clearly, as we have heard, were recruited from WhatsApp and other online social media and who clearly did not have the time or the training to do quarantine? Did you advise the minister on that?

Prof. SUTTON: No, I was not involved in any of that decision-making whatsoever.

Mr RIORDAN: So no advice from anywhere in your department for how quarantine should be managed?

Prof. SUTTON: I cannot speak to the broader department. I was not informed of it, and I was not asked for advice.

Mr RIORDAN: As someone in charge of the worst pandemic in living memory, do you think that your role, or senior people in DHHS, should have had some say in how quarantine was run?

Prof. SUTTON: I am sure senior people were involved in DHHS. I can only speak to my involvement, and it was not in relation to the contracting of security guards.

Mr RIORDAN: Well, it is not only security guards—it is the general operation. So no input from you at all on that.

Prof. SUTTON: No.

Mr RIORDAN: Okay. Are you confident with the quality of face masks being provided to our healthcare workers? Paramedics are having reactions to face masks. They do not fit properly. We hear constantly from people at the coalface that they are low in stock, even though the Premier has made us aware they are in warehouses. And paramedics have told us it is okay to buy their own, and they will be reimbursed if they buy their own. Why are we still not providing proper face masks to paramedics?

Prof. SUTTON: I am not involved in the provision of PPE. That is a matter for other areas of the department. Obviously I am engaged with AHPPC, the national committee that provides general advice and receives advice from the Infection Control Expert Group in relation to what appropriate recommended PPE is for various staff, including paramedic staff, dealing with COVID cases or in health services. But it is for Safer Care Victoria and the Chief Medical Officer, Professor Andrew Wilson, to help frame the advice in the Victorian context.

I am not aware of any PPE shortages in terms of the supply in our stockpile in Victoria, nor of issues with distribution, but I take it on face value that if there are health workers who feel that they are not getting PPE, then that is a matter for the health services to engage with and to make sure that it is fed back to the department around issues of distribution.

Mr RIORDAN: Professor Sutton, we are sort of getting into six months. Much of the media was occupied yesterday—

The CHAIR: I am sorry to cut you off, Deputy Chair, but the time for your questions has expired. I will pass the call to Mr Gary Maas, MP.

Mr MAAS: Thank you, Chair. And thank you, Minister, for your appearance and your presentation. Thank you to the departmental officials and to Professor Sutton and Professor Cheng for your appearances today. My question is to the minister. Minister, I would like to take you to the topic of modelling and projections, because it has become apparent that throughout this pandemic the government has had to, you know, readily adapt to the challenges that the coronavirus has presented. And certainly since we last met, since we had our first set of hearings, Victoria has moved through various stages of added restrictions, from postcode lockdowns to stage 3 for Melbourne metro and Mitchell shire and now stage 4 restrictions for Melbourne metro and stage 3 for regional Victoria—and now of course the state of disaster, too. Minister, would you be able to explain why each of these steps was necessary and what the projections are for the next few weeks?

Ms MIKAKOS: Well thank you very much for that very important question. And just for completeness, for the committee to undertake its work, I will ask my department to provide the committee with a comprehensive list of all the legal directions that were issued since I last appeared before the committee.

Mr MAAS: Thank you.

Ms MIKAKOS: But the important point to make is that all the steps that we have taken, all the restrictions that have been put in place, all the legal directions issued by the Chief Health Officer, have been based on public health advice—led by Professor Sutton—and the public health team have been doing incredibly important work in developing the modelling and presenting advice to government. And as Professor Sutton has just indicated, advice that has been followed, advice that has needed to be taken to bring down the case numbers to make sure we can save lives. And that has been the absolute focus of everyone working in my department. And I take this opportunity to thank everyone from across the department, playing very different roles and very specific roles as part of that effort, and of course our healthcare workers who are at that last line of defence, looking after all of us.

But coming to each of the stages, essentially, we have seen community transmission—these are the mystery cases, as the Premier has explained them—increasing. The numbers of cases we could not attribute the cause of the infection were increasing, so we took various steps. On 1 July we introduced stage 3 restrictions for 10 hotspot postcodes. That was based on the data around the north-west of Melbourne. That was introduced specifically to essentially ring fence areas of concern in those particular locations. On 4 July we added two additional postcodes that met the criteria that we had established at that time. That was particularly due to a concentration of new cases that we were seeing in some of the public housing towers in those particular postcodes, and no doubt we will have a further discussion about that during the course of these hearings. Then on 8 July we moved to stage 3 restrictions for metro Melbourne and Mitchell shire, again reflective of the data around the spreading number of cases across different LGAs, different postcodes, including in Mitchell shire itself.

So each of those steps was not taken lightly. They were reflective of the data that we had at that time. We have seen from the data evidence of outbreaks concentrated in the early period in household transmission from one family member to the other. This is why, for example, we put in place restrictions to prevent people having visitors at the home. Then we saw a shift to a greater concentration of cases and outbreaks in a workplace setting, and this is why we introduced a range of measures around workplaces, including in the course of these stage 4 restrictions. So, for example, in recognition of what we have been seeing in workplaces, we have had to limit the scale of operations in some of the high-risk industries.

Just to give you a bit of a sense of where we have been seeing particular concentrations of cases in recent weeks, as of today we have got 14 outbreaks at abattoirs across Victoria. We have had concentrations of cases in food processing sites, in food and other distribution centres, in call centres. Aged care has been a particular area of concern. As of yesterday we have had 2328 cases in aged-care facilities since the start of the year, of which 1746 are currently active, and 121 aged care outbreaks are currently active. That has led, sadly, to

151 deaths associated with aged care outbreaks in Victoria. So the largest source of fatalities that we have had to date has been associated with nursing homes.

The point that I make is that we have had particular issues. The trends, the data have shifted as this pandemic has evolved over time. The public health advice has also evolved in accordance with that, and we have had to be nimble and we have had to be responsive to each of these changing circumstances. This is why we have had to change the settings along the way, from certain postcodes to certain LGAs, to all of Melbourne, to now on a statewide basis, to make sure that we can continue to bring those case numbers down.

As I said right at the outset in terms of the data that I presented, which was current as of yesterday, we are starting to see in the last few days a downward trend. That is a promising sign that reflects the stage 3 restrictions and the introduction of masks. We are yet to see stage 4 restrictions having an impact. I think we will start to see that by next week, and then there will be a time lag in terms of the number of fatalities. That will take longer. We may well see a decrease in the number of fatalities in a couple of weeks time.

But it is dependent on all of us of course to continue to follow the important public health advice. We can do this. As Victorians we can do this. We can address this issue. We can bring these numbers down if we take the public health advice seriously and we all do our bit to look after each other.

Mr MAAS: Thank you, Minister. I am really interested in masks and why the advice around the wearing of masks changed. Would you be able to enlighten us as to why the government's advice changed on the wearing of masks?

Ms MIKAKOS: Thank you, Mr Maas. I might also ask Professor Sutton in a moment to supplement my answer as well. But in essence the advice changed. In the first wave earlier in the year there was different advice, both internationally and also through AHPPC. We had more recently different advice through the WHO and through the international literature. AHPPC's advice then changed in Australia, and the advice that came to the Victorian government followed accordingly. But I will invite Professor Sutton perhaps to say some further things about masks specifically.

Prof. SUTTON: Thank you, Minister, and thank you, Mr Maas. Yes, certainly the evidence has changed over time. AHPPC were always of the view that when there was very limited community transmission, masks were not a recommendation for the general community. With circumstances changing in Victoria, it was clear that there was more community transmission, but at the same time there was changed advice from WHO. The US Centers for Disease Control also modified its advice, and I reflected on that as well as a *Lancet* analysis of a number of international studies that really provided much more compelling evidence that, although imperfect, cloth masks worn very broadly in the community can have a significant effect on driving transmission down, especially noting that there are a number of people who are infectious before they develop symptoms or people who can be infectious with no symptoms and/or very mild symptoms. And even though it does not present as a game changer, we were really looking to have whatever interventions that we possibly could in Victoria, especially ones that were of relatively low cost, low impost, compared to needing to take more significant measures that might make a difference. I think we are seeing the effects of near-universal mask wearing in Victoria now, with a continued decline in case numbers that really are not a consequence of stage 4 restrictions; they will be seen in the next week or two. So we are talking about effects that we are seeing now that relate at least in part to the very broad wearing of masks both in community settings but in work settings, as we have advised.

Mr MAAS: Thank you, Professor Sutton. My next question is to the minister and is around our contact-tracing team. Minister, could you inform us why or what investment the government has made to support the efforts of the public health team in response to COVID-19? And how large is the contact-tracing team now?

Ms MIKAKOS: Thank you. Can I firstly thank all the members of the contact-tracing team. They are now more than 2600 strong. They draw upon people with different skill sets. We are also grateful for the support that we have had from interstate, state governments, from the ADF and others who are supporting our efforts. This is a team that is working around the clock. They work seven days a week, 24 hours a day, and they are doing a very important job in following through each and every case. The team has grown immensely since the start of the year. We started with an announcement from the Premier and me back in March. At that time we had a team of 57, and it has grown immensely since that time. In essence what they are doing is they are

identifying people who might have had exposure to the virus and making sure that they can get the advice that they need about needing to isolate to stop the transmission of this virus further. So we have had additions to the leadership of that team, and I thank them, being Dr Allen Cheng—who is participating in the hearings today—and others, who have come on board to support those efforts, and they are playing an important role.

The Premier earlier, I understand, in his own presentation outlined some of the key metrics that we are using around measuring our performance. The important thing to note there is that they are endeavouring to call every single person that is diagnosed with coronavirus within a 24-hour period, and in the data that the Premier recently presented to the national cabinet—a report on 9 August, so very, very recent data—every single one of those cases was contacted in fact within that 24-hour period. And the important thing to emphasise here is that people get a text message or a phone call from a private laboratory, a pathology lab, or from a public health service. They get that notification, but then the department gets contacted subsequently. So people think it is instantaneous when they get notified about their positive result that DHHS and the contact-tracing team are immediately, simultaneously contacted; that is not necessarily the case. There is always a time lag involved, but despite that time lag they are contacting everyone within that 24-hour period. After making that initial contact they then do a very lengthy case interview. That can go for more than an hour in some cases. They are probing, they are asking important questions; this is why we refer to them as the disease detectives, because they are trying to prompt people's memories and their recollection about everywhere that they might have been within that relevant infectious period, whether it was at the local shops or with family members that they might have had contact with or with colleagues, and asking those questions.

In the data that the Premier presented to the national cabinet we had 10 to 25 per cent of new cases that are awaiting interview after a 24-hour period. Many of these cases are because they cannot make contact with them through the telephone or they are not at home, and this is why we are very grateful now for the efforts of the public health sector working together with ADF and others and VicPol going and knocking on doors and actually chasing up those individuals and making sure that they can take the call and give us the important information about their close contacts. In terms of the proportion of known contacts that are awaiting notification—these for more than a 48-hour period since the health department has been notified of a positive result—we have had less than 1 per cent of known contacts that are awaiting notification.

We have had a massive number of new cases. Currently we have got 7880 active cases in Victoria, and as of today 12 479 are close contacts of confirmed cases that are currently being monitored. So that just gives you a sense of the massive scale of the exercise that is involved. I know that there are jurisdictions in other parts of the world, and when they have this extent of cases, this extent of close contacts, they basically give up this type of work altogether. They think that it is not worth pursuing. That has not been our approach. We have endeavoured to look for efficiencies, for improvements, and grow the team overall to make sure that this important work can be sustained. They are working incredibly hard, and I thank them for their efforts.

Mr MAAS: Thank you, Minister. For my last question, I was wondering if you could take me through some of the skill sets that are required of our contact tracing teams.

Ms MIKAKOS: Thank you. This is a massive team with people with different skill sets. We have got people who are infectious disease physicians. We have got people who are occupational health physicians, public health physicians or registrars. We have had people who have come from the private sector. We have had people who have come from our universities. We have had, as I have mentioned earlier, people from interstate. I am grateful to my interstate colleagues who have been very receptive to requests for support, to ADF and others doing logistics-type work and to the people doing the data entry. Every person in the team is very much a valued member of the team. They all have a contribution to make, and they are playing a very important role. So we have grown that team. We have added to it more recently as well through greater support in a regional sense through our regional public health teams as well, establishing those teams in Ballarat, Bendigo, Latrobe and Goulburn Valley. Barwon Health of course was the first one that we established. That is adding to contact tracing ability at a regional level. Thank you.

