SCHEDULE OF DOCUMENTS – FOI 1936 **ATTACHMENT A**

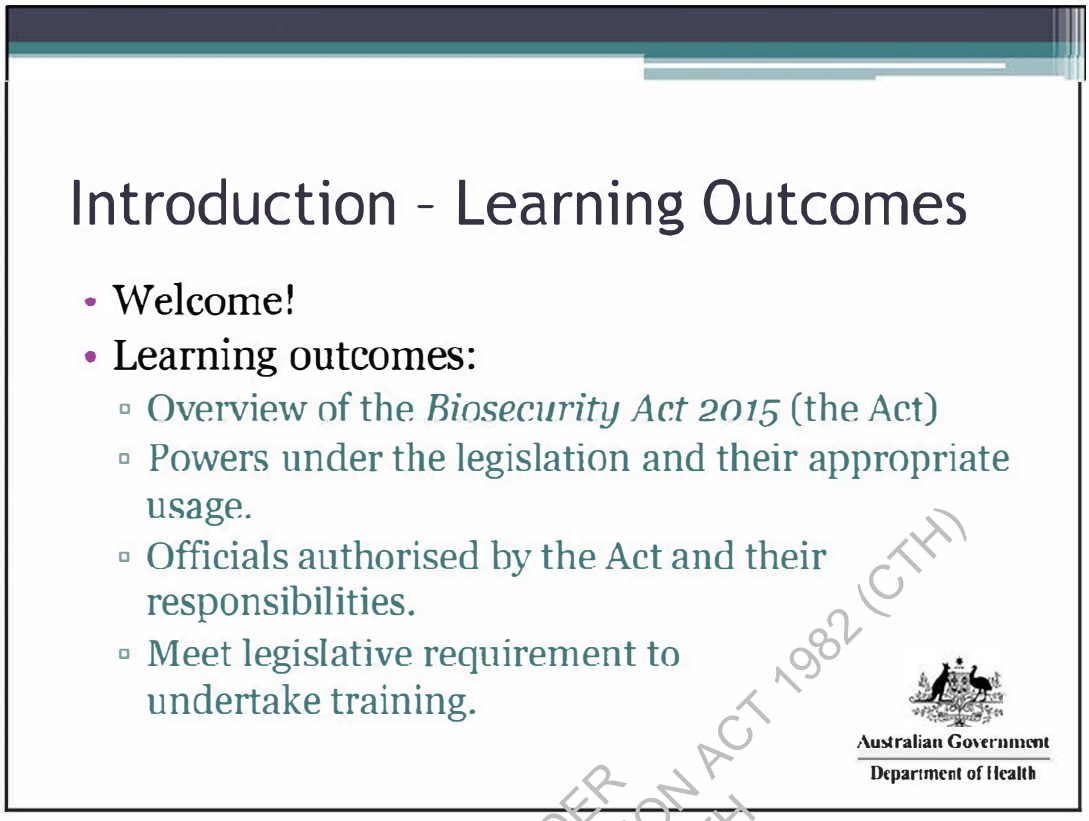
Document No.	Date	Number of pages	Description	Decision on access[1]	Exemption
1	04.2016	117	PowerPoint – Biosecurity training	RI	s 22

[1] RI = Release with irrelevant information removed.

Biosecurity Act 2015

Managing Biosecurity Risk: Human Health

Australian Government
Department of Health



Welcome to todays training on the human health provisions of the *Biosecurity Act 2015* and related provisions.

Today's outcomes are to provide you with:

- An overview of the *Biosecurity Act 2015*
- Health related power under the legislation and their appropriate usage from 16 June 2016
- The officer who are authorised by the Act and their corresponding responsibilities; and
- To meet the legislative requirements to undertake training for those authorised under the Act.

Please do not hesitate to ask questions during the training, but note there is allocated time towards the end specifically for questions.

We hope that you enjoy todays training!

Introduction - the Act

- *Quarantine Act 1908* over 100 years old, has been amended approximately 50 times!
  - Written before international trade and travel was so commonplace, and before planes.
  - Cumbersome and inflexible.
  - No human rights considerations.
- 'Beale Review' of biosecurity in 2008 set the stage for new legislation framework.
- Biosecurity is the new black.

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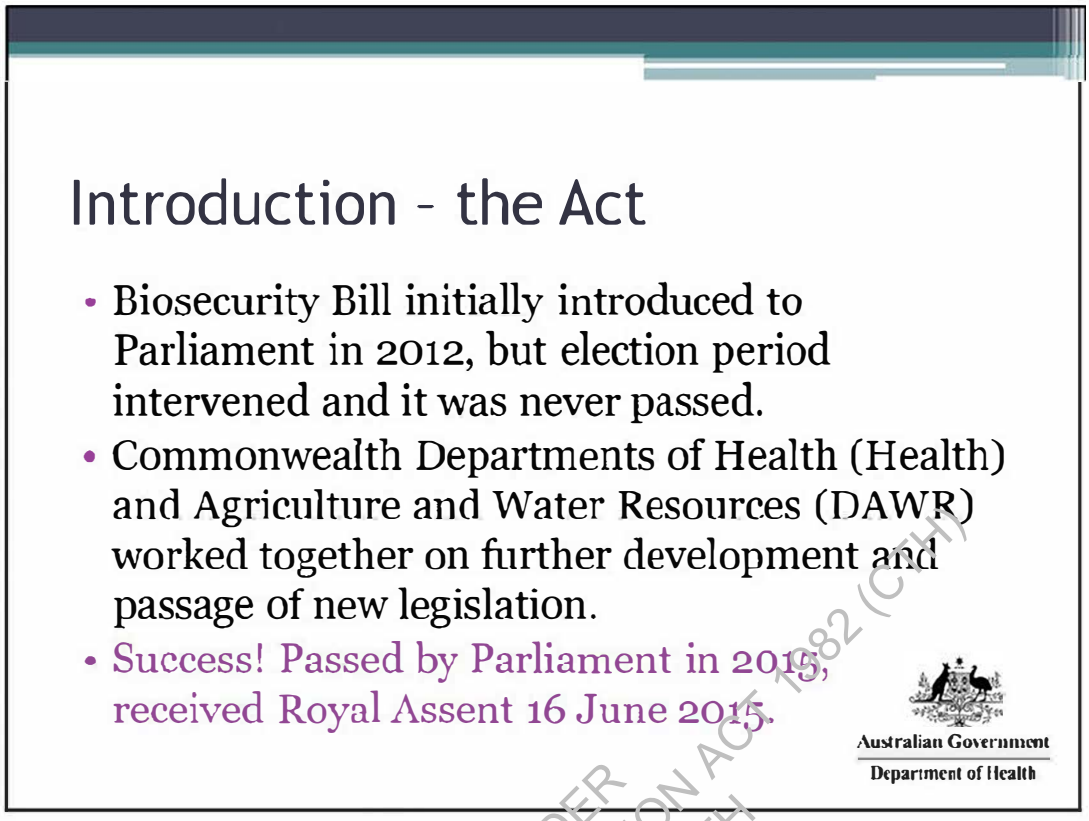
Australia has a world class biosecurity system. This system helps is preserve Australia's unique pest and disease status and protect our environment, the well being of our domestic animals, plant and our human health.

The legislation that currently enables us to do this, the Quarantine Act, has been amended no less than 50 times over the last 106 years. While the legislation has served us well in the past, it has become cumbersome to administer, difficult to interpret and incompatible with our needs as business and our risks change.

It was written when people and goods arrived by sea and today's air and sea craft weer unimaginable. It was a time of threat and diseases such as the bubonic plague, small pox, cholera and measles were at the forefront of policy makers' minds and those of the community.

In 2008, an independent review of Australia's quarantine and biosecurity arrangements was undertaken, known at the Beale Review. The Beale Review noted the importance of ensuring the Australian had appropriate tools and measures to manage biosecurity threats across the continuum – offshore and prior to arrival, at the border, and post border.

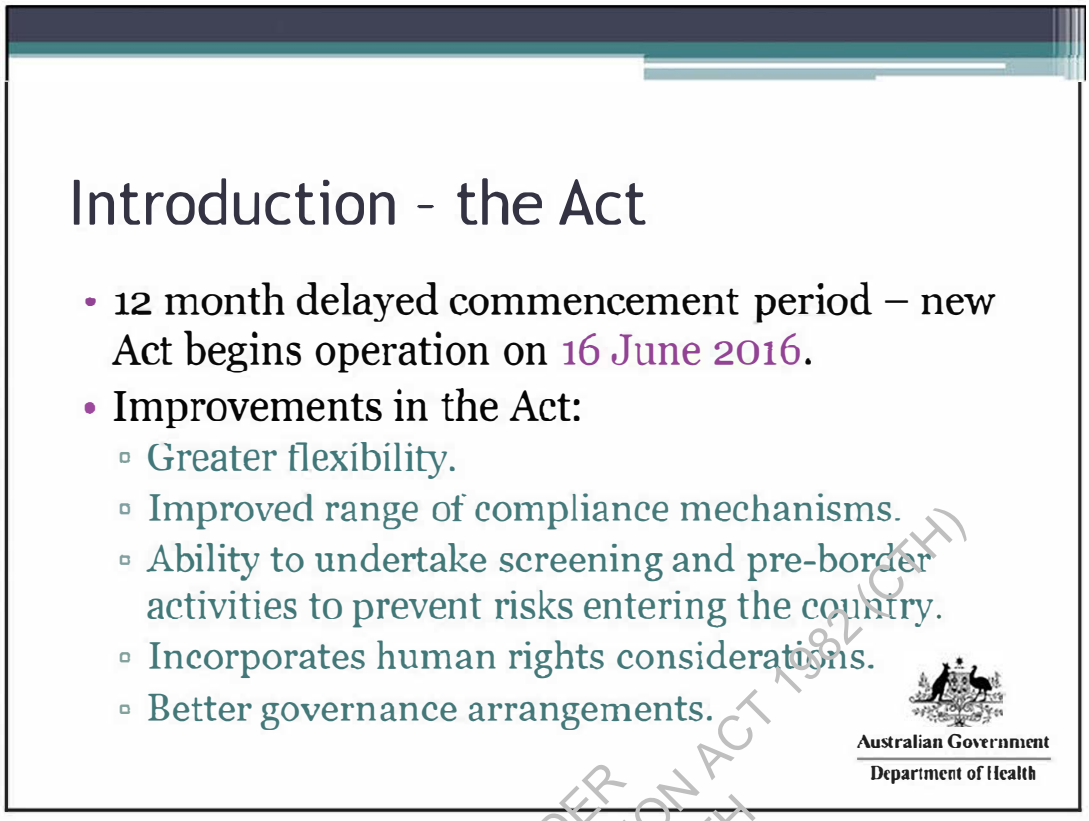
And so it was, that the our new Biosecurity Act 2015 was developed and passed by Parliament which was a culmination of many years work, designed to support the biosecurity system in any age.



The Biosecurity legislation was initially introduced to Parliament on 29 November 2012, however, the legislation lapsed when Parliament was prorogued in late 2013 due to the Federal Election.

Following the Federal Election, both Commonwealth Department's of Health and Agriculture and Water Resources worke together on further development and passage of new legislation.

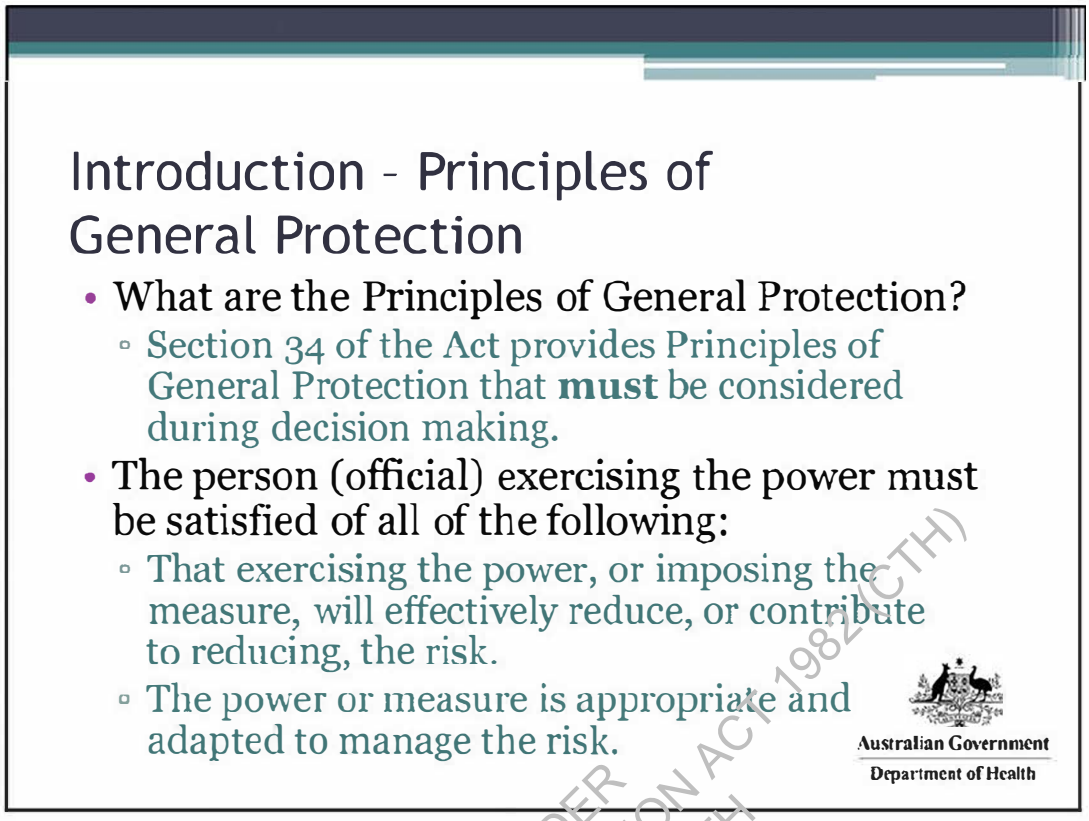
Following the reintroduction of the legislation into Parliament on 27 November 2014, the Biosecurity Act passed both houses of parliament, receiving Royal Assent on 16 June 2015.



The biosecurity legislation will commence 12 months after this date on 16 June 2016.

The Act provides for many similar powers and functions as the Quarantine Act, but includes a greater focus on flexibility and risk management, recognition of individual human rights, and appropriate delegation of responsibility.

There are a number of significant departures from the Quarantine Act, including the management of individuals suspected to have or to gave been exposed to listed human diseases, powers of officials, and vector monitoring and management at first points of entry, all of which will be discussed in further detailed throughout the course of today's training.



One significant addition to the Biosecurity Act not just mentioned includes the Principles of General Protection.

Section 34 of that Act provides Principles of General Protection that must be considered during decision making exercised only in relation to human diseases that cause significant harm to human health, by authorised officials.

More specifically, the Principles which the official exercising power must be satisfied of include all of the following:

- That exercising the power, or imposing the measure, will effectively reduce, or contribute to reducing, the risk.
- The power or measure is appropriate and an adapted to manage the risk.

Introduction – Principles of General Protection

- Principles continued:
  - The circumstances are sufficiently serious to justify use of the power.
  - The power, and the manner in which it is exercised, is no more restrictive or intrusive than is required to manage the risk.
  - The period in which the power is to operate is only as long as necessary.
- Exercising a power must not interfere with urgent or life-threatening medical needs.

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- The circumstances are sufficiently serious to justify use of the power.
- The power, and the manner in which it is exercised, is no more restrictive or intrusive than is required to manage the risk.
- The period in which the power is to operate is only long as necessary.

In summary, powers provided for managing human health biosecurity risks are only used when the circumstances are sufficiently serious to justify them, and only if the biosecurity measure is likely to be effective, is proportionate to the risk, is the least restrictive or intrusive and only for as long as necessary to manage the disease risk.

In addition, the Principles ensure that are exercise of powers do not conflict with an individual's urgent or life threatening medical needs....

Introduction – Principles of General Protection

- Child or incapable person who is subject to a requirement may be accompanied.
- A child or incapable person who is not accompanied must not be subject to requirements until an officer has taken all reasonable steps to contact a parent, guardian or next of kin.

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...and sets out additional steps that must be carried out before subjecting a child or incapable person subject to a requirement.

Specifically, this particular clause referring to protections of children and incapable persons is to ensure compliance with existing Commonwealth guidelines and international obligations.

Topic One:

Chief / Human Biosecurity Officers

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1.1 Chief/Human Biosecurity Officer - Definitions

- New Act has the same positions for officials but different names:
  - Director of Human Quarantine =
    - Director of Human Biosecurity
  - Chief Human Quarantine Officer =
    - Chief Human Biosecurity Officer
  - Human Quarantine Officer =
    - Human Biosecurity Officer
  - Quarantine Officer =
    - Biosecurity Officer
- And new position – Biosecurity Enforcement Officer.

