Australian Health Protection Principal Committee

Agenda - Emergency Teleconference

Novel Coronavirus COVID19

Wednesday 3 June 2020 1200 – 1400 AEST

Members attending	
Prof Brendan Murphy	Commonwealth Chief Medical Officer (Chair)
Dr Andrew Robertson	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier	Chief Health Officer, South Australia
Adj Prof Brett Sutton	Chief Health Officer, Victoria
Dr Michelle Cretikos (proxy)	Chief Health Officer, New South Wales
Dr Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch	Director of Public Health, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie/ Dr Charles Pain	Chief Health Officer, Northern Territory
Ms Alison McMillan	Chief Nursing and Midwifery Officer
Dr Jenny Firman (proxy)	Chair, Communicable Diseases Network Australia and Deputy Commonwealth Chief Medical Officer
Prof Ben Howden	Chair, Public Health Laboratory Network
Mr Joe Buffone (proxy)	Director-General, Emergency Management Australia
Prof Len Notaras	National Critical Care and Trauma Response Centre
Prof Lyn Gilbert	Director, Infection Prevention and Control, Institute of Clinical Pathology, University of Sydney
Invited Experts	
Prof Jodie McVernon Prof James McCaw	University of Melbourne
Prof Allen Cheng	Director, Infection Prevention and Healthcare Epidemiology Unit, Alfred Health
Commonwealth attendees	
Prof Paul Kelly	Deputy Commonwealth Chief Medical Officer
Dr Nick Coatsworth	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd	Deputy Commonwealth Chief Medical Officer
Ms Celia Street	First Assistant Secretary, Office of Health Protection
Ms Rhonda Owen	Assistant Secretary, Health Emergency Management Branch
Mr Graeme Barden	Assistant Secretary, National Incident Room
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Medical Advisor and 2IC Public Health and Forward Planning Branch
s47F s47F	AHPPC Secretariat

s22 [redacted]

s22 [redacted]

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Agenda Item 4 – Modelling update

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Members discussed the modelling update, including:

- The use of genomics to link unlinked cases to the same cluster to feed into modelling.
- Using information about transmission in one jurisdiction (SA) and imposing disease numbers from other jurisdictions (NSW and Vic) to help inform consideration of reopening domestic borders.
- The need for modelling which takes into account geographic spread, for example modelling for remote locations.

s22 [redacted]

s22 [redacted]

Agenda Item 7 – Other business

a) Jurisdictional update

Members noted the following updates from jurisdictions:

s22 [redacted]

- NT – Upcoming election and consideration of opening domestic border.

s22 [redacted]

Members discussed the issue of reopening domestic borders and agreed further consideration is necessary in the week commencing 8 June 2020. Prof Murphy suggested the discussion should be led by those jurisdictions that currently have closed borders, in order to consider their concerns. Members noted that differences in approaches to easing restrictions may cause issues for domestic travel. Members noted that the risk is low in absolute terms but is currently a dominant risk of outbreak, as one individual with a high viral load can infect many others.

Prof McCaw will seek advice as to whether modelling regarding risk of transmission across borders will be available for this discussion. Members noted that data is not available for use through the COVIDSafe application, given the strict privacy restrictions on use of the data. s22 [redacted]

s22 [redacted]

Australian Health Protection Principal Committee

Outcomes - Emergency Teleconference

Novel Coronavirus COVID19

Friday 5 June 2020 1200 – 1400 AEST

Members attending	
Prof Brendan Murphy	Commonwealth Chief Medical Officer
Prof Paul Kelly	Deputy Commonwealth Chief Medical Officer (Chair)
Dr Andrew Robertson	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier	Chief Health Officer, South Australia
Adj Prof Brett Sutton	Chief Health Officer, Victoria
Dr Michelle Cretikos	Chief Health Officer, New South Wales
Dr Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch	Director of Public Health, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie/ Dr Charles Pain	Chief Health Officer, Northern Territory
Dr Caroline McElnay/ Dr Niki Stefanogiannis	Director of Public Health, New Zealand Ministry of Health
Ms Alison McMillan	Chief Nursing and Midwifery Officer
Dr Vanessa Johnston (proxy)	Chair, Communicable Diseases Network Australia
Prof Ben Howden	Chair, Public Health Laboratory Network
CDR Nicole Curtis/ Dr Vicki Ross (proxies)	Commander Joint Health and Surgeon General, ADF
Mr Joe Buffone (proxy)	Director-General, Emergency Management Australia
Prof Len Notaras	National Critical Care and Trauma Response Centre
Prof Lyn Gilbert	Director, Infection Prevention and Control, Institute of Clinical Pathology, University of Sydney
Invited Experts	
Prof Jodie McVernon Prof James McCaw	University of Melbourne
Prof Allen Cheng	Director, Infection Prevention and Healthcare Epidemiology Unit, Alfred Health
Commonwealth attendees	
Dr Nick Coatsworth	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd	Deputy Commonwealth Chief Medical Officer
Ms Celia Street	First Assistant Secretary, National Incident Room
Ms Rachel Balmanno	First Assistant Secretary, National Incident Room
Ms Rhonda Owen	Assistant Secretary, National Incident Room
Mr Graeme Barden	Assistant Secretary, National Incident Room
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Medical Advisor and 2IC Public Health and Forward Planning Branch
s47F	Border Health, National Incident Room
s47F	AHPPC Secretariat

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s22 [redacted]

s22 [redacted]

Agenda Item 8 – Other Business

s22 [redacted]

b) Cross border travel for international travellers in quarantine

A/Prof Nicola Spurrier provided an overview of an in-principle agreement for international travellers who cross borders upon arrival without being quarantined in the port of arrival.

Members agreed that they would prefer advice to come to the receiving jurisdiction's public health unit about requests for exemptions to undertaking quarantine in the port of arrival.

ACTION

6. The NIR to engage with the Australian Border Force about the process for managing incoming international travellers in each airport.

Australian Health Protection Principal Committee

Outcomes - Emergency Teleconference

Novel Coronavirus COVID19

Monday 8 June 2020 12:00 – 14:00 AEST

Members attending	
Prof Brendan Murphy (Chair)	Commonwealth Chief Medical Officer
Ms Alison McMillan	Chief Nursing and Midwifery Officer
Dr Andrew Robertson	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier	Chief Health Officer, South Australia
Adj Prof Brett Sutton	Chief Health Officer, Victoria
Dr Kerry Chant	Chief Health Officer, New South Wales
Dr Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch	Chief Health Officer, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie	Chief Health Officer, Northern Territory
Captain Katherine Tindall (Proxy)	Commander Joint Health and Surgeon General, ADF
Mr Joe Buffone	Assistant Secretary, Emergency Management Australia
Dr Caroline McElnay	New Zealand Ministry of Health
Dr Sonya Bennett	Chair, Communicable Diseases Network Australia
Prof Ben Howden	Chair, Public Health Laboratory Network
Ms Bronte Martin Prof Len Notaras	National Critical Care and Trauma Response Centre
Invited Experts	
Professor Jodie McVernon Professor James McCaw	University of Melbourne
Professor Allen Cheng	Director, Infection, Prevention and Healthcare Epidemiology Unit, Alfred Health
Professor Lyn Gilbert (APOLOGY)	Director, Infection Prevention and Control, Institute of Clinical Pathology, University of Sydney
Department of Health	
Prof Paul Kelly	Deputy Commonwealth Chief Medical Officer
Dr Nick Coatsworth	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd	Deputy Commonwealth Chief Medical Officer
Dr Jenny Firman	Deputy Commonwealth Chief Medical Officer
Dr Ruth Vine	Deputy Commonwealth Chief Medical Officer
Ms Celia Street	First Assistant Secretary, Office of Health Protection
Ms Rhonda Owen	Assistant Secretary, Health Emergency Management Branch
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Medical Advisor and 2IC Public Health and Forward Planning Branch
Mr Graeme Barden	Assistant Secretary, National Incident Room
s47F	AHPPC Secretariat

s22 [redacted]

Agenda Item 2 - Stratification of stage 3 of the 3-step framework

The Chair noted that while there had initially been support for a detailed table outlining the stratification of step 3, it had become apparent that due to the differences in each jurisdiction, that a narrative supported by principles might be a better approach. All Chief Health Officers agreed.

Members went on to discuss the draft narrative and principles, and agreed to amend the draft by:

s22 [redacted]

- Noting that interstate travel will increase over time, and jurisdictions will give consideration to opening borders based on national epidemiology

s22 [redacted]

ACTION: NIR to amend the statement for re-consideration by AHPPC on 9 June 2020

s22 [redacted]

s22 [redacted]

s22 [redacted]

s22 [redacted]

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s22 [redacted]

[redacted]

Australian Government
Department of Health

Australian Health Protection Principal Committee

Principles for Phased Implementation of Stage 3

AHPPC Meeting 08 June 2020

Recommendations:

That AHPPC Members:

i. **Note** that stratification of phase 3 has proved difficult due to jurisdictional differences in epidemiology and pressures

ii. **Review** the following narrative and principles for a phased implementation of stage 3

Background

The 3-step framework was submitted to National Cabinet on 08 May (Ref A) with the caveat that stage 3 required further planning for phased implementation. Although a nationally consistent approach to implementation is desired, in stratifying stage 3 it became evident that jurisdictional differences in epidemiology would cause difficulty in setting out a clear and consistent path for the next few months. As an alternative, a narrative; underpinned by principles for a safe, phased implementation of stage 3 is presented.

Narrative

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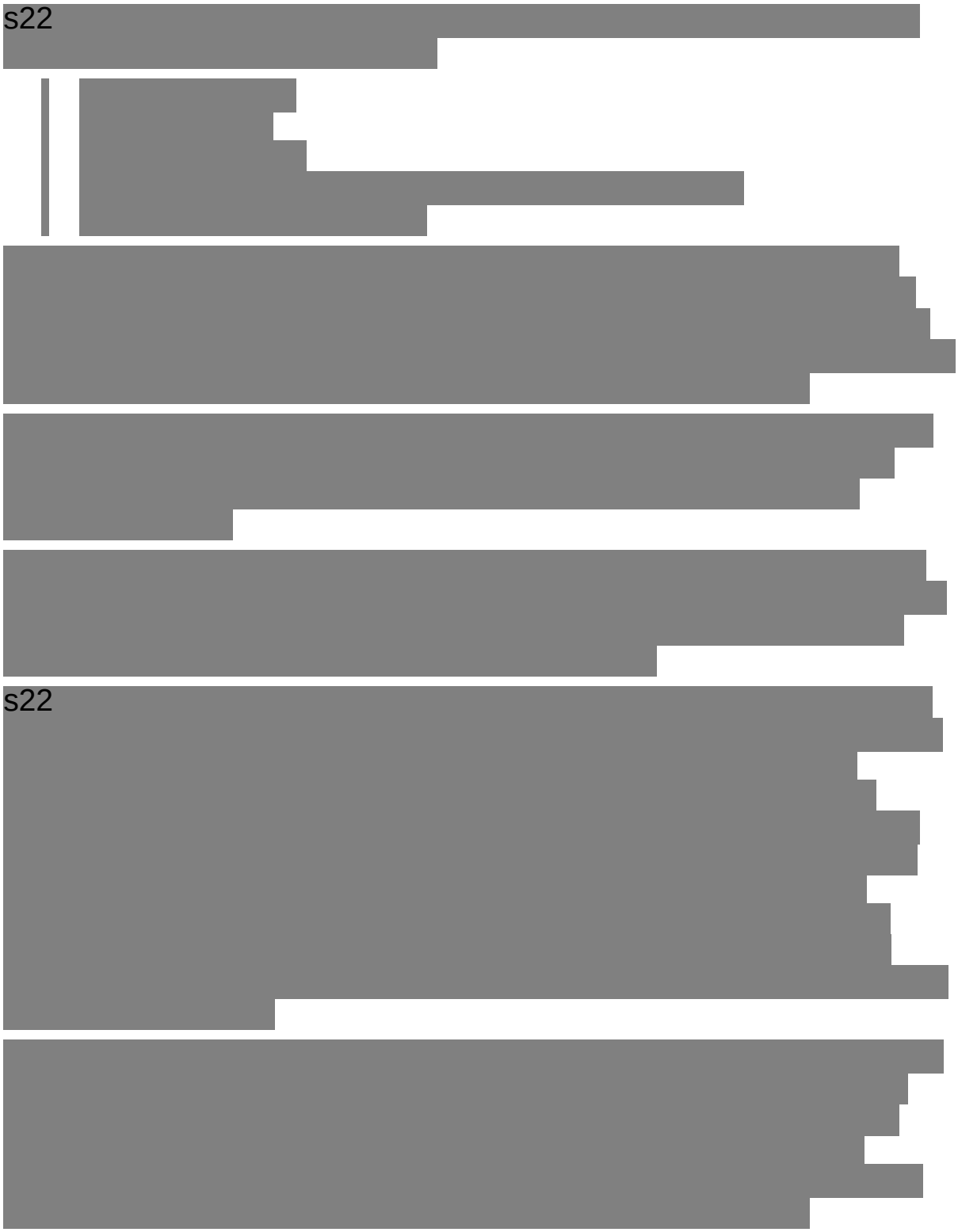

s22

Jurisdictions will give consideration to opening interstate borders, based on national epidemiology, and interstate travel may resume. Domestic border closures have been successful in limiting the spread of disease within Australia, and although this positive health outcome must be balanced with the broader economic impacts on the States and Territories, such measures remain useful for disease control and enable relaxation of other measures whilst they are in force.

s22 [redacted]

Principles for phased implementation of Stage 3 of the 3-Step Framework

The safe implementation of Stage 3, and a move toward a new normal with COVID-19, requires principles to guide actions under current conditions. The capacity of States and Territories to test, contact trace, and manage cases and outbreaks is limited, and may not withstand prolonged pressure; therefore all actions taken to adjust public-health related measures must:

- minimise interactions between people who are not known to each other to limit disease transmission;
- minimise respiratory droplet transmission;
- minimise fomite transmission
- protect laboratory and testing capacity;
- protect the public health system capacity to respond to cases through contact tracing and quarantine; and
- protect the health system capacity to manage cases and provide safe, quality healthcare.

s22 [redacted]

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Jurisdictions will consider domestic border restrictions in Stage 3, and where local and national epidemiology is compatible with opening borders, interstate travel may resume.

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Australian Health Protection Principal Committee

Outcomes - Emergency Teleconference

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Wednesday 10 June 2020 12:00 – 14:00 AEST

Members attending	
Prof Brendan Murphy	Commonwealth Chief Medical Officer
Ms Alison McMillan	Chief Nursing and Midwifery Officer
Dr Andrew Robertson	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier	Chief Health Officer, South Australia
Adj Prof Brett Sutton	Chief Health Officer, Victoria
Dr Michelle Cretikos (Proxy)	Chief Health Officer, New South Wales
Dr Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch	Chief Health Officer, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie	Chief Health Officer, Northern Territory
RADM Sarah Sharkey	Commander Joint Health and Surgeon General, ADF
Mr Rob Cameron	Director General, Emergency Management Australia
Dr Caroline McElany	New Zealand Ministry of Health
Dr Sonya Bennett	Chair, Communicable Diseases Network Australia
Prof Ben Howden	Chair, Public Health Laboratory Network
Ms Bronte Martin Prof Len Notaras	National Critical Care and Trauma Response Centre
Professor Lyn Gilbert	Director, Infection Prevention and Control, Institute of Clinical Pathology, University of Sydney
Invited Experts	
Professor Jodie McVernon Professor James McCaw	University of Melbourne
Professor Allen Cheng	Director, Infection, Prevention and Healthcare Epidemiology Unit, Alfred Health
Department of Health	
Prof Paul Kelly	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd	Deputy Commonwealth Chief Medical Officer
Dr Nick Coatsworth	Deputy Commonwealth Chief Medical Officer
Dr Jenny Firman	Deputy Commonwealth Chief Medical Officer
Dr Ruth Vine	Deputy Commonwealth Chief Medical Officer
Ms Celia Street	First Assistant Secretary, Office of Health Protection
Ms Rhonda Owen	Assistant Secretary, Health Emergency Management Branch
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
Mr Graeme Barden	Assistant Secretary, National Incident Room
s47F	AHPPC Secretariat

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s22 [redacted]

s22 [redacted]

s22 [redacted]

s22 [redacted]

s22 [redacted]

Agenda Item 6 – Interstate Borders

Members discussed the issue of interstate border closures and noted the following:

- Decisions around border closures have been based on reducing transmission and confidently easing restrictions.
- That a number of jurisdictions require self-quarantine when crossing interstate borders.
- Border closures do not justify a going back to 'normal' approach (removing public health measures).
- That while NSW and Vic have been successful in reducing transmission, NSW is likely to continue to see cases due to the sheer volume of return travellers.
- By the end of July most jurisdictions will be aligned in their restrictions.

Members agreed that Prof Murphy should provide a verbal update at the National Cabinet meeting this Friday 12 June 2020, advising that jurisdictions continue to watch and monitor local epidemiology and that there is collective support to consider a unified approach to open all interstate borders at the same time – noting that NT continues to be in different position.

s22 [redacted]

s22 [redacted]

COMMITTEE-IN-CONFIDENCE

Australian Health Protection Principal Committee

Outcomes - Emergency Teleconference

Novel Coronavirus COVID19

Monday 6 July 2020 12:00 – 14:00 AEST

Members attending	
Prof Paul Kelly	Acting Commonwealth Chief Medical Officer
Dr Nick Coatsworth	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd	Deputy Commonwealth Chief Medical Officer
Ms Alison McMillan	Chief Nursing and Midwifery Officer
Dr Andrew Robertson	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier	Chief Health Officer, South Australia
Adj Prof Brett Sutton (Apology) Dr Sonya Bennett (Proxy)	Chief Health Officer, Victoria
Dr Kerry Chant	Chief Health Officer, New South Wales
Dr Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch	Chief Health Officer, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie	Chief Health Officer, Northern Territory
RADM Sarah Sharkey (Apology) BRIG Craig Schramm (Proxy)	Commander Joint Health and Surgeon General, ADF
Mr Rob Cameron	Director General, Emergency Management Australia
Dr Caroline McElnay	New Zealand Ministry of Health
Dr Sonya Bennett Dr Paul Armstrong (Proxy)	Chair, Communicable Diseases Network Australia
Prof Ben Howden	Chair, Public Health Laboratory Network
Ms Bronte Martin Prof Len Notaras	National Critical Care and Trauma Response Centre
Invited Experts	
Professor Jodie McVernon Professor James McCaw	University of Melbourne
Professor Allen Cheng (Apology)	Director, Infection, Prevention and Healthcare Epidemiology Unit, Alfred Health
Professor Lyn Gilbert	Director, Infection Prevention and Control, Institute of Clinical Pathology, University of Sydney
Department of Health	
Dr Ruth Vine	Deputy Commonwealth Chief Medical Officer
Ms Celia Street	First Assistant Secretary, Office of Health Protection
Ms Rhonda Owen	Assistant Secretary, Health Emergency Management Branch
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Medical Advisor and 2IC Public Health and Forward Planning Branch
Mr Graeme Barden	Assistant Secretary, National Incident Room
s47F	AHPPC Secretariat

COMMITTEE-IN-CONFIDENCE

Agenda Item 1 – Meeting opening

Prof Paul Kelly opened the meeting and acknowledged the Traditional Owners, and paid his respects to Elders past and present.

Prof Kelly noted today's press conference from Victoria's Premier, Mr Daniel Andrews and the pending press conference from New South Wales' Premier, Ms Gladys Berejiklian and advised members that the 2nd half of today's teleconference will be allocated to discuss Victoria's situation and the announced border closure.