The CHAIR: Sorry to interrupt you there, Minister. The member's time has expired. I will pass the call to Mr David Limbrick, MLC.

Mr LIMBRICK: My first question I would like to ask to Professor Sutton, please. I questioned the Premier earlier about the endgame, and I do not think we quite got to where I wanted to get, so I am going to follow up

that line of questioning with you, Professor Sutton. The Premier indicated that the suppression strategy that we are using is to get the case numbers down so that they are manageable. That is fine. I understand that. But that still does not lead us to an endgame. I mean, we either suppress for forever or however long it takes, probably decades, before everyone gets some sort of herd immunity or a vaccine. Or is there some other option here that I am not seeing? This seems to be fairly confusing. If suppression is the current strategy and there is no vaccine, then how long does that suppression strategy go for?

Prof. SUTTON: It is a wicked problem, Mr Limbrick. Certainly the suppression strategy is to drive cases down as far as is humanly possible. We cannot speak to the feasibility of being able to drive cases down to the point where they disappear, but I think the national strategy, and it has been updated through national cabinet on the advice of AHPPC, is called aggressive suppression. That talks about there being no community transmission. Other people might call that elimination. The reason it is not called elimination is that there is a recognition that the virus is always there globally and the virus will always be there in international travellers and in maritime crew who might arrive on our shores, so it is a recognition that we cannot get rid of the virus entirely from Australia's shores but that we can and should aim for no community transmission if it is feasible.

I think the alternative is indeed long-term suppression with the kind of constraints that can manage that. It is highly problematic, it is enormously complex and it has all of the weaknesses that are kind of playing out in the Middle East, in Asia, in Europe and in North America, where second waves come and there is an uptick in cases and a reapplication of restrictions. There may be a path that has very, very low case numbers with a kind of baseline level of restrictions, universal mask wearing and changed human behaviours very broadly applied across the population that can keep those numbers low, but I think it always comes with the danger that it can re-emerge and take off again.

Mr LIMBRICK: But this sort of strategy that you are talking about, Professor Sutton, how long would that need to go for? I mean, the current lockdown that we are seeing now and the current restrictions are clearly not sustainable over the long term, right? And presumably some less stringent lockdowns might be a little bit more sustainable, but ultimately, we have to get back to some sort of normal. If there is no vaccine available or a cure or something, presumably we would be following these suppression strategies for decades, wouldn't we?

Prof. SUTTON: I think there is significant optimism about the development of a vaccine. There are over 100 that are in various stages of development. Over a dozen of them have gone into phase 2 trials where they are actually exploring the safety and efficacy in human populations, and a number of those are not far away from phase 3 trials where they are actually demonstrated, hopefully, to be able to provide some protection at a population level. I do not think that vaccine will be available necessarily in the next six months, but I do think that there is a very, very good chance that it will be available within the next 12 to 18 months, so I do not expect that we are looking at years or decades of suppression. But it is a matter for national consideration and AHPPC certainly have also put their mind to, 'How do we manage this if there isn't a vaccine?'. I think the idea of aggressive suppression is one of those, where you can manage without too many population constraints and with very low case numbers or actually end community transition and then manage the risk of re-importation into Australia. But it is not easy to determine the long-term response when it is not yet clear if a vaccine may be available. I might throw to Professor Cheng, who is an ID physician and might be able to say more on vaccines.

Mr LIMBRICK: Thank you.

Prof. CHENG: Thanks. I am a Chair of the Australian Technical Advisory Group on Immunisation and the Advisory Committee on Vaccines for the Therapeutic Goods Administration. There are actually over 200 vaccine candidates, and it would be hard to think that at least one of them would not be effective. There are vaccines that are entering phase 3 trials, as Professor Sutton has outlined, and some of these are looking fairly promising in their phase 2 studies. They generate antibodies. Those antibodies can be shown to neutralise the virus. Phase 3 studies are necessarily fairly large undertakings, and it is going to take at least some months to work out if these vaccines do indeed work and are safe enough to give to a population. So I would agree that they are probably not going to be ready for deployment in the next six months, but I would also be fairly confident that in 12 months or perhaps 18 months there will be something available that really is a very hopeful step. There are really quite a lot of resources that are going into this.

I would also say that the pace of vaccine development is really extraordinary. There are companies that are producing vaccines already, assuming that they might be effective. If they turn out not to be effective, they are

going to have to throw out a lot of vaccine, but a lot of these steps are being accelerated or done in parallel so that we can be ready if one of them is shown to work.

Mr LIMBRICK: Thank you very much for that. How much hope are we putting in a vaccine becoming available? You sound very confident that we will get a vaccine at least sometime in the future, but if it turns out that a vaccine does not happen—I remember back with other diseases, like HIV, for example, everyone thought that there was going to be vaccine and it turned out that we could not get one. If it turns out that we cannot get a safe and effective vaccine, are we pursuing the wrong strategy?

Prof. SUTTON: I think we have to bear in mind that we are not relying on the development of a vaccine in how we manage this. The reality is that our numbers took off in July under a stage 2 level of restrictions, and therefore going back to that kind of level with our current case numbers would see an exponential increase and some of the modelled predictions would come to bear—and that means an overwhelmed health system. We are managing with our current daily numbers, but as we have seen we are looking at 20 deaths per day at those relatively modest numbers when you consider what modelling demonstrates the epidemic could increase to. So I think we have to look at controlling those numbers and then maintaining them through the least restrictive mechanisms possible. But in the absence of a vaccine, that does require the kind of broad structural and behavioural changes that suppress transmission enough not to have thousands upon thousands of cases a day and hundreds and hundreds of deaths. The UK has had over 45 000 deaths and is looking at a potential second wave now. Spain is going through a second wave. Israel is going through a very large second wave. The alternative is to see very, very significant morbidity and mortality and a potentially overwhelmed health system, so we do have to balance, with the least restrictive mechanisms, the control of the epidemic. But what we were looking at in early July was a very, very rapid and significant increase in numbers that would not have been addressed unless we had gone to these additional restrictions.

Mr LIMBRICK: Thank you, Professor Sutton. Another question which I raised with the Premier, and I would be interested in your viewpoint on this, is the harms from the restrictions themselves. We know that the disease causes harm, but also the restrictions themselves can cause harm. In economic modelling they will term this ‘quality-adjusted life years’. I am sure you are familiar with that. Has there been any modelling at all on the possible damage to quality-adjusted life years of the population due to the government interventions to manage this disease, so things like harm to mental and physical health, potential suicides, poverty—all of these sort of issues that will cause harm? What sort of modelling has been done? Because the question that lots of people are asking is: are the current actions causing more harm than other possible less stringent actions that the government could be taking?

Prof. SUTTON: A very reasonable question, and it has been in our minds as the AHPPC and me as Chief Health Officer but also broadly with cabinet right through this period. I am not involved in the specific review of the data across very broad areas that do relate to psychological wellbeing and other harms from reduced access to medical care, but Professor Wallace, CEO of Safety Care Victoria, might be able to speak to some of those broader components. But it is absolutely recognised that there is a balancing of harms here.

What has been demonstrated, again in Europe, is that even with the 30 000, 40 000 deaths that have occurred in some countries, that is only with between 5 and 10 per cent of the population having become immune. So we would be looking at half a million or more cases before some of those countries get to herd immunity. The deaths that we might have seen so far in Australia, or in other countries, are really only a very small proportion of what would be required if we were to let this run and get to a point of herd immunity. So it is a very significant morbidity and mortality. We are starting to see some of the very significant potential long-term effects that involve the respiratory system and neurological and other systems from coronavirus. So it is not just deaths; there does seem to be some chronic incapacity that people are left with as well. But Professor Wallace might speak to some of the broader components.

Mr LIMBRICK: Thank you, Professor Sutton.

Prof. WALLACE: Thank you. I am Euan Wallace. I am the CEO of Safer Care Victoria, and, as you know, we are the state’s quality and safety improvement agency for health. From the outset, one of the things that the department asked us to do was to track what we have phrased as ‘unintended consequences’—what are the potential and collateral outcomes of restrictions or changes to health provision in response to the pandemic.

Right at the very beginning, Safer Care set up a clinical leadership expert group, and they have 11 expert working groups feeding into that, all tracking areas of their own disciplines—stroke, cardiology, maternal-newborn health et cetera et cetera. And there have been changes, as you might be aware, in presentations through our medicine departments, particularly people with acute stroke, people with acute ischemic heart disease—so heart attacks. We provided that advice to the health department, and previously the minister has actually made announcements to the public about ‘please do not put off urgent health care because of the pandemic’. So while we were in stage 3 restrictions, and now stage 4, if you have urgent health issues, please present either to your family physician, your GP, or to your local hospital ED department or wherever.

Similarly, the cancer expert working group are looking at acute presentations and new diagnoses of cancer. So we are tracking these things very carefully, and that information is fed through to the department proper and the minister. And, as I said, the minister has made public announcements to encourage people to come forward.

Mr LIMBRICK: But they are not coming forward, are they? The rates are very low still.

Prof. WALLACE: Yes. Certainly in the first wave and the first restrictions there were significant decreases in presentations for heart attack and for stroke, and they have come back. We are too early in the current restrictions to know whether that is going to recur. Our cancer groups have also been tracking acute cancer presentations, and again, they fell initially. Hence why the minister made those announcements previously, encouraging people not to ignore changes in their own health and come forward appropriately.

Mr LIMBRICK: Yes. Thank you very much. I am getting close to running out of time. One thing I would like to ask Professor Sutton, and I think I asked you this last time, was around the issue of immunity. It was not certain at our last hearing whether people had a long-lasting immunity when they recovered from the disease. Are there any further updates on that? And my question there is: if someone is immune because they have recovered from the disease, and that immunity is lasting, what is the rationale for maintaining the restrictions on their freedoms if they are not going to be a carrier anymore and they are not going to catch the disease? Why can't they participate back in society again?

Prof. SUTTON: I might also throw to Professor Cheng on this, but my understanding is that there is good evidence or there is increasing evidence that the immunity that individuals get having been infected is potentially substantial. How long-lasting it will be and how protective that immunity will be will really only be borne out as we proceed down the track of this pandemic to see if it lasts beyond six months or beyond 12 months, but certainly from the serological tests and other tests of immunity people do respond with antibodies, they have other effects in their serum that should be an indication of some protection from reinfection, and therefore for those individuals there is some confidence that at least for a period of months if not several months to years they will have relative if not absolute protection, but Professor Cheng—

Mr LIMBRICK: But ‘Should they get their freedoms back?’ is the question.

Prof. SUTTON: Well, I think to the degree that we do not apply requirements for quarantine or that we will have individual exemptions for those people who might have been previously infected, then yes, those freedoms are available to them, but we do have some uncertainty about what it would mean to broadly not apply restrictions to individuals. We do not have advice, either from WHO or other international bodies, about the idea of an immunity passport being a valid approach.

Mr LIMBRICK: Yes, I note that I would have been horrified at the idea of immunity passports a while ago, but now we have work permits it does not seem so bad a way of getting some sort of freedom back. I think am just about out of time—

The CHAIR: Just about.

Mr LIMBRICK: Yes. Thank you very much.

The CHAIR: Thanks, Mr Limbrick. I will pass the call to Mr Danny O'Brien, MP.

Mr D O'BRIEN: Can I just go back to Professor Sutton. You would be aware, Professor, there was a report in the *Age* on 3 July that suggested that key players in the hotel quarantine system had warned you and other

public health officials that there were major problems back in April. Do you recall that warning and did you pass it on to the minister or anyone else senior in the department?

Prof. SUTTON: I have no correspondence that I can recall that relates to that. I do not know what those stories refer to, I am afraid.

Mr D O'BRIEN: Okay. Can I then move to the Secretary, Ms Peake. If I could ask: did DHHS have final oversight of the hotel quarantine program?