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The arrangements for governance under the Biosecurity Act are similar to the Quarantine Act, however some difference include:

- Naming conventions
  - DHQ – DHB
  - CHQO – CHBO
  - HQO – HBO
  - QO – BO
- Chief Human Biosecurity Officers may now be appointed by the Director of Human Biosecurity, rather than by Ministerial appointment
- Director of Human Biosecurity must determine requirements (training and qualifications) for Chief Biosecurity Officers and Human Biosecurity Officers.
- And the new position of Biosecurity Enforcement Officers

1.1 Director of Human Biosecurity

- Individual who occupies position of Chief Medical Officer.
- Legislative powers – determines Listed Human Diseases, disinsection requirements, ship sanitation ports, requirements for negative pratique, training requirements etc.
- Power to review measures under a Human Biosecurity Control Order.
- Authorises human health officials.

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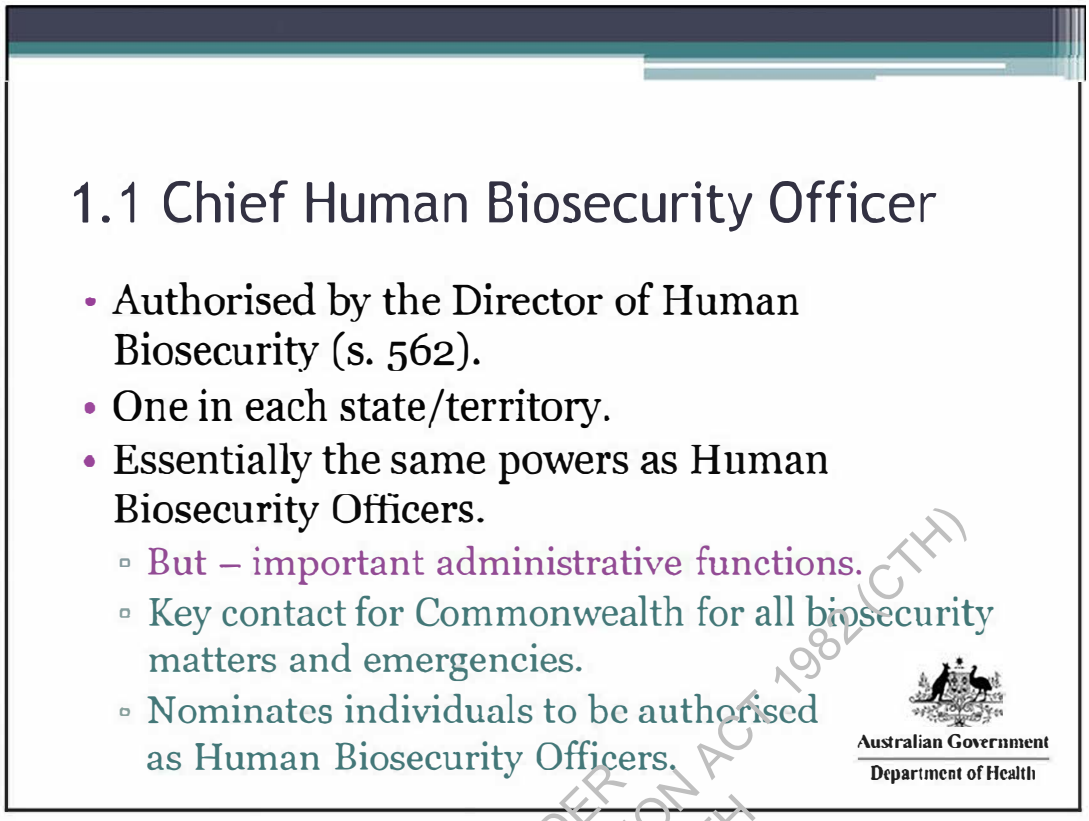
The Director of Human Biosecurity is the Commonwealth Medical Officer.

If the Director of Human Biosecurity considers that a human disease may be communicable and could cause significant harm to human health, they may determine that the disease is a listed human disease. Powers to control the spread of communicable disease apply only to listed human diseases.

The Director of Human Biosecurity will have the required medical training to make decisions to manage human diseases. This ensures that the functions and powers of the Director, which can be intrusive, are vested in an individual with appropriate competencies to make decisions under the Act and is bound by the appropriate professional standards when exercising functions or powers under the Act.

The Director of Human Biosecurity will have some joint responsibilities with the Director of Biosecurity where there are biosecurity and human health risks – for example, both have responsibilities in relation to first points of entry because the entry of an international vessel or aircraft into Australian territory could create risks for human health and/or matters of biosecurity concern.



The Director of Human Biosecurity may authorise a person to be a chief human biosecurity officer for a state or territory. A chief human biosecurity officer must be a medical practitioner employed by the state or territory body responsible for the administration of health services in the state and territory. This ensures that these officers have appropriate competencies to make decision regarding the management of ill individuals and are bound by appropriate professional standards when exercising functions under the Act.

Chief human biosecurity officers have powers to:

- Gather information – this includes powers to ask questions, require answers to questions or provide written information
- Impose, vary or revoke a human biosecurity control order on an individual.

Chief human biosecurity officers also provide advice on human health risks to biosecurity officers.

In performing functions or exercising power under the Act, chief human biosecurity officers must comply with any directions of the Director of Human Biosecurity.

1.1 Human Biosecurity Officers

- Authorised by the Director of Human Biosecurity (s. 563).
- Powers to identify and manage human biosecurity threats:
  - Negative pratique.
  - Imposing Human Biosecurity Control Orders.
  - Information gathering.
  - Directing management of ill travellers.
  - Provide advice to Biosecurity Officers as required.

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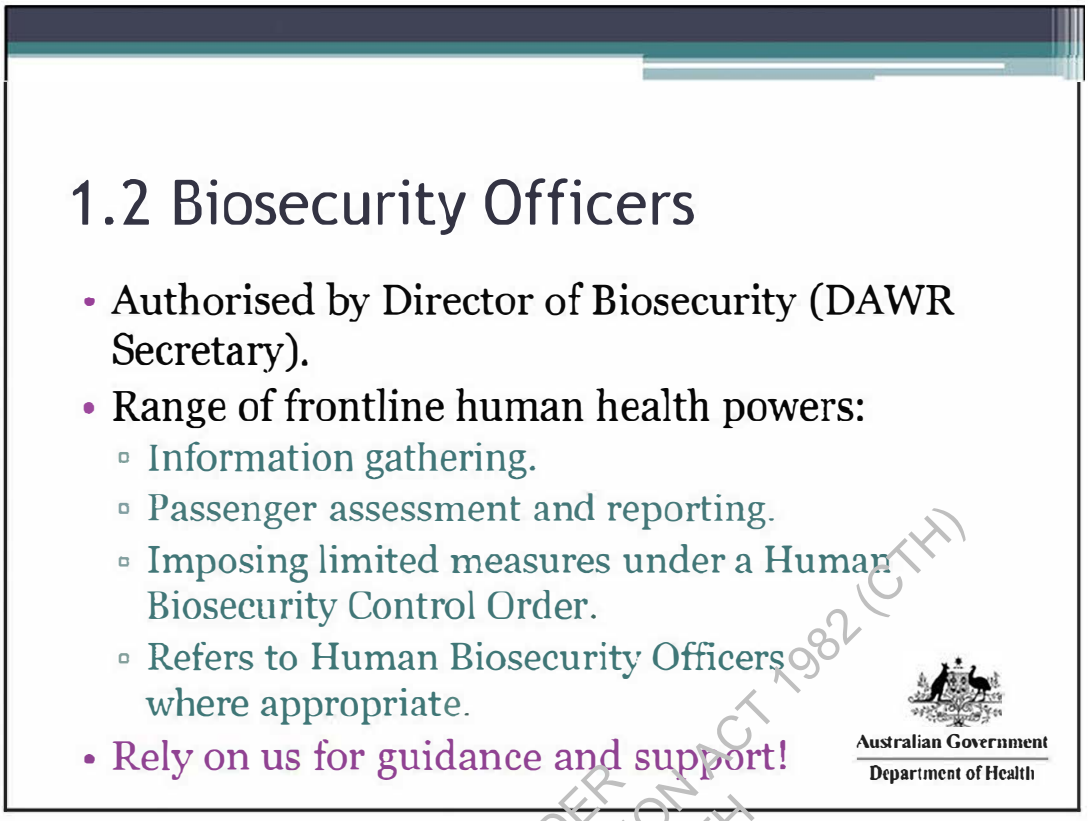
The Director of Human Biosecurity may authorise a person to be a human biosecurity officer for a state or territory. Human biosecurity officers exercise powers relating to the management of human health risks that require medical training (for example, examination, treatment and medication).

Human biosecurity officers have the powers to:

- Gather information – this includes powers to ask questions, require answers to questions or provide written information
- Impose, vary or revoke a human biosecurity control order on an individual.

Department of Health employees, state and territory health employees and members of the Australian Defence Force can be authorised as human biosecurity officers. Department of Agriculture and Water Resources staff cannot be authorised as human biosecurity officers.

The powers of human biosecurity officers are potentially personally invasive and restrictive. Human biosecurity officers must have appropriate competencies to make decision regarding the management of ill individuals and are bound by appropriate professional standards when exercising functions or powers under the Act.

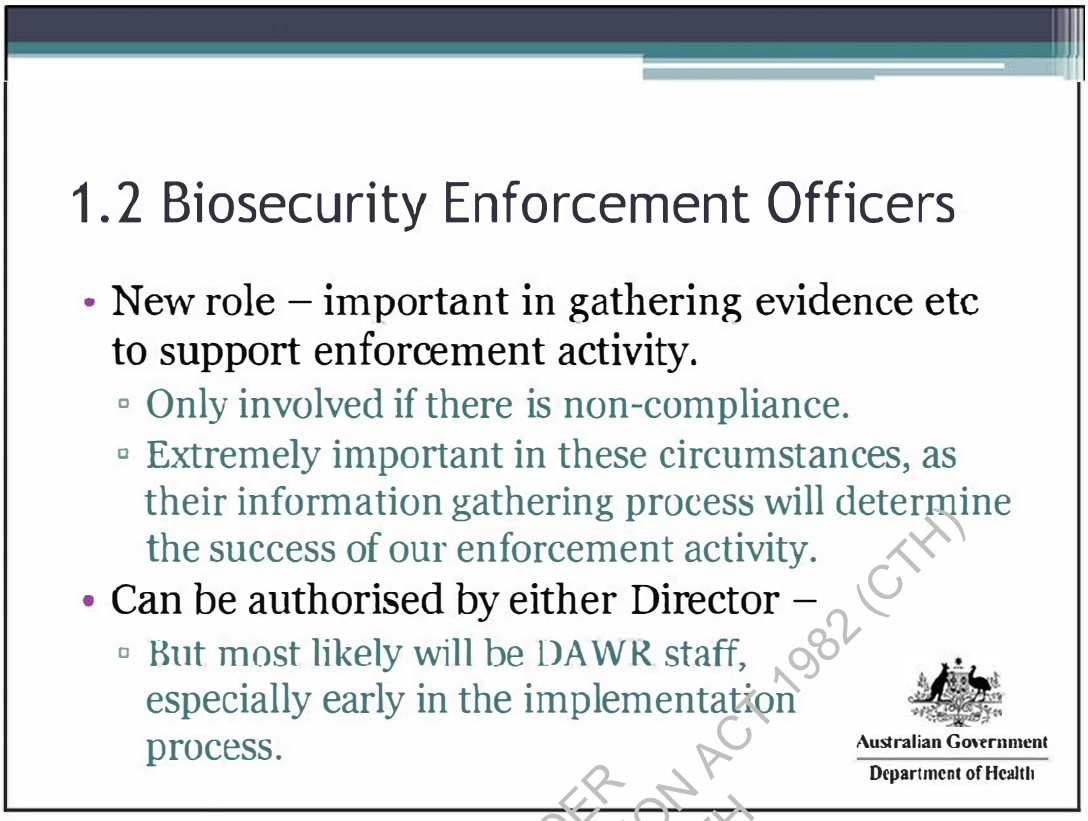


Biosecurity Officers may be authorised by the Director of Biosecurity (Department of Agriculture and Water Resources Secretary).

Biosecurity officers have powers to manage and asses biosecurity risks in a day to day operational environment.

Biosecurity officers will have powers at the border to manage and assess biosecurity risks relating to goods and conveyances, as well as new powers to manage and assess biosecurity risks onshore.

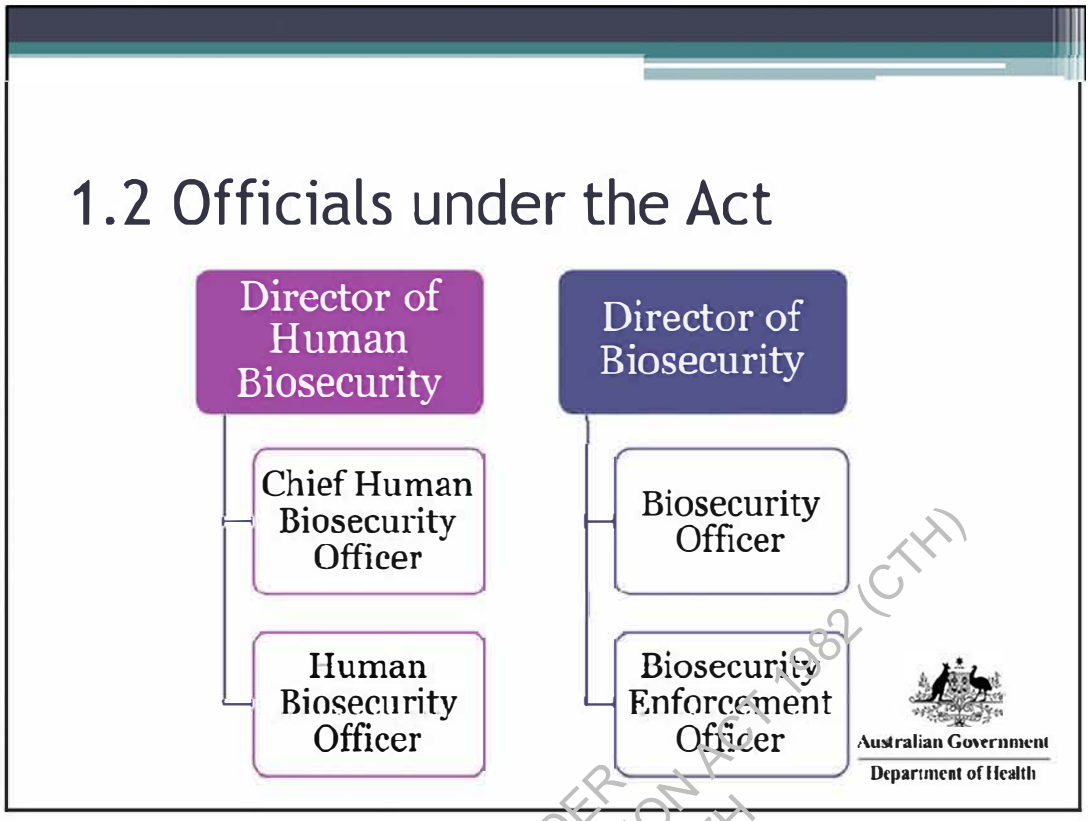
Biosecurity officers will also have limited powers to assist in the management of listed human diseases in conjunction with chief human biosecurity offices and human biosecurity officers (for example, the Australian Government's response to Ebola which may involve biosecurity officers asking questions and directing travellers to a medical facility).