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s22 [redacted]

Agenda Item 5 – Other Business

a) Victoria epi & situational update

Prof Paul Kelly noted that:

- s22 [redacted]
- The NSW and Victorian Governments have announced that the border between New South Wales and Victoria will be closed from 0001hrs Wednesday 8 July 2020.

s22 [redacted]

- s22 [redacted]
- [redacted]
- [redacted]

b) Jurisdictional update

Jurisdictions provided the following update, by exception:

New South Wales

- All 43 border crossings between New South Wales and Victoria will close at 0001hrs Wednesday 8 July 2020.
- All of Greater Melbourne is being considered a hotspot (by NSW) as of 2359hrs today.
- Police are leading the implementation of this process with support from the Defence Force, including manned road blocks.

Australian Capital Territory

- Will be mirroring NSW border controls.

s22 [redacted]

- [redacted].

Northern Territory

- First Minister to announce the borders will be opened as previously announced, however those travelling from hotspots will be quarantined.
- Noted a traveller had transited from New Zealand through Brisbane without being detected – agreed to send information to QLD and Ms Rhonda Owen.

Tasmania

- Specifically requested an exemption from the NSW/Vic border measures for travellers from Tasmania transiting through Victoria to other destinations

Queensland

- Advised that there were specific exemptions for essential workers (e.g., agricultural workers) and requested that they also be considered for a specific exemption

s22 [redacted]

[redacted]

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- [redacted]
- [redacted]
- [redacted]
- [redacted]

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COMMITTEE-IN-CONFIDENCE

Australian Health Protection Principal Committee

Outcomes - Emergency Teleconference

Novel Coronavirus COVID19

Wednesday 8 July 2020 12:00 – 14:00 AEST

Members attending	
Prof Paul Kelly	Acting Commonwealth Chief Medical Officer
Dr Nick Coatsworth	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd	Deputy Commonwealth Chief Medical Officer
Ms Alison McMillan	Chief Nursing and Midwifery Officer
Dr Andrew Robertson	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier	Chief Health Officer, South Australia
Adj Prof Brett Sutton	Chief Health Officer, Victoria
Dr Kerry Chant	Chief Health Officer, New South Wales
Dr Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch	Chief Health Officer, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie	Chief Health Officer, Northern Territory
RADM Sarah Sharkey (Apology) BRIG Craig Schramm (Proxy)	Commander Joint Health and Surgeon General, ADF
Mr Rob Cameron	Director General, Emergency Management Australia
Dr Caroline McElnay (Apology)	New Zealand Ministry of Health
Dr Sonya Bennett Dr Paul Armstrong (Proxy)	Chair, Communicable Diseases Network Australia
Prof Ben Howden	Chair, Public Health Laboratory Network
Ms Bronte Martin Prof Len Notaras	National Critical Care and Trauma Response Centre
Invited Experts	
Professor Jodie McVernon Professor James McCaw	University of Melbourne
Professor Allen Cheng (Apology)	Director, Infection, Prevention and Healthcare Epidemiology Unit, Alfred Health
Professor Lyn Gilbert	Director, Infection Prevention and Control, Institute of Clinical Pathology, University of Sydney
Department of Health	
Dr Ruth Vine	Deputy Commonwealth Chief Medical Officer
Ms Celia Street	First Assistant Secretary, Office of Health Protection
Ms Rhonda Owen	Assistant Secretary, Health Emergency Management Branch
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Medical Advisor and 2IC Public Health and Forward Planning Branch
Mr Graeme Barden (Apology)	Assistant Secretary, National Incident Room
s47F	AHPPC Secretariat

COMMITTEE-IN-CONFIDENCE

Agenda Item 1 – Welcome

Prof Paul Kelly opened the meeting and acknowledged the Traditional Owners, and paid his respects to Elders past, present and emerging. The Chair acknowledged that all domestic borders now have some restrictions in place.

s22 [redacted]

Agenda Item 3 – Update on Victoria's Situation

s22 [redacted]

While there was no specific update on the regional/rural areas, Adj Prof Sutton undertook to provide advice to Dr Kerry Chant later in the day.

- Dr Chant asked to assist with reviewing the cases in border towns, as this would also help New South Wales to inform decisions around border town cordons.

s22 [redacted]

Emerging epidemiology – other jurisdictions

s22 [redacted]

Borders

A/Prof Nicola Spurrier advised members that anyone travelling to South Australia through Victoria from other states would need to undertake quarantine on arrival into South Australia.

Members also noted teething issues with people transiting into and through New South Wales and on to Queensland. Adjustments to arrangements will be made if necessary.

Agenda Item 4 – Additional National Cabinet Preparation

Domestic Border Protocols

Members were asked if they would consider and identify an agreed position on what thresholds should be to impose border restrictions. Members noted that this is difficult at the national level.

It was agreed between members that with what has been learned about border closers to date, it would be useful to be in a position where a Chief Health Officers can speak with the Chief Medical Officer and note that an agreed set of metrics has been met. Members were asked to consider what trigger points would be required for border closures.

Members noted that any policy or principle decision made about borders may have implications for current court proceedings. Some members noted the difficulty of identifying metrics on a matter that was before the High Court, where the Commonwealth is involved.

Members noted that there were metrics already identified in the Forward Plan document that border closures are appropriate in some circumstances, and that these were the kind of circumstances which can lead to a considered and appropriate public health response.

Members noted local environment metrics, risk to certain populations, care and response, pre-emptive use of border closure as a tool, and other items already contained in the Forward Plan document will be used to inform a principle document for the committee to consider tomorrow.

Action: Dr s47F to develop a paper on Domestic Border Protocols and present to AHPPC at tomorrow's meeting.

s22 [redacted]

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- s22 [redacted]

Agenda Item 8 – Other business

- **Jurisdictional Update**

Members were asked if they are now re-considering their planned schedule of relaxing restrictions:

Western Australian are considering delaying implementing the next phase of relaxation of restrictions.

Northern Territory Government will soon be going into Caretaker. Dr Heggie advising Northern Territory will maintain the plan relaxation of restrictions.

South Australia are remaining on step 3, but due to the situation in Victoria, preparing to impose further restrictions if cases appear in their state.

Tasmania's planned relaxation of borders and measures are under consideration.

New South Wales may be re-introduced so previously relaxed restrictions and possibly more stringent domestic border controls.

Queensland are still planning on opening borders to everyone but Victoria on Friday. In line with the opening of the border, they will be increasing their testing.

s22 [redacted]

COMMITTEE-IN-CONFIDENCE

Australian Health Protection Principal Committee

Outcomes - Emergency Teleconference

Novel Coronavirus COVID19

Thursday 9 July 2020 12:00 – 14:00 AEST

Members attending	
Prof Paul Kelly	Acting Commonwealth Chief Medical Officer
Dr Nick Coatsworth	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd	Deputy Commonwealth Chief Medical Officer
Ms Alison McMillan	Chief Nursing and Midwifery Officer
Dr Andrew Robertson	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier	Chief Health Officer, South Australia
Adj Prof Brett Sutton	Chief Health Officer, Victoria
Dr Kerry Chant	Chief Health Officer, New South Wales
Dr Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch	Chief Health Officer, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie	Chief Health Officer, Northern Territory
RADM Sarah Sharkey (Apology) CDRE Nicole Curtis (Proxy)	Commander Joint Health and Surgeon General, ADF
Mr Joe Buffone	Emergency Management Australia
Dr Caroline McElnay	New Zealand Ministry of Health
Dr Sonya Bennett (Apology) Dr Paul Armstrong (Proxy)	Chair, Communicable Diseases Network Australia
Prof Ben Howden	Chair, Public Health Laboratory Network
Ms Bronte Martin Prof Len Notaras	National Critical Care and Trauma Response Centre
Invited Experts	
Professor Jodie McVernon Professor James McCaw	University of Melbourne
Professor Allen Cheng (Apology)	Director, Infection, Prevention and Healthcare Epidemiology Unit, Alfred Health
Professor Lyn Gilbert	Director, Infection Prevention and Control, Institute of Clinical Pathology, University of Sydney
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Mr Graeme Barden (Apology)	Assistant Secretary, National Incident Room
s47F	AHPPC Secretariat

COMMITTEE-IN-CONFIDENCE

Agenda Item 1 – Welcome

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Border Updates

Dr Kerry Chant provided a summary on the current border restriction between New South Wales and Victoria.

It was noted that the advice provided by Queensland in relation to border closures was extremely useful, however, the process was very complex. Dr Chant noted there is a lot of interconnectivity across the border communities.

Cross border activity in relation to health services was noted and this is being worked through. People from broader Victoria are being excluded from New South Wales unless for a critical reason.

Dr Jeannette Young advised that she had recently met with the freight industry who had indicated a preference for a national consistency on permits. The differences in permit lengths between New South Wales and Queensland for freight drivers were discussed.

Dr Chant also updated members on the issue with Jetstar and advised that while health staff were at the airport, and Jetstar had not waited until they were finished assessing passengers from another flight.

A/Prof Nicola Spurrier noted that South Australia reintroduced its hard border with Victoria. People coming through from Victoria are required to wear masks on their way to quarantine. Quarantine now has more specific conditions and will include testing. South Australian residents are allowed to return under quarantine conditions, with exemptions required for others wishing to enter.

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Agenda Item 6 – Update on National Cabinet Advice

Further to yesterday's discussion on domestic border controls and agreed metrics of response, Dr s47F presented a draft paper to members for consideration. The flags would trigger the imposition of movement restrictions. Dr s47F asked members to note that work still needed to be done to define a geographical area.

Members noted that having movement restrictions in place would have the effect of a cordon sanitaire and would provide confidence to the rest of the country. Members agreed that any of the flags listed would be concerning on their own. Members also agreed that it was important to provide a barrier to ensure that higher numbers of transmissions did not move from one area to another.

Members pointed out that the public health directions used to close borders will have legislative restrictions, including only being used to protect the jurisdiction's own citizens, rather than those of other jurisdictions.

Some members noted that borders had previously been closed in some instances as a pre-emptive, protective measure, and that these principles are in conflict with that approach.

Members agreed that Dr s47F would make changes to the paper to reflect members' views. The paper will be provided to members for their information, and presented to National Cabinet on 9 July 2020.

Action: Dr s47F to update the paper to reflect members' views. The paper will be provided to members for their final review this evening prior to being presented to National Cabinet on 9 July 2020.

Agenda Item 7 – Other Business

The Chair asked Dr Chant and Dr Coleman to confirm if they had made retrospective public health directions about people who have been in Victoria, and if they were clear about this in their public messaging.

Dr Chant advised that yes, New South Wales does have a direction that anyone who has been in Melbourne since 23 June must isolate for 14 days. Dr Coleman advised that the Australian Capital Territory direction about isolation is from 3 July. There has also been strong messaging asking people who had returned from Melbourne prior to that, to isolate for the good of the community for a period of 14 days. Restrictions to people who have come from other parts of Victoria came into effect on 8 July.

s22 [redacted]

COMMITTEE-IN-CONFIDENCE

Australian Government
Department of Health

Principles for State and Suburb Closures

AHPPC Meeting 9 July 2020

Recommendations:

That AHPPC Members:

i. **Discuss** and **endorse** the principles for imposing movement restrictions for both
   a. Geographically defined areas e.g. postcodes, suburbs, LGAs
   b. Domestic State borders

Background

National Cabinet requested AHPPC consider the thresholds that should prompt jurisdictions to consider imposing restrictions:

- In geographically defined locations within their jurisdiction; and/or
- Closing their state or territory borders.

As states and territories have eased restrictions, transmission potential has increased. This can result in swift propagation of growth of COVID-19 cases. Australia must take a vigilant approach to prevent growth when cases do occur in the community. An early, proportionate and robust public health response is required in order to minimise the risk of outbreaks.

Accordingly, the following thresholds for defined geographical areas have been identified to 'flag' to jurisdictions that they should begin an escalating pathway of public health measures in these regions. This is to minimise the risk of further spread of COVID-19; protecting populations in unaffected regions both locally and interstate.

Flags for initiating movement restrictions within a defined geographic area

Notes:

- Satisfying Flags 1-3 should be cause for considering initiation of movement restrictions for a suburb
- Satisfying Flags 2-4 should be cause for considering initiation of movement restrictions for a n LGA
- Where Flag 5 is satisfied, in addition to Flags 2-3 should be cause for considering state border closures
- For the purposes of these indicators, a postcode refers to an area containing approximately 1,000 residents
- For the purposes of these indicators, a Local Government Area (LGA) refers to an area containing approximately 10,000 residents

Flag 1: Unknown chains of transmission

- Where the upstream cases (looking back one incubation period) cannot be found within 1 day of notification of a positive result

Flag 2: Doubling Rate

- Where there is doubling rate of 1.3 or more, for a two day period (compared to the previous two day period)

Flag 3: Public Health System Capacity

- Where cases cannot be isolated within 24 hrs of notification of a positive result
- Where close contacts cannot be identified within a 48 hour period

Flag 4: Dispersal of cases

- Any cases are identified in two geographically dispersed postcodes, where the upstream cases (looking back one incubation period) cannot be found within 1 day of notification of a positive result

Flag 5: Wide dispersal of cases

- Any cases are identified in more than two geographically dispersed LGAs, where the upstream cases (looking back one incubation period) cannot be found within 1 day of notification of a positive result

Exclusions

1. Imported cases identified in quarantine
2. Secondary cases to imported cases, who are identified whilst in quarantine
3. Secondary cases to cases in isolation, where it is clear that the transmission event occurred in the closed environment (e.g home, or as listed in the SoNG).
4. High risk transmission environments, or closed population setting (e.g. a workplace, RCF, detention facility)

Escalating pathway of public health measures

1. Stay at home advisory and public communications
2. Targeted stay at home orders in specific postcodes or local government areas
3. State and Territory Emergency Powers and Public Health Orders to impose stay at home orders
4. Where thresholds are met over a geographically dispersed area, it may be necessary to implement state border closures
5. Commonwealth use of the Biosecurity Act 2015
    - Protect vulnerable communities
    - Implement border closures
    - Note: takes approximately 1 week to conduct the necessary engagements and to draw up the legislative instruments.

COMMITTEE-IN-CONFIDENCE

Australian Health Protection Principal Committee

Outcomes - Emergency Teleconference

Novel Coronavirus COVID19

Friday 10 July 2020 12:00 – 14:00 AEST

Members attending	
Prof Paul Kelly (Apology)	Acting Commonwealth Chief Medical Officer
Dr Nick Coatsworth	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd	Deputy Commonwealth Chief Medical Officer
Ms Alison McMillan	Chief Nursing and Midwifery Officer
Dr Andrew Robertson	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier (Apology) Dr Evan Everest (Proxy)	Chief Health Officer, South Australia
Adj Prof Brett Sutton	Chief Health Officer, Victoria
Dr Kerry Chant	Chief Health Officer, New South Wales
Dr Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch Ms Lisa Caswell	Chief Health Officer, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie Dr Charles Pain	Chief Health Officer, Northern Territory
RADM Sarah Sharkey (Apology) BRIG Craig Schramm (Proxy)	Commander Joint Health and Surgeon General, ADF
Mr Rob Cameron (Apology) Mr Joe Buffone (Proxy)	Director General, Emergency Management Australia
Dr Caroline McElnay	New Zealand Ministry of Health
Dr Sonya Bennett (Apology) Dr Paul Armstrong (Proxy)	Chair, Communicable Diseases Network Australia
Prof Ben Howden	Chair, Public Health Laboratory Network
Ms Bronte Martin Prof Len Notaras	National Critical Care and Trauma Response Centre
Invited Experts	
Professor Jodie McVernon Professor James McCaw	University of Melbourne
Professor Allen Cheng (Apology)	Director, Infection, Prevention and Healthcare Epidemiology Unit, Alfred Health
Professor Lyn Gilbert	Director, Infection Prevention and Control, Institute of Clinical Pathology, University of Sydney
Department of Health	
Dr Ruth Vine	Deputy Commonwealth Chief Medical Officer
Ms Celia Street	First Assistant Secretary, Office of Health Protection
Ms Rhonda Owen	Assistant Secretary, Health Emergency Management Branch
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Medical Advisor and 2IC Public Health and Forward Planning Branch
Mr Graeme Barden (Apology)	Assistant Secretary, National Incident Room
s47F	AHPPC Secretariat

COMMITTEE-IN-CONFIDENCE

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[redacted]

Domestic Border Issues

New South Wales:
Dr Kerry Chant provided an update on the current border restriction between New South Wales and Victoria.

It was noted that it is a complex border arrangement and management of border communities is challenging. A permit system is being set up and there is a lot of people moving across the border for services. They are trying to balance public health constraint against some critical shortages of staff in some facilities.

It was also noted that the main aim currently is making sure New South Wales stays on top of any transmission and ramping up testing in the eastern seaboard area in areas like caravan parks etc.

Dr Jeannette Young confirmed with Dr Chant in regards to the quarantine arrangements for travellers moving from New South Wales to Victoria and back as she had received some incorrect information.

Ms Celia Street noted that there was currently a table of all the different border measures out with members for review to ensure it remains current.

South Australia:
Dr Evan Everest noted that South Australia now had a complex set of orders, with restrictions on travellers from New South Wales and Victoria tightened. Police and the ADF are establishing fixed border posts and country tracks are being closed with covert surveillance cameras established.

Dr Everest noted that South Australia has turned back a number of travellers, but the specific number is not known. They have also sought police assistance to inform travellers on flights of the current restrictions noting that a number of South Australians are returning from other states. A process for testing these travellers is being put in place.

Western Australia:
Dr Andrew Robertson reported that the border has been tightened into Western Australia with no travellers admitted from Victoria with strict exemptions only permitted.

Australian Capital Territory:
Dr Kerryn Coleman noted that there was concern in the community in regards to leakage into the Territory but that the only cases in the Territory can be traced to Victoria or close contacts.

Queensland:
Dr Jeannette Young noted that the borders into Queensland are open to all except travellers who have been in Victoria in the last 14 days, with strict exemptions only permitted.

Tasmania:
Dr Mark Veitch noted that Tasmania has tighten its borders last Sunday to include essential workers only.

Northern Territory:
Dr Hugh Heggie noted that the border into the Northern Territory remains closed and an exemption process is being put in place.