Ms PEAKE: Thank you, Mr O'Brien, for the question. The department really had three roles in relation to hotel quarantine. The first was supporting the development of an operational plan for the multiple agencies that were involved in the delivery of the program for approval by the emergency management commissioner, the second was overseeing the delivery of health and wellbeing supports for return travellers and the third was issuing legal directions under the health and wellbeing Act. In terms of the first of those responsibilities, following the announcement of the program the State Control Centre brought together the relevant departments and agencies and, supported by the ADF, there was a first operational plan that was developed very quickly which just defined the roles and responsibilities of all the agencies and departments that were involved. That was a plan that was then updated regularly and was—

Mr D O'BRIEN: Secretary, under that plan did DHHS have the final say, was it the final arbiter of that program? If not, who was?

Ms PEAKE: Under the plan—I was just going to take you through that, thank you, Mr O'Brien—there was an overarching governance group that was established to play that function of monitoring the progress of the program and be a place for there to be any issues that emerged to be escalated to. That governance group involved our department, DJPR, VicPol, the Department of Transport and the Department of Premier and Cabinet. As I say, it was a group that was responsible for sharing intelligence, the escalation of any issues that could not be managed by the individual agencies in line with the responsibilities they had defined by that plan, but also for coordinating daily reporting that reflected all of those activities.

Mr D O'BRIEN: Secretary, can I just cut to the chase? Was there any single department or minister that was ultimately responsible for the whole hotel quarantine plan?

Ms PEAKE: Under the plan this governance group was responsible. There was a deputy state controller that was established initially with emergency management expertise to establish that governance. And then in about the middle of April there was an emergency operations centre that was created to support that governance, with a COVID-19 accommodation commander who chaired that governance group.

Mr D O'BRIEN: Can I ask which departments were involved in that governance group?

Ms PEAKE: Yes, certainly. That was us, the Department of Jobs, Precincts and Regions, VicPol, the Department of Transport and the Department of Premier and Cabinet.

Mr D O'BRIEN: Transport and DPC. Thank you. You would be aware that the *Age* also reported on 14 July on an email sent by a senior bureaucrat in DJPR to both DHHS and Emergency Management Victoria raising concerns and basically saying that police needed to have oversight of the hotel quarantine. Were you aware of that warning, and did you take action through the governance group?

Ms PEAKE: I can only speak to the role of policing enforcement, and my understanding there was that that email, if you are referring to the email from very early in the program, was talking about concerns about returned guests absconding. That was escalated to the health controller position—the DHHS health controller. On 29 March the Chief Health Officer wrote to the commissioner of Victoria Police requesting assistance in the enforcement of CHO directions, which is a requirement under the *Public Health and Wellbeing Act*. That was agreed, and there was work that was done in the next few days about protocols to deal with the escalation of any non-compliance by authorised officers to Victoria Police. Those protocols were finalised on or about 4 April, and the program operated under those protocols.

So under those protocols Victoria Police responded to any issues that required escalation to law enforcement. Then in the middle of April Victoria Police suggested that in addition to being able to have an escalation path

through authorised officers, that it would make sense for the security guards to be able to directly escalate any issues to them, which was agreed to. So that was the enforcement regime that was in place for the duration of the program.

Mr D O'BRIEN: Did at any stage DHHS or the governance group request police to physically oversight at each hotel, or did police offer?

Ms PEAKE: I can only talk to that exchange around enforcement, where the issue was raised and within a few days there were protocols that were agreed.

Mr D O'BRIEN: Okay. You have just mentioned a letter that was written by the CHO. Could the committee please have a copy of that letter?

Ms PEAKE: Certainly. It is a pretty standard form that is under the *Public Health and Wellbeing Act*. Under the *Public Health and Wellbeing Act*, Victoria Police cannot act as authorised officers, so for enforcement purposes. For any of the government directions there is a role for both the authorised officers and VicPol. So that was a standard form under the Act.

Mr D O'BRIEN: Could that be provided to the committee—

Ms PEAKE: Certainly.

Mr D O'BRIEN: Secondly, just going back to the governance group, who actually chaired it? Was there ultimately a department or a person that was in charge?

Ms PEAKE: For the first period of time there was a deputy commander, who was someone with emergency management expertise, who was from DELWP. Subsequent to that there was an accommodation commander from DHHS. The role of that position was to both coordinate the health and social care aspects of the operation but also to facilitate the agendas for that governance group that had shared accountability for the program.

Mr D O'BRIEN: Were those people at different times the chair? Were they in charge? Was an officer from DELWP in charge?

Ms PEAKE: No. Sorry, Mr O'Brien, to interrupt you. The governance group was established to provide shared accountability, with the plan that was developed defining the roles and responsibilities of different agencies, and the governance group helped to coordinate those shared accountabilities.

Mr D O'BRIEN: This is sort of getting to the nub of the problem and responsibility, Secretary. I am just trying to work out who in fact it was, and if you can get me a name of the deputy commander that was in control, that would be good. I am just trying to find out: was there someone ultimately who called the meetings, who set the agenda, who made the decisions?

Ms PEAKE: I think of it as a little bit like the analogy of commonwealth-state meetings, where there is someone who is chairing the meeting, but there are very clearly defined responsibilities for the parties who are participating in the forum. So the critical instrument, if you like, was the operational plan, which really clearly defined those responsibilities. In the first instance the ADF helped put that plan together, and that plan was then updated through that governance group throughout the duration of the program.

Mr D O'BRIEN: Thank you, Secretary. Can I just move back to the minister. I think in response to the Deputy Chair you said you first became aware of the hotel quarantine breaches on 27 May, and feel free to correct me if that is not right. That is when it was first made public. Can I ask: what action did you take as a result of that to satisfy yourself that the outbreaks in the hotel quarantine would not become a wider outbreak?

Ms MIKAKOS: Firstly, Mr O'Brien, I think you have just got a sense from the Secretary's evidence about the complexity of the governance structures involved in this program and the multiagency response that was involved. In terms of my knowledge around infection control issues, as I said before to Mr Riordan, to the best of my recollection I would have been informed of a first case of a security guard who was infected at the first hotel. I believe that was Rydges hotel on or about 26 May, and subsequent to that my department has informed me of the various steps that they have taken in response, working together with other agencies and other departments in relation to these issues.

It would have been around the fact that the outbreak team that our government established would have gone into that hotel to provide advice and to satisfy themselves about the steps that needed to be taken. That would have been one of the very first steps that would have occurred. Obviously there is the contact tracing team's involvement in terms of speaking to that particular security guard, tracing through all of their close contacts and then talking to the hotel and the security company and others about what steps needed to be taken. These are not operational matters that I would be involved in in any way, of course. The Secretary of course can provide you with further details around specifics, but I was being briefed about the infection control responses in terms of the outbreak team going in and providing advice to those various parties and doing the contact tracing work.

Mr D O'BRIEN: I understand that, Minister. The question was: what action did you take to satisfy yourself that we would not get an outbreak from hotel quarantine?

Ms MIKAKOS: Firstly, in terms of me being able to divine before we had that first case diagnosed the processes that were put in place, they were put together by different agencies and departments working together to establish these structures. I was not involved in approving the governance model myself.

Mr D O'BRIEN: So who did, Minister? We are getting a lot of groups and governance arrangements and protocols, but we are trying to find out who was ultimately responsible. Were you ultimately responsible for hotel quarantine as a minister or not?

Ms MIKAKOS: Mr O'Brien, I think you are getting a sense today of just how complex this all was, and this is why—

Mr D O'Brien: And how confusing it was.

Ms MIKAKOS: And this is why we actually need Judge Coate to look at all of these matters and the respective role that each department, each agency, each private sector organisation as a contractor played in this program so we can get to the answers, because they are complex.

Mr D O'BRIEN: And the Coate inquiry will take its course, Minister. The question I asked was: were you ultimately responsible as minister, as a minister of the Crisis Council of Cabinet, or was it someone else? Just a simple answer.

Ms MIKAKOS: I am responsible for my own department, but this is a multi-agency response with many organisations all playing their part in providing support to this program. That is what my Secretary has just given you evidence about, about how complex the structure was, and that is why the judge needs to be allowed to look at those thousands of documents and question witnesses thoroughly about exactly what went wrong here, because I—

Mr D O'BRIEN: Minister, I am asking you now at a parliamentary inquiry—

The CHAIR: Mr O'Brien, let the minister answer the question.

Mr D O'BRIEN: She is not answering the question, Chair.

The CHAIR: Because you are talking over the top of her. The minister has the call.

Mr D O'BRIEN: Chair, can you let us ask the questions? I have asked the question: who was ultimately responsible? It is a pretty simple question. I understand it is complex but ultimately at the end of the day, Minister, someone had to be responsible for this program. If you are going to say it was multi-agency, therefore it was the Premier as the head of the government, just say so. If it was you, please tell us.

Ms MIKAKOS: Mr O'Brien, I am explaining to you it was various agencies involved in this program all playing their role. I am responsible for my own department but I am not responsible for every single department across the government, so this is why we need to have the inquiry do its important work to get to the bottom of exactly what went wrong here.

Mr D O'BRIEN: I am getting frustrated, Minister, because I understand how complex it was and that there were multiple agencies involved, but I am trying to get a sense of ultimately who had the final say—you, as

minister for your department? Was it Minister Pakula? Can I perhaps ask—the Secretary said there was a health controller—was the health controller from DHHS?

Ms MIKAKOS: I will ask the Secretary to respond.

Ms PEAKE: Certainly. Under the emergency management arrangements the plans are signed off by the emergency management commissioner on recommendation of the governance group. There is a state controller of health who is responsible for providing advice on that operational plan and the governance to support it.

Mr D O'BRIEN: Where are they from, Secretary?

Ms PEAKE: A health controller from the health department, and then there was a deputy commander who was established to set all of this up who had emergency management expertise. And, Mr O'Brien, the only other thing I might add is that the establishment of the program and the operation of the program did recognise that there was expertise that was available and drawn upon to provide a range of the different functions—everything from the transport from the airport and the information from border force about incoming planes through to the health and wellbeing support that we arranged within the hotels through to the processes of actually ensuring that the CHO's legal directions were applied—and authorised officers were again drawn from right across local government and government to make that possible.

Mr D O'BRIEN: Okay, thank you. Minister, can I move on to contact tracing? It was reported that in June, as the numbers of positive cases started to increase, we were down again to just 57 contact tracers in the department. Is this correct?

Ms MIKAKOS: I am very pleased that you have asked me that question, because that media report was completely wrong. We started with 57 contact tracers back in March, and had that journalist come to my department and actually fact-checked that he would have been told that that was entirely incorrect.

Mr D O'BRIEN: How many did we have then in early June?

Ms MIKAKOS: In early June? Look, I will have to ask my department to see if we have that figure at hand, but we certainly can provide you with that figure if we do not have it at hand.

Mr D O'BRIEN: While the Secretary is looking for that, Minister, then can I ask: given we were down to zero cases on some days in early June and certainly down in single digits and low teens, how is it that the contact tracing, if it had enough people involved, actually allowed the outbreak to get out of control?

Ms MIKAKOS: Firstly, I have found that we had 1891 staff in June in the contact tracing team. As I said, we had a massive scaling up of that team in a very rapid period of time. Sorry, what is the specific of your question, if you could just repeat—

Mr D O'BRIEN: That is a useful answer to part of my question. There were 1800 contact tracers when we only had single digit numbers of cases in early June. How is it that we did not manage to get on top of this outbreak before it got beyond control?

Ms MIKAKOS: Are you referring to the hotel outbreak?

Mr D O'BRIEN: I am referring to the second wave, Minister.

Ms MIKAKOS: The second wave, okay. This just makes the point of just how contagious this virus is, that it spreads like wildfire. It is possible to have one case, one person, that is responsible for many, many cases in our community. Let us not forget that this started from one person, potentially, in China back—

Mr D O'BRIEN: Minister, we know where it started—

The CHAIR: Thank you. Mr O'Brien, Minister, sorry to interrupt but the member's time has expired. I will pass the call to Ms Richards, MP.