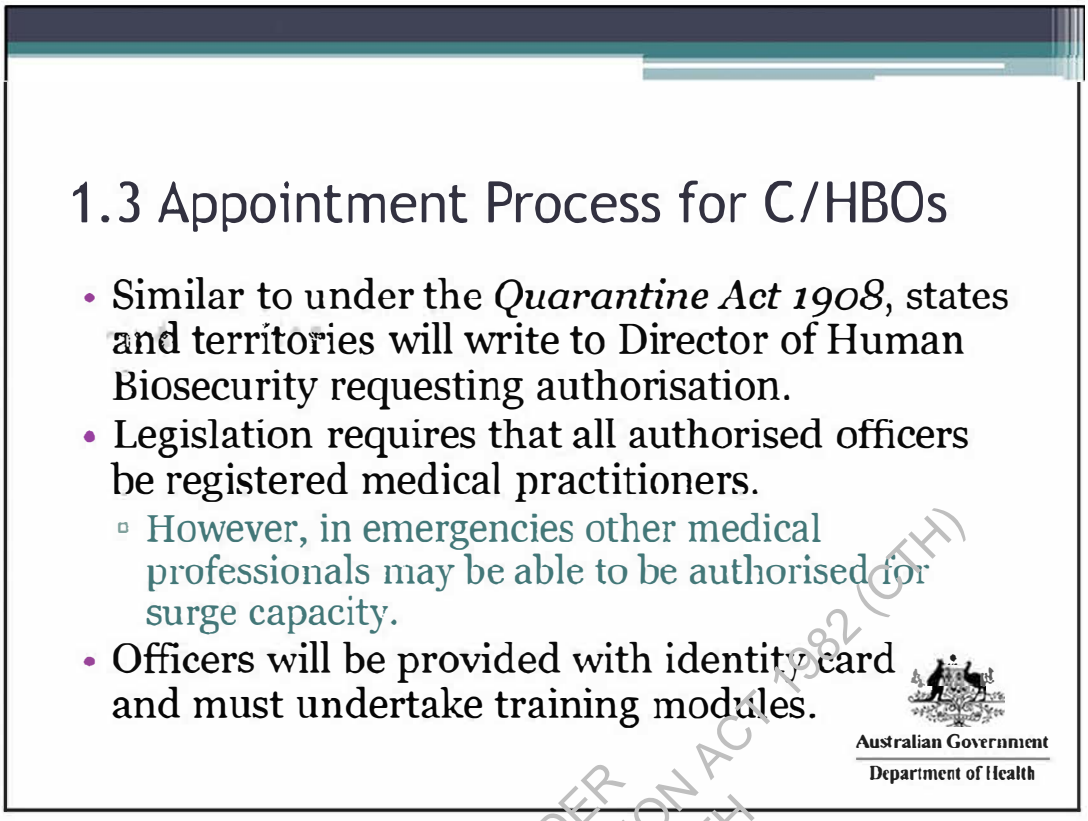
Biosecurity enforcement officers are a new category of biosecurity officer who will have powers to investigate and monitor compliance with the Act and to assist in the management of biosecurity risk by entering premises or executing warrants. These officers can also assist with enforcing preventative biosecurity measures to reduce the risk of entry or spread of listed human diseases.

The Biosecurity Act provides biosecurity enforcement officers with a flexible range of compliance tools, including civil penalties.

While BOEs will mostly be DAWR staff and be appointed by the Director of Biosecurity, the Director of Human Biosecurity may also appoint Biosecurity Enforcement Officers as short-term officials with the implementation of preventative biosecurity measures.



Here is a streamlined visual representation of the officials under the Act.



Similar to the current process, state and territories (usually being the Chief Human Biosecurity Officer for HBOs and CHOs for CHBOs) will write to the Director of Human Biosecurity (via the Border Health Team) requestion authorisation for state and territory officers or employees to be authorised as CHBOs and HBOs. This will be officially authorised in the form of an instrument of appointment – again, similar to the current process.

Unlike the current process though, from 16 June, it will be legislated specifically that all authorised officers must be registered medical practitioners.

However, the powers of the Director of Human Biosecurity allow for the appointment of Human Biosecurity Officer with appropriate expertise to perform specified functions, for a specified period of time, during a human biosecurity emergency i.e nurses, paramedics.

Those who will become authorised officers will be provided with identity cards and must undertake training modules – which will be available via Govdex prior to the commencement of the Act.

While we're on the subject of appointing CHBOs and HBOs, this will be required to be done prior to the commencement of the Act. Over the next weeks, the Border Health Team will be in contact with current state and territory CHQOs seeking their appointment nominations for these positions to ensure that appointments are made, IDs are provided and training is undertaken prior to 16 June.

1.3 Appointment Process for C/HBOs

- Please remember:
  - You must have your identity card with you to perform the duties and functions of your authorisation.
  - It is important to inform the Commonwealth team when you leave or change jobs, and to return you identity card...
    - Failure to return your identity card is an offence under the Act.
    - However, offences do not apply if the card is lost or stolen.

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With regards to the identify cards, authorised officer are required to carried their identity cards on their person at all times while performing the duties and functions of your authorisation under the Act.

There will be a minor change in the process for identification cards. The Commonwealth Department of Health will now be producing identity cards for human health officials, however this change in administrative process should have minimal impact for state and territory colleagues.

It is very important that the Border Health Team is notified immediately when leaving or changing jobs, and to ensure that your identify card is returned to the Commonwealth, as it is now a strict liability offence if you fail to return the identify cards. Of coarse, these offences do not apply if the card is lost or stolen, but we still need to be notified so as to replace your ID card.

Note: Offence is one penalty unit.

Topic Two:

Listed Human Diseases

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2.1 Listed Human Diseases

- Listed Human Diseases (LHDs) are determined by the Director of Human Biosecurity (s42 of Biosecurity Act).
- From 16 June, the LHDs will be:
  - Human influenza with pandemic potential
  - Severe acute respiratory syndrome
  - Middle East respiratory syndrome
  - Viral haemorrhagic fevers
  - Smallpox
  - Yellow fever
  - Plague.

(As agreed by AHPPC , CDNA, CHQOs and the Director of Biosecurity in November 2015 to be included in the Biosecurity (Listed Human Diseases) Determination 2016)

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- Section 42 of the Act provides that the Director of Human Biosecurity may determine human communicable diseases to be a listed human disease. In making the declaration, the Director must consider that the disease may be communicable and cause significant harm to human health.

- Many of the powers and functions that LHDs can trigger are personally invasive. To ensure that there are appropriate safeguards for individuals, the powers and functions in the Act flow only in response to preventing or managing the entry, establishment, emergence or spread of a listed human disease in Australia or to another country.

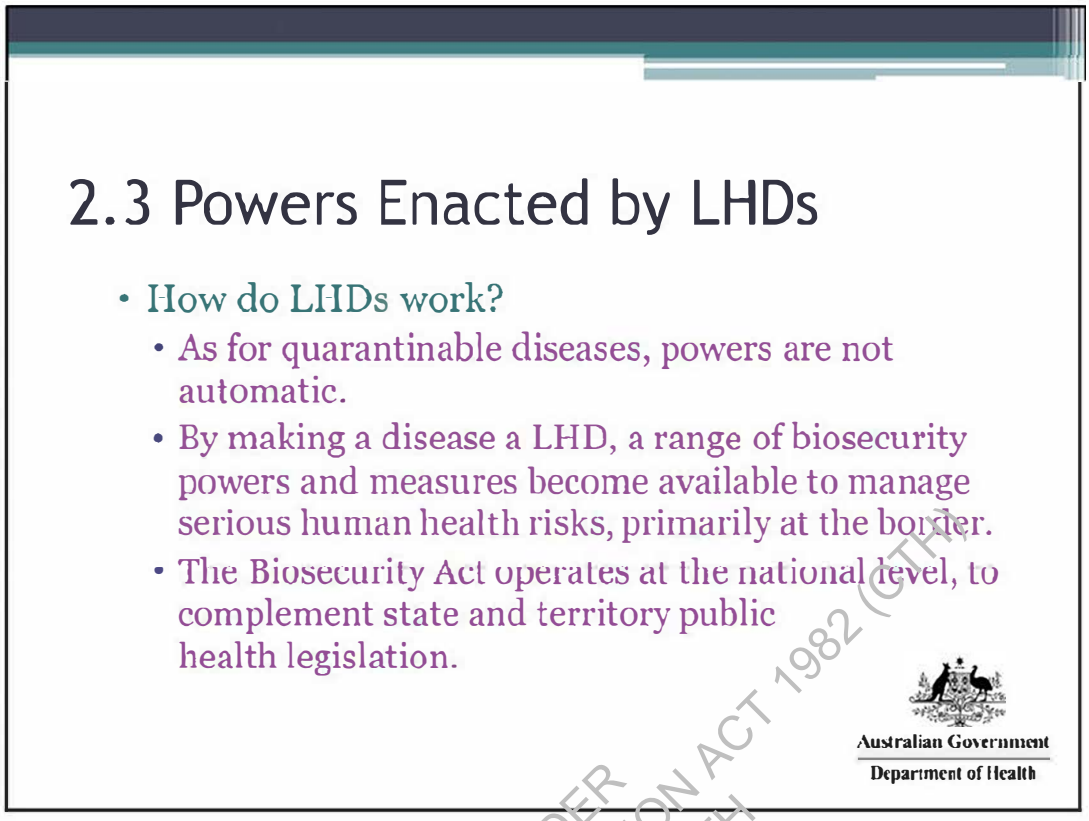
- This determination requires consultation with Chief Health Officers and the Director of Biosecurity.

2.2 Quarantinable Diseases

LHDs replace quarantinable diseases under section 21 of the *Quarantine Proclamation 1998*.

Quarantine Proclamation	LHDs
• Highly Pathogenic Avian Influenza in Humans (HPAIH) • Human swine influenza with pandemic potential • Middle East respiratory syndrome (MERS) • Severe Acute Respiratory Syndrome (SARS) • Viral haemorrhagic fevers of humans (VHF) • Smallpox • Yellow fever • Plague • *Cholera* • *Rabies*	• Human influenza with pandemic potential • MERS • SARS • VHF • Smallpox • Yellow fever • Plague

- The *Quarantine Act 1908* provides that the Governor-General may declare, by proclamation, a disease to be a quaratinable disease.
- A quarantinable disease is one that has been identified as being a serious communicable disease, the entry, emergence or spread of which into Australia can be prevented or delayed through the use of quarantine measures at Australia's international borders.
- Such measures include disease surveillance and reporting systems at Australian international borders and enforcing appropriate quarantine measures if suspected cases of disease are identified.
- The *Quarantine Act 1908* does not automatically implement these powers, but allows their use should the situation require it.
- Current quarantinable diseases include Cholera, Highly Pathogenic Avian Influenza in Humans, Human swine influenza with pandemic potential, Plague, Rabies, Severe Acute Respiratory Syndrome (SARS), Middle East respiratory syndrome, Smallpox, Viral haemorrhagic fever, and Yellow fever.
- The major change from the Quarantine Act:
    - the removal of specific screening for HPAIH and human swine influenza with pandemic potential. These have been grouped under the heading human influenza with pandemic potential and have the same exposure questions as they have similar symptoms.
    - Screening for rabies and cholera will no longer take place as they are not LHD under the *Biosecurity Act 2015*.



- Determining that a disease is a listed human disease allows for the operation of additional border screening and monitoring powers under the Act, as well as the application of human biosecurity control orders in appropriate circumstances.

- LHDs work in a very similar way to quarantinable diseases under the *Quarantine Act 1908*, in that by making a disease a listed human disease, a range of powers and measures become available to manage serious human health risks. LHDs determine the scope of the screening measures conducted by Agriculture on Health's behalf at Australia's international borders.

- Minimising the entry of LHDs is achieved through a continuum of management strategies which operate pre-border, at the border and post-border. Pre-border strategies primarily include the provision of information for travellers through the internet and targeted communication campaigns. Post-border strategies include the use of state and territory public health systems to identify and treat diseases not intercepted through the border processes.

- The Biosecurity Act is intended to operate at the national level, as complementary to, rather than as a replacement for, state and territory public health legislation.

2.3 Powers Enacted by LHDs (ctd)

- What do LHDs allow Human Biosecurity Officials (and Biosecurity Officials) to do at the border?
  - Information gathering
  - Screening
  - Entry and exit requirements
  - Pratique for incoming aircraft and vessels
  - Preventative biosecurity measures
  - Human health response zones
  - Human Biosecurity Control Orders.

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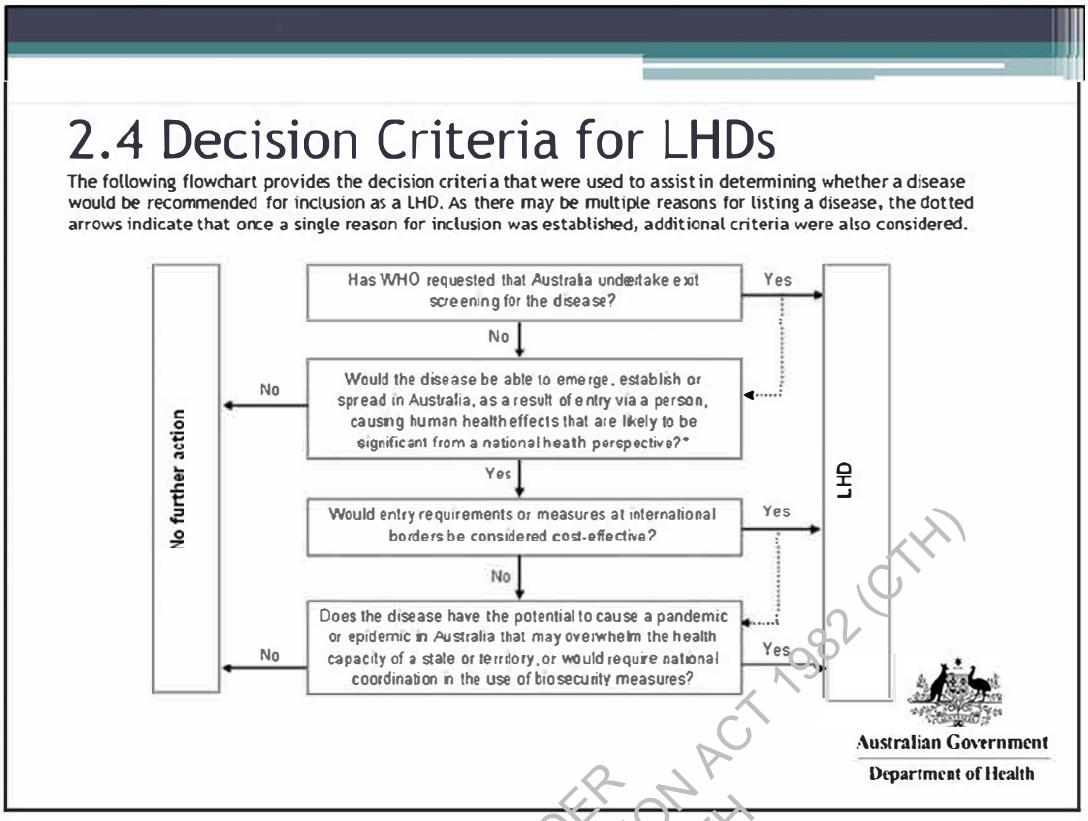
- Although the Act was intended to provide Chief Human Biosecurity Officers (CHBOs) with a range of measures pre, at, and post border, the Act is primarily a border Act. LHDs determine the scope of the screening measures conducted by Agriculture on Health's behalf at Australia's international borders.

- Many diseases are difficult to detect at the border based on symptoms and travel history and the cost-effectiveness of border measures to control the entry of diseases will therefore need to be carefully considered before adding a new LHD.

- Powers and measures may include information gathering, screening, application of human biosecurity measures to individuals, preventative biosecurity measures and human health response zones.

  - Entry and exit requirements,
  - Positive and negative pratique for incoming aircraft and vessels,
  - Information gathering powers,
  - HBCOs,
  - Human health response zones, and
  - Preventative biosecurity measures such as banning or restricting behaviour or practice, requiring a behaviour

or practice, requiring a specified person to provide a specified report or keep specified records, or conducting specified tests on specified goods



LHDs were considered in the context of the following criteria:

- The World Health Organization has requested Australia to undertake screening for the disease
- The disease would be able to enter, emerge, establish or spread in Australia, as a result of entry via a person, causing human health effects that are likely to be significant from a human health perspective
- Entry requirements or measures at Australia's international borders would be considered effective in preventing or managing the entry, establishment or spread in Australia
- The disease has the potential to cause a pandemic or epidemic in Australia that may overwhelm the health capacity of a state or territory, or would require national coordination via the use of biosecurity measures

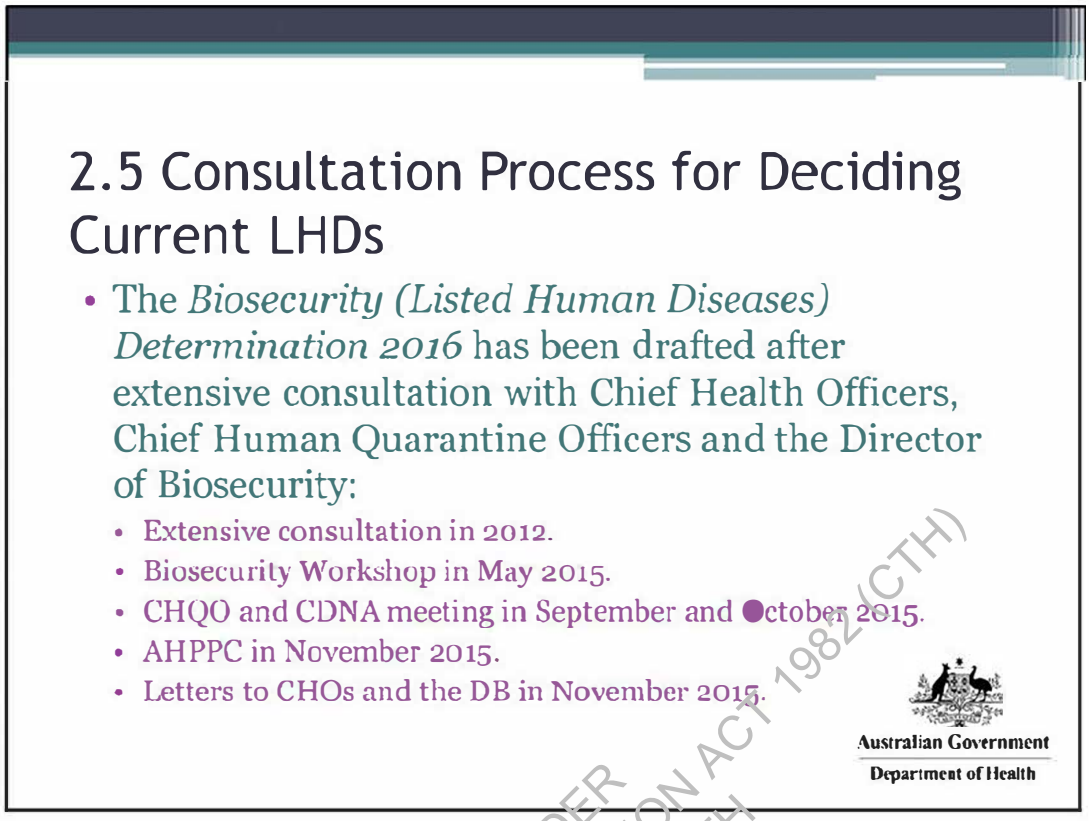
The algorithm was approved by CDNA and AHPPC in October/November 2015, noting that following implementation of the Biosecurity Act on 16 June 2016, a regular review of the list and the algorithm/criteria should occur.