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COMMITTEE-IN-CONFIDENCE

Australian Health Protection Principal Committee

Outcomes - Emergency Teleconference

Novel Coronavirus COVID19

Monday 13 July 2020 12:00 – 14:00 AEST

Members attending	
Prof Paul Kelly (Chair)	Acting Commonwealth Chief Medical Officer
Dr Nick Coatsworth	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd	Deputy Commonwealth Chief Medical Officer
Ms Alison McMillan	Chief Nursing and Midwifery Officer
Dr Andrew Robertson	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier (Apology) Dr Evan Everest (Proxy)	Chief Health Officer, South Australia
Adj Prof Brett Sutton	Chief Health Officer, Victoria
Dr Kerry Chant	Chief Health Officer, New South Wales
Dr Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch	Chief Health Officer, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie	Chief Health Officer, Northern Territory
RADM Sarah Sharkey (Apology) BRIG Craig Schramm (Proxy)	Commander Joint Health and Surgeon General, ADF
Mr Joe Buffone	Emergency Management Australia
Dr Caroline McElnay	New Zealand Ministry of Health
Dr Sonya Bennett	Chair, Communicable Diseases Network Australia
Prof Ben Howden	Chair, Public Health Laboratory Network
Prof Len Notaras	National Critical Care and Trauma Response Centre
Invited Experts	
Professor Jodie McVernon Professor James McCaw	University of Melbourne
Professor Allen Cheng	Director, Infection, Prevention and Healthcare Epidemiology Unit, Alfred Health
Professor Lyn Gilbert	Director, Infection Prevention and Control, Institute of Clinical Pathology, University of Sydney
Department of Health	
Mr Michael Lye	Deputy Secretary, Aged Care Group
Dr Lucas De Toca	Acting First Assistant Secretary, Primary Care Division
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
Dr Lucas De Toca	Acting First Assistant Secretary, Primary Care Division
Mr Graeme Barden	A/g First Assistant Secretary, Office of Health Protection and Response Division
Ms Rhonda Owen	Assistant Secretary, Health Emergency Management Branch
s47F	Medical Advisor and 2IC Public Health and Forward Planning Branch
s47F	AHPPC Secretariat

COMMITTEE-IN-CONFIDENCE

s22 [redacted]

s22 [redacted]

Agenda Item 3 – Outcomes from National Cabinet

s22 [redacted]

National Cabinet noted the AHPPC paper on domestic border controls and that work still needed to be done. Two jurisdictions did not agree to all the principles contained at this stage but that it was valuable work to assist decision making.

s22 [redacted]

Agenda Item 4 – CDNA update

s22 [redacted]

The other two papers considered by CDNA today included an AHPPC paper on the principles for state and suburb border closures and the Pandemic Health Intelligence Plan metrics for public health system capacity. CDNA members will be providing comments out of session on both these papers, and note that more detail will be required for escalation around restrictions.

s22 [redacted]

s22 [redacted]

Agenda Item 6 – Other Business

a) Jurisdictional Update

New South Wales

s22 [redacted]

A/Prof Sutton sought further information on current NSW restrictions on pubs and freight drivers entering NSW. Dr Chant advised that the 4 square metre rule applies to all pubs and that freight drivers are required to minimise contact with others as part of the agreement for freight drivers to

travel between jurisdictions. Dr Young asked that further work be done to develop a nationally consistent approach to freight drivers crossing borders. The Chair advised that there was extensive discussion at National Cabinet on this issue and that work is currently being undertaken by the relevant authorities.

s22 [redacted]

Tasmania

Dr Mark Veitch advised that border restrictions are being tightened to manage the risk from Victoria and the decision to reopen the border will be deferred for another week.

s22 [redacted]

COMMITTEE-IN-CONFIDENCE

Australian Health Protection Principal Committee

Outcomes - Emergency Teleconference

Novel Coronavirus COVID19

Wednesday 15 July 2020 12:00 – 14:00 AEST

Members attending	
Prof Paul Kelly	Acting Commonwealth Chief Medical Officer
Dr Nick Coatsworth	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd	Deputy Commonwealth Chief Medical Officer
Ms Alison McMillan	Chief Nursing and Midwifery Officer
Dr Andrew Robertson	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier	Chief Health Officer, South Australia
Adj Prof Brett Sutton	Chief Health Officer, Victoria
Dr Kerry Chant	Chief Health Officer, New South Wales
Dr Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch	Chief Health Officer, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie	Chief Health Officer, Northern Territory
RADM Sarah Sharkey (Apology) BRIG Craig Schramm (Proxy)	Commander Joint Health and Surgeon General, ADF
Mr Joe Buffone	Emergency Management Australia
Dr Caroline McElnay	New Zealand Ministry of Health
Dr Sonya Bennett	Chair, Communicable Diseases Network Australia
Prof Ben Howden	Chair, Public Health Laboratory Network
Prof Len Notaras	National Critical Care and Trauma Response Centre
Invited Experts	
Professor Jodie McVernon Professor James McCaw	University of Melbourne
Professor Allen Cheng	Director, Infection, Prevention and Healthcare Epidemiology Unit, Alfred Health
Professor Lyn Gilbert	Director, Infection Prevention and Control, Institute of Clinical Pathology, University of Sydney
Department of Health	
Dr Ruth Vine	Deputy Commonwealth Chief Medical Officer
Ms Celia Street	First Assistant Secretary, Office of Health Protection
Dr Lucas De Toca	Acting First Assistant Secretary, Primary Care Division
Ms Rhonda Owen	Assistant Secretary, Health Emergency Management Branch
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Medical Advisor, Public Health and Forward Planning Branch
Mr Graeme Barden	Assistant Secretary, National Incident Room
s47F	AHPPC Secretariat

COMMITTEE-IN-CONFIDENCE

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s22 [redacted]

Agenda Item 6 – Other Business

Dr Jeanette Young sought an update on:

- s22 [redacted]
- Freight movement across domestic borders, there was a paper circulated at National Cabinet outlining a national position on freight movement.
- s22 [redacted]

ACTIONS:

1. s22 [redacted]
2. The AHPPC Secretariat to follow up on the freight movement across Domestic Borders paper that was discussed at National cabinet and provide and update to Members on the agreed national position.
3. s22 [redacted]

s22 [redacted]

COMMITTEE-IN-CONFIDENCE

Australian Health Protection Principal Committee

Agenda - Emergency Teleconference

Novel Coronavirus COVID19

Friday 17 July 2020 12:30 – 14:30 AEST

Members attending	
Prof Paul Kelly	Acting Commonwealth Chief Medical Officer
Dr Nick Coatsworth	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd	Deputy Commonwealth Chief Medical Officer
Ms Alison McMillan	Chief Nursing and Midwifery Officer
Dr Andrew Robertson	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier	Chief Health Officer, South Australia
Adj Prof Brett Sutton	Chief Health Officer, Victoria
Dr Kerry Chant	Chief Health Officer, New South Wales
Dr Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch	Chief Health Officer, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie	Chief Health Officer, Northern Territory
RADM Sarah Sharkey (Apology) BRIG Craig Schramm (Proxy)	Commander Joint Health and Surgeon General, ADF
Mr Rob Cameron	Director General, Emergency Management Australia
Dr Caroline McElnay	New Zealand Ministry of Health
Dr Sonya Bennett	Chair, Communicable Diseases Network Australia
Prof Ben Howden	Chair, Public Health Laboratory Network
Prof Len Notaras	National Critical Care and Trauma Response Centre
Invited Experts	
Professor Jodie McVernon Professor James McCaw	University of Melbourne
Professor Allen Cheng	Director, Infection, Prevention and Healthcare Epidemiology Unit, Alfred Health
Professor Lyn Gilbert	Director, Infection Prevention and Control, Institute of Clinical Pathology, University of Sydney
Department of Health	
Dr Ruth Vine	Deputy Commonwealth Chief Medical Officer
Ms Celia Street (Apology)	First Assistant Secretary, Office of Health Protection
Dr Lucas De Toca	Acting First Assistant Secretary, Primary Care Division
Ms Rhonda Owen	Assistant Secretary, Health Emergency Management Branch
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Medical Advisor, Public Health and Forward Planning Branch
Mr Graeme Barden	Acting First Assistant Secretary, Office of Health Protection
s47F	AHPPC Secretariat

COMMITTEE-IN-CONFIDENCE

s22 [redacted]

Agenda Item 2 – Fact Sheet – Class Exemption from COVID-19 Government Operated Quarantine Facilities in Australia

s22 [redacted]

Members also noted that:

- the class exemption policy does not grant Australian Government officials and/or their dependents, the ability to take a domestic connecting flight within 14 days of arrival in Australia;
- individuals in home quarantine by this class exemption must adhere to relevant state and territory public health requirements, including routine testing; s22 [redacted]

Members discussed the functionality around managing this process with current individual border restrictions if travel across a border is required.

s22 [redacted]

s22 [redacted]

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s22 [redacted]

Agenda Item 6 – Planning for Localised Outbreaks and Re-implementing Movement Restrictions

s47F [redacted] provided a summary of the paper and asked Members to consider the flags for re-implementing movement restrictions in response to COVID-19 cases.

Dr s47F [redacted] worked with CDNA to develop the 'flags' that may be used to signal that jurisdictions should escalate public health measures in response to COVID-19 cases. Each of these flags is a potential trigger for a suite of disease control measures, of which restriction of movement is one. These flags will be refined overtime as effectiveness is evaluated.

It was also noted that this paper is trying to articulate a sound basis for the application of restrictions, providing a sophisticated and transparent approach to movement restriction and escalation of public health responses.

It was noted that this concept would be a useful way of backing the position of a jurisdiction but it also needs to be flexible as well as providing a basis for decisions.

Members noted that absolute number of cases should also be a flag.

ACTION:

Professor Kelly asked Members to review this document closely for further discussion over the weekend prior to being provided to National Cabinet next week.

s22 [redacted]

s22 [redacted]

COMMITTEE-IN-CONFIDENCE

Australian Government
Department of Health

Australian Health Protection Principal Committee

AHPPC ADVICE – PLANNING FOR LOCALISED OUTBREAKS
RE-IMPLEMENTING MOVEMENT RESTRICTIONS

AHPPC Meeting 17 July 2020

Recommendations:

That AHPPC Members:

i. **Endorse** the flags for re-implementing movement restrictions in response to COVID-19 cases

Background

National Cabinet requested AHPPC consider the thresholds that should prompt jurisdictions to consider imposing restrictions:

- In geographically defined locations within their jurisdiction; and/or
- Closing their state or territory borders.

Current Situation

As states and territories have eased COVID-19 restrictions, transmission potential has increased. This creates an environment wherein swift growth of COVID-19 cases can occur. Australia must take a vigilant approach to prevent transmission and geographic spread when cases do occur in the community. An early, proportionate and robust public health response is required in order to minimise the risk of outbreaks and sustained transmission.

In the Australian context, there are now, and likely to be moving forward, jurisdictions with a higher risk of SARS-CoV-2 transmission, and jurisdictions with a low risk, where SARS-CoV-2 has been virtually eliminated. It is therefore timely to reconsider public health responses to rapidly and effectively limit the spread between geographic areas in order to ensure that outbreaks of COVID-19 can be managed within public health system capacity.

Movement restrictions are appropriate and effective public health measures which can help minimise the spread of disease. The early re-implementation of movement restrictions to halt movement out of an area with COVID-19 transmission minimises the risk of further spread of COVID-19; protecting populations in unaffected regions both locally and interstate.

Movement Restrictions

AHPPC has worked with the Communicable Disease Network Australia (CDNA) to develop a series of flags that may be used to signal that jurisdictions should consider escalating public health measures in response to COVID-19 cases. Each of these flags is a potential trigger for

a suite of disease control measures , of which restriction of movement is one. These flags will be refined overtime as effectiveness is evaluated.

Key Considerations

- Movement restrictions include:
    - Restrictions on movement within a defined geographic area (range from determined hotspot areas, to rings of containment, to entire jurisdictions)
    - Exit restrictions
    - Entry restrictions
- It is important that the affected state or territory acts early to re-implement movement restrictions, up to and including state border closures to prevent exit and entry.
- Affected jurisdictions may need to consider much larger rings of containment than traditionally used in other communicable disease containment strategies.
- Entry restrictions (border closures) may need to be imposed early by non-affected jurisdictions to prevent importation and community spread across borders.
    - AHPPC members expressed concern that jurisdictional legislative powers generally allow actions that protect the health of the population within their jurisdiction. This means that in some circumstances, while intra-jurisdiction movement restrictions may be possible, it may not be lawful to prevent people exiting the jurisdiction where there is a higher rate of disease, as those exiting pose no risk to the population under the legislation.
    - Border restrictions by unaffected jurisdictions may be the only way to manage such movement and prevent disease spread across the country.
- The approach to domestic border restrictions will be informed by the broader health strategy moving forward.

Escalating pathway of movement restrictions

- **Movement restrictions – Prevent community transmission**
    - **Stay at home advisory** - public communications
    - **Stay at home orders** - targeted use of state and territory emergency powers and public health orders to impose stay at home directions in [defined geographic areas]
- **Exit restrictions – Prevent geographic spread**
    - **Rings of containment within jurisdictions** – broad use of state and territory emergency powers and public health orders to impose stay at home directions in [defined geographic areas]
    - **Border closures** – Implementation of state border closures through legislative instruments such as emergency powers and public health orders
- **Entry restrictions – Protect communities**
    - **Border closures** - Implementation of state border closures through legislative instruments such as emergency powers and public health orders
    - **Human Biosecurity Emergency declaration** – Commonwealth use of the *Biosecurity Act 2015*

- **Remote First Nations communities – whole-of-community lockdown**
  - For remote First Nations communities whole-of-community lockdown is recommended, given:
    i. An uncontained outbreak in a remote community of 1,000 people will spread rapidly. Early case detection and prompt response are crucial.
    ii. Lockdown of non-quarantined households for 14 days in community is a highly effective strategy for epidemic control.
    iii. Compliance with lockdown must be at least 80-90% however, or epidemic control will be lost, with almost no benefit observed at lower levels of compliance.
    iv. The benefits of lockdown are greatest in communities of 1,000 or more people but are still observed in communities of 500 people.
  - A combination of stay at home orders, rings of containment and, in the Northern Territory, use of the Commonwealth *Human Biosecurity Act* will be required.
  - Community-level planning and consultation with First Nations communities and organisations to ensure understanding of the importance of whole-of-community lockdown prior to emergence of cases is recommended.

Flags for consideration of initiating movement restrictions either within a defined geographic area or at the state border (entry and exit)

Flag 1: Unknown chains of transmission

- Where there are multiple instances where the likely source of infection for a case is not found within 1 day of notification to the jurisdictional health department.[1] These include cases where the source of infections is:
  - Locally acquired – no known epidemiological link
  - Under investigation

Flag 2: Cases in remote First Nations communities (NB: Exclusions below)

- Where there are any cases in remote First Nations communities

Flag 3: High rate of increase in case numbers (NB: Exclusions below)

- Where there is an increase in the number of cases
  - at a rate of increase of ≥ 1.3 (130%) in a two day period (compared to the previous two day period); or

[1] Note CDNA definition of geographical areas at risk for community transmission: Local government areas (LGA) with ≥5 locally-acquired cases who do not have links to a confirmed case at the time of contact tracing, which all occur in a 14 day window.

- at rate of increase based on the estimated disseminated ratio over 7 day period (the sum of numbers of case over the previous 7 days period compared to the 7 days prior i.e. Sum of the current week's cases divided by the sum of the previous week).[2]
- increase in absolute numbers – this will be dependent on setting and bound by time and space. The absolute increase in cases will have varying thresholds between jurisdictions as well as within jurisdictions.

Flag 4: Increasing risk to disease control (any of the below)

- Where the time between test and notification to the public health authority of a positive result is increasing above baseline
- Where any cases cannot be isolated within 24 hrs of notification to the public health authority of a positive result
- Where close contacts cannot be identified, contacted and quarantined within a 48 hrs of notification to the public health authority of a positive result
- Where an increasing number of cases or contacts are lost to follow up

Flag 5: Capacity for case investigation is likely to be exceeded

- Where activated (within jurisdiction) surge capacity is supplemented by more than one jurisdiction

Flag 6: Number of close contacts is high (an indicator of the level of mixing)

- Where the median number of close contacts (excluding household contacts) is greater than 5 for each confirmed case

Flag 7: Geographic dispersal of cases (NB: Exclusions below)

- Where cases occur outside of known clusters or defined geographic areas with known community transmission (spotting outside of clusters, geographical outliers)

Exclusions

1. Imported cases identified in quarantine
2. Secondary cases to imported cases, who are identified whilst in quarantine
3. Secondary cases to cases in isolation, where it is clear that the transmission event occurred in the closed environment (e.g. a household, or as listed in the SoNG).
4. High risk transmission environments, or closed population setting (e.g. a workplace, RCF, detention facility, hospitals)

[2] Using the EDR requires that the jurisdiction ascertains the baseline number at which to set the rate of increase for the jurisdiction. For example, 2 to 4 cases over 2 days would not necessarily raise the flag but an increase from 10 to 20 over 2 days may (depending on setting of cases in the jurisdiction).
The 7-day period removes fluctuations due to testing cycles.

COMMITTEE-IN-CONFIDENCE

Australian Health Protection Principal Committee

Agenda - Emergency Teleconference

Novel Coronavirus COVID19

Saturday 18 July 2020 12:30 – 14:30 AEST

Members attending	
Prof Paul Kelly	Acting Commonwealth Chief Medical Officer
Dr Nick Coatsworth	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd	Deputy Commonwealth Chief Medical Officer
Ms Alison McMillan	Chief Nursing and Midwifery Officer
Dr Andrew Robertson	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier	Chief Health Officer, South Australia
Adj Prof Brett Sutton	Chief Health Officer, Victoria
Dr Kerry Chant	Chief Health Officer, New South Wales
Dr Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch	Chief Health Officer, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie	Chief Health Officer, Northern Territory
RADM Sarah Sharkey (Apology) BRIG Craig Schramm (Proxy)	Commander Joint Health and Surgeon General, ADF
Mr Joe Buffone	Director General, Emergency Management Australia
Dr Caroline McElnay	New Zealand Ministry of Health
Dr Sonya Bennett	Chair, Communicable Diseases Network Australia
Prof Ben Howden	Chair, Public Health Laboratory Network
Prof Len Notaras	National Critical Care and Trauma Response Centre
Invited Experts	
Professor Jodie McVernon Professor James McCaw	University of Melbourne
Professor Allen Cheng	Director, Infection, Prevention and Healthcare Epidemiology Unit, Alfred Health
Professor Lyn Gilbert	Director, Infection Prevention and Control, Institute of Clinical Pathology, University of Sydney
Department of Health	
Dr Ruth Vine	Deputy Commonwealth Chief Medical Officer
Ms Celia Street (Apology)	First Assistant Secretary, Office of Health Protection
Dr Lucas De Toca	Acting First Assistant Secretary, Primary Care Division
Ms Rhonda Owen	Assistant Secretary, Health Emergency Management Branch
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F s47F	Medical Advisor, Public Health and Forward Planning Branch
Mr Graeme Barden	Acting First Assistant Secretary, Office of Health Protection
s47F	AHPPC Secretariat

COMMITTEE-IN-CONFIDENCE

s22 [redacted]

Agenda Item 3 – AHPPC Advice – Planning for Localised Outbreaks Re-implementing Movement Restrictions

Dr s22 s22 noted the minor updates to the paper post AHPPC members feedback yesterday. Prof Kelly reminded members of the purpose of this paper and how it is to assist jurisdictions when they need assistance.

Members discussed if the flags as they are would be too complicated. Members suspended the discussion on this topic until tomorrow.

s22 [redacted]

s22 [redacted]

s22 [redacted]

COMMITTEE-IN-CONFIDENCE

Australian Health Protection Principal Committee

Outcomes - Emergency Teleconference

Novel Coronavirus COVID19

Tuesday 21 July 2020 12:30 – 14:30 AEST

Members attending	
Prof Paul Kelly	Acting Commonwealth Chief Medical Officer
Dr Nick Coatsworth	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd	Deputy Commonwealth Chief Medical Officer
Ms Alison McMillan	Chief Nursing and Midwifery Officer
Dr Andrew Robertson	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier	Chief Health Officer, South Australia
Adj Prof Brett Sutton	Chief Health Officer, Victoria
Dr Kerry Chant Dr Laura Collie (proxy)	Chief Health Officer, New South Wales
Adj Prof Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch (Apology) Dr Scott McKeown (Proxy)	Chief Health Officer, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie	Chief Health Officer, Northern Territory
RADM Sarah Sharkey	Commander Joint Health and Surgeon General, ADF
Mr Rob Cameron (Apology) Mr Joe Buffone (Proxy)	Director General, Emergency Management Australia
Dr Caroline McElnay (Apology) Dr Harriette Carr (Proxy)	New Zealand Ministry of Health
Dr Sonya Bennett	Chair, Communicable Diseases Network Australia
Prof Ben Howden	Chair, Public Health Laboratory Network
Prof Len Notaras	National Critical Care and Trauma Response Centre
Invited Experts	
Professor Jodie McVernon Professor James McCaw (Apology)	University of Melbourne
Professor Allen Cheng	Director, Infection, Prevention and Healthcare Epidemiology Unit, Alfred Health
Professor Lyn Gilbert	Director, Infection Prevention and Control, Institute of Clinical Pathology, University of Sydney
Department of Health	
Dr Ruth Vine	Deputy Commonwealth Chief Medical Officer
Ms Celia Street	First Assistant Secretary, Office of Health Protection
Dr Lucas De Toca	Acting First Assistant Secretary, Primary Care Division
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
Mr Graeme Barden	Assistant Secretary, National Incident Room
Ms Rhonda Owen (Apology)	Assistant Secretary, Health Emergency Management Branch
s47F s47F	Medical Advisor, Public Health and Forward Planning Branch
s47F	AHPPC Secretariat

COMMITTEE-IN-CONFIDENCE

s22 [redacted]

Agenda Item 2 – Department of Infrastructure – Freight Movement Protocol

Members noted the summary of the paper provided by Mr David Hallinan, Deputy Secretary, Department of Infrastructure. They noted that there is complexity of restrictions, variations across jurisdictions and short notice for industry to implement changes.