Ms RICHARDS: Thank you, Minister, for appearing this afternoon. Of course I would like to take the opportunity to thank the officials and the clinicians in service of our community. I have had some feedback that

people are very grateful to our last line of defence as well, of course. Leading on from Mr O'Brien's questions, I am interested in gaining some insights into outbreak management and I am interested in understanding how the response to outbreaks evolved since earlier in the year. I am interested particularly in some examples of how the management has evolved in sites like schools and meat processing facilities. Thank you, Minister.

Ms MIKAKOS: Thank you very much for that important question. It does kind of segue to the previous question as well. It has been an evolving situation as we have had, I guess, different types of outbreaks, as I explained right at the outset. Many cases are driven by outbreaks in a family setting, particularly extended family groups coming together, having big social gatherings, and then more recently it has been workplace settings. We had to respond nimbly to each of these changing circumstances, and the response has evolved. We have had an outbreak management unit established as part of the public health team, the outbreak rapid response squads going out to each outbreak, providing advice to employers, to school principals and to others depending on the particular setting, providing infection control advice—advice about providing a deep clean for those premises and different measures that needed to be put in place by that organisation—in a preventative sense but also providing advice in a responsive sense around contact tracing and things that particular organisation would have needed to do.

For example, in terms of where we have gone with outbreaks in high-risk settings in particular, we had regulations approved on 28 July under the *Occupational Health and Safety Act*—that obviously sits with a different minister—specifying that when employers and self-employed persons have had a case they must notify WorkSafe of a confirmed diagnosis of coronavirus in the workplace. Similarly, we have had an obligation on employees. I am raising these issues because I know the committee has raised some issues in their interim report around these issues; just be aware that we had already taken steps around these issues much, much earlier.

We have had lots of industry roundtables, there has been lots of engagement with both employers and unions about these issues and we have been responding accordingly. We have embedded occupational health physicians in the outbreak teams, and we have increased liaison with the regional departmental staff to increase the cooperation across all of these different stakeholders. In terms of schools, we have embedded staff from the Department of Education and Training, who have been seconded to provide a contact point for school principals, to undertake contact tracing for those schools and to provide a triage hotline for queries from schools and early child care settings. So it is very much a tailored response, an evolving response, responding to the particular changes in the circumstances.

I might ask Professor Sutton, perhaps, if he wanted just to add something further in relation to our evolving response to outbreaks, and perhaps even Professor Euan Wallace might have something to add as well.

Prof. SUTTON: Thank you, Minister. Yes, certainly we are learning as the world is learning in terms of some of the complex settings and the best responses in those settings. The core pillars of response for outbreaks remain the same. We need to identify those cases as early as possible, ensure their isolation and support their isolation as early as possible, identify their close contacts and make sure that we can support their quarantine as early as possible.

But there is a significant prevention element that we need to get to with complex settings where we know that they have got explosive outbreak potential, and that means that the kind of preventive elements need to be there all of the time. That has been a significant element that has informed the workplace directions in terms of having guidance and in terms of having public health directions that really oblige workplaces to make sure that they are managing that risk of transmission all of the time, because there is this issue of individuals with very mild symptoms who may or may not isolate themselves in the few days before they get tested. And even though we have reinforced that message multiple times, those obligations need to extend to employers. They need to extend to other workmates to make sure either that those individuals are either not coming into work or, if they are coming into work, everyone is wearing a mask where it is feasible and that people are keeping their distance, that people are practising hand hygiene, cough etiquette and the like. So they are really important elements because there are some issues that you cannot adequately respond to other than to make sure they do not get introduced in the first place.

We know that abattoirs are an issue. One individual in a chill room where they are working very vigorously and are forced into closer contact with a number of other individuals—all of the personal protective equipment in

the world can do something, but the really key issue is to make sure that that infected individual does not come to the workplace in the beginning. All of the things that support that person to stay at home, to get tested, are really critical interventions. The same really applies in aged-care settings. The critical intervention is to make sure that any staff member with the mildest of symptoms is not coming into work, and so a lot of those outbreak responses are now informed by those really complex settings where there is explosive outbreak potential.

Ms RICHARDS: Thank you, Professor Sutton. Did you want to add to that, Professor Wallace, at all?

Prof. WALLACE: Thank you, Ms Richards. We need to see, as both Professor Sutton and the minister have said, that the case and contact tracing teams are always laser focused on stopping transmission—I mean, this virus begins and ends with individual cases—and have a very tightly focused function on identifying those cases as quickly as possible, isolating them, interviewing them in depth. And as the minister says, those interviews can take up to 2 hours, the most complex ones, through those interviews identifying their close contacts and then quarantining those close contacts as quickly as possible. And as Professor Sutton says, I think, like the rest the world, we have learned about this virus very quickly over these last six months and have identified some very high risk workplaces—abattoirs, meat-processing plants, aged-care facilities clearly and so on and so forth. The responses that happen today with a single case in an abattoir or a meat-processing plant are very different to how we might have or the rest of the world would have approached this six months ago—so identifying through those interviews, ‘Who are you? Where do you work? Who are your close contacts?’ and then responding in a very bespoke manner to who they are, where they work, what we think the risks are, all with the intent of shutting this down as quickly as possible.

Ms RICHARDS: Thank you for your insights there. Minister, I would like to unpack and get some understanding around our hospital preparedness. As we have now begun to understand, Victorians that are admitted to hospital as a result of the coronavirus, regardless of whether they are young or old or fit or unwell, can require some intensive treatment during their stay. And I think you flagged in your presentation that the government had invested significantly, \$1.9 billion, to prepare our hospitals to tackle this global pandemic and increased activity from the coronavirus. Could you update the committee on how the government is boosting Victoria’s intensive care bed capacity to help treat coronavirus patients? That would be particularly helpful for us as a committee to understand the steps that you are taking at the moment.

Ms MIKAKOS: Thank you, Ms Richards, for that question. So we started very early on in the year with a health sector pandemic preparedness plan, and we put this significant investment in to expand our capacity. We were engaged very early on. We were in fact the first state to sign an agreement with private hospitals as well to work together as one system. So together both public and private provides 20 000 hospital beds across our state, but when we started, at the start of this pandemic, we had about 450 ICU beds. We now have 1550 ICU and critical care spaces available to us. We also have many hundreds of ventilators in our centralised warehouse.

So we have the capacity to surge up and create more capacity if that is required, because it is, I guess, the sophisticated medical equipment that turns a hospital bed into an ICU bed—the ventilators, the other types of equipment that go with that, as well as of course the expertise of the healthcare professionals. And so we have worked on putting in place the infrastructure that is necessary to create more hospital beds and procuring the medical equipment that would be required, as well as training our healthcare workers to make sure that people who might be working in a general ward, for example, get some additional training in how to work in an ICU environment. So all of those are steps had to be put in place in terms of our preparations.

But the important thing to stress here is whilst we have got surge capacity and we have got contingency plans in place should we need to go further—to stage 3, as I indicated in my initial slides—we hope we never need to take those steps. As of today we have 650 people in hospitals across Victoria with COVID-19, of which 43 are in ICU beds and 24 are on ventilators, so we have not needed to use any of that additional capacity, but it is there should we need it. And all the messaging we have been doing every day—the Premier, myself and other ministers—has been about making sure that we do never need it. Because if people keep doing the right thing and following the stage 4 restrictions in Melbourne, stage 3 restrictions in regional Victoria, then we will start to see the downward trend of case numbers, as we have said in recent days, and we will not need that additional capacity. But we had to of course plan for worst-case scenarios, and that is the work that we have been doing since the start of the year.

Ms RICHARDS: Thank you, Minister. I think it was Mr Limbrick that was asking about other health-related issues that people are experiencing. And I know you briefed the committee in May that the government had been delivering additional general inpatient bed capacity to ensure that those non-coronavirus patients continue to get access to health care. I am interested in gaining some sort of insights and an update on those additional general inpatient beds, how that is going with that delivery that the government was about to undertake.

Ms MIKAKOS: Thank you, Ms Richards. So as part of the planning and the response for the pandemic we moved very early to think about what additional infrastructure we might need, so there was a lot of work undertaken by VHHSBA, the building authority within the department, to put all that infrastructure in place very, very quickly. And I am grateful for the work that they have done, working together with construction companies to create that additional capacity. So we have actually completed more than 400 additional beds, and those are available at St Vincent's on the Park, and that is ready to go. Thankfully we have not needed to use that extra capacity yet, but I expect it may get utilised in coming days, particularly given the issues we have had in the private aged-care facilities across Melbourne. So we have got the 84 additional beds available there at St Vincent's on the Park. We have had extra beds commissioned at Baxter House in Geelong, delivering 50 new beds and consulting rooms as well as a new acute respiratory assessment clinic to assess mild to moderately unwell patients, and there is further work underway there. We commissioned an additional 45 beds at Bendigo Health to create a dedicated respiratory ward back in March.

We also brought forward projects that we had had underway—being very well aware, Ms Richards, given your past interest in these matters, of the \$7 billion pipeline we have had in health infrastructure projects across Victoria—commissioning them earlier so we could utilise that extra bed capacity as well. So that has meant, for example, we fast-tracked the commissioning of 140 beds at the new Casey Hospital tower, comprising 128 inpatient beds as well as 12 ICU beds, giving that community access to ICU beds for the very first time at their hospital and in their local community, as well as bringing forward the Shepparton hospital redevelopment inpatient tower. The new tower there was accelerated to make another 88 beds available, including 64 inpatient beds and 10 intensive care beds, new operating theatres and other facilities as well. So there has been new infrastructure—those more than 400 beds—created but also the procurement of all the equipment, the conversion and the upscaling, with new oxygen lines, including gas lines, put in and more minor capital works undertaken across various hospitals to actually create those 1550 ICU critical care spaces so we have got that surge capacity should it be required.

Ms RICHARDS: Thank you, Minister. I know you outlined in the presentation that there had been some significant additional resources for PPE and medical equipment, and obviously ventilators, as we are all learning, in a community are key to treating respiratory infection. I am aware that there has been a global shortage—again something that the community has learned a great deal about. How many ventilators do we currently have in Victorian hospitals, in the warehouse, and how many are on order? And if you have the time, what have we done to also support Victorian manufacturers of ventilators?

Ms MIKAKOS: Thank you very much for that important question as well. We started the year doing worst-case scenario planning. We did a lot of modelling. It was modelling that we released publicly, where we were looking at the need to procure really important medical equipment like ventilators. There was really a worldwide hunt, a search, for this type of medical equipment from every government all around the world. So we centralised our procurement processes for things like medical equipment and PPE to make sure also that our hospitals were not competing with each other. Unlike other states, we have a very devolved health system here, and we could well have seen big metropolitan hospitals basically outpricing smaller regional hospitals, and that would be the last thing we would want to see—our own health services competing with each other for all the vital equipment that would have been needed. We had predicted a peak of 5118 patients requiring intensive care services at the start of the year. That was part of that early modelling that we had put out, looking at how many people might require ventilation as part of that modelling. Essentially, we have—and I will not apologise for this—over-ordered in terms of the number of—

The CHAIR: Sorry, Minister. I might have to interrupt you there. The member's time has expired, and I will pass the call to Mr Sam Hibbins, MP.

Mr HIBBINS: Thank you, Chair, and thank you, Minister, and your team for appearing before the inquiry today. I want to ask about our healthcare workers, who are working day in and day out and putting themselves

in harm's way and on the front line to protect others. Obviously it is concerning—I think the latest information that is up there is that there have been over 1000 infected healthcare workers, and protecting them needs to be one of our highest priorities. Can I ask, Minister: can you now guarantee that any public hospital staff member who is responsible for patient care will now be supplied with an N95 mask should they want one?

Ms MIKAKOS: Thank you for that question, and firstly can I say that I have absolute admiration for our healthcare workers, whether they are our nurses, our doctors, allied healthcare professionals, cleaners, cooks, security. Everybody doing their bit in our hospitals in whatever capacity is doing an absolutely tremendous job. They are people who are fronting up for work knowing that they may well be putting themselves and their loved ones at risk by turning up to, I guess, an environment where they are more likely to be exposed to coronavirus by virtue of the extended community transmission that we have at the moment and patients coming in who need medical care in our hospitals.