LHDs will generally be limited to either:

- Human diseases that may overwhelm the capacity of a state or territory, or would require national coordination of biosecurity measures.
- Human diseases for which international border entry/exit requirements or measures (e.g. vaccination, prophylaxis, screening or decontamination) are available and considered cost-effective.

* the asterisk at step 2 is to note that a yes to this question implies that the disease is:

- Exotic or not considered to be established in Australia, or is recently emerged, or under control or eradication in Australia. This would include vaccine preventable diseases for which immunisations are funded under the Immunise Australia Program.
- Transmissible from a person, either to other people, or to vectors or reservoirs of the disease. Humans are not considered to be incidental or dead-end hosts. If required for disease transmission, competent or suspected competent, vectors or reservoirs of the disease are present in Australia.
- Is considered to be a serious or significant disease, capable of causing morbidity, mortality, public fear or economic effects that would be discernible from a national perspective.



- **In 2012,** the Commonwealth led a comprehensive review and consultation with over 188 experts consulted and CDNA, CHQOs and AHPPC agreeing to the current criteria and LHDs. As part of the extensive 2012 consultation process, CDNA members were asked to comment on the draft LHD out of session in June 2012. A list of 5 LHDs was agreed by AHPPC and the then Minister (Human Influenza with pandemic potential, SARS, smallpox, VHF and yellow fever)

- **On 22 July 2015,** the Commonwealth hosted a workshop with Chief Human Quarantine Officers (CHQOs) to consult about the Biosecurity Act, including the draft LHDs. At that meeting, it was highlighted that CHQO powers under the Act hinged on the LHDs and that those powers could be used for disease control post-border in some circumstances. It was proposed that a review of the criteria for inclusion on the LHDs and a subsequent review of the LHDs should be undertaken by CDNA.

- In July 2015, MERS was added to the list of quarantinable diseases (and to the draft LHDs).

- In August 2015, the Australian Health Protection Principal Committee (AHPPC) noted that the current draft LHDs and criteria were developed and agreed following a comprehensive consultation process with health experts, including CHOs and CHQOs and the then Minister for Health, in 2012. CHOs discussed the extent to which the LHD criteria and current draft should be reviewed, in particular with regard to the potential post-border application of measures in the Act.

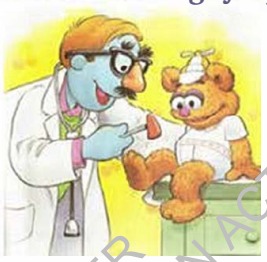
- In **<u>September and October 2015</u>**, CHQOs and CDNA re-considered the 2012 material and justifications for the LHD, and agreed with the 2012 findings subject with the (re) inclusion of plague and MERS. The rationale for including plague included the transmissibility of its pnuemonic form to close contacts, the severity of illness, and the political consequences of a secondary case. CDNA also expressed some reservations about the LHD criteria and algorithm, noting that a regular review of the list and the algorithm/criteria should occur.

- In **November 2015,** AHPPC endorsed the LHDs and the Chief Medical Officer (in his capacity as Chair of AHPPC and soon-to-be DHB) wrote to Chief Health Officers and the Director of Biosecurity to finalise the list.

2.6 Prescribed Signs and Symptoms

- Signs and symptoms of a LHD are no longer prescribed in the legislation (Regulation 6, *Quarantine Regulations 2000*).
- Rather, symptoms will align with the Traveller with Illness Checklist:

1. Fever, plus one or more of the following symptoms:
2. Jaundice, or
3. A new rash, or
4. Unusual bleeding, or
5. A new coughing illness.



Australian Government
Department of Health

To identify the possible presence of an LHD, travellers are assessed for five specific symptoms under the Traveller with Illness Checklist:

1. Fever, plus one ore more of the following symptoms:
2. Jaundice, or
3. A new rash, or
4. Unusual bleeding, or
5. A new coughing illness.

Biosecurity Officers are not medically trained. The these symptoms are therefore designed to make the initial TIC assessment more practical for non-medically trained staff.

- In addition to noting the symptoms, travellers may also be questioned under the TIC on their potential exposure to an LHD. Criteria used to determine exposure include:
    - travel history – areas of most concern include persons who have travelled to yellow fever endemic countries, countries with human influenza with pandemic potential, the Middle East and Africa, and
    - history of direct contact with a sick person.

FOR INFORMATION ONLY

- Plague (bubonic and pneumonic), SARS and smallpox are not specifically targeted in

the screening process as they cannot be readily identified at the border, or are extremely unlikely to occur and can be identified through screening processes for other LHDs, or are already circulating in the population.

- In the case of SARS and pneumonic plague, their symptoms are similar to those of human influenza with pandemic potential, and are identified through screening for human influenza with pandemic potential.

- In the case of smallpox, it is not currently circulating in humans. No cases of smallpox have occurred anywhere in the world since the late 1970s. Smallpox has been made an LHD as a health security measure. If this situation changed (for example, a heightened security concern) it would be important to specify identification of this illness through our border screening process.

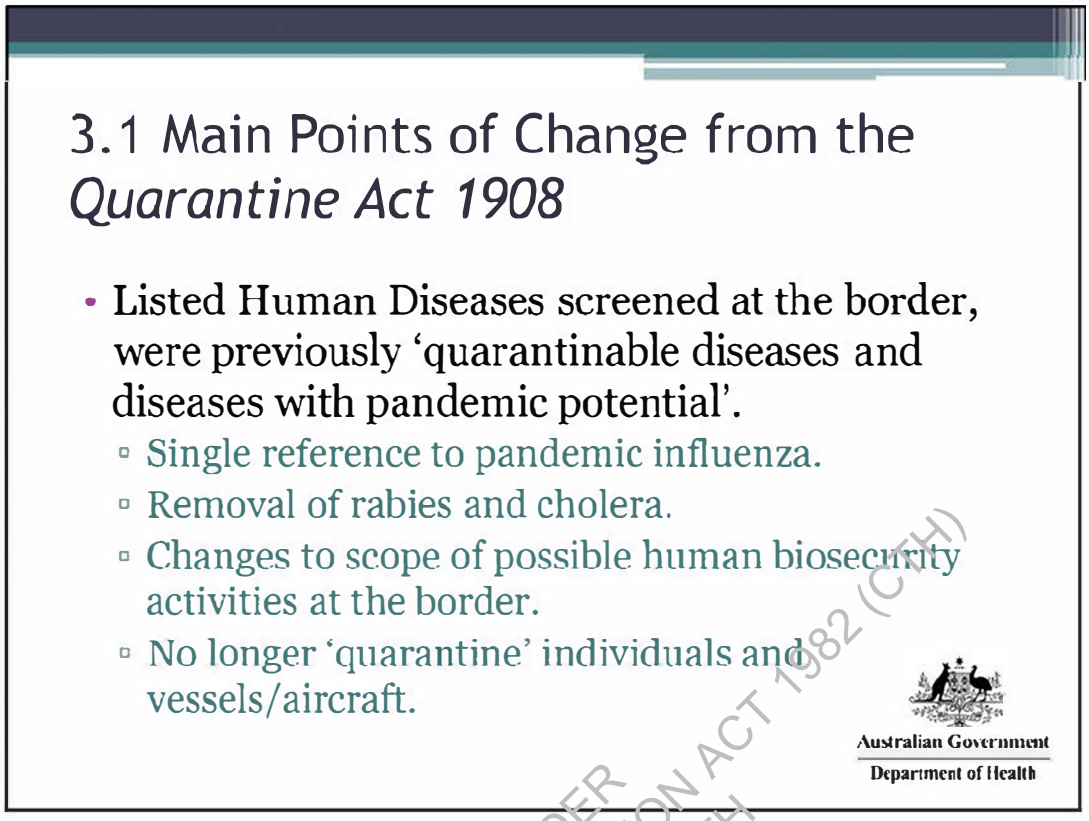
Symptoms/signs in the quarantine regulations (and the MSAU's recent comments):

- Temperature over 38^{o}c
- Acute unexplained skin rashes or lesions, and rashes or lesions caused by illness or exposure to hazardous agents (but not heat rashes, dermatitis, eczema or similar common skin condition);
- Persistent or severe vomiting (but not vomiting caused by inebriation or motion sickness);
- Persistent, watery, or profuse, diarrhoea;
- Bleeding from the eyes, ears, nose, mouth, anus or skin, (but not if the subject is predisposed to nosebleeds or haemorrhoids, or has cuts or abrasions);
- Glandular swelling in the armpits or neck;
- Prolonged loss of consciousness, if the subject cannot be roused (but not loss of consciousness caused by consumption of alcohol, drugs or medications, fainting or sleeping);
- Persistent coughing or difficulty breathing with no apparent cause and no history of similar symptoms (but not persistent coughing or difficulty breathing due to asthma, heart disease, obesity, chronic bronchitis or emphysema);
- An inability to disembark from a vessel without assistance (but not if an otherwise healthy child or person with prior restricted mobility)

Topic Three:

Assessing Travellers at the Border

Australian Government
Department of Health

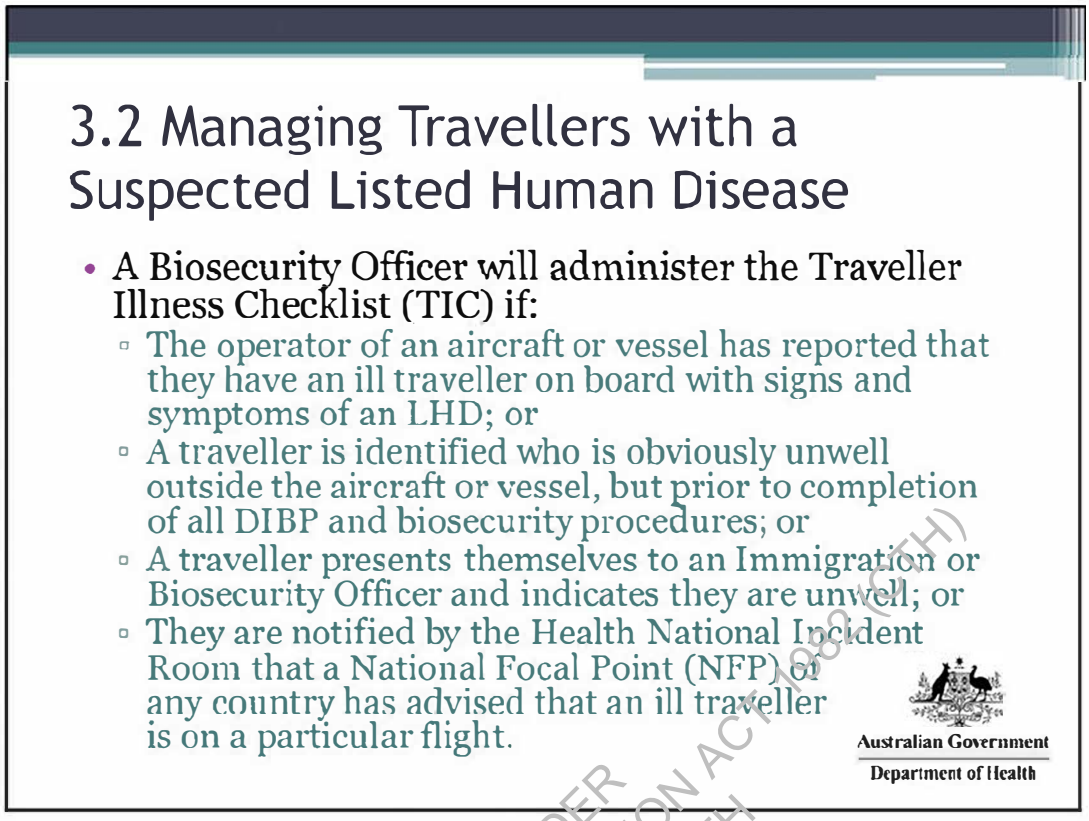


Under the *Quarantine Act 1908,* quarantinable diseases and diseases with pandemic potential were screened at Australia's international borders.

Under the *Biosecurity Act 2015*, the term LHD replaces quarantinable diseases as I outlined in topic 2.

The major change for assessing ill travellers at the border involves the removal of specific screening for HPAIH and human swine influenza with pandemic potential. These have been grouped under the heading human influenza with pandemic potential and have the same exposure questions as they have similar symptoms.

Screening for rabies and cholera will no longer take place as they are not LHD under the *Biosecurity Act 2015*.



The primary assessment tool used at our borders to screen for the presence of LHDs is the TIC.

The TIC is administered by Biosecurity Officers and is designed to provide information required to determine whether an ill traveller poses a serious risk to Australian public health. While most travellers are anticipated to cooperate with its completion, section 56 of the *Biosecurity Act 2015* enables the DHB, an CHBO, an HBO or Biosecurity Officer to require an individual to answer questions, or provide written information if:
the individual has one or more signs or symptoms of an LHD, or
the individual has been exposed to:

- an LHD, or
- another individual who has one or more signs or symptoms of an LHD, or

the questions asked or the information sought relates to:

- human remains, or
- an individual who died in transit before arriving in Australian territory, or
- an individual who died on arrival in Australian territory.

Biosecurity Officers are not medically trained. The questions used in the TIC are therefore designed to make reporting requirements more practical for non-medically trained staff.

A Biosecurity Officer will administer the TIC if:

- The operator of an aircraft or vessel has reported that they have an ill traveller on board with signs and symptoms of an LHD or infectious disease, except if it is made

clear that the symptoms reported are a result of an accident, injury, operation, or non-infectious source (i.e. intoxication, allergy or motion sickness).

- A traveller is identified who is obviously unwell outside the aircraft or vessel, but prior to completion of all DIBP and biosecurity procedures.
- A traveller presents themselves to a DIBP or Biosecurity Officer and indicates they are unwell.
- They are notified by the Health National Incident Room that a National Focal Point (NFP) of any country has advised that an ill traveller is on a particular flight. Under the IHR all countries are required to nominate a NFP. From time to time they may report the passage of ill travellers.

3.2 Managing Travellers with a Suspected Listed Human Disease

- Information collected in the TIC is protected by the Australian Privacy Principle 5 (APP 5)
  - As with the *Quarantine Act 1908*, a printed copy of the APP 5 notification will still be given to the individual when administering the TIC.
  - Privacy information is also available on the Commonwealth Health website.

Australian Government
Department of Health

To comply with the *Privacy Act 1988*, all individuals assessed through the TIC process or imposed with an HBCO are provided with a short statement around why the information is being gathered, by whom and where more information can be found on privacy principles and policies.

When the TIC is administered, a form is printed out and provided to the traveller being assessed.
Health's website includes the entire APP 5 notice requirements and links to Health and DAWR privacy policies.

3.2 Managing Travellers with a Suspected Listed Human Disease

- Depending on the answers given in the TIC, the Biosecurity Officer will:
  - Advise the ill traveller to seek their own medical advice (if the TIC does not indicate likelihood of an LHD):
    - All ill travellers who are not referred for further assessment will be advised to seek medical attention and to inform the doctor of their travel history.