In light of the critical role that freight and logistics operators provide, Mr Hallinan advised that National Cabinet met on 10 July and agreed that Transport Ministers develop a freight movement protocol that supports minimal disruption to freight movements across borders, including options for a national permit system.

Members noted that freight and logistics operators were happy to take all appropriate steps to manage risk. Members discussed current jurisdictional arrangements for the management of freight drivers and supported in principle the adoption of a 7 day cyclical testing regime for freight workers.

Members endorsed the Protocol for Domestic Border Controls- Freight Movements and noted that the paper will be going to National Cabinet on Friday 24 July 2020.

s22 [redacted]

s22 [redacted]

Agenda Item 5 – Latest Epidemiology Update

s22 [redacted]

Australian Capital Territory

s22 [redacted]

Dr Coleman also advised that police and Chief Ministers have been in discussions regarding a possible ACT regional bubble to implement border restrictions in the region.

s22 [redacted]

Agenda Item 6 – Other Business

Jurisdictions provided an updated by exception:

s22 [redacted]

Western Australia

Dr Andrew Robertson advised that they have finalised further border restrictions excluding all NSW residents from entering WA, exemptions to only health care workers and government officials.

s22 [redacted]

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COMMITTEE-IN-CONFIDENCE

Australian Government
Department of Health

Australian Health Protection Principal Committee

Domestic Border Controls – Freight Movements

AHPPC Meeting 21 July 2020 Speakers: Mr David Hallinan & s47F

Recommendations:

That AHPPC Members:

i. **Note** that governments are balancing the risks posed by the spread of COVID-19 with the economic and community impacts of various restrictions, including critical supply chain continuity.

ii. **Endorse** the Protocol for Domestic Border Controls – Freight Movements (the Protocol) at **Attachment A,** which provides guidance on limiting the COVID-19 risks from the movement of freight across Australian internal borders.

iii. **Note** that the Protocol is listed for consideration by National Cabinet on 24 July 2020.

Background

Australian governments' approach to suppress, rather than eliminate, COVID-19 requires a risk-based approach that balances health measures with ongoing economic and community activity. Compliance with health measures and the resilience of supply chains is put at risk by complexity of restrictions, variations across jurisdictions and short notice for industry to implement changes.

Freight and logistics operators carry critical supplies (eg food and medicine), support economic activity (eg commodity exports such as iron ore) and deliver basic services (eg post and deliveries). Freight is also carried in an integrated supply chain and it is not generally feasible to determine which freight is essential to food security, heath and infrastructure. Disruption to supply chains can therefore result in considerable unintended consequences for Australia's economy and communities. Delays at borders can also impact on the fatigue management requirements that heavy vehicle and rail crew must meet, leading to broader safety and community risks for road users and rail passengers.

Throughout the COVID-19 pandemic, freight industry representatives and regulators have worked closely with the Australian Government and state and territory governments to ensure the safety of supply chains for the community and workers, and they have contributed to the development of this Protocol.

Current Status/Situation

Border control measures have been introduced in New South Wales, Queensland, Western Australia, South Australia, Tasmania, the Australian Capital Territory and the Northern Territory. National Cabinet met on 10 July and agreed for Transport Ministers to develop a freight movement protocol and return to National Cabinet with recommendations that support minimal disruption to freight movements across borders, including options for a national permit system.

Many companies transport freight across multiple borders, and are required to meet multiple border control measures including exemption processes, self-isolation requirements, use of PPE, and COVID-19 testing requirements. A more consistent, risk-based approach across Australia would reduce complexity for industry and improve compliance, whilst minimising potential vectors for transmission of COVID-19.

New developments/Evidence

The Protocol has been developed as policy guidance for freight movements across interstate borders to improve consistency for freight movements in a COVIDsafe manner.

The Protocol is intended to complement WHS laws and health directions, as implemented and enforced by individual jurisdictions, and take into account existing fatigue management regulations. The Protocol is intended to complement state and territory COVIDSafe work plan requirements and it is not a legally enforceable document.

The Protocol is based on guidance currently available from the Department of Health and Safe Work Australia and draws from current best practice measures introduced by state and territory governments throughout the pandemic.

The Protocol provides advice to:

- Manage the risks of freight disruption to the community and economy;
- Manage risks to the health and wellbeing of freight workers; and
- Manage risks of community transmission of COVID-19 from workers moving across state borders.
- Enhance risk mitigation measures in relation to declared COVID-19 hotspots.

The Protocol includes specific requirements for heavy vehicle drivers, support workers and rail crew that must be observed alongside and in addition to the requirements of COVIDSafe workplans. Additional requirements for operators entering, exiting and transiting hotspots are also included.

Ongoing communication between transport and health agencies in each jurisdiction, as well as communication and consultation with industry is also required under the Protocol. The Protocol would be subject to regular review to take into account any emerging challenges. Enforcement and implementation of the Protocol would be a matter for each jurisdiction.

References

1. Attachment A - Protocol for Domestic Border Controls – Freight Movements

Protocol for Domestic Border Controls – Freight Movements

The movement of domestic freight via heavy vehicles is critical to ensuring supply chains continue to operate smoothly and individuals, businesses and service providers can access the goods they need. While freight movements have not been identified as a source of community transmission of COVID-19 to date, any movement of people across the community needs to be risk-managed to ensure the safety of both the workforce and broader community.

A 'hotspot' is any zone identified by a state or territory as an area of increased COVID-19 prevalence that has additional restrictions or differential advice (eg on travel from a particular area). Additional measures to limit the potential transmission of COVID-19 should be introduced to manage any movement in or through hotspot zones, and it is critical that operators ensure any employees are trained appropriately to support implementation of COVIDsafe workplans. Outside of hotspot zones, ongoing attention to health directions, hygiene measures and physical distancing is required to ensure freight does not become a vector for transmission.

Land freight routes carry substantial volumes by road and rail, with large numbers of heavy vehicles and train journeys every day. While restrictions in movements of people are important to manage the potential spread of COVID-19, disruptions to supply chains have substantial implications for the wider community. This includes ensuring delivery to regional and remote communities as well as maintaining high volumes and efficient timeframes for major urban centres.

Unanticipated delays at the border can have implications for safety on the roads and the health of critical transport workers. Heavy vehicle drivers are required by law to take regular breaks at set intervals to manage fatigue. Long delays at borders can result in either freight not meeting critical timeframes, or drivers breaching their mandated fatigue requirements, which can result in road accidents or mental health and other health impacts on workers. Requiring quarantine or self-isolation of freight workers who travel for their work could have a dramatic impact on freight movement through key corridors.

Greater consistency in border management of supply chains will assist industry to comply. Where any variations exist between jurisdictions, these need to be clearly communicated to both the freight and logistics industry and to border control authorities.

Operators need to ensure that all workers are familiar with their COVIDsafe workplan, public health orders in all jurisdictions in which they will work, practice good hygiene and have appropriate training to manage any risks. Workers also need to take personal responsibility for minimizing their risk of becoming a vector for transmission, both in the workplace and when not working.

This protocol applies to drivers of any heavy vehicles over 4.5 GVM and rail crew.

Support workers[1] essential to the supply chain but not travelling in a heavy vehicle or train, including those carrying out repairs, empty trailers and prime movers that are repositioning to carry freight should also be regarded covered by this protocol.

This protocol will be regularly reviewed to take into account any emerging developments.

[1] Some of these requirements may apply to services such as distribution centres and repair centres where they support the supply chain.

The following applies to state and territory governments where border controls are used:

Managing risks of freight disruption to the community and economy

- Border controls applying to heavy vehicle drivers, support workers and rail crew should be streamlined, standardised and recognised across jurisdictions wherever possible to ensure minimal disruption.
- At road border check points, a dedicated freight lane, waive through of freight or prioritised entry should be provided where road conditions and infrastructure allows to minimise delays for heavy vehicles.
- Where permits are required, the duration and conditions (including display) should be standardized and recognized across jurisdictions. Pre-approval processes and timeframes should enable companies to plan and schedule transport operations.
- A clearly identified program of targeted checks based on assessed intelligence as well as random checks should be conducted at a level that does not unreasonably delay freight.
- Permits for support workers where required should be expedited to ensure essential work, including heavy vehicle or train breakdowns, can be conducted without delay.
- Heavy vehicle drivers and rail crew should not be required to quarantine or self-isolate for 14 days following a border crossing in relevant jurisdictions, unless they develop symptoms of COVID-19 or have been a close contact of someone who has COVID-19, or as directed by health authorities.
- COVID-19 tests should be available at no cost to heavy vehicle drivers and rail crew whether or not symptoms are present if required by this protocol.

Managing risks to the health and wellbeing of freight workers

- Heavy vehicle drivers and rail crew should continue to observe their requirements under relevant heavy vehicle or rail regulations respectively, in particular fatigue requirements.
- The National Cabinet decision in relation to rest stops, will continue to apply and can be accessed at: www.infrastructure.gov.au/vehicles/vehicle_regulation/files/non-essential-services-exemption-rest-stop-facilities.pdf
    - Assistance on how to locate a heavy vehicle rest place can be found at: www.nhvr.gov.au/road-access/route-planner
- Arrangements should be made to allow heavy vehicle drivers to change over at, or close to, a state border to enable drivers to stay within a state where practical. This should be facilitated by utilising rest stop facilities where possible.

Managing risks of community transmissions from workers moving across state borders

- Any heavy vehicle driver or rail crew with any COVID-19 symptom present, should seek immediate COVID-19 testing and medical advice.
- Routine COVID-19 testing of heavy vehicle drivers or rail crew should be required for drivers that are planning on entering or leaving hot spots, or if directed by medical or health agency advice.
- To assist with contact tracing, heavy vehicle drivers and rail crew who cross borders and/or enter or leave hotspots, should be required to keep a record of all close contacts. A close contact is a face-to-face contact for 15 minutes or more, or a person sharing an enclosed space for over 2 hours.
    - A common national form for records will be developed, to be lodged with work diary records.
- Heavy vehicle drivers and rail crew should be required to have minimal or no close person to person contact at any border check locations, truck rest stops and roadhouses, and any accommodation facilities used on a journey, where practical.
- All businesses should have a COVIDsafe workplan and ensure all staff are familiar with the plan and trained appropriately.
- State and territory government agencies should consult with other relevant governments, regulators and with industry in relation to border controls at shared borders to ensure that requirements are communicated and understood.
- State and territory governments will mutually recognise COVIDsafe workplans developed by the relevant operator.
- Prior to implementing directions pertinent to supply chains, state and territory governments should consult with industry to understand the effect and impacts of potential changes ahead of any new directions being been put place and to ensure that industry can implement any new requirements quickly and achieve strong compliance.
- State and territory governments should ensure regular training is available to industry on the development of COVIDsafe workplans, and the use of PPE.
- State and territory governments will implement appropriate compliance mechanisms or controls to ensure COVIDsafe workplans are being adhered to and implemented appropriately.

In addition to the COVIDSafe workplans that freight companies have in place, the following protocols will also apply to reduce the risk of COVID-19 transmission.

Heavy vehicle drivers, support workers and rail crew must observe the following:

- No passengers will be allowed to travel in trucks or trains unless they are freight workers, for example authorised two up teams.
- Only exit the vehicle to access rest stop facilities, refuelling, accommodation, activities directly related to the delivery or loading of freight or to meet required regulated activities, e.g. work health and safety or fatigue management.
- Follow all COVID-19 related instructions from employees at any premises accessed.
- Employ or introduce non-contact receipt and collection processes for freight when possible.
- Wash or sanitise hands at all appropriate times, but especially at entry to a premises, and prior to leaving.
- Maintain appropriate social distancing while in any premises.
- During freight journeys, drivers should avoid large venues/restaurants and use roadhouse facilities wherever possible.
- Overnight stays at accommodation should occur only when necessary to fulfil fatigue requirements. Accommodation providers must apply COVIDSafe protocols and cleaning procedures to minimise risk. Truck drivers are not permitted to use common areas in accommodation premises and will adhere to physical distancing and limit contacts.
- PPE (such as gloves, eye protection and face masks) should be used whenever physical distancing is not possible, where directed by state or territory government, the Department of Health or Safe Work Australia, or when indicated by COVIDSafe workplans.
- If displaying symptoms of illness such as a fever, cough or sore throat do not enter a premises, advise your employer, seek medical assistance, self-isolate until you seek medical assistance and do not continue your journey.

SPECIFIC ADDITIONAL REQUIREMENTS FOR TRAVELLING THROUGH HOTSPOTS

The following applies to state and territory governments

- Routine COVID-19 testing of heavy vehicle drivers, support workers or rail crew will be encouraged for all those entering or leaving a hot spot or directed by medical or health agency advice.
- State and territory governments will offer pop-up testing facilities at areas that protect the safety of the driver and will not impact on fatigue requirements or add undue time to the journey.
- Once a hot spot has been identified, state and territory governments will consult across jurisdictions to ensure that drivers are only being tested once within a period no less than 7 days and not exceeding 14 days.

The following applies to heavy vehicle drivers, support workers and rail crew

- Adhere to strict physical distancing and undertake additional precautions when operating in areas experiencing increased COVID-19 cases.
- Restrict stops to dedicated rest stops and roadhouse facilities.
- Transit through hotspots without stopping overnight unless required to meet required regulated activities, e.g. work health and safety or fatigue management.
- In the 14 days following entering or transiting a hotspot or until their next shift, limit activities to restrict interactions with the public and broader family and friends, preferably by staying at their place of residence or appropriate venue where possible. However, this restriction will not apply if the vehicle has not stopped during transit through a hotspot.
- Should wear appropriate PPE when providing services in hotspot locations. Face masks should be used in accordance with advice provided by the relevant jurisdiction, the Department of Health and Safe Work Australia.

Advice from the Department of Health on avoiding infection, including guidance on hand hygiene, cough etiquette and social distancing is available here: www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/what-you-need-to-know-about-coronavirus-covid-19#protect-yourself-and-others

For general information concerning the Novel Coronavirus (COVID-19) please refer to the Department of Health website: www.health.gov.au/health-topics/novel-coronavirus-2019-ncov)

For information on work health and safety requirements please refer to the Save Work Australia website: https://www.safeworkaustralia.gov.au/covid-19-information-workplaces

21 July 2020

Australian Health Protection Principal Committee

Outcomes - Emergency Teleconference

Novel Coronavirus COVID19

Wednesday 22 July 2020 12:30 – 14:30 AEST

Members attending	
Prof Paul Kelly	Acting Commonwealth Chief Medical Officer
Dr Nick Coatsworth	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd	Deputy Commonwealth Chief Medical Officer
Ms Alison McMillan	Chief Nursing and Midwifery Officer
Dr Andrew Robertson	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier	Chief Health Officer, South Australia
Adj Prof Brett Sutton (Apology) Professor Allen Cheng (Proxy)	Chief Health Officer, Victoria
Dr Kerry Chant	Chief Health Officer, New South Wales
Adj Prof Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch	Chief Health Officer, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie	Chief Health Officer, Northern Territory
RADM Sarah Sharkey	Commander Joint Health and Surgeon General, ADF
Mr Rob Cameron (Apology) Mr Joe Buffone (Proxy)	Director General, Emergency Management Australia
Dr Caroline McElnay (Apology) Dr Harriette Carr (Proxy)	New Zealand Ministry of Health
Dr Sonya Bennett	Chair, Communicable Diseases Network Australia
Prof Ben Howden	Chair, Public Health Laboratory Network
Prof Len Notaras	National Critical Care and Trauma Response Centre
Invited Experts	
Professor Jodie McVernon Professor James McCaw(Apology) s47F (Proxy)	University of Melbourne
Professor Allen Cheng	Director, Infection, Prevention and Healthcare Epidemiology Unit, Alfred Health
Professor Lyn Gilbert	Director, Infection Prevention and Control, Institute of Clinical Pathology, University of Sydney
Department of Health	
Dr Ruth Vine	Deputy Commonwealth Chief Medical Officer
Ms Celia Street	First Assistant Secretary, Office of Health Protection
Dr Lucas De Toca	Acting First Assistant Secretary, Primary Care Division
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
Mr Graeme Barden	Assistant Secretary, National Incident Room
Ms Rhonda Owen	Assistant Secretary, Health Emergency Management Branch
s47F s47F	Medical Advisor, Public Health and Forward Planning Branch
s47F	AHPPC Secretariat

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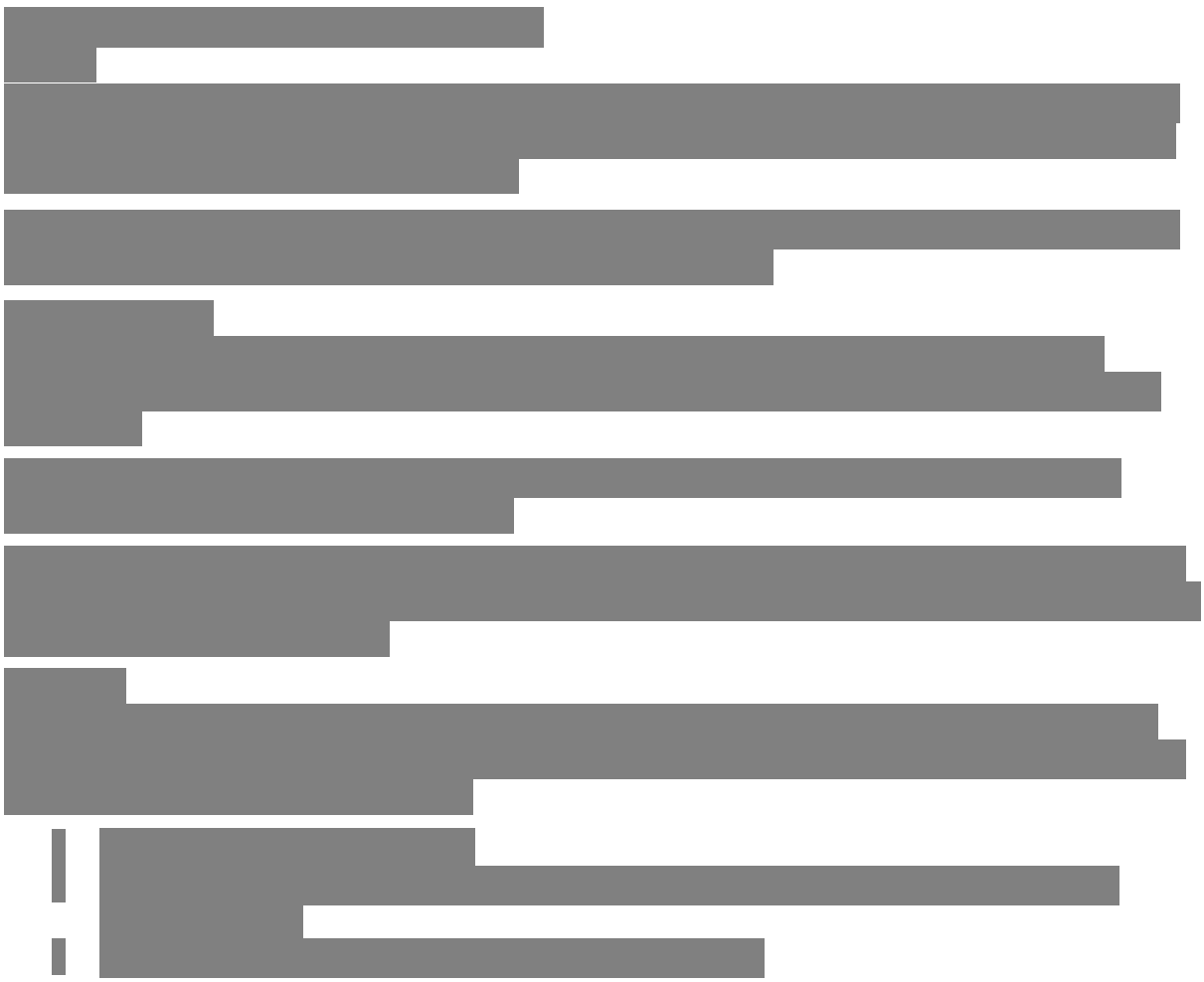

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s22 [redacted]

Agenda Item 7 – Other business

s22 [redacted]

Final Comments

Dr Mark Veitch asked members whether any jurisdiction has enforced mandatory testing of asymptomatic people crossing their border.