This is why we have striven to protect healthcare workers throughout our response to the pandemic. We have had massive supplies of PPE that have been procured. We have put those numbers out publicly on quite a regular basis. Hundreds of millions of items have been procured, but also we are really responding to the emerging evidence from the international literature and responding also to the advocacy of health sector unions.

I have made a point of engaging with unions on a very regular basis. My office and my department have meetings with them on a weekly basis in response to concerns raised by organisations like the ANMF and the AMA. I did ask Professor Euan Wallace and Safer Care Victoria as well as Professor Andrew Wilson, our Chief Medical Officer, who chairs a dedicated PPE task force, to look at the adequacy of that PPE. In fact late in July Victoria did move to introduce a higher level of PPE than is the case under the national guidelines, and we are now providing N95 masks in the highest risk settings—that is, COVID-positive wards, ICU wards and emergency departments.

I know there is a bit of a push on now from some physicians and some organisations to have the Victorian guidelines adopted as the national guidelines. I know that has caused some confusion in some of the media reporting that we have seen in recent days, but we are always looking to how we can make further improvements and really support the wellbeing of our healthcare workers. Can I just say—

Mr HIBBINS: Sorry, Minister—

Ms MIKAKOS: Can I just say one more thing, Mr Hibbins, if you would just let me complete my answer? Recently I directed my department to establish a Victorian healthcare worker wellbeing task force that will be chaired by the Chief Medical Officer, Professor Andrew Wilson, to continue to look at the data and to look at how we can do even more work in a preventative sense to keep our healthcare workers safe. So there are some things that are in our control, in our hospitals—our public hospitals in particular. I have to say that the data we are reporting daily has at least one-third of those cases in aged-care settings. Obviously the commonwealth plays a role in terms of the PPE that they provide and the standards that they set in an aged-care setting that relates to healthcare workers who might be exposed to coronavirus in that environment.

Mr HIBBINS: In regard to the task force then, is one of the considerations in increasing those protections that all public hospital staff who are responsible for patient care be provided with an N95 mask should they request it?

Ms MIKAKOS: Mr Hibbins, as I said, we have already taken steps to update our guidelines, and we are providing N95 masks in those high-risk settings. But I will ask Professor Allen Cheng to add some further words in relation to N95 masks. I know he has some particular expertise in this area. Professor Euan Wallace certainly is the full bottle on these issues as well and might want to add some remarks as well.

Prof. CHENG: This is a very personal issue for me. I am a hospital clinician, and healthcare workers—you know, these are my friends and colleagues. Although I have not obviously been seeing so many patients recently, certainly in the first wave I saw, personally, quite a number of patients. I think the issue is that it is really very much an evolving situation in terms of evidence and data. We have consistently applied international and national guidance, so recommending droplet precautions, surgical masks for routine care and airborne precautions for aerosol-generating procedures. However, in recent weeks obviously we have been seeing increasing notifications of healthcare workers, and a number of hospitals have changed to using routine

airborne precautions for suspected and confirmed patients with COVID-19. This is now reflected in the Victorian guidelines as of 1 August.

I think I would also point out that you do not want to use an N95 mask unless you really need to. They are very uncomfortable. To wear them for hours at a time is—you know, you get pressure sores on your face, and it is very hard to avoid trying to adjust them or trying to make them a little bit more comfortable. But we have really invoked the precautionary principle in saying that while we are not entirely sure why this is occurring, we are requiring N95 masks or particle filter respirators to try to improve protection for healthcare workers.

Mr HIBBINS: Thank you. Minister, can I ask about the data that you are providing in regard to healthcare workers, and can I ask: as of now, how many public hospital staff are currently off work either because they are infected or are a contact of someone who is infected?

Ms MIKAKOS: Thank you for your question. I will see if I can find the number, but perhaps if I do not have it, we will take it on notice. Perhaps Mr Symonds might be able to assist me with that particular question. But just to add, as I explained earlier, the numbers that we are reporting every day are not just hospital workers. It is important to stress that we have got primary care healthcare workers included in the data, so that would be, you know, GPs or pharmacists or dentists—

Mr HIBBINS: I am sorry, Minister. I am aware of that. I am just asking about public hospital workers.

Ms MIKAKOS: and others. As I have said, at least a third are in an aged-care setting or might be disability workers.

Mr HIBBINS: But my question is going specifically to hospital workers.

Ms MIKAKOS: I will just ask Mr Symonds if he has that number at hand, otherwise we will provide it to the committee.

Mr SYMONDS: Thanks, Minister. Mr Hibbins, we do not have a breakdown today of public hospital workers, which I think was your question in particular, amongst the healthcare workers generally. I am very happy to take that question away. My guess would be that there are roughly 1000 workers who are, in addition, furloughed because of potential exposure in hospitals to confirmed cases. They are furloughed for various periods of time. Most of them, obviously, return to duty after a short time.

Mr HIBBINS: Thank you, and if that information could also—

Ms MIKAKOS: Can I just add to that, just for a moment, Mr Hibbins? Hospitals take a very conservative approach beyond what would be done in another workplace setting in terms of close contacts, and through the abundance of caution do tend to furlough staff that they might think, I guess, have a remote connection to the source of the infection just to make sure we can keep patients safe.

Mr HIBBINS: Okay, thank you. If that information on those could also be provided as a percentage of the hospital workforce, that would be very helpful to the committee. Can I also ask: can we have a breakdown of cases by hospital and by workplace as well?

Ms MIKAKOS: I am not sure if we have it by workplace. We certainly report on a daily basis any new outbreaks in any particular health service as well as any other workplace, but I think we could provide you with healthcare worker type. As I explained—

Mr HIBBINS: Sorry, Minister. I am looking specifically for public hospitals. Can we get a breakdown by infections and by workers because of close contact by hospital?

Mr SYMONDS: Mr Hibbins, how about we go away and look at what data we can provide and come back to you?

Mr HIBBINS: Well, can it be broken down by hospital?

Mr SYMONDS: If it can be, we will give it to you. That is probably the best answer we can give, I think. At the moment the data around this is one of our challenges. I have looked at the line list, for example, of

healthcare workers, and some of the data is of variable quality. It is a bit unclear sometimes where in fact people worked. So we have got some people trying to clean that data up. If we can provide the breakdown that you have asked for, Mr Hibbins, I am happy to provide it.

Mr HIBBINS: I think it would probably—

Ms MIKAKOS: I guess, Mr Hibbins, the challenge with the question that you have posed—because I am aware we have had specific cases—is where you have a healthcare worker who might work across multiple hospital settings. Which hospital do you attribute them to? They might be a doctor who might work across multiple sites.

Mr HIBBINS: Hopefully multiple. Take this as a comment: I think it would inspire confidence in the public if we knew that the government could break down that data by individual hospital or multiple hospitals if they work at those. Can I also ask: can data be provided in terms of the breakdown of infections for healthcare workers whether they were acquired either in a hospital or in the workplace or were a community-acquired infection?

Ms MIKAKOS: Again I will ask someone from the public health team perhaps to add some further comments to what I am going to say, but we have had these issues looked at, including by Professor Andrew Wilson most recently as the chief medical officer but as the chair also of the PPE task force, and the advice that he has provided has been that roughly about 10 to 15 per cent of those cases are believed to have been acquired in the workplace. We have got, as you know, very extensive community transmission at the moment. It is possible that people are bringing the virus into a workplace setting and then colleagues are infecting other colleagues, perhaps in a tearoom-type environment where people might take their mask off and be I guess in a more relaxed frame. So I might ask perhaps if Professor Euan Wallace wanted to add something further to this particular issue. And it is very difficult of course to be that precise about the source of an infection.

Prof. WALLACE: Thank you, Minister. Some time ago Safer Care established a function to work with health services when they identified a member of their staff who had become infected to then get information to understand how and where they may have become infected. As the minister says, that work continues to be led by Professor Andrew Wilson, our chief medical officer. It is a changing and evolving thing, but currently it would appear that about 10 per cent of healthcare workers acquire their infection in the workplace and the majority acquire their infection out in the community or elsewhere or at least not in relation to patient-to-healthcare worker transmission. Even in the workplace at the moment it appears that the work that Andrew and his team are doing suggests that the majority of transmissions are between colleagues rather than from patients to healthcare workers. But I agree with you, Mr Hibbins; it is extremely important, and we have to look after our healthcare workforce so they can look after us as patients, which I think is why Safer Care and the department established that function many months ago to interrogate each and every healthcare worker infection.

Mr HIBBINS: Will you actually be providing that information more publicly and more proactively in terms of the divvy between infections acquired at work and the infections acquired in the community by healthcare workers?

Ms MIKAKOS: Mr Hibbins, we have been providing data on a daily basis about the number of active cases amongst healthcare workers. As I said, we are meeting and briefing health sector unions on a weekly basis, so there is a lot of data that is being shared with them around the PPE stocks that we have, around infection control issues. As I explained earlier, they have a PPE task force that is in place, and I have asked the department to establish a healthcare worker wellbeing task force—it will be chaired by Professor Andrew Wilson—that will start work this week. That will be engaging with those organisations really to drill down to the heart of what more we could do to protect our dedicated healthcare workers in their important work. So we will certainly be looking to make whatever data we think is helpful available, particularly to those organisations who work and support these healthcare professionals in this important work. But this is information that we have been sharing with them now for some time.

Mr HIBBINS: Thank you, Minister. Minister, we have had reports of student nurses and student doctors stepping up and plugging some of the gaps in our public healthcare system. Do you have any data on how many student doctors and nurses have been infected in the workplace?

Ms MIKAKOS: I am not sure if we have that figure today, but I do have some data around nurses overall. In terms of the active cases amongst healthcare workers, the department estimates that approximately 37 per cent of those cases are amongst nurses. I should say that is as an occupational group. That does not tell me whether they are students or not. It does not tell me whether they are in a public or private hospital. It does not tell me if they are in an aged-care setting.

Mr HIBBINS: Thank you, Minister.

Ms MIKAKOS: But if we have that data, we are happy to make it available to you, Mr Hibbins.

Mr HIBBINS: Thank you, Minister. I want to ask about further preventative measures. My understanding is that plastic ventilation hoods that sit over infected patients and that limit the spread of infectious aerosol have been developed at Melbourne University and trialled at the Western Health ICU. Will the government now organise for these to be produced and supplied in hospitals?

Ms MIKAKOS: I am grateful for the fact that you have asked me that question because I had a discussion with my department just in recent days about this particular trial at Western Health. It is something that we will be having a look at. We are very interested in looking at what additional measures can be put in place to protect our healthcare workers. We will not hesitate to look to the international literature or, if there is innovation happening at a local level, about things that could be scaled up and done on a broader scale. But we need to be driven by the science, by the data, by the feedback from health sector unions about what healthcare professionals themselves are saying might be helpful to them. I might ask Professor Euan Wallace again to comment on this issue because he is, I believe, familiar with this particular program at Western Health.

Prof. WALLACE: Thanks, Minister. Actually, I might ask Allen Cheng because Allen is much more familiar with this than I am.

Prof. CHENG: This has been looked at by the clinical leadership experts group. I think it is important to say that this is still a product that is in development. The regulatory status of these hoods is still for trial only, so it is obviously a promising tool. But until it is accepted as being safe and effective it is probably not quite ready for prime time at this stage.

The CHAIR: Thank you, Professor Cheng, and thank you, Mr Hibbins. The member's time has expired. We might take a short break for lunch at this point and resume consideration of the witnesses at 1.45, so I will adjourn the hearing for the moment.

We will resume the hearing of the Public Accounts and Estimates Committee and the consideration of the witnesses: Minister Mikakos, the Chief Health Officer, the Deputy Chief Health Officer and officials of their department. The call is with Ms Ingrid Stitt, MLC.

Ms STITT: Thank you, Chair. My question is to Minister Mikakos. Minister, thank you for appearing before the committee this afternoon. I wanted to just take you to the issue of workforce preparedness and some of the issues that have already been asked by—

The CHAIR: Sorry, I might just interrupt you, Ms Stitt. I will pause the clock and ask the committee secretariat: there appear to be people in the waiting room. Does that include the minister?

Okay, it looks as if we now have the minister and Professor Sutton, yes? Great. Thank you. Ms Stitt, you have the call.