Australian Government
Department of Health

The TIC includes the following questions:

1. Have you had fever, chills or sweats in the last 24 hours?
2. Do you have a new coughing illness, which developed in the last 2 weeks?
3. Have you been in contact with any birds or bird products within the last two weeks (e.g. handling, slaughtering, defeathering, butchering, preparation for consumption)?
4. Have you consumed raw poultry or raw poultry products (including blood)?
5. Have you been caring for, speaking with, or touching a person who is a suspected, probable, or confirmed Avian Influenza case?
6. Have you handled samples (animal or human) suspected of containing Avian Influenza virus in a laboratory or other setting?
7. Have you been caring for, speaking with or touching a person who is a suspected or confirmed MERS case while they were ill?
8. Have you been in a healthcare facility (as a patient, worker or visitor) while in a country in the Middle East? A checklist of countries of concern is included in the TIC.
9. Have you touched camels or other bodily fluids, including having been coughed or sneezed on by a camel, or drunk raw camel milk or consumed camel meat in a country in the Middle East?
10. Do you have any unusual bleeding, such as bleeding from the eyes or ears or nose?
11. Do you have any severe bruising?
12. Do you have any of the following symptoms: muscle aches, vomiting, diarrhoea or severe headache?
13. Have you been in any country within Africa in the last 3 weeks?
14. Do you have a new rash which developed in the last 2 weeks? Is the rash itchy? The person may provide a verbal description of the location of the rash or mark the

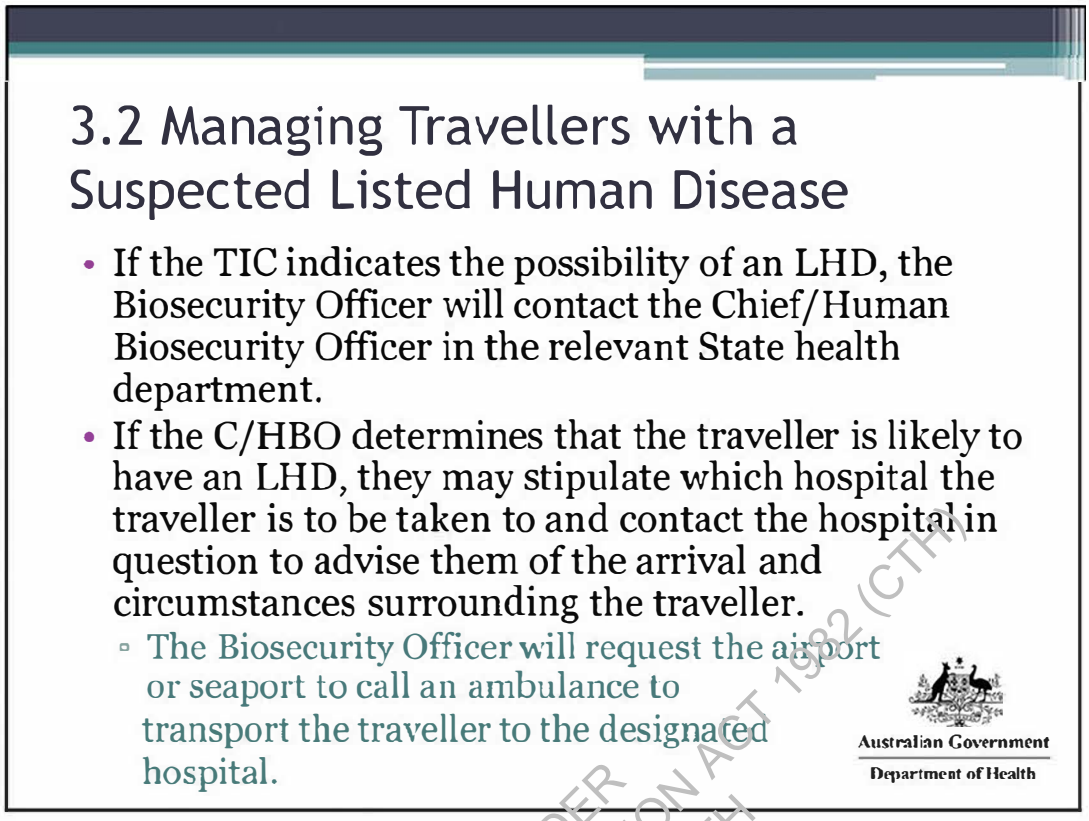
location on the human body diagram supplied to them.

15. Have you, or anyone around you, noticed the whites of your eyes and/or skin has yellowed?
16. Were you in Africa, South/Central America or the Caribbean within the previous 6 days (including transit)? Which country(s) did you visit? A checklist of countries of concern is included in the TIC. Do you have a valid Yellow Fever vaccination certificate?

Additional questions may be added from time to time to screen for a specific infectious disease.

Depending on the answers given, the Biosecurity Officer will:

- advise the ill traveller to seek their own medical advice (if the TIC does not indicate likelihood of an LHD), or
- contact the (C)HBO in the relevant State health department (the TIC provides guidance on this). The (C)HBO will determine a course of action depending on the information reported by the Biosecurity Officer.



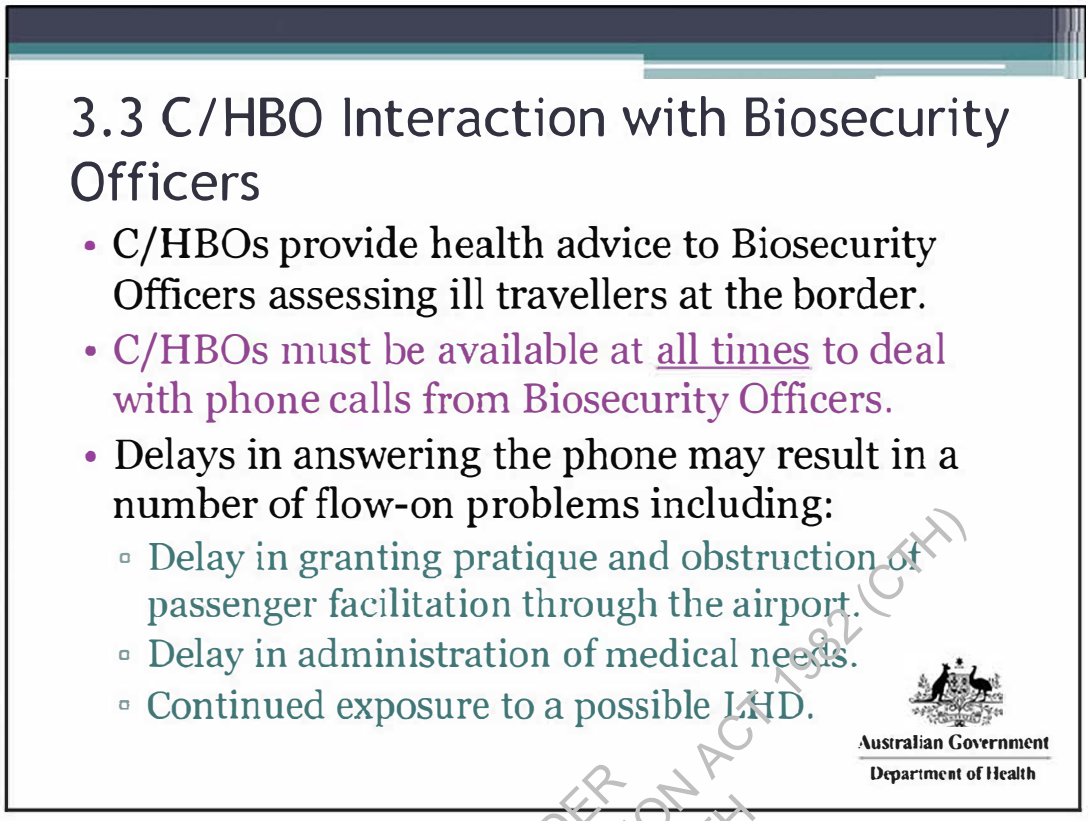
All ill travellers who are not referred for further assessment will be advised to seek medical attention and to inform the doctor of their travel history.

If the (C)HBO determines that the traveller is likely to have an LHD, they will stipulate which hospital the traveller is to be taken to and contact the hospital in question to advise them of the arrival and circumstances surrounding the traveller.

The Biosecurity Officer will request the airport or seaport to call an ambulance to transport the traveller to the designated hospital.

In the administration of the TIC, the medical needs of a traveller should **always** take first priority. Under section 35 of the *Biosecurity Act 2015*, urgent or life-threatening medical needs should not be delayed in order to complete the TIC. If a traveller's health is deteriorating rapidly during the administration of the TIC, the Biosecurity Officer will call airport authorities.

If the traveller is seriously ill on arrival, particularly if they cannot walk or talk, the Biosecurity Officer will follow appropriate procedures to facilitate the traveller's Immigration and biosecurity clearance and transfer to a hospital. The Biosecurity Officer should report the details of the incident to the (C)HBO for follow up.



As mentioned earlier, Biosecurity Officers are not medically trained. They follow a process to assess the possibly of a person having an LHD and then refer to (C)HBOs for health advice.

(C)HBOs must be available at all times to deal with phone calls from Biosecurity Officers.

Delays in answering the phone may result in a number of flow-on problems including:

- Delay in granting positive pratique and obstruction of passenger facilitation through the airport
- Delay in administration of medical needs to a traveller, and
- Continued exposure of a Biosecurity Officer, passengers and crew to a possible LHD

3.4 Yellow Fever Lifetime Immunity

- On 16 June 2016, the period of protection afforded by yellow fever vaccination, and the term of validity of the international vaccination certificate, will change from 10 years to the duration of the life of the person vaccinated.
- These changes will not affect current entry requirements for yellow fever.

Australian Government
Department of Health

The Australian Government is adopting the WHO amendment to the IHR, that the period of protection afforded by yellow fever vaccination, and the term of validity of the certificate, will change from 10 years to the duration of the life of the person vaccinated. This is based on data demonstrating for the majority of recipients, a single dose of yellow fever vaccine results in life-long immunity.

However, the legal requirements for travellers entering Australia from yellow-fever declared countries will remain in place until the commencement of the *Biosecurity Act 2015* on 16 June 2016. Therefore, individuals without a yellow fever vaccination certificate that has been issued in the period of 10 years prior to arrival will still be required to go through border control processes when entering Australia. As is current practice, entry to Australia will not be refused on the basis of non-compliance with yellow fever monitoring and control requirements.

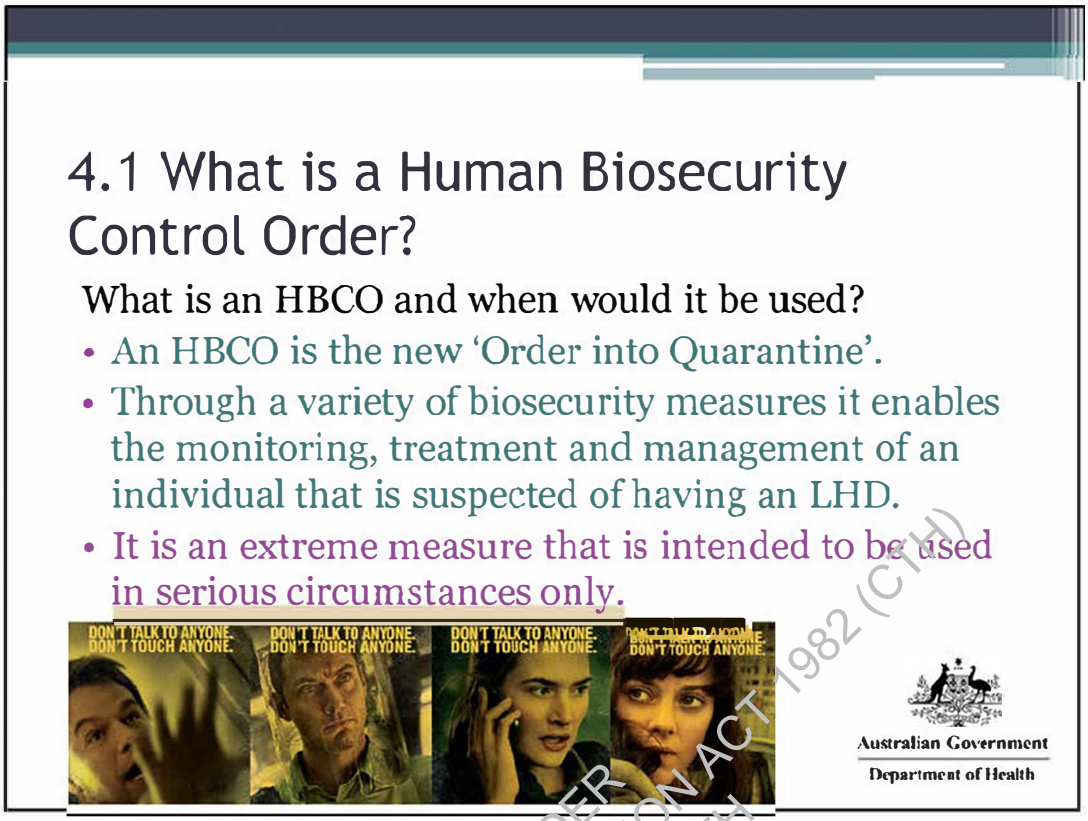
Individuals who are travelling to yellow fever declared countries and are due to have a booster vaccination before 16 June 2016 should note that this is not required for health protection purposes.

Vaccination is still strongly recommended for travellers who have never been vaccinated for yellow fever and who intend to travel to countries where there is a risk of transmission. Border biosecurity processes will remain in place for unvaccinated travellers post June 2016.

Topic Four:

Human Biosecurity Control Orders

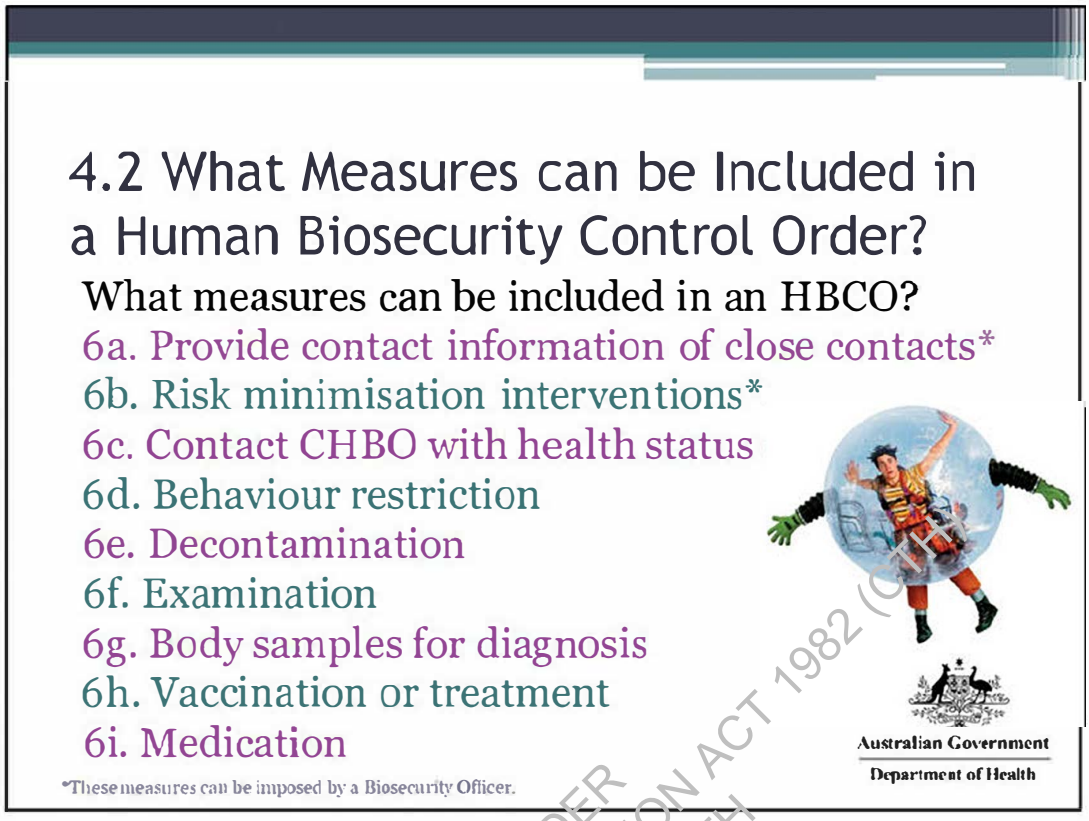
Australian Government
Department of Health



A human biosecurity control order (HBCO) is a new power available under the Biosecurity Act to manage human biosecurity risks posed by an individual who may have or is suspected of contact with a listed human disease. It is not a power that is intended to be used regularly, and can only be used for individuals suspected of having a Listed Human Disease.

An HBCO is an administrative tool that meets legislative requirements and has been approved in a form by the DHB.

A copy of the HBCO has been included in the training pack.



An HBCO may include a number of measures as appropriate to manage the risk.

These measures are outlined in Part 4 (page 2) of the form.

Not all measures are required for every HBCO and rely on the judgment and expertise of the Chief Human Biosecurity or Human Biosecurity Officer or Biosecurity Officer on a case-by-case basis.

The subject of the HBCO should, if practicable, consent to a measure before it is imposed.