- Dr Jeanette Young advised that is testing NSW residents from hot spot areas and Victorians who cross the Queensland border.
- Dr Andrew Robertson advised that in Western Australia all residents from NSW and Victoria with exemptions are tested
- A/Prof Nicola Spurrier advised that all residents from NSW, ACT and Victoria are tested when crossing the South Australian Border.

s22 [redacted]

Australian Health Protection Principal Committee

Outcomes - Emergency Teleconference

Novel Coronavirus COVID19

Thursday 23 July 2020 12:00 – 14:00 AEST

Members attending	
Prof Paul Kelly	Acting Commonwealth Chief Medical Officer
Dr Nick Coatsworth	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd	Deputy Commonwealth Chief Medical Officer
Ms Alison McMillan	Chief Nursing and Midwifery Officer
Dr Andrew Robertson	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier	Chief Health Officer, South Australia
Adj Prof Brett Sutton (Apology) Prof Allen Cheng (Proxy)	Chief Health Officer, Victoria
Dr Kerry Chant	Chief Health Officer, New South Wales
Adj Prof Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch	Chief Health Officer, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie	Chief Health Officer, Northern Territory
RADM Sarah Sharkey	Commander Joint Health and Surgeon General, ADF
Mr Rob Cameron	Director General, Emergency Management Australia
Dr Caroline McElnay (Apology) Dr Harriette Carr (Proxy)	New Zealand Ministry of Health
Dr Sonya Bennett	Chair, Communicable Diseases Network Australia
Prof Ben Howden	Chair, Public Health Laboratory Network
Prof Len Notaras	National Critical Care and Trauma Response Centre
Invited Experts	
Professor Jodie McVernon Professor James McCaw (Apology)	University of Melbourne
Professor Allen Cheng	Director, Infection, Prevention and Healthcare Epidemiology Unit, Alfred Health
Professor Lyn Gilbert	Director, Infection Prevention and Control, Institute of Clinical Pathology, University of Sydney
Department of Health	
Dr Ruth Vine	Deputy Commonwealth Chief Medical Officer
Ms Celia Street	First Assistant Secretary, Office of Health Protection
Dr Lucas De Toca	Acting First Assistant Secretary, Primary Care Division
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
Mr Graeme Barden	Assistant Secretary, National Incident Room
Ms Rhonda Owen	Assistant Secretary, Health Emergency Management Branch
s47F s47F	Medical Advisor, Public Health and Forward Planning Branch
s47F	AHPPC Secretariat

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Agenda Item 7 – Other Business

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Tasmania

No further cases identified, and there is likely to be an announcement on borders tomorrow.

Australian Health Protection Principal Committee

Outcomes - Emergency Teleconference

Novel Coronavirus COVID19

Tuesday 28 July 2020 12:30 – 14:30 AEST

Members attending	
Prof Paul Kelly	Acting Commonwealth Chief Medical Officer
Dr Nick Coatsworth	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd	Deputy Commonwealth Chief Medical Officer
Ms Alison McMillan	Chief Nursing and Midwifery Officer
Dr Andrew Robertson (apology) Dr Paul Armstrong (proxy)	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier	Chief Health Officer, South Australia
Adj Prof Brett Sutton	Chief Health Officer, Victoria
Dr Kerry Chant	Chief Health Officer, New South Wales
Dr Jeannette Young (apology) Dr Sonya Bennett (proxy)	Chief Health Officer, Queensland
Dr Mark Veitch	Chief Health Officer, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie	Chief Health Officer, Northern Territory
RADM Sarah Sharkey	Commander Joint Health and Surgeon General, ADF
Mr Rob Cameron	Director General, Emergency Management Australia
Dr Caroline McElnay	New Zealand Ministry of Health
Dr Vanessa Johnston (proxy)	Chair, Communicable Diseases Network Australia
Prof Ben Howden	Chair, Public Health Laboratory Network
Prof Len Notaras	National Critical Care and Trauma Response Centre
Invited Experts	
Professor Jodie McVernon Professor James McCaw	University of Melbourne
Professor Allen Cheng	Director, Infection, Prevention and Healthcare Epidemiology Unit, Alfred Health
s47F (proxy)	Director, Infection Prevention and Control, Institute of Clinical Pathology, University of Sydney
Department of Health	
Dr Ruth Vine	Deputy Commonwealth Chief Medical Officer
Ms Celia Street	First Assistant Secretary, Office of Health Protection
Dr Lucas De Toca	Acting First Assistant Secretary, Primary Care Division
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
Mr Graeme Barden	Assistant Secretary, National Incident Room
Ms Rhonda Owen	Assistant Secretary, Health Emergency Management Branch
s47F s47F (Proxy)	Medical Advisor, Public Health and Forward Planning Branch
s47F	AHPPC Secretariat

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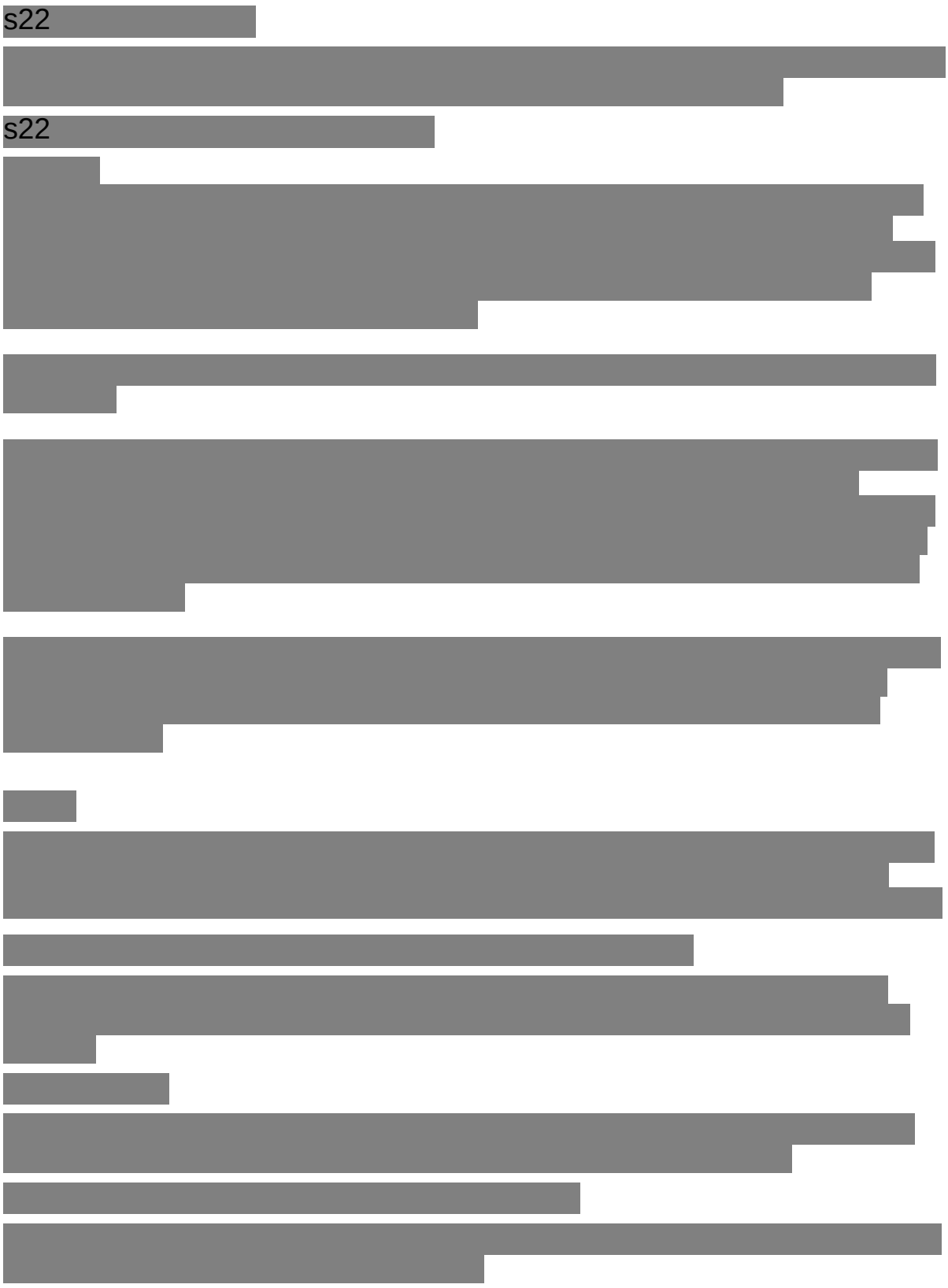

Agenda Item 3 – Domestic Border Closure Protocol

Mr Paul Grigson advised that the Department of Home Affairs had been tasked with developing a draft Domestic Border Controls – Protocol for Closures document.

Mr Grigson advised that he is keen to be sure that all jurisdictions are comfortable with the document. He advised that the document follows a principles based approach and is largely based on Public Health Orders from three jurisdictions, and input received from jurisdictions.

Members raised concerns about people transiting through jurisdictions clustering at borders; the challenging nature of localised shutdowns in suburbs which may lead to perverse outcomes and the fact that jurisdictions all have different geography and demographic and more nuance may be needed.

Members noted that the Secretariat would send out the document again to provide Chief Health Officers with the opportunity to provide further comment.

Action:
Secretariat to send out the Domestic Border Controls – Protocol for Closures document to Chief Health Officers with comments due by noon Friday 31 July 2020.

Agenda Item 4 – Other Business

Jurisdictional updates

s22 [redacted]

South Australia

s22 [redacted]

In addition, border controls are likely to be tightened overnight.

s22 [redacted]

Tasmania

Dr Mark Veitch offered a comment on the Domestic Border Control document. Add moderate risk to allow the possibility to contain an outbreak, and that should be considered in concert with other measures. If other public health measures are followed, the need to restrict movement becomes less likely.

s22 [redacted]

s22 [redacted]

Northern Territory

Dr Hugh Heggie advised that since the border opened, they have had between 15,000 and 20,000 people arrive in the NT. Only a small number are doing quarantine in Howard Springs, the rest have

come from areas which makes quarantine unnecessary. If a new hotspot is announced, the obligation rests with the traveller to contact the NT COVID hotline to undertake a risk assessment.

s22 [redacted]

Australian Health Protection Principal Committee

Outcomes - Emergency Teleconference

Novel Coronavirus COVID19

Wednesday 29 July 2020 12:30 – 14:30 AEST

Members attending	
Prof Paul Kelly	Acting Commonwealth Chief Medical Officer
Dr Nick Coatsworth	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd	Deputy Commonwealth Chief Medical Officer
Ms Alison McMillan	Chief Nursing and Midwifery Officer
Dr Andrew Robertson	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier	Chief Health Officer, South Australia
Adj Prof Brett Sutton	Chief Health Officer, Victoria
Dr Kerry Chant	Chief Health Officer, New South Wales
Dr Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch	Chief Health Officer, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie	Chief Health Officer, Northern Territory
RADM Sarah Sharkey	Commander Joint Health and Surgeon General, ADF
Mr Rob Cameron	Director General, Emergency Management Australia
Dr Caroline McElnay	New Zealand Ministry of Health
Dr Sonya Bennett (Apology) Dr Vanessa Johnston (Proxy)	Chair, Communicable Diseases Network Australia
Prof Ben Howden	Chair, Public Health Laboratory Network
Prof Len Notaras	National Critical Care and Trauma Response Centre
Invited Experts	
Professor Jodie McVernon Professor James McCaw	University of Melbourne
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Professor Lyn Gilbert	Director, Infection Prevention and Control, Institute of Clinical Pathology, University of Sydney
Department of Health	
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Ms Rhonda Owen	Assistant Secretary, Health Emergency Management Branch
s47F s47F (Proxy)	Medical Advisor, Public Health and Forward Planning Branch
s47F	AHPPC Secretariat

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Queensland
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Queensland has also closed the border to anyone from the Greater Sydney Region, effective 1am Saturday. s22

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Agenda Item 5 – Other Business

s22 [redacted]

Jurisdictional updates

s22 [redacted]

Victoria

Prof Sutton raised concerns over the freight movement protocol and the possibility of blockage at borders. Prof Kelly reminded members the AHPPC endorsed policy went to National Cabinet last week and if there are issues, it would be better to raise these with the Premier's office.

s22 [redacted]

s22 [redacted]

s22 [redacted]

[redacted]

Australian Health Protection Principal Committee

Outcomes - Emergency Teleconference

Novel Coronavirus COVID19

Friday 31 July 2020 12:30 – 14:30 AEST

Members attending	
Prof Paul Kelly (Apology)	Acting Commonwealth Chief Medical Officer
Dr Nick Coatsworth	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd	Deputy Commonwealth Chief Medical Officer
Ms Alison McMillan	Chief Nursing and Midwifery Officer
Dr Andrew Robertson (Apology) Dr Paul Armstrong (Proxy)	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier	Chief Health Officer, South Australia
Adj Prof Brett Sutton	Chief Health Officer, Victoria
Dr Kerry Chant	Chief Health Officer, New South Wales
Dr Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch	Chief Health Officer, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie	Chief Health Officer, Northern Territory
RADM Sarah Sharkey	Commander Joint Health and Surgeon General, ADF
Mr Rob Cameron	Director General, Emergency Management Australia
Dr Caroline McElnay	New Zealand Ministry of Health
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Ms Rhonda Owen	Assistant Secretary, Health Emergency Management Branch
s47F (Apology) s47F (Proxy)	Medical Advisor, Public Health and Forward Planning Branch
s47F	AHPPC Secretariat

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[redacted]

[redacted]

Queensland

s22 [redacted] Members noted that the border will be closed to residents of greater Sydney as of 1am 1 August 2020.

s22 [redacted]

[redacted]

[redacted]

s22 [redacted]

[redacted]

[redacted]

s22 [redacted]

[redacted]

[redacted]

Agenda Item 7 – Other Business

A/Professor Nicola Spurrier noted that the paper on domestic border control that came to AHPPC on Tuesday had not had input from health in South Australia. They will mark up the document and return to AHPPC. The paper will be discussed next week, noting it will not be an AHPPC paper.

s22 [redacted]

Australian Health Protection Principal Committee

Outcomes - Emergency Teleconference

Novel Coronavirus COVID19

Monday 03 August 2020 12:30 – 14:30 AEST

Members attending	
Prof Paul Kelly	Acting Commonwealth Chief Medical Officer
Dr Nick Coatsworth (Acting Chair)	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd	Deputy Commonwealth Chief Medical Officer
Ms Alison McMillan	Chief Nursing and Midwifery Officer
Dr Andrew Robertson Dr Paul Armstrong (Proxy)	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier	Chief Health Officer, South Australia
Prof Allen Cheng	Chief Health Officer, Victoria
Dr Michelle Cretikos	Chief Health Officer, New South Wales
Dr Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch	Chief Health Officer, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie	Chief Health Officer, Northern Territory
RADM Sarah Sharkey	Commander Joint Health and Surgeon General, ADF
Mr Rob Cameron	Director General, Emergency Management Australia
Dr Caroline McElnay	New Zealand Ministry of Health
Dr Sonya Bennett (Apology) Dr Vanessa Johnston (Proxy)	Chair, Communicable Diseases Network Australia
Prof Ben Howden	Chair, Public Health Laboratory Network
Prof Len Notaras	National Critical Care and Trauma Response Centre
Invited Experts	
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Professor Lyn Gilbert	Director, Infection Prevention and Control, Institute of Clinical Pathology, University of Sydney
Department of Health	
Dr Ruth Vine	Deputy Commonwealth Chief Medical Officer
Ms Celia Street	First Assistant Secretary, Office of Health Protection
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s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
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Mr Graeme Barden	Assistant Secretary, National Incident Room
Ms Rhonda Owen	Assistant Secretary, Health Emergency Management Branch
s47F s47F	Medical Advisor, Public Health and Forward Planning Branch
s47F	AHPPC Secretariat

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Agenda Item 5 – Paediatric Interstate Transfers
Prof Brett Sutton presented a proposal, which is supported by Australian neonatal and paediatric retrieval directors. He advised that the Paediatric Expert Working Group approached him to support a consistent, national approach for cross-border paediatric care to facilitate better, safer care for critically ill babies and children by medical retrieval teams.

Members noted that the proposed National approach includes:

- A "no tarmac handover" default to minimise patient harm.
- Full PPE to be worn when leaving the aircraft by the delivering retrieval team to minimise risk of COVID-19 transmission.
- Exemption to the mandatory 14-day quarantine for retrieval team members returning to their referring state, after the team has taken the patient to the receiving hospital.
- Authorising State Retrieval Directors and CEOs to grant these exemptions.

Members further noted that AHPPC has never agreed to a mandatory 14 day quarantine for retrieval team members. Members also asked for clarification about what form the handover would take and how relatives of the child would be managed. Members also agreed that additional words should be included to alert retrieval teams about the relevant jurisdictional requirements to manage exemptions for relatives.

Members supported this process with the additional comments. The document does not need to be reviewed again

ACTION:
Additional comments to be included on the management of exemptions by Professor Brett Sutton.

s22 [redacted]

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Australian Government
Department of Health

Australian Health Protection Principal Committee

PAPER: FACILITATION OF SAFER PAEDIATRIC INTERSTATE TRANSFERS DURING COVID-19

Recommendations:

That AHPPC Members:

Support a national approach to facilitate safer, cross border transfers of critically ill babies and children by medical retrieval teams. The proposed National approach includes:

- A "no tarmac handover" default to minimise patient harm.
- Full PPE to be worn when leaving the aircraft by the delivering retrieval team to minimise risk of COVID-19 transmission.
- Exemption to the mandatory 14-day quarantine for retrieval team members returning to their referring state, after the team has taken the patient to the receiving hospital.
- Authorising State Retrieval Directors and CEOs to grant these exemptions.

Description:

This paper summarises the issues and recommendations for facilitating safer care for transferring children interstate during the coronavirus (COVID-19) pandemic.

Background:

- Directors of paediatric care across the country, with the Paediatric Expert Working Group, are requesting the Department of Health and Human Services and the Victorian Chief Health Officer to support a consistent, national approach for cross-border paediatric care to facilitate better, safer care for critically ill babies and children by medical retrieval teams.
- Specialist neonatal and paediatric medical retrieval services are state based. Some paediatric care is only accessible from another state, for example the Royal Children's Hospital (RCH) in Melbourne is the nationwide centre for paediatric cardiac transplantation.
- Nationally, approximately 250 complex patients a year are transferred to another state for treatment, and an estimated 50-60 complex patients (20-24%) are referred to Victorian paediatric hospitals.

Issues:

- Following an interstate patient transfer to Victoria, retrieval team members are required to quarantine for 14 days, as mandated by border restrictions due to coronavirus (COVID-19).
- The patients they transfer are not COVID-19 positive, but they all have high acuity illness severity.
- State and Territory Chief Health Officers (CHO) have granted an exemption from quarantine if there is a "tarmac handover" of the infant/child to a retrieval team from the receiving state.
- Tarmac handovers disrupt care continuity in a high-risk environment and exposes the infant/child to additional handling and risks, associated with disconnecting and reconnecting critical drug infusions and breathing support. A tarmac handover adds a critical time delay for the infant/child to be stabilised at the receiving health service.