Ms STITT: Thank you, Chair. Minister, the last time that you appeared before us, in May, you talked about a range of measures that the government was taking in terms of ensuring the hospitals and clinical staff had the appropriate skills and equipment that they needed to respond to this pandemic. Since then obviously staff have been required to not only support our public hospitals, but we have also seen public health staff have to intervene in a number of private aged-care facilities in Victoria. Can you provide the committee with an update on these workforce preparedness measures, including in our private aged-care settings?

Ms MIKAKOS: Thank you, Ms Stitt, for that important question, because our healthcare workers are really at the heart of our pandemic response, and we could not do anything without them. I am so, so grateful to them

and take this opportunity to express my gratitude on behalf of all Victorians to our true heroes who are working every day on that last line of defence for all of us, to keep us all safe.

There have been many things that have been done to support healthcare professionals during our pandemic response. We established a portal very early on to enable both students—and nursing students came up in our discussion earlier—as well as retired healthcare professionals to express an interest in supporting our efforts. Amazingly more than 16 000 of them signed up to make themselves available as part of our planning for whether we needed to create any surge capacity. We have had doctors, nurses, midwives, paramedics, allied health professionals and students in all of these health disciplines who have signed up. It is truly amazing the extent of that. It will surprise no-one that more than one-third of this pool have been nurses and midwives. I want to take this opportunity to thank Lisa Fitzpatrick and the ANMF in particular, who have done amazing work putting a call-out to nurses and midwives both in metropolitan Melbourne but also in regional Victoria to support us in these efforts. We have had thousands of people sign up and also many of these professionals being utilised.

As of yesterday, the most recent numbers that I have is that we have already onboarded more than 1800 of these skilled healthcare professionals, with hundreds already contracted and working in health services and other healthcare settings across the state and many hundreds more ready to be deployed. Already these staff—largely nurses—have completed more than 3200 shifts across the state and have been deployed in a range of settings in hospitals, in community testing programs and also in aged-care settings.

We did remark, Ms Stitt, to your question, on the efforts that have been underway in terms of supporting private nursing homes in our state. I want to thank healthcare workers both in our public hospital system but also in our private hospitals, who have both been working together and doing amazing work supporting those staff who work to support some of our most vulnerable people—and that is aged-care residents—and stepping in and providing that support to them at this really challenging time.

In addition to the portal, we also spent a lot of time earlier on providing training, because as I explained earlier, you cannot stand up an ICU bed just with ventilators and medical equipment; you need the staff to go with it. We do not have thousands of ICU healthcare professionals, and so we have had to provide additional training to maximise the capacity of the existing workforce. We developed and launched several new training programs to upskill our healthcare workers as part of this, with a particular focus on critical care. Nearly 11 000 healthcare workers have engaged in training to prepare themselves to acquire the skills that they needed. We have had nearly 7250 Victorian nurses who have completed commonwealth and state-funded training courses to equip themselves for this challenge as well.

There have been a range of things that have been undertaken, working in conjunction with health sector unions and working in conjunction with professional organisations and colleges and our universities to provide our workforce with the types of support that they need. I also want to thank the nursing staff and paramedics who have arrived from South Australia and Queensland to assist us in our testing sites and our respiratory clinics, as well as ADF personnel who have been providing support in various roles as well as our testing sites and our hospital respiratory clinics as well. I want to thank all those people involved who have been doing amazing work, and obviously we hope that they will not be put in harm's way. The only way we can of course ensure that is by all of us continuing to follow the public health advice.

Ms STITT: Thank you, Minister. We have had some reports of PPE equipment. We heard some evidence this morning from the Premier about that, but there have also been obvious concerns around adequate supplies for healthcare workers to keep them as safe as we can. Can you outline for the committee what the current stocks of PPE are in Victoria and how the government is ensuring that we have got enough equipment there for our health workforce?

Ms MIKAKOS: Thank you, Ms Stitt. As I explained earlier, we have a devolved healthcare system in Victoria, unlike other states. That means that usually, or in the past, each health service has gone and done its own separate procurement. One of the very important reforms we have put in place is to centralise our procurement process. We have established a big warehouse, and Monash Health is managing that distribution process, working together with Health Purchasing Victoria to make sure that our health services get the access to the PPE that they need. So currently we have 69 million gloves, 19 million surgical masks, 2.4 million N95 masks, 1.8 million face shields and many other pieces of important equipment. Truckloads are sent out

each and every day and to our health services across the state. We have been making sure that that process can work as efficiently as possible. I know that there have been some media reports suggesting that somehow we have shortages. I just wanted to reassure the community and our healthcare professionals that we not only have the PPE that we need—and we have put in massive, massive orders for hundreds of millions of these items—but we are making sure it is being distributed to our health services as well.

Ms STITT: Thanks, Minister. Can I ask now in relation to staffing preparedness in the aged-care sector—and obviously, Minister, some of the stories that have come out of some of the private aged-care facilities have been truly heart-wrenching—given that these facilities in the private sector are governed and regulated by the commonwealth, can you explain to the committee how the public health services have been assisting those private aged-care facilities in dealing with significant outbreaks? And in particular, when we have a circumstance where some of those staff in private aged-care facilities, who are working as hard as they can and are doing the best job they can, but if they are deemed close contacts, then how is the public-sector workforce working to ensure that those aged-care facilities have the staff and the skills that they need?

Ms MIKAKOS: Thank you for that important question. So just coming to aged care firstly, we have had some significant challenges in Victoria in terms of what has been overwhelmingly private aged-care homes that have had outbreaks. We are always particularly concerned about that because we know that whilst COVID-19 can strike anyone at any age and of any background, it is our most vulnerable in our community who are most at risk. So we have had, as of today, 1832 active cases related to approximately 122 separate aged-care facilities in Victoria. To date almost 350 aged-care residents have been transferred from residential aged care to hospital due to coronavirus outbreaks. So we have had health services and nurses in particular from both public and private hospital [Zoom dropout]—

The CHAIR: Sorry, Minister, it is just breaking up a little bit there.

Ms MIKAKOS: in private aged-care facilities to date. So we thank them for their [Zoom dropout]. Chair, can you still hear me?

The CHAIR: We can now, yes.

Ms MIKAKOS: I was just saying, Chair, that as of today we have had health services and nurses fill around 1148 shifts in our private aged-care facilities to date. We thank them for their assistance. That has been very important. We have had arrangements put in place where public health services have effectively reached out to aged-care facilities in their catchment, in their geographical location, to provide them with advice and assistance that has been required.

Coming to the broader issue around how we support healthcare workers generally and the issue of furloughed staff, as I explained earlier, we take the issue of infection control in our health services very seriously. It has been concerning to me to see increasing numbers of healthcare workers with infections. This is why I asked my department to do some additional work through the PPE taskforce and the work that Andrew Wilson has undertaken—to make sure that we can look at what additional measures need to be put in place to keep staff safe.

But what happens is where there is an outbreak or a case in a health service, the infection control team within a health service themselves swing into action and are supported by the public health team in the department. We see both public health services responding in terms of drawing on additional workforce pools that I mentioned and the additional surge capacity that we have created as well as providing other supports. We have had to temporarily pause all non-urgent elective surgery. This has been a very difficult decision to make, because we know it does inconvenience many in doing so, but it has enabled us to free up additional capacity to provide that support in time. So we will continue to take steps to support our dedicated healthcare workers. We have a program that we established, the Hotels for Heroes program, which enables healthcare workers who are either diagnosed or are close contacts to be placed into hotel accommodation free of charge so that they can serve that period of time away from their families and keep their own family members safe. We also provide that support for compassionate reasons. So, for example, if a healthcare worker were to have a family member who might be immunocompromised, then they would be able to access that hotel accommodation as well.

Ms STITT: Thank you, Minister. Obviously our healthcare workers are going through an enormous amount of the moment, with not just the physical care of people but also all the mental stress that that puts on them and

their families. Are you able to advise the committee on particular mental health supports or other supports for our doctors and nurses and allied health professionals that the government has initiated?

Ms MIKAKOS: Thank you very much, Ms Stitt. We think providing our healthcare workers with all the supports that they need, including additional mental health and wellbeing support, is critically important. We have provided and will continue to provide support to our clinical workforce through support to the Victorian Doctors Health Program; I have provided additional funding of \$500 000 to that program, as well as \$350 000 for the Nursing and Midwifery Health Program, to enable these services to expand their confidential free counselling and support services. And only a few days ago we boosted the Nursing and Midwifery Health Program with a further \$250 000 expansion, essentially to provide nurses and midwives who had presented at and had supported private nursing homes in recent weeks with additional support as well. They have had to see some very distressing things and to deal with some very challenging circumstances, and so it has been very important that they have been able to access that additional support. And I would point out that that is also available to aged-care personal care workers as well.

So we do encourage our healthcare workers to seek support. There are many innovative programs that exist. Ambulance Victoria, for example, have a very important peer support program that they provide to their paramedics. And I would take this opportunity to encourage anyone who might be needing that additional support to reach out and to get the support that they might need.

Ms STITT: Thank you, Minister. Back on aged care, if we can, you have outlined a little bit for the committee the response in terms of assisting with staffing in aged-care facilities. Are you able to outline what the government has done to assist the federal government in addressing the outbreaks in specific residential aged-care facilities?

Ms MIKAKOS: Thank you very much. I might ask Mr Symonds as well perhaps to add further to my comments, but whilst the Victorian government runs approximately 10 per cent of aged-care beds in Victoria—we are the state with the largest public aged-care facilities in the country, as I understand it, something that I am very, very grateful for as those facilities have nurse-to-patient ratios available to them—the remaining 90 per cent of course are privately run; they are either for-profit or not-for-profit organisations. They are all regulated and funded by the commonwealth, and so we have had to work very closely with the commonwealth to respond to outbreaks that we have had in our nursing homes.

We have seen some very distressing circumstances play out in recent weeks—tragically, many lives lost in our aged-care facilities. I take this opportunity to express my condolences to all the families who have lost a loved one. There are important partnerships that have been formed with the commonwealth, particularly around the aged-care national response centre, to cooperate and work with them. They do step in, and the commonwealth, through contracted lab Sonic, go into every nursing home and do the testing themselves when there is an outbreak. Obviously we are involved with our contact-tracing efforts to support those efforts. I must ask Mr Symonds in the very brief time we have available to us to supplement my answer.

Mr SYMONDS: Thanks, Minister. I might just touch on the aged-care response centre that you have brought up, Minister. I think although the private aged-care sector is commonwealth regulated and funded, the aged-care response centre is a joint effort. We have got staff in there from our team, from DHHS, from Emergency Management Victoria and Australia, ADF. We have got people seconded from health services in Victoria. There is an attempt to provide a one-stop shop for rapid response, sharing of information in real time between the regulator—the Australian commission for quality and safety in aged care is also represented inside the centre—funder and of course our health services who are responding to crises as they pop up in the private aged-care sector. So all of those services are co-located in one unit. It is an attempt by Victoria to step up and support the commonwealth in their efforts to address issues as they arise in the sector.

The CHAIR: Thank you, Mr Symonds, and the member's time has expired. I will hand the call to Ms Bridget Vallence, MP.

Ms VALLENCE: Secretary, my questions are to you. Thank you, Chair. Secretary, who was the health coordinator appointed to Operation Soteria?

Ms PEAKE: Thank you, Ms Vallence, for your question. There were a number of positions that were created, so which was the position that you—

Ms VALLENCE: Specifically the deputy health coordinator that was appointed to manage hotel Soteria.

Ms PEAKE: Initially there was a deputy state controller who was appointed who was someone who had been heavily involved in the bushfires during the summer period. He was an experienced emergency management leader from DELWP. I will have to get you details for—

Ms VALLENCE: Can you provide me their name? That is the state—

Ms PEAKE: I can certainly provide you with that. I do not have it with me, but I can provide you with that.

Ms VALLENCE: You do not have the name with you. So can you please let me know the name of the person that Mr Crisp appointed as the deputy health coordinator to manage Operation Soteria?

Ms PEAKE: I certainly can. And as I indicated in the previous conversation with Mr O'Brien, that position was in place for the first month to help set up the governance arrangements. The governance group was then created, and an accommodation commander was then appointed.