FOR INFO

If the subject does not consent to the measures specified in Parts 6a and 6e to h of the HBCO they may make an application for review through the *Administrative (Judicial Review) Act 1977*. If the outcome of this review process is that they should comply or 7 days have passed since the subject refused to consent to the measure then the Director of Human Biosecurity (DHB) can give a direction to comply.

If the subject does not consent to the measures specified in Parts 6b to d and 6i to k the DHB will conduct a review of the diagnosis and the biosecurity measure proposed and order a direction to comply if they agree that the measure is necessary. If the subject wants to appeal the outcome of this review and go through the judicial review process they must comply with the direction by the DHB in the interim.

Further information about the review process and the obligations of the subject of the HBCO are provided at Part 8 of the HBCO.

4.2 What Measures can be Included in a Human Biosecurity Control Order?

What measures are included in an HBCO?

6j. Isolation measure:

- Passenger has to remain isolated at a specified medical facility.

6k. Traveller movement measure:

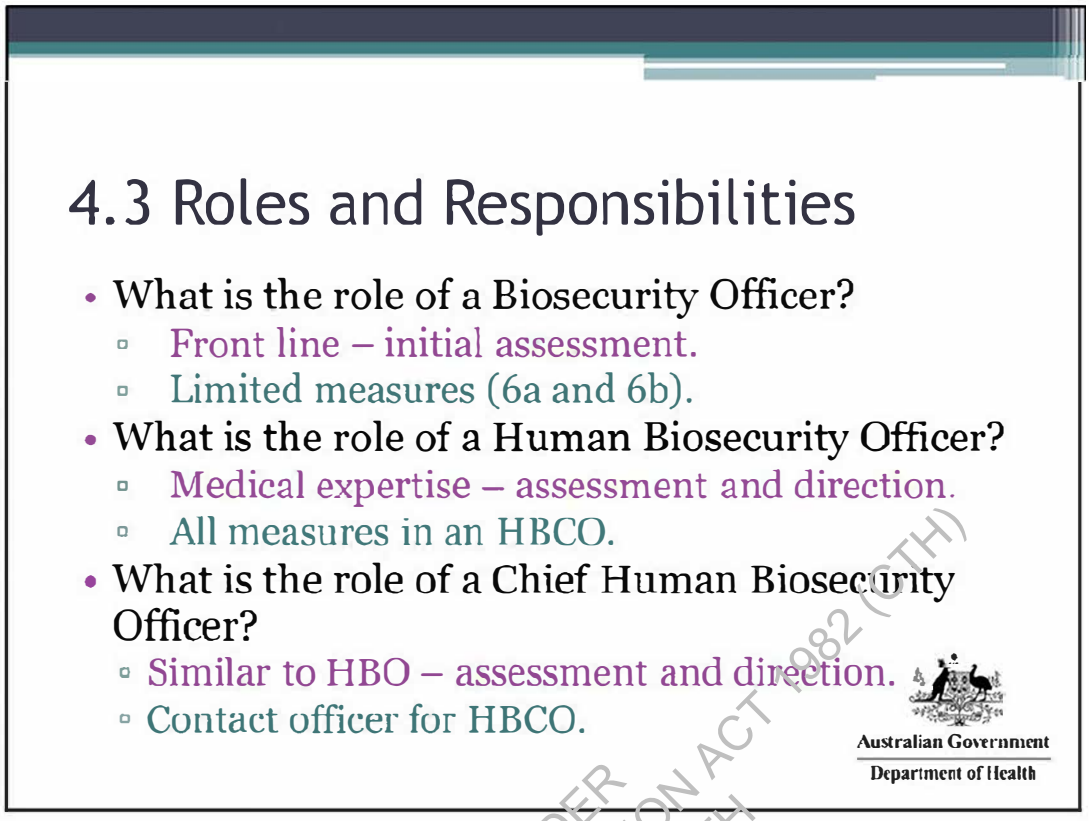
- Prevents the passenger from leaving Australia.
- Maximum of 28 days.
- New measure can be imposed if expired.

Australian Government
Department of Health

If the subject of the HBCO does not consent to the measures listed in the last slide, measures 6j and 6k (isolation measures and traveller movement measures) can be imposed to manage the risk that that subject may pose.

If the subject does not consent to either of these measures (6j and 6k) the DHB will have to review the appeal within 72 hours, however these measures will remain in force until:

- the subject consents to the required measures that caused the imposition of an isolation or traveller movement measure;
- the DHB has given a direction that the measure(s) do not need to be in force; or
- it has been more than 72 hours since the subject refused to consent to the measure(s).



An HBCO may be imposed on an individual by a Chief Human Biosecurity Officer, an Human Biosecurity Officer, or a Biosecurity Officer to a limited degree, but not by the DHB.

A Biosecurity Officer is a DAWR officer at the first point of entry into Australia. The Biosecurity Officer will undertake the TIC which could lead to them imposing an HBCO with limited measures and/or calling upon a Chief Human Biosecurity Officer or a Human Biosecurity Officer to assess a traveller.

A Human Biosecurity Officer can impose an HBCO and all the measures contained in it.

A Chief Human Biosecurity Officer has the same powers as a Human Biosecurity Officer with the addition of being the contact person for the subject of the HBCO. Part 5 of the HBCO requires the details of the relevant Chief Human Biosecurity Officer be provided for the purpose of support and information. The Chief Human Biosecurity Officer may also be contacted if the subject's health status and/or contact details change.

4.3 Roles and Responsibilities

- When should you notify the Director of Human Biosecurity?
  - Once an HBCO has been imposed.
  - If the HBCO is being varied or revoked.
  - If the traveller refuses to consent to measures.
- How do I notify the Director of Human Biosecurity?
  - Through the NIR/NFP

s22

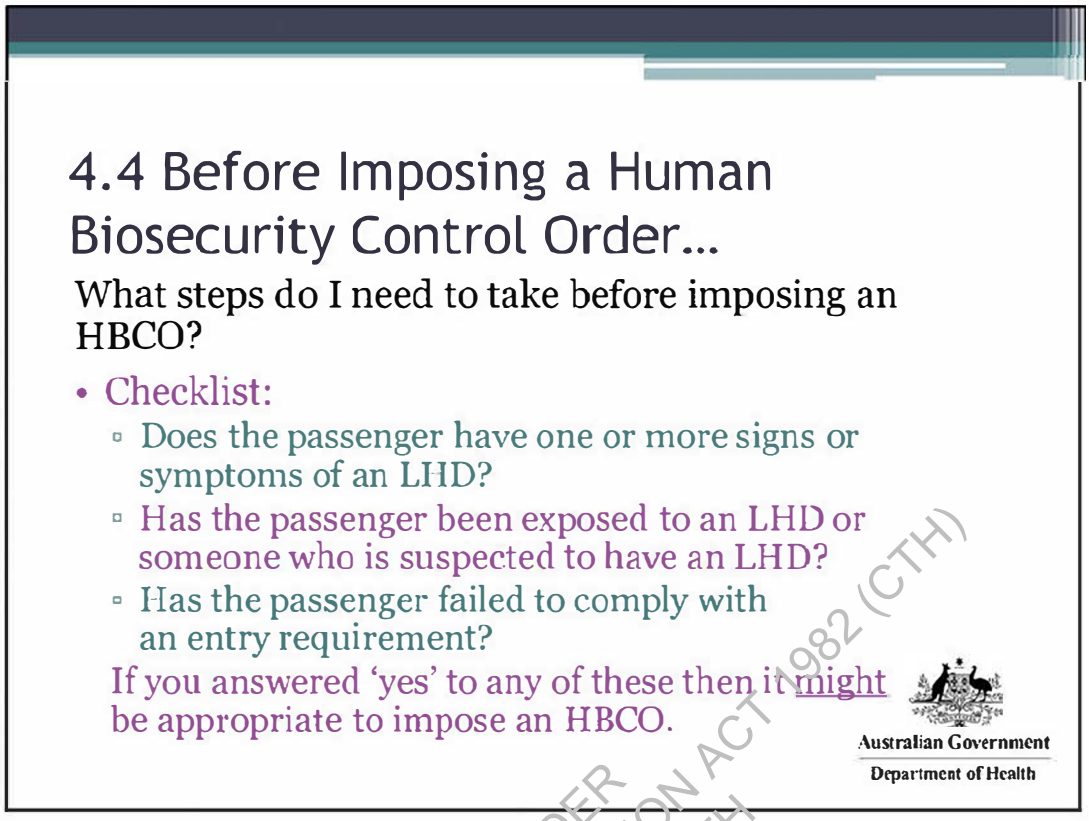
s22

Australian Government
Department of Health

The DHB must be informed when an HBCO has been imposed and subsequently when it is varied or revoked.

If an individual refuses to consent to an HBCO (aside from 6j and 6k – isolation and traveller movement measures) they are not required to comply unless a direction has been given by the DHB.

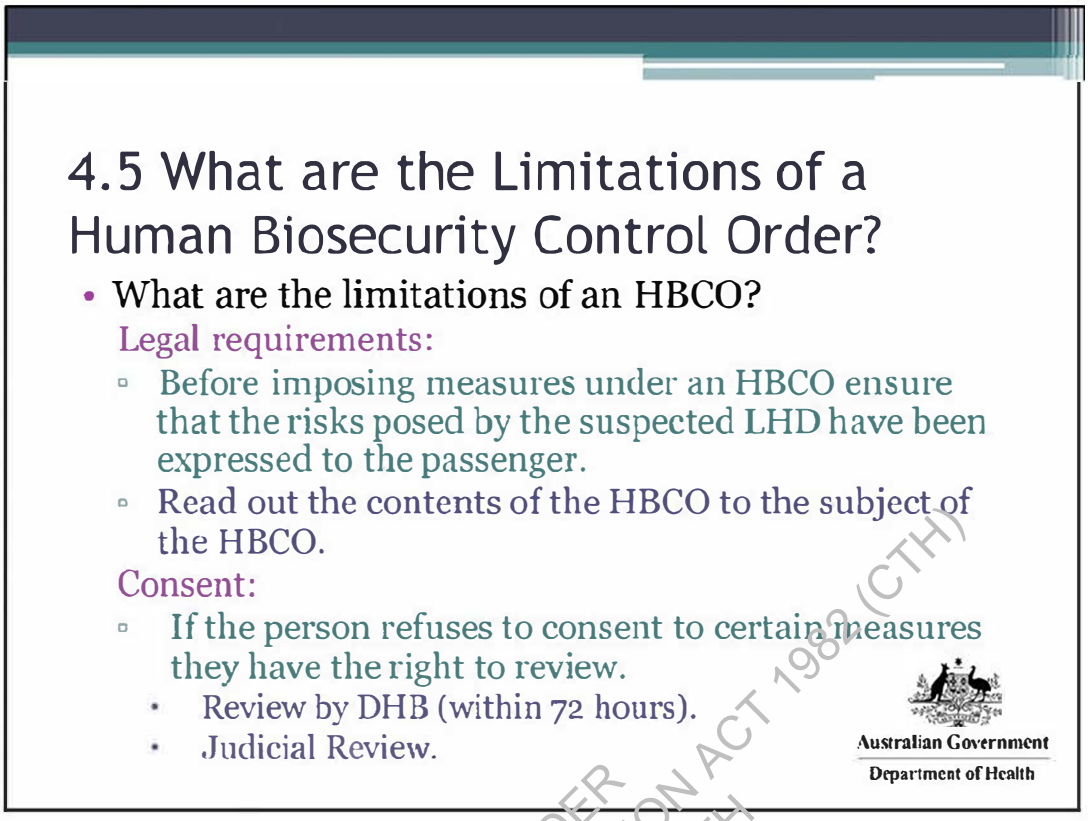
As discussed, the DHB has powers of review and can require compliance with measures contained in an HBCO.



HBCOs can only be imposed on an individual if that individual has:

- one or more signs or symptoms of a listed human disease; or
- has been exposed to a listed human disease; or
- has failed to comply with entry requirements in relation to a listed human disease.

Each HBCO will be specific to the individual to whom it is being applied. An HBCO is a serious measure to be imposed at the discretion of a medically trained officer in the interest of protecting the health of the individual and the public.



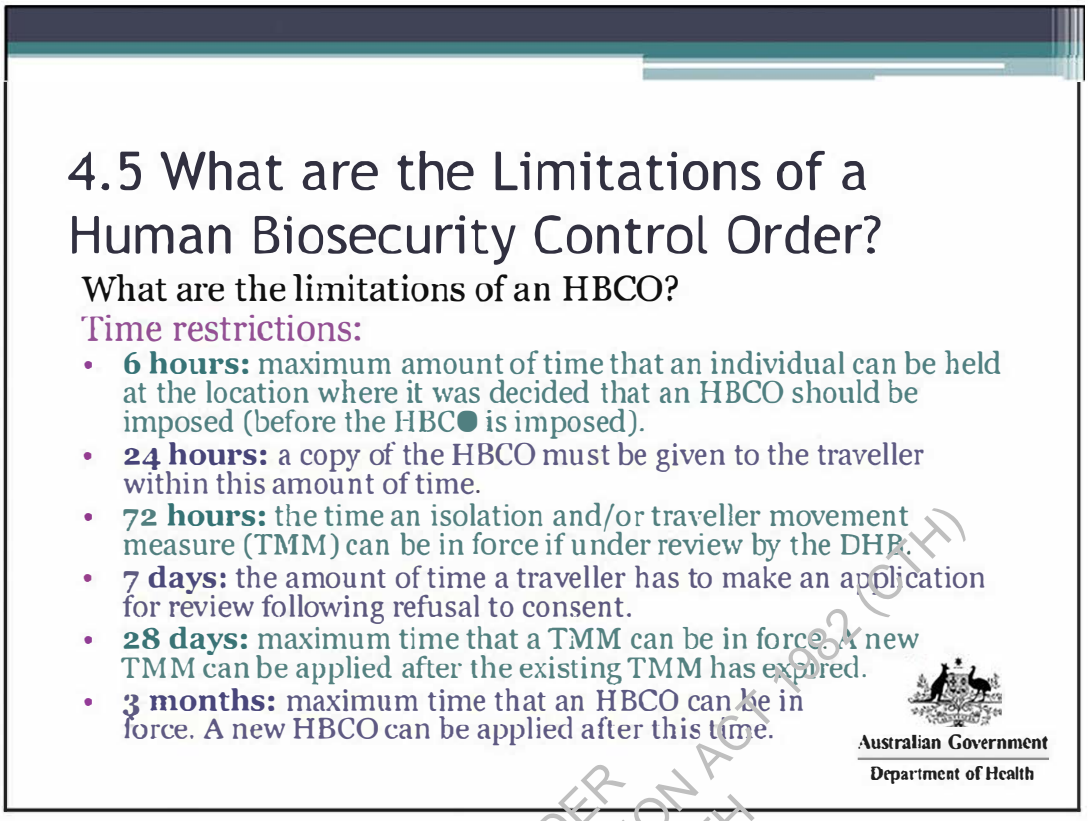
To ensure that the HBCO is enforceable it is important that the legal requirements of the Biosecurity Act are met.

An HBCO must abide by the principles of general protection, referenced earlier.

This requires a subject to be informed of the risks posed to themselves and the general public by the suspected LHD before the HBCO is imposed.

It is also necessary for the contents of the HBCO to be read out to the person that is the subject of the HBCO.

As outlined previously the subject has the right to review if they refuse to consent to a measure in an HBCO.