- A child experienced a serious near miss in Victoria recently which is associated with treatment delay due to a tarmac handover.
    - Last week, an unwell, COVID-19 negative child was referred from interstate to the RCH.
    - The CHO from the referring state denied exempting their retrieval team from 14 days of quarantine upon returning from Victoria, if the retrieval team went any further than the tarmac, even if the team donned full PPE.
    - The child did not tolerate the transfer well. A lengthy handover was conducted in near freezing temperatures and within 18 hours, the child required emergency mechanical cardiac support.
- These events are low frequency, but the risks have severe consequences.
- Health workers wearing appropriate PPE are highly protected. The risk in infection control to the referring team completing a patient transfer to the receiving unit is minimal, providing that appropriate PPE is used, and a process is followed to minimise the time that the referring team are in the receiving health service.

Proposal:

- The proposed National approach includes:
    - A “no tarmac handover” default to minimise patient harm.
    - Full PPE to be worn when leaving the aircraft by the delivering retrieval team to minimise risk of COVID-19 transmission.
    - Exemption to the mandatory 14-day quarantine for retrieval team members returning to their referring state, after the team has taken the patient to the receiving hospital.
    - Authorising State Retrieval Directors and CEOs to grant these exemptions.
- This proposal is supported by Australian neonatal and paediatric retrieval Directors.

Australian Health Protection Principal Committee

Outcomes - Emergency Teleconference

Novel Coronavirus COVID19

Friday 07 August 2020 12:30 – 14:30 AEST

Members attending	
Prof Paul Kelly (Apology)	Acting Commonwealth Chief Medical Officer
Dr Nick Coatsworth (Chair)	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd (Apology)	Deputy Commonwealth Chief Medical Officer
Ms Alison McMillan	Chief Nursing and Midwifery Officer
Dr Andrew Robertson (Apology) Dr Clare Huppatz (Proxy)	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier (joined late) Alison Lloyd-Wright	Chief Health Officer, South Australia
Adj Prof Brett Sutton (joined late) Prof Allen Cheng (Proxy)	Chief Health Officer, Victoria
Dr Kerry Chant (Apology) Michelle Cretikos	Chief Health Officer, New South Wales
Dr Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch	Chief Health Officer, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie (Apology) Dr Charles Pain (Proxy)	Chief Health Officer, Northern Territory
RADM Sarah Sharkey Dr Victoria Ross (Proxy)	Commander Joint Health and Surgeon General, ADF
Mr Rob Cameron	Director General, Emergency Management Australia
Dr Caroline McElnay	New Zealand Ministry of Health
Dr Sonya Bennett (Apology) Dr Vanessa Johnston (Proxy)	Chair, Communicable Diseases Network Australia
Prof Ben Howden (Apology) Dr Gary Lum (Proxy)	Chair, Public Health Laboratory Network
Prof Len Notaras	National Critical Care and Trauma Response Centre
Invited Experts	
Professor Jodie McVernon Professor James McCaw	University of Melbourne
Professor Allen Cheng	Director, Infection, Prevention and Healthcare Epidemiology Unit, Alfred Health
Professor Lyn Gilbert (Apology) s47F (Proxy)	Director, Infection Prevention and Control, Institute of Clinical Pathology, University of Sydney
Department of Health	
Dr Ruth Vine	Deputy Commonwealth Chief Medical Officer
Ms Celia Street	First Assistant Secretary, Office of Health Protection
Dr Lucas De Toca	Acting First Assistant Secretary, Primary Care Division
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
Mr Graeme Barden	Assistant Secretary, National Incident Room
Ms Rhonda Owen	Assistant Secretary, Health Emergency Management Branch
s47F	Medical Advisor, Public Health and Forward Planning Branch
s47F	AHPPC Secretariat

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Agenda Item 5 - Latest Epidemiology Update

s22 [redacted]

New South Wales

s22 [redacted]

New border changes with Victoria came in this morning.

s22 [redacted]

Australian Capital Territory

Dr Kerryn Coleman reported no further cases identified. Further, she is currently working with New South Wales on border issues and negotiations with Federal parliamentarians returning to Canberra to quarantine are going well.

Queensland

s22 [redacted]

s22 [redacted]

The Queensland border is closed to most people with a few exemptions and a requirement to fly in.

s22 [redacted]

s22 [redacted]

s22 [redacted]

s22 [redacted]

s22 [redacted]

s22 [redacted]

[redacted]

Australian Health Protection Principal Committee

Outcomes - Emergency Teleconference

Novel Coronavirus COVID19

Friday 14 August 2020 12:30 – 14:30 AEST

Members attending	
Prof Paul Kelly	Acting Commonwealth Chief Medical Officer
Dr Nick Coatsworth	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd (Chair)	Deputy Commonwealth Chief Medical Officer
Ms Alison McMillan	Chief Nursing and Midwifery Officer
Dr Andrew Robertson	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier	Chief Health Officer, South Australia
Adj Prof Brett Sutton Prof Allen Cheng (Proxy)	Chief Health Officer, Victoria
Dr Kerry Chant	Chief Health Officer, New South Wales
Dr Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch	Chief Health Officer, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie	Chief Health Officer, Northern Territory
RADM Sarah Sharkey	Commander Joint Health and Surgeon General, ADF
Mr Rob Cameron	Director General, Emergency Management Australia
Dr Caroline McElnay	New Zealand Ministry of Health
Dr Sonya Bennett Mr Graeme Barden (Proxy)	Chair, Communicable Diseases Network Australia
Prof Ben Howden	Chair, Public Health Laboratory Network
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Invited Experts	
Professor Jodie McVernon Professor James McCaw	University of Melbourne
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Ms Rhonda Owen	Assistant Secretary, Health Emergency Management Branch
s47F	Medical Advisor, Public Health and Forward Planning Branch
s47F	AHPPC Secretariat

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Agenda Item 5 – Other business

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- [redacted]
- [redacted]

Organ transplants and domestic borders

Ms Celia Street noted AHPPC had previously agreed to facilitate organ transplants between jurisdictions but that there had apparently been recent examples where there had been barriers to this. Jurisdictional members noted that they would facilitate any urgent or critical health needs. While requests may need to be made, this process ensures that it is brought to the CHOs attention and therefore facilitation. Members noted that the Prime Minister was likely to have a discussion with first ministers at National Cabinet next week.

s22 [redacted]

COMMITTEE-IN-CONFIDENCE

Australian Health Protection Principal Committee

Outcomes - Emergency Teleconference

Novel Coronavirus COVID19

Monday 17 August 2020 12:30 – 14:30 AEST

Members attending	
Prof Paul Kelly (Chair)	Acting Commonwealth Chief Medical Officer
Dr Nick Coatsworth	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd	Deputy Commonwealth Chief Medical Officer
Ms Alison McMillan	Chief Nursing and Midwifery Officer
Dr Andrew Robertson	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier	Chief Health Officer, South Australia
Adj Prof Brett Sutton	Chief Health Officer, Victoria
Dr Kerry Chant	Chief Health Officer, New South Wales
Dr Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch	Chief Health Officer, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie	Chief Health Officer, Northern Territory
RADM Sarah Sharkey (apology) Kate Tindall (Proxy)	Commander Joint Health and Surgeon General, ADF
Mr Rob Cameron	Director General, Emergency Management Australia
Dr Caroline McElnay	New Zealand Ministry of Health
Dr Sonya Bennett Mr Graeme Barden (Proxy)	Chair, Communicable Diseases Network Australia
Prof Ben Howden	Chair, Public Health Laboratory Network
Prof Len Notaras	National Critical Care and Trauma Response Centre
Invited Experts	
Professor Jodie McVernon Professor James McCaw	University of Melbourne
Professor Allen Cheng	Director, Infection, Prevention and Healthcare Epidemiology Unit, Alfred Health
Professor Lyn Gilbert	Director, Infection Prevention and Control, Institute of Clinical Pathology, University of Sydney
Department of Health	
Dr Ruth Vine	Deputy Commonwealth Chief Medical Officer
Ms Celia Street	First Assistant Secretary, Office of Health Protection
Dr Lucas De Toca	Acting First Assistant Secretary, Primary Care Division
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
Mr Graeme Barden	Assistant Secretary, National Incident Room
Ms Rhonda Owen	Assistant Secretary, Health Emergency Management Branch
s47F	Medical Advisor, Public Health and Forward Planning Branch
s47F	AHPPC Secretariat

COMMITTEE-IN-CONFIDENCE

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Agenda Item 5 - Other business

The Chair noted there has been significant interest from members of the public getting access to exemptions for crossing borders for compassionate reasons. Members noted that the NIR would seek information about the application process from each jurisdiction.

Action: NIR to ask CHOs about application process for crossing borders for compassionate reasons.

Mr Cameron advised that an emergency management meeting has been convened for tomorrow to discuss crossing borders for emergency responders during the bushfire and cyclone seasons.

Australian Health Protection Principal Committee

Outcomes - Emergency Teleconference

Novel Coronavirus COVID19

Wednesday 19 August 2020 12:30 – 14:30 AEST

Members attending	
Prof Paul Kelly	Acting Commonwealth Chief Medical Officer
Dr Nick Coatsworth	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd (Chair)	Deputy Commonwealth Chief Medical Officer
Ms Alison McMillan	Chief Nursing and Midwifery Officer
Dr Andrew Robertson	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier	Chief Health Officer, South Australia
Adj Prof Brett Sutton	Chief Health Officer, Victoria
Dr Kerry Chant	Chief Health Officer, New South Wales
Dr Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch	Chief Health Officer, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie	Chief Health Officer, Northern Territory
RADM Sarah Sharkey Dr Vicki Ross (Proxy)	Commander Joint Health and Surgeon General, ADF
Mr Rob Cameron	Director General, Emergency Management Australia
Dr Caroline McElnay	New Zealand Ministry of Health
Dr Sonya Bennett Mr Graeme Barden (Proxy)	Chair, Communicable Diseases Network Australia
Prof Ben Howden	Chair, Public Health Laboratory Network
Prof Len Notaras	National Critical Care and Trauma Response Centre
Invited Experts	
Professor Jodie McVernon Professor James McCaw	University of Melbourne
Professor Allen Cheng	Director, Infection, Prevention and Healthcare Epidemiology Unit, Alfred Health
Professor Lyn Gilbert	Director, Infection Prevention and Control, Institute of Clinical Pathology, University of Sydney
Department of Health	
Dr Ruth Vine	Deputy Commonwealth Chief Medical Officer
Ms Celia Street	First Assistant Secretary, Office of Health Protection
Dr Lucas De Toca	Acting First Assistant Secretary, Primary Care Division
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
Mr Graeme Barden	Assistant Secretary, National Incident Room
Ms Rhonda Owen	Assistant Secretary, Health Emergency Management Branch
s47F	Medical Advisor, Public Health and Forward Planning Branch
s47F	AHPPC Secretariat

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Agenda Item 5 – Border issues and closures – health care impacts

Ms Rhonda Owen outlined that in response to concerns that border restrictions are impacting the provision of essential health services, a summary table outlining input from states and territories will be provided to National Cabinet as part of a larger discussion around border movements.

Members agreed to provide further statistics on border exemptions to the Commonwealth to include as part of the National Cabinet's discussion this Friday, 21 August 2020.

Members noted the summary table.

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Tasmania

The Tasmanian Premier announced that the border restrictions will remain in place until 1 December 2020.

s22 [redacted]

[redacted]

[redacted]

	Question	Jurisdiction							
		ACT	NSW	NT	QLD	SA	TAS	VIC	WA
	Relevant Legislation	Public Health (COVID-19 Interstate Travellers) Emergency Direction 2020	Public Health (COVID-19 Border Control) Order 2020	COVID-19 Directions (No. 45) 2020 Directions for Territory Border Restrictions	Border restrictions Direction (No. 11) *Web page only	Emergency Management (Cross Border Travel No 11) (COVID-19) Direction	(General) Directions in relations to Persons arriving in Tasmania from Affected Regions and Premesis		Quarantine (Closing the Border) Directions
1	Are health related movements automatically exempt?	The Public Health (COVID-19 Interstate Travellers) Emergency Direction 2020 restricts travel from Victoria to the ACT unless an exemption is granted. Regardless of whether an exemption is granted, some individuals are required to complete a period of 14 days quarantine. There are no other border restrictions in place. Health related movements are not automatically exempt from the ACT's public health directions.	Under the NSW Public Health (COVID-19 Border Control) Order 2020, an "affected person" can only enter NSW if permitted to do so under the Order. An affected person is a person who has been in Victoria in the last 14 days. In general, affected persons require a permit to enter NSW. A Victorian resident can relevantly obtain a permit to enter NSW for the purpose of receiving medical or hospital services (other than in emergency situations). For people living in the border zone, a border zone permit can be obtained that allows permit holders to travel within the border zone for the purpose of work (if the person cannot work from home) and obtaining medical care or health supplies. In addition, a critical service permit is available for people who provide medical, hospital, dental or veterinary care. In emergency situations, a permit is not required. NSW may provide exemptions on a case-by-case basis if affected persons do not meet the conditions under the order. This may be in the case of a healthcare worker who does not meet the criteria for a border zone permit, such as those who live outside the border region in Victoria and needs to travel into NSW to provide services. These scenarios are assessed individually, which includes a public health risk assessment. Any exemptions granted are subject to a range of conditions and can be revoked at any time. Exemptions are granted by the Minister for Health, Chief Health Officer, or their authorised	No. Under Chief Health Officer (CHO) Directions, patients can apply for an exemption to mandatory supervised quarantine and seek approval to quarantine in an alternate location. This can be at their home in rare cases, or through the Patient Assistance Travel Scheme process, where they can be accommodated at hospital as they may still require clinical care. For health staff there are a number of options: • New employees – will be required to quarantine and may seek an approval to quarantine in an alternate location. Most will not be granted an exemption and will be required to attend mandatory supervised quarantine. On rare occasions a clinician may have be issued with approval to work under emergency situations only and quarantine for the rest of the time. (e.g. – a neurosurgeon in an emergency when no other specialist is available). • Staff returning from leave – follow the process as above. Most will be required to attend mandatory supervised quarantine. • Retrieval staff – under the CHO directions are able to quarantine in an alternate location and/or leave that quarantine to attend to another medical retrieval • AUSMAT staff – are required to quarantine, but can do so at an alternate location, as approved by the CHO.	[Input to be provided]	No. Emergency cases are exempt from cross border restrictions. Elective cases are reviewed with regard the urgency and from where the patient is coming from. All non-urgent transfers are assessed by a group of Deputy Chief Public Health Officers. An appeal process is also in place where decisions of the exemption panel can be further reviewed by the CPHO and CEO	There are no restrictions on movement out of Tasmania. Each movement into Tasmania requires an assessment.	Victoria does not have restrictions on movement of residents from other states accessing healthcare in Victoria. Under the Stage 3 restrictions currently in effect in regional Victoria and affecting Victorians living near the state borders, seeking medical treatment and travelling to work are two of the four permitted reasons to leave home. Persons from other jurisdictions/states who enter Victoria are subject to the same requirements. No exemption is required to leave home or cross into Victoria for these reasons.	No, however we have a mechanism whereby approval is granted by the Chief Health Officer (CHO). This can be completed urgently verbally and followed up in writing, if required. We also have developed a specific plan for organ retrievals. To ensure timely facilitation, liaison with Police occurs within the State Health Incident Coordination Centre (SHICC).
2	What documentation/evidence is required?	The ACT requests documentation from the treating professiona outlining need to enter the ACT. If the service to be provided is in a hospital facility, the application is referred to the relevant hospital for approval and facilitation of the appointment.	For non-emergency situations, the person must carry their permit while in NSW. They should also carry documentation relating to the medical appointment or service.	The NT has an online application for an exemption to mandatory supervised quarantine. Once an application is received it is reviewed by an assessment team. Depending on the situation/request, this team will include a clinician and / or the CHO or Deputy CHO.		Documentation on the need is as essed by asking the person to provide a doctor's letter on the need for treatment Further clarification can is often s ught by Deputy CPHO discussing the case with the patients GP or consultant	All applicants (health care workers, retrieval team, patient, family and friends or support workers) are required to complete the on-line G2G form. 1. Patients Patients returning from care interstate require a letter from he mainland facility that was caring for them stating their are is now complete and they are well enough to return to Tasmania. It should also note what type of on-going care the patient requires (home, home with support, hospital). The patient also requires a letter from the accepting Tasmanian facility noting that they can care for that patient in the appropriate care setting such as a single room or an ICU bed. Patients returning to a Tasmanian health care facility require a COVID swab prior to leaving the mainland so their COVID status is known. Someone may apply on the patient's behalf. The patient does not need to be the person physically making the G2G application. 2. Health care staff/ retrieval staff - Health Care staff must supply information showing they are a resident of Tasmania and an employee of the health service. 3. Family/friends/support workers - Must supply evidence that they are a resident of Tasmania or that they are necessary for caring for the patient (usually in the form of a letter from the	Not applicable as no permits are required outside of Stage 4 restricted zones	The request usually comes from the Executive Director or Chief Executive of the hospital via email. The request must provide the name of the person in respect of whom the request is made, the employment details and the rationale for the request.
3	If health related movements are not automatically exempt								
a	who can seek an exemption?	There are no restrictions relating to who can apply for an exemption.	For non-emergency situations, a person with a permit can enter NSW provided that the service is not available in Victoria and or cannot be accessed remotely. If an individual does not meet the criteria for a permit, an exemption can be sought. An example of this is detailed above.	Anyone can. The exemption is from mandatory supervised quarantine where an application is for an alternate location to quarantine. There are very limited exemptions from quarantine.		Anyone, patients are the most common source	Anyone may apply for an exemption. Supporting documentation from the health care facility (either from the Tasmanian or interstate hospital) is required to show that they need to travel back into Tasmania. There are special categories for health care workers and retrieval teams to apply under.	not applicable given Victoria is not restricting cross movement for healthcare	Anyone with a valid reason can seek an exemption either for treatment purposes or for the purpose of being a provider of a treatment
b	Are these health related movements exempt?						The below answers apply for someone coming from an affected area or affected premises (e.g. Victoria). The patients and their family/support person needs the approval of the State Controller to not quarantine in a government provided accommodation facility. If the patient, family member or support person is travelling from NSW or SA then the default position for those persons is to quarantine at home. Any direction to quarantine at home always contains a provision for attending a medical appointment.		
i	Organ donation retrieval teams	There is no automatic exemption under the public health order, however, exemption applications to enter the ACT for human tissue retrieval have previously been approved. In the ACT, Canberra Health Services (CHS) is responsible for the ACT DonateLife agency which coordinates organ and tissue donation for transplantation. Under current administrative arrangements, the ACT is supported by NSW to undertake organ and tissue donation activity. In the event that organs and tissue are deemed suitable for transplantation from the donor in the ACT, a team of retrieval surgeons and organ donation specialists is sent from NSW to facilitate the retrieval and transport of organs. A contingency plan for possible border closures as a result of the COVID-19 pandemic is in place. Should border restrictions come into place which prevent movement across the ACT border, CHS has provided in principle support for exemptions to interstate retrieval teams, deeming organ retrieval for the purposes of transplantation an essential service.	Organ donation retrieval teams would be able to obtain a critical services permit	See above Yes from mandatory supervised quarantine however the applicant can seek approval to quarantine in an alternate location.		Depends on where these teams are coming from and if there is a local mechanism where the organs can be retrieved by a local team	No, they apply through the retrieval team option in G2G.	N/A	A specific plan has been developed for organ retrievals due to the time critical nature of this work
ii	Access to cancer chemotherapy	There is no automatic exemption under the public health order. This would be considered in accordance with the process outlined under question 2.	The medical or hospital (non-emergency) permit could be applied for	Patients can access cancer care. This can be from home quarantine or mandatory supervised quarantine, although written approvals are granted in consultation with the treating team		According to need as above	No, they apply through the G2G system as "Other Persons or Classes of Persons Approved by the State Controller"	N/A	WA has limited need to send or receive patients from other states with the exception of highly specialised treatments such as CAR-T and a small number of remote Aboriginal communities who receive care in the NT.
iii	Access to medical specialist services	There is no automatic exemption under the public health order, however, exemption applications to enter the ACT to access specialist medical services have been granted to a small number of individuals.	The medical or hospital (non-emergency) permit could be applied for	As in ii above		According to need as above	No, these patients first apply for the Patient Transport Access Scheme and then in G2G as "Other Persons or Classes of Persons Approved by the State Controller"	N/A	As above
iv	Access to mental health services	There is no automatic exemption under the public health order. This would be considered in accordance with the process outlined under question 2.	The medical or hospital (non-emergency) permit could be applied for	NT offers mental health support to people in mandatory supervised quarantine. Services are also available via telehealth People can access services as described above in ii		According to need		N/A	As above
v	Maternity services	There is no automatic exemption under the public health order. This would be considered in accordance with the process outlined under question 2.	The medical or hospital (non-emergency) permit could be applied for	As in ii above		According to need	Tasmania does not transfer maternity service patients out of the state. We tend to only do internal transfers within Tasmania. If we needed to the patient would first apply for the Patient Transport Access Scheme and then in G2G as "Other Persons or Classes of Persons Approved by the State Controller"	N/A	As above