Ms VALLENCE: Ms Peake, with the greatest of respect, I am just asking for a name. Surely—they are in your department—you know the name.

Ms PEAKE: They were not in my department. That is what I have just indicated. So the deputy state commander who was appointed initially was someone with deep emergency management experience. They were not from DHHS.

Ms VALLENCE: You have referred to the governance group. Could you please let me know who was the chair of the governance group?

Ms PEAKE: So initially it was the deputy state commander and then from the middle of April it was chaired by the accommodation commander. One of the other examples perhaps that is useful to think about in this arrangement would be a multi-agency panel. So we have a lot of these sort of structures for services and programs where you really are drawing on the expertise of many different parts of government, and their roles and responsibilities are defined alongside their expertise. In this particular program, clearly there were a set of responsibilities around the hotels and security arrangements that were contracted. There were responsibilities around the health—

Ms VALLENCE: Ms Peake, I am not asking about the roles and responsibilities; I am specifically asking for a name. So far in the evidence today you have talked a lot about these positions, so it certainly sounds like you know a lot about them. We are asking for the names. These are publicly held positions. Victorians deserve to know who is actually sitting in these positions. Could you please release their names?

Ms PEAKE: I actually do not have the name of the—

Ms VALLENCE: Can you take their names on notice?

Ms PEAKE: I am certainly happy to take that on notice.

Ms VALLENCE: Thank you very much. Also on notice, will you provide an organisational chart for the governance group and DHHS secondment at any point during the pandemic to Operation Soteria?

Ms PEAKE: I am very happy to do that. As I indicated, we had particular responsibilities in relation to the health and wellbeing supports and also in relation to the development of the legal directions and administration of those directions, so there were two functions. I am very happy to provide a structure that shows—

Ms VALLENCE: Yes, provide the org structure and all of that detail that you just referred to then. Did the governance group address problems of hiring untrained security staff in hotel quarantine?

Ms PEAKE: Our department was not involved in that decision-making, and I do not have any—

Ms VALLENCE: Which department chaired the governance group and was ultimately responsible for the governance group? To cut to the chase, if you would let me know which department.

Ms PEAKE: The governance group was initially chaired by the deputy commander, and then it was subsequently chaired by the emergency operations centre.

Ms Vallence interjected.

The CHAIR: Ms Vallence, could you please allow the Secretary to complete her answer? You might actually find the answer to the question you are asking.

Ms VALLENCE: Chair, she is not answering the question, so that is why I am trying to—

The CHAIR: But you are not giving her an opportunity to, Ms Vallence.

Ms PEAKE: Ms Vallence, sorry, so that I can answer your question appropriately, are you talking about the governance for the decision-making on contracting or are you talking about the governance actually once Operation Soteria was established and the ongoing operation?

Ms VALLENCE: Both. You have said that you will provide it on notice, so if you could please provide that org chart and all of those details associated on notice—and what is the chain of responsibility, chain of command, as you have said. Thank you.

I will just move on. Secretary, at the last hearings that we had we heard that there was—the title here is an ‘outbreak management unit’, which would be established in the department. Has this been established? You said it would involve the EPA and WorkSafe. Has it been established?

Ms PEAKE: It has been established, and last time we talked about two things. We talked about the establishment of the outbreak management teams and we also talked about the joint intelligence unit. The joint intelligence unit was the mechanism for the involvement of the EPA but also for other parts of government as well to be involved. Victoria Police is also involved in that joint intelligence unit, as are other regulators. As we have seen different outbreaks—for example, if we see an outbreak in the meat industry, then we work very closely with DJPR through that joint intelligence unit for engaging that industry.

Ms VALLENCE: Thank you. Specifically on the outbreak management unit, who is in charge of that?

Ms PEAKE: The outbreak management unit works under our contact-tracing and outbreak management team, and I might ask Professor Wallace to just talk a little bit about how that unit works and how it fits into the organisation.

Ms VALLENCE: No, I just want to know who heads the unit.

Ms PEAKE: That particular unit?

Ms VALLENCE: Yes.

Prof. WALLACE: Currently there are two deputy secretaries, me and Sandy Pitcher, who are responsible for the case contact and outbreak management team.

Ms VALLENCE: Okay. Do you report into the governance group?

Prof. WALLACE: We report through the executive board and the department and to the Secretary.

Ms VALLENCE: Did you attend the outbreaks? I will just name a couple: the outbreaks in Colac, the outbreaks at Al-Taqwa College, at Bertocchi Smallgoods. Did you attend these outbreaks and manage those? As the outbreak management unit, were you responsible for managing those outbreaks?

Prof. WALLACE: So certainly the outbreak management team in association with other bits of the pandemic response attend those. For Colac, for example, we established a regional incident management team in Colac, working with Barwon Health, working with Colac health, working with the local community. The case and contact management of that bit of the incident management team actually is managed in association with Barwon through a regional case and contact management team.

Ms VALLENCE: Okay. And, Professor Wallace, were you involved in the hotel quarantine outbreak?

Prof. WALLACE: No, I was not. At the time of that I was still CEO of Safer Care, and I have just come across—

Ms VALLENCE: If you were not, who was?

Prof. WALLACE: I was CEO of Safer Care Victoria at the time.

Ms VALLENCE: All right. Was your unit also responsible in the Cedar Meats outbreak?

Prof. WALLACE: The case and contact, that big management team, is responsible for all case contact and outbreak management, including Cedar Meats.

Ms VALLENCE: Thank you. Secretary, back to you. How many ICU beds are currently fully available today?

Ms PEAKE: Certainly, and I might ask Mr Symonds just to take you through that detail.

Ms VALLENCE: Just a number.

Ms PEAKE: Thanks, Ms Vallence; I will just ask Mr Symonds to take you through this.

Ms MIKAKOS: Ms Vallence has not been listening to much of the evidence I have already given, because I have covered outbreak management units, ICU beds—but Mr Symonds.

Ms VALLENCE: The question is: how many ICU beds are available?

Mr SYMONDS: Today there are 426 that are staffed and open. There are up to 515 possible on a usual day and could be opened.

Ms VALLENCE: Thank you. Secretary, has the department engaged legal representation for the purposes of responding to the Coate inquiry?

Ms PEAKE: We have.

Ms VALLENCE: What is the budget?

Ms PEAKE: As with these things, the actual expenditure will be determined at the end of the process. There is not a set budget. It is under the budget of our legal team.

Ms VALLENCE: You must have done an estimation perhaps, based on previous sorts of, similar, inquiries? What is the budget estimate?

Ms PEAKE: No. It will be met within the existing budget of our legal team.

Ms VALLENCE: Okay. I have got some questions for the Chief Health Officer, Professor Sutton. Professor Sutton, in terms of contact tracing we have heard a lot about aggressive suppression and elimination strategies. They rely on excellent contact tracing: quick tests, quick follow-up, accurate and clear instructions, and rapid dissemination of data. But we know that the contact tracing has really been plagued in Victoria until recently. Until recently in Victoria we had the smallest team per capita for contact tracing. When did you request surge capacity?

Prof. SUTTON: It was very early on that we were looking to scale up our surge capacity. Obviously with our initial team of public health officers in my health protection branch we looked for additional staff on the 14th floor and more broadly in the division before going to departmental staff and then looking to other secondees to come into the system. But it was from the very early days of the February cases.

Ms VALLENCE: February, right. So it was not until recently that that increased.

Prof. SUTTON: No, it has been increased right from that early stage. It has obviously had a very significant expansion in the last two months.

Ms VALLENCE: Okay, in the last two months. Professor Sutton, we have heard earlier today that there were 2600 people in the contact tracing team. Are they all full-time?

Prof. SUTTON: Many of them are full-time but not all of them will be full-time. Some of them have other—

Ms VALLENCE: How many?

Prof. SUTTON: I do not know.

Ms VALLENCE: Could you please provide that to the committee on notice?

Prof. SUTTON: Yes, I am sure we can.

Ms VALLENCE: Thanks. And, on notice, could you please provide the breakdown, in the contact tracing team, of health workers, of ADF, private security, and any other organisations that make up that 2600 headcount?

Prof. SUTTON: Yes, we will be able to do that.

Ms VALLENCE: Okay. Is it true that epidemiologists and registrars have been stretched so thin but are still required to also be involved in the contact tracing efforts?

Prof. SUTTON: No, I am not sure what you mean by that. Obviously our intelligence team has a number of epidemiologists. They are working extremely hard, but they do not get involved in the day-to-day work of contact tracing. They are not doing interviews in the way that our contact tracer interviewers are doing, nor are they picking up the phone as our close-contact contact tracers are doing. They are involved in all of the analysis of our epidemiology, the demographics and all of the data that we have on our current cases and the trajectory.

Ms VALLENCE: So I have received some information that says that epidemiologists and registrars are involved in contact tracing efforts. Are you saying that they are not doing that, then?

Prof. SUTTON: Well, we are all involved in contact tracing efforts in the sense that we need to look at all of the daily notified cases, the trends, the demographics of those cases every day in order to understand where we need to focus our attention, where we need to prioritise our efforts.

Ms VALLENCE: Will you provide all the genomic testing to date to both this committee on notice and also to the Coate inquiry?

Prof. SUTTON: I will take it on notice. I am not in possession of all of the genomic data. But for that which is in my possession I am open to providing it of course.

Ms VALLENCE: Is it you that engages those who do the genomic testing? That surely comes through to you as the Chief Health Officer, doesn't it?

Prof. SUTTON: No, it comes through to the intelligence team, who are meeting regularly to, again, analyse the genomics data with the epidemiological data to understand what it means.

Ms VALLENCE: Do they report to you?

Prof. SUTTON: They report to the public health commander, who reports to me, yes.

Ms VALLENCE: So ultimately they report to you, so you therefore would be able to access it. Can you make sure that it is all available on notice to the committee?

Prof. SUTTON: Yes, I can.

Ms VALLENCE: Thank you. The current second wave was predicted by one of the Burnet models in June, and we know from that the testing rate dropped off. Why is that, and did we miss an opportunity to stop the second wave sooner?

Prof. SUTTON: I do not know that there has been any specific prediction of a second wave other than what the global community has said about the risk of a second wave. Whenever the virus has not been completely eliminated there is always a potential for it to take off again, which is obviously what has happened in Victoria. To the extent that we can control transmission, then we can suppress second waves, but we have seen that even with very robust contact tracing, even with a very large team and even with the stage 2 restrictions that were in place the nature of the virus and the extent of transmission that was occurring from June especially made it enormously challenging. You cannot control it by contact tracing alone with significant transmission, and you need to look at other tools in order to manage it, and that is exactly what we have done.

Ms VALLENCE: Two questions just on that point there, Professor Sutton. There has been a number of Burnet models, and I was referring to one in June. The government have those models available to them, don't they?

Prof. SUTTON: We have a number of models available to us. I am not sure of the specific one you are referring to.

Ms VALLENCE: Okay—the one that said that the testing had dropped off. Also, on that, you said that contact tracing is not the only thing that can help stem the spread that you are currently overseeing right now. The Premier has in a press conference that he has just delivered said that he could not guarantee that stage 4 restrictions would work. You as the Chief Health Officer are the one that provides the advice to the government, the health advice to the government, and the advice to implement stage 4. The Premier is saying that he could not guarantee stage 4 restrictions would work. What do you say to that and to the Victorian public?

Prof. SUTTON: Well, I am not sure that any public health professional, politician or anyone else engaged in this global fight against the pandemic would provide a guarantee in any sense. We have all been surprised at what has happened in various countries, and we cannot guarantee the activities of an entire population, the compliance that might occur for segments of that population. I am very, very confident that the stage 4 restrictions will absolutely drive transmission down and that we will get to much, much smaller case numbers that will make it increasingly easy to manage that transmission with our contact tracing in particular. It comes to the fore when we can focus our attention on a much smaller number of cases.

Ms VALLENCE: Professor Sutton, just finally, with the time allowed and on notice, what is the average time and maximum time to receive results of positive cases, how quickly are positive cases contacted and will you provide these benchmarks to the committee on notice so that the public can see this?