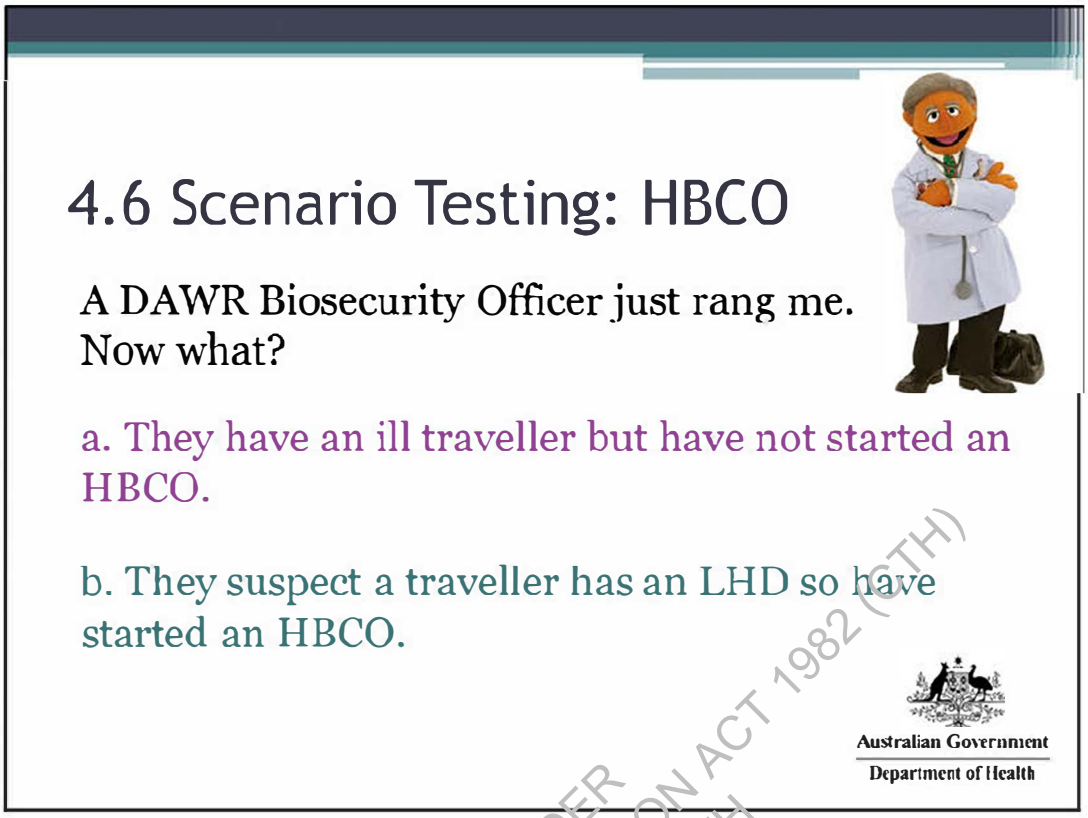


There are certain timeframes which must be considered and observed when imposing an HBCO.

While a copy of the HBCO has to be provided to the subject of the HBCO within 24 hours it would be preferable to provide the subject with Attachment A (page 13 of the HBCO) at the time of imposition.

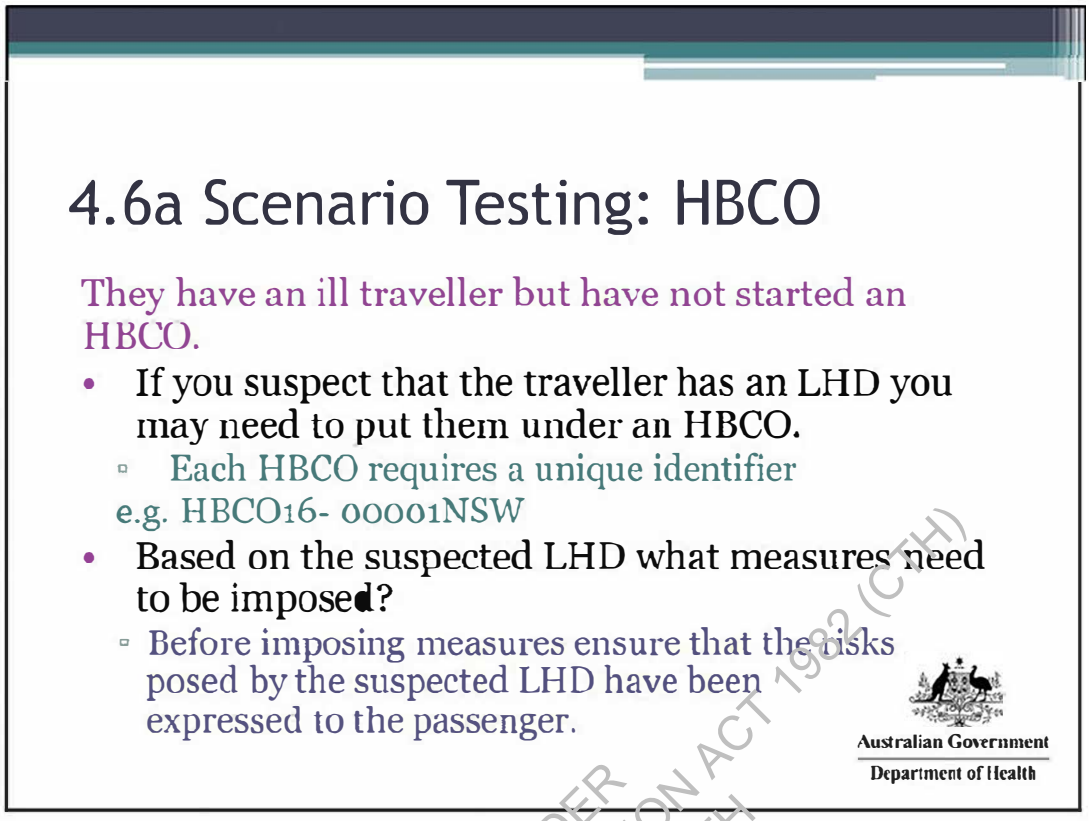
It is important to note that even though an HBCO expires after 3 months, if it has not been revoked prior, a new HBCO can be imposed if it is believed that the subject still poses an LHD related health risk requiring them to be under measures in an HBCO.

In this vein it is worth nothing that HBCOs can be issued over the phone via a BO, however it is advisable that they be imposed in person.



Okay, so now we are going to run through two scenarios that involve putting a subject under an HBCO.

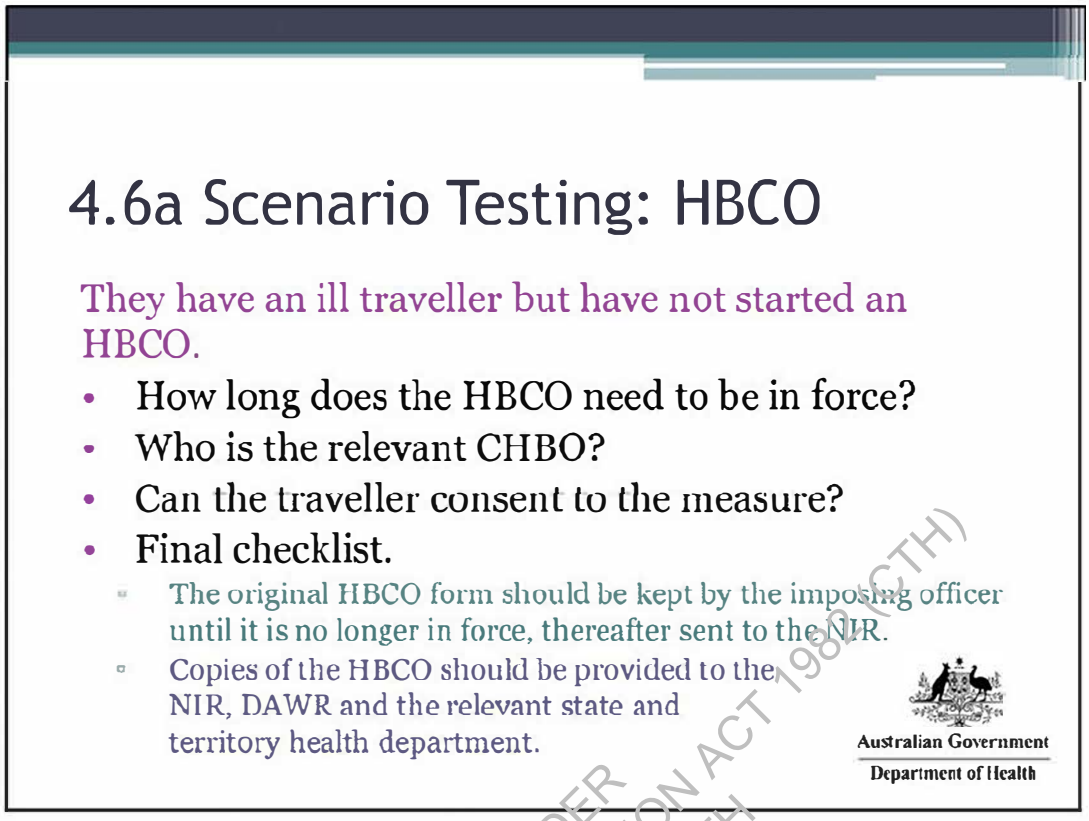
Both scenarios start with a DAWR BO ringing you because they have gone through the TIC and suspect a traveller has an LHD.



In the first instance a BO has not started an HBCO.

Each HBCO requires a unique identifier. The protocol for this unique identifier is something that can be established within each state.

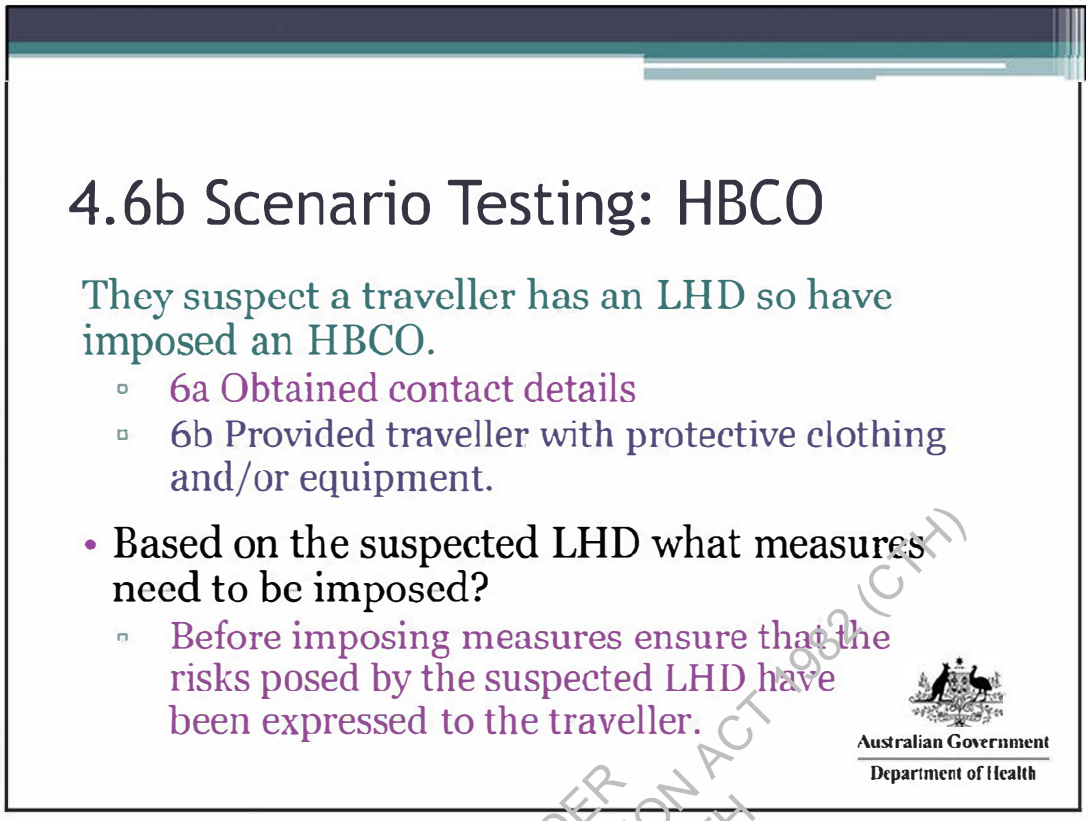
For this scenario you will need a blank copy of the HBCO, which is provided in the training pack.



When completing an HBCO it is important to follow the steps in the form.

As mentioned, the measures required under each HBCO are unique to the individual, the LHD and the situation.

An example of an HBO completed version of the form is provided in the training pack.



As mentioned, a BO can impose an HBCO with limited measures.

In the second scenario a BO suspects that an ill traveller has an LHD so has imposed an HBCO.

An example of a form completed by a BO is provided in the training pack.

4.6b Scenario Testing: HBCO

They suspect a traveller has an LHD so have imposed an HBCO.

- What further measures need to be imposed?
- Who is the relevant CHBO?
- Can the traveller consent to the measure?
- Final checklist.
  - The original HBCO form should be kept by the (C)HBO until it is no longer in force, thereafter sent to the NIR.
  - Copies of the HBCO should be provided to the NIR, DAWR and the relevant state and territory health department.

Australian Government
Department of Health

A HBCO imposed by a Biosecurity Officer will generally be taken on by the relevant Human Biosecurity Officer. The relevant HBO will impose other measures as necessary, noting that BOs have limited powers, and be responsible for the HBCO and management of the subject from that point. This allows the original HBCO to be varied or revoked based on medical expertise.

Topic Five:

Pratique

Australian Government
Department of Health

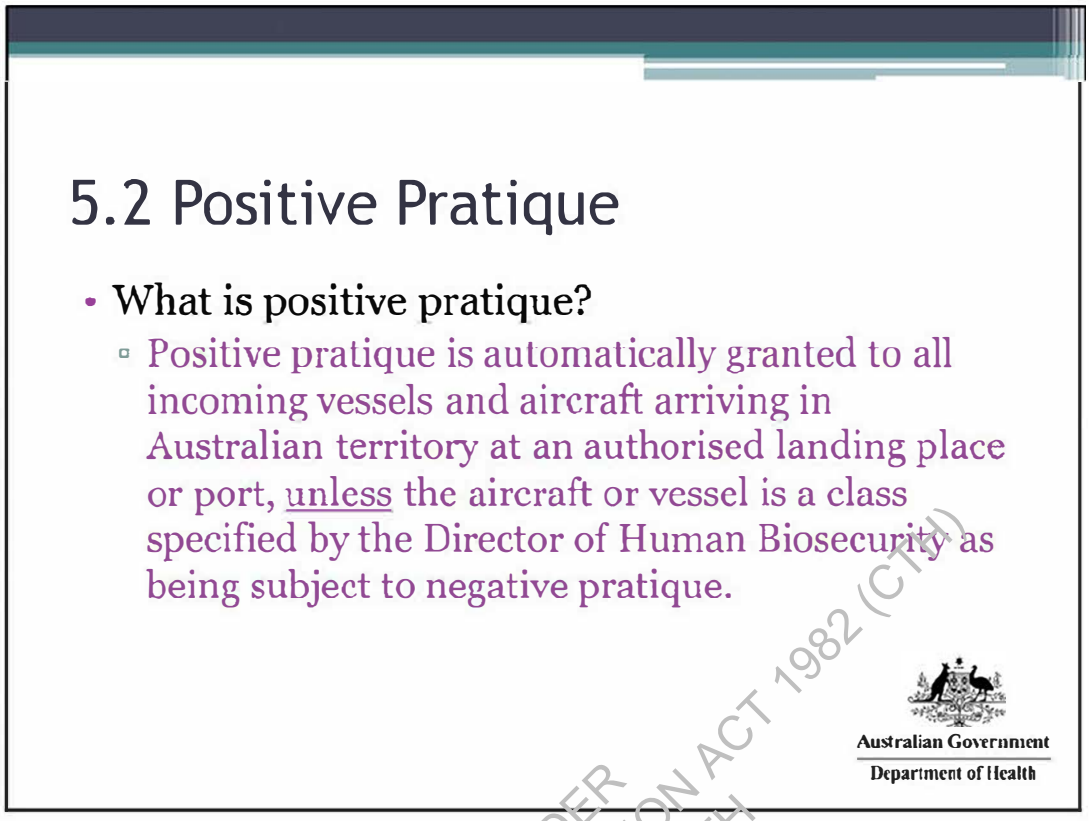
5.1 What is Pratique?

- What is pratique?
  - Pratique is a permission to enter an Australian port, disembark and embark persons, and unload and load goods.
  - An operator of an incoming vessel or aircraft cannot perform these activities unless pratique has been granted in some form.

Australian Government
Department of Health

Before entering Australia, aircraft and vessels must be granted pratique. Pratique is a clearance given to a mode of transport on an assurance that the incoming aircraft or vessel is free from persons or vectors with communicable disease.

Pratique is granted via pre-arrival reports, which must be completed by the operator of the aircraft or vessel. Aircrafts also require prescribed disinsection measures to be undertaken before pratique is granted. Once pratique is granted passengers and/or crew are able to disembark.



Positive pratique is automatically granted to all incoming vessels and aircraft arriving in Australian territory at an authorised landing place or port, unless the aircraft or vessel is a class specified by the DHB as being subject to negative pratique.

Classes of aircraft and vessels that are not subject to positive pratique include those that have an individual on board who has or is displaying signs or symptoms of a listed human disease or has died on the aircraft or vessel. In addition, negative pratique is applied to aircrafts that have not undertaken prescribed pre-arrival disinsection measures.