vi	GP services	There is no automatic exemption under the public health order. This would be considered in accordance with the process outlined under question 2.	The medical or hospital (non-emergency) permit could be applied for	This is provided via telehealth while in quarantine			Tasmanian does not transfer GP patients out of the state in order to access GP services. GPs can refer patients for elective procedures to interstate facilities if they and patient believe this is the best option (e.g. to access private services with a particular doctor whom the patient wishes to see). The patient would then need to apply through G2G when they were ready to return to Tasmania. This is not a common occurrence.	N/A	As above	
vii	Doctors and nurses travelling to work over the border from where they live	Doctors and nurses who travel across borders are asked to comply with respective jurisdictional directions/public health orders and the requirements of the health facilities within which they work. Doctors and nurses employed within an ACT hospital facility who have travelled into high risk areas must comply with the Clinical Health Emergency Coordination Centre (CHECC) recommendations. Current advice recommends that any staff member who has travelled to Greater Sydney or Newcastle LGAs should not enter a health care facility, aged care facilities or other high risk settings for a period of 14 days after leaving the areas. Doctors and nurses employed within an ACT hospital facility who have travelled into Victoria must quarantine on their return to the ACT for a period of 14 days. Staff exemptions will only be considered by the facility when it can be established that: • the staff member cannot work from home; • the staff member's role cannot be fulfilled by another individual either from within the ACT or from an interstate location where no restrictions apply, and • the staff member is deemed an essential worker (defined as there would be a greater risk posed to patients and/or staff if the staff member was excluded from work)	Doctors and nurses can apply for either the critical services permit or the border zone permit.	See above question 1.		vii. Doctors and nurses travelling to work over the border from where they live Generally we have limited cross border travel for Doctors and nurses. Exemptions are given depending on the circumstances. For example there is no limits in SA doctors going to Broken Hill for clinics, operating theatres sessions etc. They are exempt from quarantining on returning to SA. There is one doctor from SA undertaking procedures in Vic who has been exempt from quarantining on return. All others are have to quarantine on return	No, medical and nursing staff who need to cross the Tasmanian border to return to work do not typically live on the mainland. There are a few who do Fly In - Fly Out type work who need to apply each time they wish to cross the border into Tasmania	N/A	As WA has no border communities in the way that other states do this is not a regular issue. There are some services in remote WA that are provided by clinicians from the NT and these are assessed on a case by case basis. Where locums are required in regional WA from other parts of Australia a quarantine period is always preferred as WA has had a previously imported case in a health care worker from the East Coast and regional and remote communities are amongst the most vulnerable with respect to their local Aboriginal populations.	
c	what is the process for applying for an exemption?	An online form is available on the ACT Government COVID-19 website - https://www.covid19.act.gov.au/community/travel	Permits can be applied for online https://www.service.nsw.gov.au/transaction/apply-covid-19-nsw-border-entry-permit	As per above		Apply to ou Health exemptions web site with the easons thet seek an exemption	All applicants wishing to cross the border are encouraged to put in a G2G electronic application within 5 days of travel to Tasmania. Depending on the category chosen supporting documentation is required (e.g. evidence of being a retrieval team members, evidence of Tasmanian residency). Applicants are assessed and are either given: • exemption to enter without quarantine requirements • given approval to enter Tasmania but subject to quarantine requirements upon arrival. The State Controller determines the place of quarantine (e.g. government provided accommodation facility, own home, hospital ward)	N/A	All access to WA is by the individual via the G2G process. Police manage this process with input from health where required. When supporting information / approval from the CHO is required an email request is received, this comes either directly to the CHO or via the SHICC. The CHO then provides a letter outlining his approval or otherwise and any specific conditions. This gets attached by the applicant to the G2G request. Where the request is urgent Police Liaison in SHICC is notified verbally and via email to facilitate processing. Processing can occur whilst patients / staff are in transit. We will always ensure clinical teams are aware that processing should not delay patient care.	
d	What documentation / evidence must be provided?	This is dependent on the type of exemption that is being sought Some examples provided below: • Returning ACT Residents – o proof of ACT residential address; o ID • Moving/Relocation – o Proof of employment in ACT (if relocating for employment reasons) o Proof of long term accommodation arrangements (greater than 6 months) o ID • Essential Workers – documentation stating that: o the work is essential i.e. it would have a negative impact to the work sector or ACT community if not provided at this time; o the work cannot be undertaken by another person within the ACT, performed remotely, or by a person from another jurisdiction other than Victoria; and/or o a letter or statement from your employer (or statutory declaration if self-employed) that your entry to the ACT is essential and cannot be undertaken remotely or by another person. • Compassionate – o Documentation from treating professional; o Relevant documentation outlining reason for urgent entry Documentation is required to be uploaded onto the online form.	Depending on the permit applied for, documentation evidence to show that the person is entitled to the permit will be required.	As per above		Same as 2 above	If applying as a Tasmania Resident – evidence of residency. • Tasmanian driver licence; or • Another Tasmanian issued licence or identification type that includes a residential address; or • Australian Tax Office Assessment (2018/19); or • Tasmanian vehicle registration papers; or • Evidence of ONE of the following that must include the address of your Tasmanian residence and your full name, and is no more than six months old: • Financial Institution Statement • Utility Account (Power, Water, Telephone, Gas) • Council rates notice • Lease or Rental Agreement • Land Tax Valuation Notice • Certificate of Title. If applying as a health care worker or paramedic – evidence of work status as such (ID, contract, letter from hospital management or employer) If applying as a patient returning to a health care facility – a letter from mainland facility and a letter from Tasmanian health facility to be placed in upon return to Tasmania.	N/A	Confirmation of the requirement from the clinical provider, for staff and retrievals this typically comes from a senior exec in the health service. Where a patient needs to travel for treatment not available in WA this comes from the senior treating clinician If staff are involved we always liaise with the service Chief Executive to ensure they are aware and comfortable for the arrangements with the staff and managing the risk.	
e	who is the authorising officer/ authority?	ACT Chief Health Officer / ACT Health Directorate	ServiceNSW maintains the online portal https://www.service.nsw.gov.au/transaction/apply-covid-19-nsw-border-entry-permit The online portal is built based on the requirements of the public health orders	The CHO or one of his delegates		Exemptions Committee see 1 above	For patients, family, friends, non-AHPRA registered health care workers – the State Controller For Health Care Workers, Paramedics and Retrieval team clinicians – Deputy and Chief Medical Officer. For Non-clinical Flight Crew – State Controller.	N/A	Ultimately it is the Police under the Emergency Management Act. The Chief Health Officer endorsement is required for clinical staff prior to police approval.	
f	how long does it take?	The ACT Health Directorate requests that applications are submitted 48 hours prior to travel date. Urgent requests can be considered on the same day.	This can vary. If an individual submits all relevant information at the time of application, the permit will most often be issued on the same day. If further details or verification are required, this can take up to a few business days.	Within 24 hours if needed urgently although generally a few days depending on when the applicat on is received and the date of travel.		There is a three level process, meets requirments, needs some degree of medical oversight, full committee decision. Steps 1 and 2 occur within hours to 1 day. The committee meets 3 times each week. Urgent decisions can be escalated 7 days a week	State Controller - Average 3-5 days for typical processing but can be done quickly through phone calls afterhours. Health Care Workers, Paramedics and Retrieval team clinicians – Average less than 24 hours but can be done quickly through phone calls afterhours.	N/A	It could be concluded in less than an hour if required. As stated above we would always expect plans to be made and commenced if required in a life threatening emergency such as a patient organ retrieval	
g	do all exemption applications get approved?	No. A review process exists should individuals request a reconsideration of the decision.	No.	No		NO	All persons in the above categories are allowed to travel into Tasmania, the issues is not about entry in it's about the quarantine requirements and where quarantine will done completed if it is required.	N/A	No, not all requests are approved. We are very strict on requiring quarantine of clinical staff if there is no life threatening emergency for which their skills are required. Health services are aware of this situation and now plan for this quarantine period in the recruitment and use of locums.	
4	Are border police allowing movements according to the exemptions outlined above?	Current NSW border restrictions do not allow individuals with a valid exemption from the ACT to drive from Victoria to the ACT by road. Whilst these restrictions are in place, ACT Health will only issue exemptions for travel to the ACT by air.	Yes, so long as they are appropriately authorised and consistent with the intent of the public health orders	Yes		No	As expected in every regularly changing situation, there have been some minor miscommunications or issues with movement after the legal Directions change. All issues have been resolved with phone calls and subsequent documentation to ensure clarity moving forward. There has not been an issue that has not been resolved. As a small jurisdiction, the key persons in the G2G space work closely together and closely with border control and police.	Movements into Victoria permitted as Victoria does not have any border restrictions in place	Yes – though this is not really an issue for WA as we do not have border towns in the same way as some other states.	
5	Do you have suggestions for how this process can be improved or streamlined?	The NSW border restrictions are impacting transport to the ACT by road. Improved communication between each of the exemption teams across the states and territories would also be helpful to assist with applications requiring more than one jurisdiction to approve the moment.	Continual work is occurring to streamline these processes	The current system described above is considered appropriate to protect the safety of people in the NT		On line process being developed	It would be helpful to have a "COVID passport" much like freight transport have for our retrieval teams (aeromedical retrieve, blood and blood product delivery, organ harvest) teams so that their applications could be expedited. I understand that AHPPC were also working through a national standard. This too will be helpful to ensure Tasmania has comfort on who is moving across the borders but also to reduce burdening these health care workers with unnecessary read tape or clinical examination/swabs.	NSW and SA border flow for healthcare is critical and a more streamlined process would be supported.	No	

https://www.dhhs.vic.gov.au/victorias-restriction-levels-covid-19

Australian Health Protection Principal Committee

Outcomes - Emergency Teleconference

Novel Coronavirus COVID19

Friday 21 August 2020 12:30 – 14:30 AEST

Members attending	
Prof Paul Kelly	Acting Commonwealth Chief Medical Officer
Dr Nick Coatsworth	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd	Deputy Commonwealth Chief Medical Officer
Prof Alison McMillan	Chief Nursing and Midwifery Officer
Dr Andrew Robertson Dr Paul Armstrong (Proxy)	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier	Chief Health Officer, South Australia
Adj Prof Brett Sutton	Chief Health Officer, Victoria
Dr Kerry Chant	Chief Health Officer, New South Wales
Dr Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch	Chief Health Officer, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie	Chief Health Officer, Northern Territory
RADM Sarah Sharkey	Commander Joint Health and Surgeon General, ADF
Mr Rob Cameron	Director General, Emergency Management Australia
Dr Caroline McElnay	New Zealand Ministry of Health
Dr Sonya Bennett Mr Graeme Barden (Proxy)	Chair, Communicable Diseases Network Australia
Prof Ben Howden	Chair, Public Health Laboratory Network
Prof Len Notaras	National Critical Care and Trauma Response Centre
Invited Experts	
Professor Jodie McVernon Professor James McCaw	University of Melbourne
Professor Allen Cheng	Director, Infection, Prevention and Healthcare Epidemiology Unit, Alfred Health
Professor Lyn Gilbert	Director, Infection Prevention and Control, Institute of Clinical Pathology, University of Sydney
Department of Health	
Dr Ruth Vine	Deputy Commonwealth Chief Medical Officer
Ms Celia Street	First Assistant Secretary, Office of Health Protection
Dr Lucas De Toca	Acting First Assistant Secretary, Primary Care Division
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
Mr Graeme Barden	Assistant Secretary, National Incident Room
Ms Rhonda Owen	Assistant Secretary, Health Emergency Management Branch
s47F	Medical Advisor, Public Health and Forward Planning Branch
s47F	AHPPC Secretariat

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[redacted]

[redacted]

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[redacted]

[redacted]

[redacted]

[redacted]

[redacted].

Agenda Item 6 - Other business

Members agreed that it would be useful to have a broad ranging, forward looking discussion on a range of topics, including:

- s22 [redacted]
- interstate borders
- s22 [redacted]

s22 [redacted]

s22 [redacted]

[redacted]

COMMITTEE-IN-CONFIDENCE

Australian Health Protection Principal Committee

Agenda - Emergency Teleconference

Novel Coronavirus COVID19

Monday 24 August 2020 12:30 – 14:30 AEST

Members attending	
Prof Paul Kelly	Acting Commonwealth Chief Medical Officer
Dr Nick Coatsworth	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd	Deputy Commonwealth Chief Medical Officer
Prof Alison McMillan	Chief Nursing and Midwifery Officer
Dr Andrew Robertson	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier	Chief Health Officer, South Australia
Adj Prof Brett Sutton	Chief Health Officer, Victoria
Dr Kerry Chant	Chief Health Officer, New South Wales
Dr Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch	Chief Health Officer, Tasmania
Dr Kerryn Coleman (Apology) Dr Vanessa Johnston (Proxy)	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie	Chief Health Officer, Northern Territory
RADM Sarah Sharkey	Commander Joint Health and Surgeon General, ADF
Mr Rob Cameron	Director General, Emergency Management Australia
Dr Caroline McElnay	New Zealand Ministry of Health
Dr Sonya Bennett	Chair, Communicable Diseases Network Australia
Prof Ben Howden	Chair, Public Health Laboratory Network
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Invited Experts	
Professor Jodie McVernon Professor James McCaw	University of Melbourne
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Professor Lyn Gilbert	Director, Infection Prevention and Control, Institute of Clinical Pathology, University of Sydney
Department of Health	
Dr Ruth Vine	Deputy Commonwealth Chief Medical Officer
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Dr Lucas De Toca	Acting First Assistant Secretary, Primary Care Division
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s47F	Principal Medical Officer, Medical and Scientific Advisory Unit
Mr Graeme Barden	Assistant Secretary, National Incident Room
Ms Rhonda Owen	Assistant Secretary, Health Emergency Management Branch
s47F	Medical Advisor, Public Health and Forward Planning Branch
s47F	AHPPC Secretariat

COMMITTEE-IN-CONFIDENCE

s22 [redacted]

Agenda Item 2 – Feedback from National Cabinet

Professor Paul Kelly provided an update on the most recent National Cabinet meeting:

- s22 [redacted]
- [redacted]
- [redacted]
- [redacted]
- Vaccines and Domestic border closures briefly discussed.

s22 [redacted]

- [redacted]
- [redacted]

s22 [redacted]

s22 [redacted]

s22 [redacted]

Agenda Item 5 – Forward Work Plan

Professor Kelly noted that it is coming to a point where the Committee needs to think more broadly and put more focus on longer term strategic discussions.

Professor Kelly advised he had a draft list of topics that would be provided to members which ~~included:~~

- s22 [redacted]
- Crossing ~~borders~~ and exemptions;
- s22 [redacted]

s22 [redacted]

ACTION:

- Secretariat to work with Members to identify an agreed order of priority of items; and
- NIR to develop relevant papers to progress the issues identified for the forward work plan.

s22 [redacted]

s22 [redacted]

s22 [redacted]

s22 [redacted]

s22 [redacted]

s22 [redacted]

s22 [redacted]

s22 [redacted]

Australian Health Protection Principal Committee

Outcomes - Emergency Teleconference

Novel Coronavirus COVID19

Friday 28 August 2020 12:30 – 14:30 AEST

Members attending	
Prof Paul Kelly	Acting Commonwealth Chief Medical Officer
Dr Nick Coatsworth	Deputy Commonwealth Chief Medical Officer
Prof Michael Kidd	Deputy Commonwealth Chief Medical Officer
Prof Alison McMillan	Chief Nursing and Midwifery Officer
Dr Andrew Robertson	Chief Health Officer, Western Australia
A/Prof Nicola Spurrier	Chief Health Officer, South Australia
Adj Prof Brett Sutton	Chief Health Officer, Victoria
Dr Kerry Chant	Chief Health Officer, New South Wales
Dr Jeannette Young	Chief Health Officer, Queensland
Dr Mark Veitch (Apology) Dr Julie Graham (Proxy)	Chief Health Officer, Tasmania
Dr Kerryn Coleman	Chief Health Officer, Australian Capital Territory
Dr Hugh Heggie	Chief Health Officer, Northern Territory
RADM Sarah Sharkey	Commander Joint Health and Surgeon General, ADF
Mr Rob Cameron	Director General, Emergency Management Australia
Dr Caroline McElnay	New Zealand Ministry of Health
Dr Sonya Bennett	Chair, Communicable Diseases Network Australia
Prof Ben Howden	Chair, Public Health Laboratory Network
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Invited Experts	
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Professor Allen Cheng	Director, Infection, Prevention and Healthcare Epidemiology Unit, Alfred Health
Professor Lyn Gilbert (Apology) s47F (Proxy)	Director, Infection Prevention and Control, Institute of Clinical Pathology, University of Sydney
Department of Health	
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Mr Graeme Barden	Assistant Secretary, National Incident Room
Ms Rhonda Owen	Assistant Secretary, Health Emergency Management Branch
s47F	Medical Advisor, Public Health and Forward Planning Branch
s47F	AHPPC Secretariat

s22 [redacted]

Agenda Item 2 - Process for listing areas of COVID-19 transmission as hotspots
Professor Kelly advised Members, National Cabinet has requested AHPPC develop a nationally agreed criteria and process for listing hotspots for the purpose of imposing movement restrictions or other necessary public health actions.

Professor Kelly welcomed having a strong discussion on this issue and noted that a position on this is required for the Prime Minister today.

Dr s47F provided a summary of the paper noting the work undertaken by CDNA to develop the first part of the definition. International examples were also provided with Germany being suggested as a possible option for consideration.

Discussion:
Members had a detailed discussion and raised points, including:

- The German approach is not sensitive enough and Australia's situation is very different;
- Concern around applying a qualitative point for the definition;
- Border restrictions remain a major issue with no community transmission for 14 days is a key component for easing border restrictions;
- Border closures have different outcomes for different jurisdictions;
- Decisions on restrictions and border closures are based on data and experience;
- The use of a risk matrix to identify the risk, the controls and the mitigation would be useful and the requirement for transparency on the metrics used to determine the hotspot;
- Possible use of different levels of hotspot;
- There are a range of Australians who choose not to obey the rules in relation to travel and border restrictions which cause major issues;
- The availability and endurance of a vaccine will have a major impact on the easing of restrictions.