Prof. SUTTON: Professor Wallace, as the manager of that team, may have some of those statistics now, and certainly we can provide them as well.

Prof. WALLACE: So the average—

The CHAIR: Sorry to interrupt you, Professor Wallace. The member's time has expired. I will hand the call to Mr Tim Richardson, MP.

Mr RICHARDSON: Thank you for the opportunity, Chair. Can I take the minister to testing. Obviously we have seen Victorians determined to flatten the curve and drive the amount of active cases down with how frequently they are coming forward with symptoms to be tested and really getting in front, as much as they can, of this virus. It has been an incredible effort so far. We know that data is critical to understanding the map of this virus and where it is in our community. Minister, data indicates Victoria has a significantly higher testing rate as a proportion of the population than indeed across the world. How have the results of these tests—these incredibly high tests relative to other parts of the world—informed the Victorian government's decision-making?

Ms MIKAKOS: Thank you, Mr Richardson, for that important question. Obviously testing has been a very important part of our pandemic response; testing, tracing and isolating cases really is the backbone of any pandemic response. So we have had significant expansion of testing availability and capacity since we have started. We currently have 188 testing sites around Victoria providing access to people in metropolitan Melbourne, with a stated objective of providing a testing site within 10 kilometres of everyone's home, and are seeking to provide that within 50 kilometres in regional Victoria. The testing sites available are drive-through or

mobile testing sites, or people can visit dedicated GP clinics or dedicated COVID-19 clinics available through our public health services. That testing of course is free of charge, and we encourage people to get tested with a Medicare card. Or even for visa holders and others who do not have access to a Medicare card, they are still able to get access through this program to get free testing. We have also 28 GP respiratory clinics that have been established across Victoria as well as Aboriginal health services working as part of this response, providing dedicated testing for Aboriginal Victorians as well. So as you said in your question, we are very proud that we have a very high testing rate in Victoria. It is one of the highest on a per capita basis in the world. With the support of both public and private pathology labs we have completed more than 1.8 million tests since the start of the year.

One thing I wanted to stress to anyone who might be watching these hearings is that just because you have been tested once and you have been cleared does not mean you are in the all clear—you could still contract the virus at a later point in time. So regardless of how many times people may have been tested and have had a negative result, if they have those relevant symptoms—even mild symptoms—we still want to encourage people to go and get tested.

Mr RICHARDSON: Well, we can go a little bit more to lab capacity. What investments have had to be made to make sure that Victorians can get those results quickly and get on with their lives or their activity at the time, and have we utilised capacity in the private sector interstate, given the tens of thousands of tests that are being processed on any given day?

Ms MIKAKOS: Yes, we have. We have 16 labs in Victoria that are currently providing this COVID-19 testing. That includes three reference labs, 10 public labs and three private pathology providers, and they have all had to build new testing capacity to manage this volume of testing. It has included the purchase of new scientific instruments, the purchase of consumables and the recruitment of new staff. I am very grateful for the amazing work that everyone working in the pathology system is doing to turn around these results as quickly as they can.

I know that a question was asked earlier around the turnaround time. We ran out of time, but currently 1.68 days is the average turnaround time from someone getting their test done to the time the result comes through and is communicated to them. The average of the processing is around about 18 000 tests per day, and with the support that we have had through interstate labs as well we are able to test more than 25 000 tests per day and to maintain those turnaround times. That has really been important, and I want to thank again my interstate counterparts who have been very helpful in providing us with that assistance. In terms of investment, we have provided \$20 million of additional investments to Victorian public health labs and also to provide support to the Doherty to assist them to provide additional testing capacity as well as to develop new innovative tests. I know that they have spoken publicly about the saliva test that they have developed and that we have been piloting in Victoria as well.

Mr RICHARDSON: Can I take you also, Minister, to the rapid response testing teams? How have they helped to respond to some of those outbreaks of COVID-19?

Ms MIKAKOS: Thank you. It is important that we can provide quick access to people who might be involved in an outbreak, particularly in a workplace setting. We have developed these rapid response testing teams to provide a mobile and responsive testing option to outbreaks, both in metropolitan and regional locations. They basically go onsite and provide that testing where there is an outbreak or a suspected outbreak, particularly where using fixed testing sites may not be appropriate. We have been using our regional providers, aligned with the five new regional public health teams in Barwon, Ballarat, Bendigo, Latrobe and Goulburn Valley, and each of these have their own team and work closely with local health services to be able to provide that onsite testing capacity through these rapid response testing teams. In Melbourne we will be mobilising four teams initially and we will scale that up if that is required. They will be able to provide community engagement as well as testing; and to provide information, through using translators, in many different community languages. Each week the department will meet with the providers to determine where they need to be deployed to make sure that we are well utilising them. As I explained, we do rely on the commonwealth, who go and do their own testing in aged-care facilities. They use their own contracted provider there for testing, but we work very closely with them where there is an outbreak in an aged-care setting.

I want to express my gratitude to particularly our regional health services at this time, who have stepped in: Barwon Health and Colac health who have provided support to the Colac community following the abattoir outbreak there, as well as to Castlemaine Health and to Bendigo Health who have provided the support to the Castlemaine community as well following a similar abattoir outbreak. This has been a very nimble response: people working with incident management teams on the ground, making sure those communities can get access not just to testing but also to other types of support that people need.

Mr RICHARDSON: Can I take you, Minister, to Call-to-Test [Zoom dropout] the program that has been established? There would not be a shortage of members, both in PAEC and across Victoria, who have had constituents who have not been able to get to a testing site on their own volition, and this initiative that has been established really complements that testing strategy. Can you take us a little bit through what that means for Victorians?

Ms MIKAKOS: Thank you for that question. I know of your interest in supporting vulnerable Victorians. This is an important innovation. We have had previously community health centres providing that testing support to vulnerable Victorians, but there has not been, I guess, a centralised process for people to access this. I have had some families with a loved one, where they have a person with a disability that they care for, really looking for ease of convenience to make testing just a little bit easier for them, so we have established our Call-to-Test program. We did a soft launch last week, and it has really been scaled up in recent days. Essentially this Call-to-Test service will involve a person with a disability or someone with a chronic illness who is essentially housebound calling through, or their carer calling through, to our coronavirus hotline; they will be triaged by the nurse that they will speak to and then we will work with them to get a GP referral so that a nurse goes to their home and the person will be able to be tested in their own home. We think that this will support approximately 200 vulnerable Victorians on a day-to-day basis, just really providing that additional support and making sure that no-one misses out on being tested. This will be done in a fairly timely way. From the time that is booked in to the time the person arrives on their doorstep, we are aiming to ensure that does not take more than 48 hours, so that person can get tested and get that test result as quickly as possible.

Mr RICHARDSON: Minister, we know how critical data is in the fight against coronavirus. Can I take you to something we talked about in the first batch of hearings: the national collaboration of sewage surveillance for COVID-19, which is led by Water Research Australia. Can you take us through a little bit more on that and some of the things they are uncovering?

Ms MIKAKOS: Thank you. So this national collaboration that we are involved in and we are providing—we are a funding partner in this national collaboration on sewage surveillance project that is being led by Water Research Australia—is really designed to look at whether doing the testing through the sewage samples can detect the virus being present in locations where case numbers might not actually be evident. So particularly in regional communities, where they might have had either no cases or very few cases, if we detect the presence of the virus through that testing program it can alert us to the fact that we then need to go in and provide more engagement and more support to that community to encourage people to get tested, even if they might not be experiencing symptoms or may be expressing very mild symptoms.

So as of 7 August 682 samples had been taken from across regional and metropolitan Victoria. The lab test methods have been independently validated by Victorian labs, in collaboration with South Australia and New South Wales labs as well. So this is an important milestone as part of this really innovative testing capacity. They have been providing tests. They have been collecting samples and freezing them, and then looking at whether there are low levels of the virus to refine how we develop these testing methods further to look at really whether we are detecting the virus in those communities. So it is an important new area that we are involved in, and I look forward to being able to share more information about what we are finding through that testing program as this new research and this new testing method evolves over time.

Mr RICHARDSON: Minister, can I take you to public housing, and obviously we heard a little bit about some of the challenges in the discussion between member Hibbins and the Premier earlier on. But can you talk about the measures the government is taking to prevent further outbreaks in our public housing sector?

Ms MIKAKOS: Thank you. So we have very vulnerable people living in our public housing, and I am very grateful for the work that our community health services are providing in engaging with families living in those housing estates, particularly in the high-rise towers but in public housing more broadly. We have had a very

extensive testing program that has been going through all of the public housing estates to provide testing as well as distribution of masks. They have been literally going door to door, engaging with communities doing it, so involving and working with various multicultural groups to make sure that we can get this message out to every Victorian, including our newly arrived migrant groups.

Mr RICHARDSON: And just going to whether you can explain the health concierge model and how it has helped prevent infections and outbreaks in the community.

Ms MIKAKOS: Thank you. So we have established a health concierge service at the entry point to high-rise towers or at various points on site in estates where there are a number of towers. So this involves two health staff members per site to provide practical assistance and easily accessible information to residents, including updated health information in accessible formats and translated material, access to single-use face masks and hand sanitiser at entry and exit points, information to reinforce the stay-at-home rule requirements, information about testing sites, quarantining guidelines, access to community leaders and referral to other support services. So this service is currently operating at Carlton, Richmond, Kensington, South Melbourne, Prahran, North Melbourne and Flemington and is aimed at ensuring residents have the information and resources that they need to protect their health and the health of the community. And can I just say in relation to the issues that were raised by Mr Hibbins earlier with the Premier, a very rapid response had to be taken in relation to those public housing outbreaks in North Melbourne and Kensington that I believe has saved lives there. If that action was not taken in response to public health advice, that virus would have absolutely ripped through those public housing towers. We managed to bring those numbers down and protect that community.

Mr RICHARDSON: Minister, can I take you to the distribution of masks, and obviously Victorians have done an incredible job to embrace those requirements. We see almost everyone out in the community helping to stop the spread, but they are not always accessible to people in vulnerable circumstances. How has the Victorian government helped those communities comply with those mask-wearing orders?

Ms MIKAKOS: Thank you. We want to make it as easy as possible for Victorians to comply. This is why we have not been, I guess, overly prescriptive in the type of mask that we stipulated that people need to use as part of that legal direction—because we did not want to effectively price people out and make it difficult for our vulnerable Victorians to comply with that advice. But we have actually stepped in and we are providing both disposable and re-usable masks to vulnerable Victorians. We are distributing 2.1 million re-usable masks to vulnerable Victorians who might find it difficult to access their own. We have ordered masks from Victorian manufacturing companies as well as from other suppliers, and we have also provided more than 3 million disposable masks and 20 000 re-usable masks to date. This has been targeted at vulnerable Victorians who might, for example, have chronic health conditions or other people who might be at risk in some other ways—for example, people living in public housing, which I have just been discussing, or crisis accommodation or who are homeless; people living in rooming houses and supported residential services; people living with disability; people experiencing a mental health condition and their carers; people with health or social issues that make them vulnerable, including alcohol and drug issues; people experiencing family violence; those living in residential facilities; young people living in mandatory facilities; Aboriginal and Torres Strait Islander people; and refugees and asylum seekers, including temporary visa holders. So there is a very extensive list of people who qualify under our criteria, and the way that we are distributing this is through various partners who are working with us—participating GPs, participating pharmacies and other partners.

The CHAIR: I am sorry to interrupt you, Minister. That concludes the opportunity that we have for questions here today. If these hearings or if this discussion has raised any issues for anyone, we again advise that the number for Lifeline is 13 11 14 and the number for Beyond Blue is 1300 224 636.

Minister, Chief Health Officer, Deputy Chief Health Officer and officials accompanying you all, thank you very much for appearing before the committee today. The committee will follow up on any of the questions taken on notice and not subsequently answered in the questioning in writing, and responses will be required within five working days of the committee's request. The committee will now take a very short break before resumption and consideration of the next witness. I declare this hearing adjourned. Thank you for your time.

Ms MIKAKOS: Thank you, too. Thank you, committee members.

Prof. SUTTON: Thank you, Chair, Deputy Chair and members.

Witnesses withdrew.