Professor Kelly agreed that the border component is an important part of the consideration, with issues in and around border communities being front of mind, including the disruption of the economy.

Professor Kelly noted that there are three different epidemics in Australia currently:

- The current situation in Victoria – established community transmission;
- The jurisdictions who have effectively eliminated the virus months ago, including Western Australia, South Australia, Northern Territory and Tasmania; and
- The remaining jurisdictions (New South Wales, Queensland and Australian Capital Territory) who are in an incursion phase, or, in the case of the ACT, at higher risk due to the open border with NSW.

It was noted this process was about simplicity, transparency and trust. Initial success was built on these. Members also discussed the importance of a decision around whether the incubation period should be brought down from two periods to one. This information could be included in this paper.

Professor Kelly noted the importance of a decision being made about what is the optimum way forward for the nation overall, as opposed to a jurisdictional view.

Summary:
Members supported the use of a colour coded risk matrix which included:

- No community transmission and no cases;
- No community transmission and sporadic cases; and
- Community transmission.

It was noted there are three different concepts which the AHPPC position can not assimilate:

- When to take borders down;
- What states should do when there is an increase in community transmission; and
- The Commonwealth's position on when resources will be made available to support jurisdictions.

Members supported the concept of three epidemics being put forward and consideration of how that would influence decision making.

While Members agreed the term Hotspot currently means different things to different jurisdictions and therefore is used differently, Members were unable to achieve consensus on an agreed definition of Hotspot.

Professor Kelly will discuss the definition of a Hotspot concept with the Prime Minister's Office.

ACTION:

s22

[redacted]

s22

[redacted]

s22

Australian Government
Department of Health

Australian Health Protection Principal Committee

PROCESS FOR LISTING AREAS OF COVID-19 LOCAL TRANSMISSION RISK AS HOTSPOTS

AHPPC Meeting 28 August 2020 Speaker: Dr s47F

Recommendations:

That AHPPC Members:

i. **Note** that National Cabinet has requested that AHPPC develop a nationally agreed criteria and process for listing 'hotspots' for the purpose of imposing movement restrictions or other necessary public health actions.

ii. **Endorse** the proposed criteria and process for listing areas of COVID-19 local transmission risk' as 'Hotspots'.

iii. **Endorse** the request to National Cabinet to seek the agreement of state and territory First Ministers to make their risk assessment processes and outcomes transparent

References:

A. COVID-19 CDNA national guidelines for public health units
B. CDNA endorsed paper, *GAR definition, underlying principles, and process of listing and de-listing*, 02 July 2020

Background

National Cabinet has requested that AHPPC develop a nationally agreed definition and process for listing areas as 'hotspots'. The national strategy is one of suppression with a goal of no community transmission. Geographically localised areas with community transmission of COVID-19, and areas with a high probability of disease emergence present a risk to achieving this goal, and hence to the success of the national strategy. As such, states and territories have interest in minimising the spread of COVID-19 where locally acquired cases occur, and in minimising the risk of importation into other areas. States and Territories will take the necessary public health actions, which range from conducting enhanced testing to imposing border controls, to limit community transmission and control the spread of COVID-19 across Australia.

Analysis

CDNA uses the term Geographic Areas of Risk (GAR) to refer to those areas with an elevated risk of community transmission, for the purpose of the epidemiological criteria for the COVID-19 suspect case definition (Reference A). The agreed definition for GAR is outlined in Reference B as:

Local government areas (LGA) with ≥5 locally-acquired cases, who do not have links to a confirmed case at the time of contact tracing, which all occur in a 14 day window.

Hotspots, however, are listed to guide decisions on a range of public health responses, which may include:

- Adjusting the testing strategy;
- Implementing public health measures such as physical distancing requirements, restrictions on gathering sizes, local movement restrictions, and the use of masks;
- Directing resources such as workforce and funding;
- Protecting vulnerable populations and settings through actions such as visitor restrictions, one worker-one site and mandatory PPE use; and
- Implementing domestic border controls and/or quarantine requirements.

There is a portfolio of public health responses that can be brought to bear when the COVID-19 situation changes. Evolution of the epidemiological situation necessitates a local risk assessment and adaptive changes in the response measures. The level of response to a given risk assessment will differ across and within individual states and territories, based on the context.

Assessment of risk at the local level is important, taking into consideration the epidemiological situation, local response capacity and lessons learned regarding the impact of previous measures. There are a number of factors that states and territories will take into consideration when considering listing a hotspot:

- **Affected state and territory.** The state or territory experiencing the COVID-19 cases will be interested in limiting transmission. This will include a focus on testing, tracing and isolation and quarantine; and re-implementing some public health measures to prevent or decrease rates of transmission in the community. The response (potentially including movement restrictions) might be applied in an area much broader than where a case is found, in order to create a safe ring of containment. To guide the level of response required, the affected state or territory will assess the:
    - geography of the area of concern;
    - epidemiological characteristics of the cases including number of cases, rate of increase of cases, source of acquisition, spread of cases;
    - interconnectedness of the people within the area of concern with other areas
    - mechanism and context of disease transmission
    - exposure days – the number of days a case has been in the community whilst infectious
    - Demography of the area of concern, including the proportion of vulnerable people and communities within; the proportion of culturally and linguistically diverse (CaLD) people; and the effective reach, understanding and compliance with public health directions

- **External state or territory.** States or territories external to the COVID-19 cases will be interested in minimising importation risk from the affected state or territory. The response will be dependent on the risk tolerance of the state or territory and will

involve a range of measures, including quarantine requirements and border controls. The response will be shaped by a number of factors including:

- The state-wide transmission potential in their own state or territory (how easily the virus could spread if imported). This is dependent on the baseline measures already in place including:
  - hygiene measures,
  - physical distancing adherence,
  - restrictions on gathering sizes, and
  - movement advice (such as work from home if you can) and restrictions.
- The state-wide transmission potential in the affected state or territory (how likely it is that transmission will be limited/brought under control), and their assessment of how well controls have been implemented since COVID-19 emergence/increase. This includes the baseline measures already in place in the state or territory (as above).
- The response implemented by the affected state or territory, including the:
  - speed of the response
  - level of the response
  - enforcement of response measures
  - testing strategy (and context), rates of testing and percentage test positivity

Given the transmission dynamics of SARS-CoV-2, there must be a low threshold for listing a hotspot to enable a rapid and proportionate response. This might mean that states and territories will not wait until there are multiple unlinked cases observed, rather they may act to list a hotspot where there is any individual case that indicates the extent of community transmission is not wholly understood.

It is important that the definition of a hotspot is flexible and appropriately sensitive. The listing of an area as a hotspot impacts not only the necessary response within and by the states and territories, but also the commonwealth response including:

- the legal implications
- decisions on the supply of PPE from the National Medical Stockpile
- the aged care response (as it relates to the commonwealth responsibilities)
- the direction of funding, for example aged care response centres, aged care workforce (including the one worker-one site initiative), mental health packages, PPE etc.

International approaches

Attachment A provides a range of examples taken internationally to define hotspots. These generally rest on two things:

i. a level of growth in growth in cases
ii. various other public health relevant factors such as testing capacity, adherence to public health measures, hospitalisations and ICU utilisation and so-on

Germany's approach to considering 'risk areas' (countries or regions) is broken into two steps. The first step is a prescribed population-based infection rate, which can be seen as a threshold trigger for undertaking the second step. The second step is a qualitative assessment of contextual public health information.

The German second step appears to have significant similarities to that which has been considered by CDNA and present here (above). It has due regard to the epidemiological and operational context of the area where transmission is occurring, and thus is not prescriptive in a way that might cause response actions (whether heavy or light) that have undesirable effects on outbreak management and socio-economic outcomes.

AHPPC may wish to consider the utility of a metric (such as rate of new infections in a given period and geography) as a trigger for initiating a hotspot risk assessment.

Proposed principles for determining a 'hotspot'

Hotspots have been variously described as areas of elevated incidence or prevalence, higher transmission efficiency or risk, or higher probability of disease emergence. For the purpose of listing areas as hotspots in the Australian COVID-19 context, CDNA considers it appropriate to refer to:

- areas where community transmission of COVID-19 is occurring
- areas that the relevant public health authority has assessed as having a higher probability of disease emergence

These elements inform the risk of geographic spread of COVID-19

Building on these elements, CDNA assisted with developing the following proposed definition for a COVID-19 hotspot is:

- Local Government Areas (LGA) or unincorporated areas, with instances of locally acquired [1] cases of COVID-19 (with or without a known epidemiological link) and surrounding areas where there is a higher probability of disease emergence.

[1] Excludes secondary cases to cases in isolation, where it is clear that the transmission event occurred in the closed environment (e.g. a household, residential care setting, workplace setting etc.) and where those cases were effectively quarantined such that they did not present a risk of exposure to the community.

The following principles lie beneath this definition:

- The purpose of listing an area as a hotspot is to guide appropriate public health responses.
- An appropriate temporal element around case incidence should be considered, for example over 7 days, or when comparing the most recent 7 days to the previous 7 days
- Recognising the interconnectedness within and between Australian communities, states and territories may choose to broaden the geographic element and combine adjacent LGA to determine an area as a COVID-19 hotspot.

- Recognising the varied geographic distribution of Australian communities, states and territories may choose to define hotspots based on postcodes or single communities as appropriate to the geographic context.
- States and territories may choose to include cases with known epidemiological links in determining a hotspot, where cases indicate that a link in a chain of transmission was missed, representing days of exposure to the community.

Noting the German approach:

1. Quantitative assessment: Where an area has more than **50 new infections per 100,000 inhabitants** in the last 7 days.
2. Qualitative assessment: Based on an assessment of the response. Key factors include
   - the number of infections
   - the type of outbreak (local or widespread)
   - testing capacities and the number of tests carried out per capita
   - measures taken to contain spread (hygiene, contact tracing, etc.)
   - whether reliable information is readily available.

AHPPC could consider taking a similar two-part approach including:

1. Trigger assessment
   a. Local Government Areas (LGA) or unincorporated areas, with instances of locally acquired [1] cases of COVID-19 (with or without a known epidemiological link) and surrounding areas where there is a higher probability of disease emergence.

   OR

   b. Where an LGA or unincorporated area has more than 20 new infections per 100,000 inhabitants in the last 7 days.
   (Note: this draws from the agreed threshold for reporting R_{eff} in the COP)

   AND

2. Qualitative criteria used to determine whether or not the area that might nominally fall below this threshold could nonetheless present an increased risk. Key factors include:
   - the number of infections
   - the type of outbreak (local or widespread)
   - testing capacities and the number of tests carried out per capita
   - measures taken to contain spread (hygiene, contact tracing, etc.)
   - whether reliable information is readily available.

In order to facilitate the purpose of this definition, AHPPC (through the CMO) must request that National Cabinet seeks the agreement of state and territory First Ministers to make their risk assessment processes and outcomes transparent. This will assist in developing a basis of confidence and trust to enable shared decision-making.

Proposed process for listing an area as a 'hotspot'

The process for listing an area as a hotspot is time sensitive. As such, a state or territory may raise the need to discuss a an area of concern at the earliest available AHPPC meeting, or request an urgent AHPPC meeting is convened at the discretion of the AHPPC Chair.

The process for listing an area as a hotspot is as follows:

1. The affected state or territory will determine the geographic area in which instances of locally acquired cases have occurred, and will make an assessment of the probability of disease emergence in interconnected or adjacent areas.
2. The AHPPC will act as the health decision-making forum to discuss listing a defined geographic area as a hotspot.
3. Key stakeholders (the affected state, surrounding states and territories, and the Commonwealth) agree to add the area to a list of hotspots to guide decisions on resource allocation and public health or disease-control measures.
4. All states and territories agree to be transparent about the public health actions that will follow as a result of listing an area as a hotspot. Ideally they will provide a list of expected actions. Such actions include:
    - Those undertaken by the affected state or territory
        - within the area defined as a hotspot (e.g. increased testing, limitations on gathering sizes, local movement restrictions, protective measures for vulnerable populations, the use of masks etc.).
        - in areas outside the area defined as a hotspot (e.g. increased testing, limitations on gathering sizes, protective measures for vulnerable populations etc.).
    - Those undertaken by external states and territories following the listing of an area as a hotspot (e.g. border controls, quarantine requirements).

Proposed process for de-listing an area as a 'hotspot'

The process for **de-listing** an area as a hotspot is not as time sensitive, the agreed list of hotspots may be reviewed on an appropriate periodic basis.

The process for de-listing an area as a hotspot is as follows:

1. AHPPC will review the list of COVID-19 hotspots on a periodic basis appropriate to the rate of change in the COVID-19 situation. For example, where the situation is considered to be changing rapidly the review interval may be weekly, but where the situation is relatively stable the review interval may be monthly.
2. The affected state or territory will determine the geographic area (s) in which COVID-19 transmission is controlled.
3. States and territories agree to de-list the selected area as a hotspot, based on the epidemiological analysis.
4. All states and territories agree to be transparent about how the public health actions will change as a result of de-listing an area, and the timing of those changes.

Attachments:

A. International hotspot definitions

COUNTRY	'HOTSPOT DEFINITION' AND CONTEXT
ECDC (Europe)	ECDC has recently published a rapid risk assessment to assist in identifying countries that are at risk of further escalation of COVID-19:[i] • Very high: o Recent increase in cases AND o An increase in hospitalisations OR an increase in test positivity rate (if lab capacity is sufficient and intensity of testing stable) AND o Do not implement or reinforce public health measures including physical distancing, contact tracing and testing capacity • High: o Recent increase in cases AND o An increase in hospitalisations OR an increase in test positivity rate (if lab capacity is sufficient and intensity of testing stable) • Moderate to High: o Recent increase in cases only o Countries with multiple measures should conduct local assessments to better understand local drivers of increased cases Council of EU has determined the following quantitative and qualitative criteria for lifting restrictions from third countries. Third countries should meet the following epidemiological criteria: • **Close to or below the EU average**, as it stands on 15 June 2020, of new COVID-19 cases over the last 14 days and per 100,000 inhabitants; • The trend of new cases over the same period in comparison to the previous 14 days is **stable or decreasing;** and • The overall response to COVID-19 taking into account available information on aspects such as testing, surveillance, contact tracing, information and data sources and, if needed, the total average score across all dimensions for International Health Regulations (IHR).]
Denmark	At a local level, Denmark defines 'hotspots' as areas that are at risk of large gatherings, in order to reduce the risk of spread of COVID: • Areas in which police need to intensify surveillance of parks and recreational areas in which large groups of people have recently gathered • Loitering can be banned in hotspots if needed

	Denmark Government assesses the reproductive number in geographic areas and population groups. • To break chains of infection among population groups with high statistical prevalence, swift and targeted interventions are implemented, such as: Targeted information campaigns, preventive measures and risk-based spot checks in accordance with the principle of proportionality to monitor whether the recommendation of self-isolation is observed. • If the recommendation on self-isolation is not observed, steps can be taken to isolate the persons infected by issuing directions under the applicable legislation. **One of the criteria for launching local initiatives is an incidence exceeding 20 per 100,000 inhabitants within the past seven days**. In this connection, local conditions must be taken into account. • To clamp down on local disease outbreaks, necessary local measures must be launched, including the use of face masks, home working, and the lock-down of social activities. Travel outside the EU and Schengen countries plus the UK is not advised. For the EU/Schengen countries and the UK: Travellers in regions where the infection rate is above **50 new infections per 100,000 inhabitants** per week are advised to get tested upon their return to Denmark. • Open countries (yellow) have fewer than **20 infected persons per 100,000 inhabitants per week**.[ii] • Once open, the threshold for changing status of a country to 'quarantine country' is **30 infected persons per 100,000 inhabitants per week** (SSI has a safety valve to override if numbers are quickly escalating, or information is not reliable). Denmark advises against all non-essential travel for these countries, due to their high numbers of new infections or local entry restrictions and significant quarantine requirements (orange)
Germany	Classification as a 'risk area' is the result of a joint analysis and decision-making process by the Federal Ministry of Health, the Federal Foreign Office and the Federal Ministry of the Interior, Building and Community. This is based on a two-step assessment:[iii] 1. Countries/regions where there are more than **50 new infections per 100,000 inhabitants** in the last seven days. 2. Qualitative criteria used to determine whether or not countries/regions that might nominally fall below this threshold could nonetheless present an increased risk of infection. • **Qualitative assessment** is based on reports from local German diplomatic representatives and takes into account measures taken to halt the spread of COVID. • Key factors include: o the number of infections o the type of outbreak (local or widespread) o testing capacities and the number of tests carried out per capita

	o measures taken to contain spread (hygiene, contact tracing, etc.) o whether reliable information is readily available from countries/regions
France	France has divided the map into 'red' and 'green' regions, with red zones remaining closed. The criteria to determine a regions red/green status are: 1. The number of COVID-19 cases, specifically, the percentage of people who present at hospital for COVID: • <6% = green • 6 – 10% = orange • >10% = red 2. The availability of ICU beds, specifically, the proportion of available ICU beds given over to COVID patients: • <60% = green • 60 – 80% = orange • >80% = red 3. The availability of testing, specifically, the coverage of estimated testing needed: • 100% = green • 70 – 100% = orange • <70% = red
Singapore	Singapore does not publish the exact risk assessment process used to identify high risk areas however it outlines the following:[iv] • The Multi-Ministry Taskforce assesses the public health risk for different countries/regions. • A risk managed approach is used to calibrate border measures based on the assessed risk of importation and onward transmission in the community. • If the situation in a country/region deteriorates, more stringent measures are put in place. Of note, recent travel advisories demonstrate that the risk assessment is context dependent and is not based on case numbers alone. For example the following factors appear to form part of the risk assessment: • Reports of **clusters** in a country/region • **Reimplementation of measures** or implementation of new measures in a country/region • Reports of **unlinked cases in the community** in a country/region
Switzerland	Switzerland defines a country or area with an increased risk of infection if at least one of the following requirements are satisfied:[v] • The number of new infections in the country or area in the past **14 days is more than 60 per 100,000 persons**

	• The available information from the country or area does not allow a reliable assessment to be made of the risk situation, and there are indications that there is an increased risk of transmission in the country or area concerned • In the past four weeks, there have been **repeated instances of infected persons** who have stayed in the country or area concerned entering Switzerland
Netherlands	Small local outbreaks (clusters) are classed as **at least three related infections.** Modelling of the reproduction number is undertaken to determine the intensity of the measures needed to prevent its further spread. Travel bans are based on the council of EU criteria:[vi] • Number of new infections is lower than the EU average of 15 June per 100,000 inhabitants in the past 14 days • Overall response to COVID-19 in the country (including tests carried out, source and contact tracing and control measures) A traffic light system is used similar to Denmark (see above): • Yellow – can travel, but be aware that risks still remain • Orange or red – travel is not advised
New Zealand	Due to the elimination strategy in New Zealand, any cases are considered of high concern: o 'Significant clusters' are classed as **ten or more cases connected through transmission** (confirmed and probable cases).[vii] Significant clusters in defined regions such as Auckland have resulted in lockdowns. o 'Locations of interest' are for people who may be 'casual contacts' of confirmed cases. Locations of Interest are removed after 14 days.

[i] https://www.ecdc.europa.eu/en/current-risk-assessment-novel-coronavirus-situation
[ii] https://fra.europa.eu/sites/default/files/fra_uploads/dk_report_on_coronavirus_pandemic_july_2020.pdf
[iii] https://www.rki.de/DE/Content/InfAZ/N/Neuartiges_Coronavirus/Transport/Archiv_Risikogebiete/Risikogebiete_07082020_19_45_en.pdf?__blob=publicationFile
[iv] https://www.moh.gov.sg/covid-19
[v] https://www.admin.ch/opc/en/classified-compilation/20201948/index.html#a3
[vi] https://www.government.nl/latest/news/2020/08/05/the-travel-ban-for-the-netherlands-as-of-5-august-2020
[vii] https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-current-situation/covid-19-current-cases/covid-19-significant-clusters