5.2 Positive Pratique

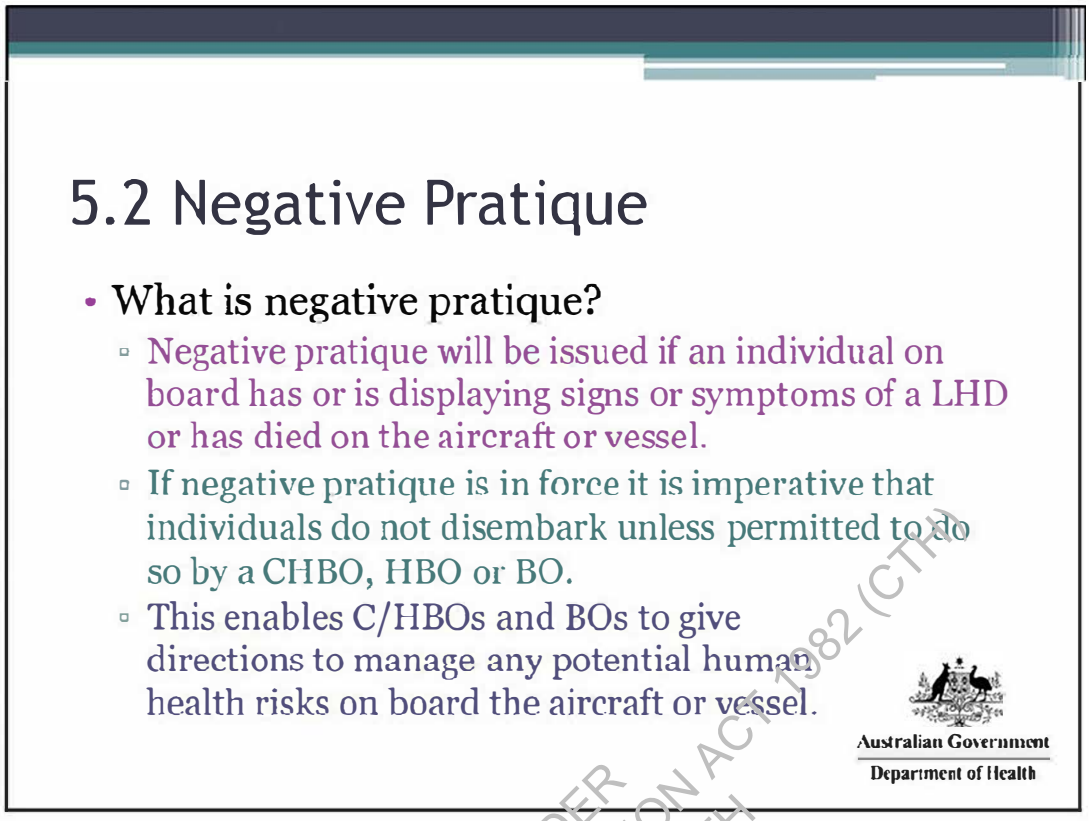
- Instances where positive pratique is not granted:

CLASS	NEGATIVE PRATIQUE
Aircraft	Failed to disinsect
Aircraft or vessels	Pre-arrival report shows: • ill traveller with possible LHD; or • deceased traveller on board. **OR** DHB, (C)HBO or BO becomes aware that a traveller(s) on board has: • signs or symptoms of an LHD; or • been exposed to an LHD; or • died during flight or voyage.
Vessels (other than non-commercial)	Failed to provide pre-arrival report

Australian Government
Department of Health

Instances where positive pratique is not granted is provided in the table below.

This information is based on the *Biosecurity (Negative Pratique) Instrument 2016*.



If an aircraft or vessel is bound by negative pratique they are not permitted to disembark and embark persons until they have been permitted by a (C)HBO or BO.

The operator is liable for a civil penalty if he or she contravenes the requirement not to unload or disembark persons before pratique has been granted.

5.3 Scenario Testing: Pratique

A DAWR Biosecurity Officer just rang me. Now what?

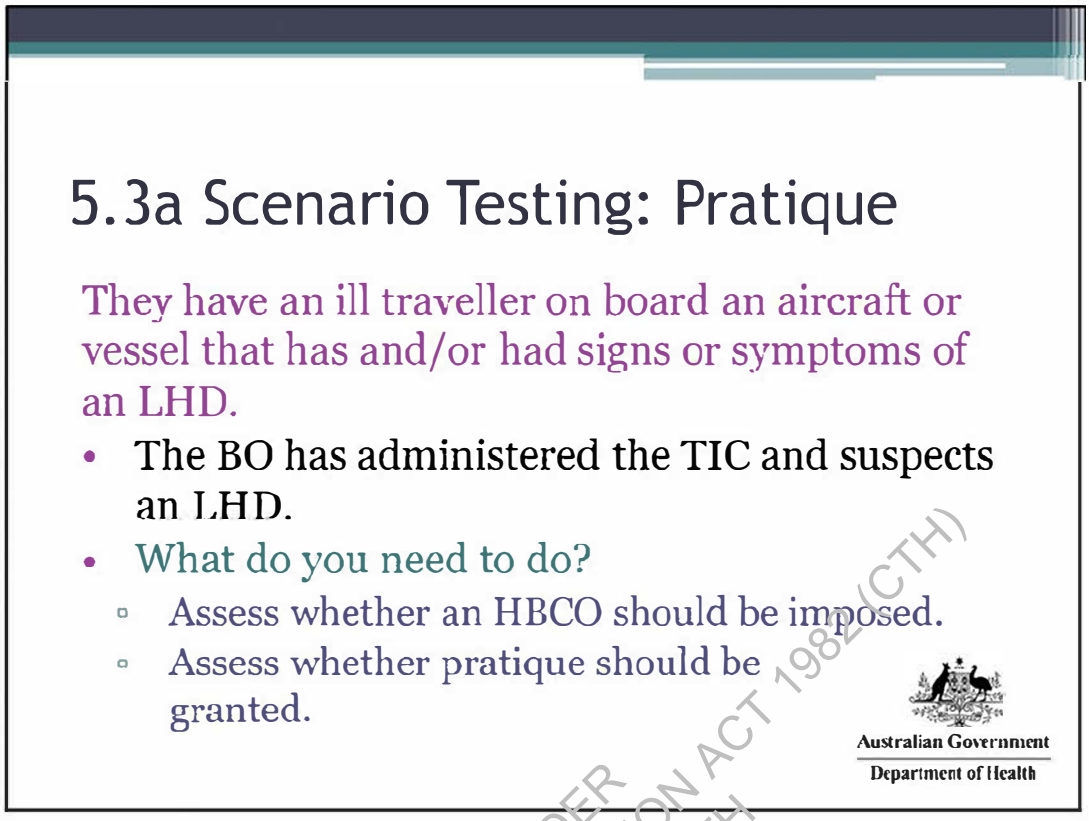
a. They have an ill traveller on board an aircraft or vessel that has and/or had signs or symptoms of an LHD.

b. Someone died during the flight or voyage on the aircraft or vessel.

Australian Government
Department of Health

Okay, so now we are going to run through two scenarios that involve granting pratique.

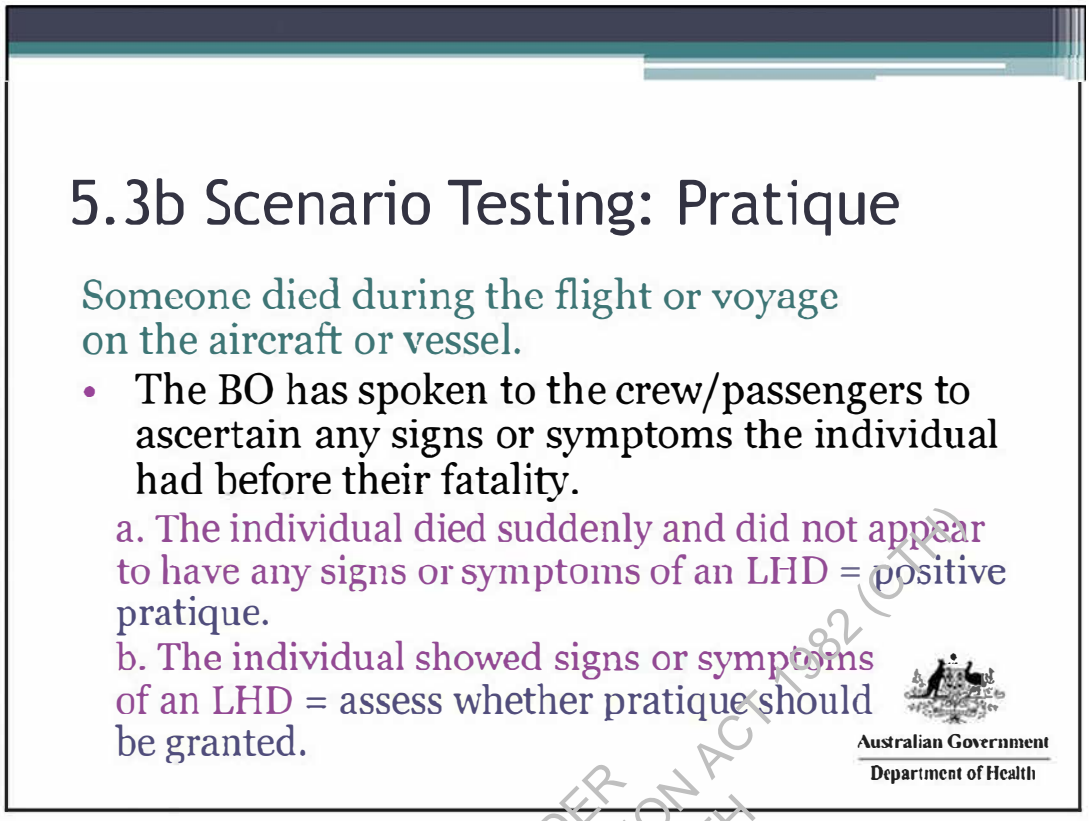
Both scenarios start with a DAWR BO ringing you because a pre-arrival report has indicated that there is an ill traveller with a suspected LHD on board and/or someone has died during travel.



In the first instance a BO has informed you that there is an ill traveller on board displaying signs or symptoms of an LHD.

The BO has administered the TIC and suspects an LHD.

Based on the circumstances of the case an assessment regarding the imposition of an HBCO and the granting of pratique needs to be undertaken.



In the second scenario a BO has rung to inform you that someone died during travel. The BO has completed a Deceased Traveller report. The deceased body is still on board the aircraft or vessel.

The BO has spoken to others on the plane to gauge whether the deceased traveller was displaying any signs or symptoms before their fatality.

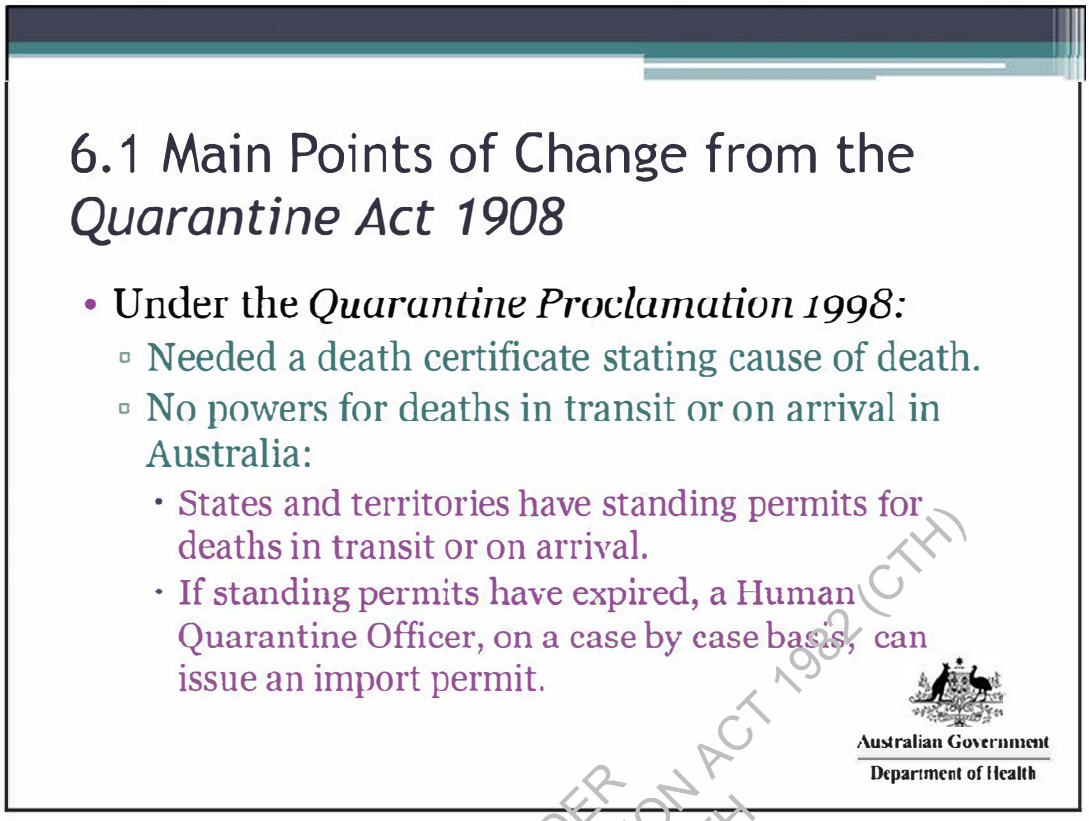
Based on the information collected by the BO a decision has to be made regarding whether pratique should be granted and what appropriate measures should be taken to manage the body.

HBOs may ask questions of BOs to make a more informed decision.

Topic Six:

Human Remains

Australian Government
Department of Health



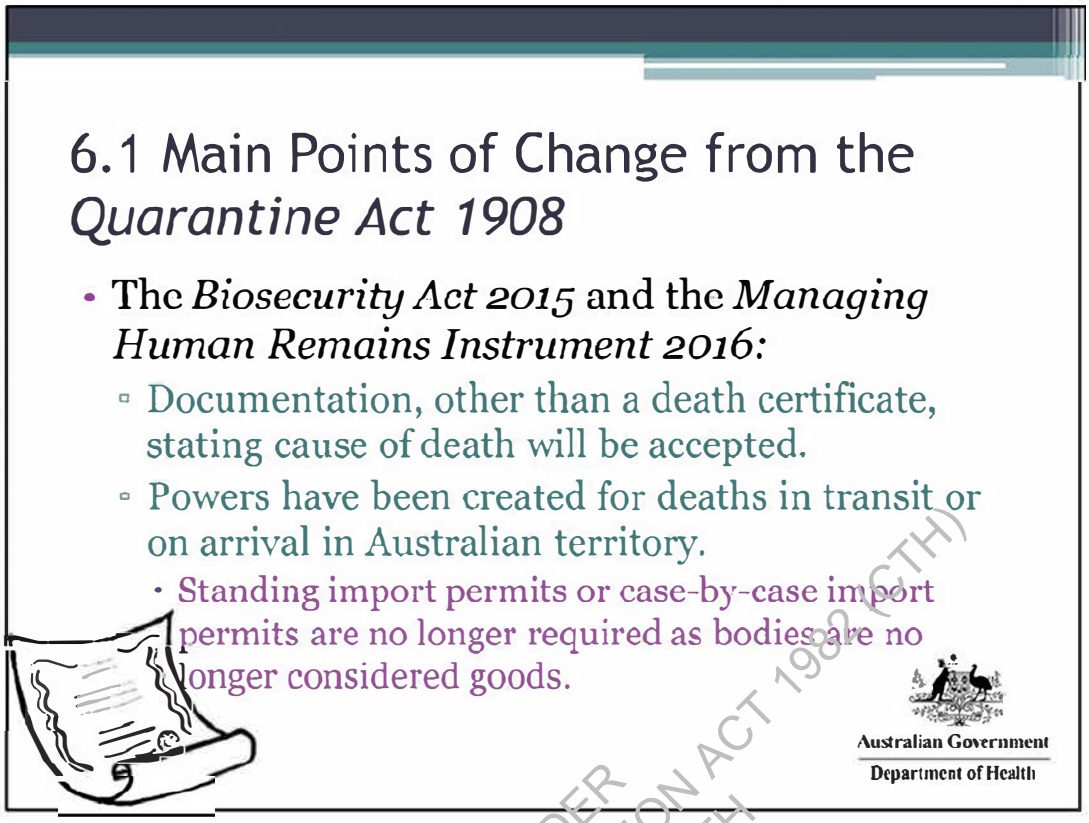
Managing human remains and deaths in transit or on arrival in Australia have been streamlined under the *Biosecurity Act 2015*.

The main points of change are around the documentation required to import human remains and the introduction of powers under the *Biosecurity Act 2015* to manage deaths in transit or on arrival in Australian territory.

It should be noted that the term human remains does not include human ashes. There are no importation requirements for human ashes under the *Biosecurity Act 2015*.

To import human remains under the *Quarantine Proclamation 1998* , the remains must be accompanied by a death certificate stating the cause of death and supporting documentation stating that the individual did not die of a communicable disease. If these documents are not provided, an import permit must be obtained from the Department of Agriculture and Water Resources (DAWR).

Powers to manage deaths in transit or on arrival are not included in the *Quarantine Act 1908* or supporting legislation. Currently in the instance of a death in transit or on arrival in Australian territory, the Director of Quarantine (DQ) has permitted states and territories to have standing import permits. A number of these standing import permits have expired and the DQ (or his delegate), on a case by case basis, issues import permits for the remains of travellers who have died in transit to Australia or on arrival in Australian territory.

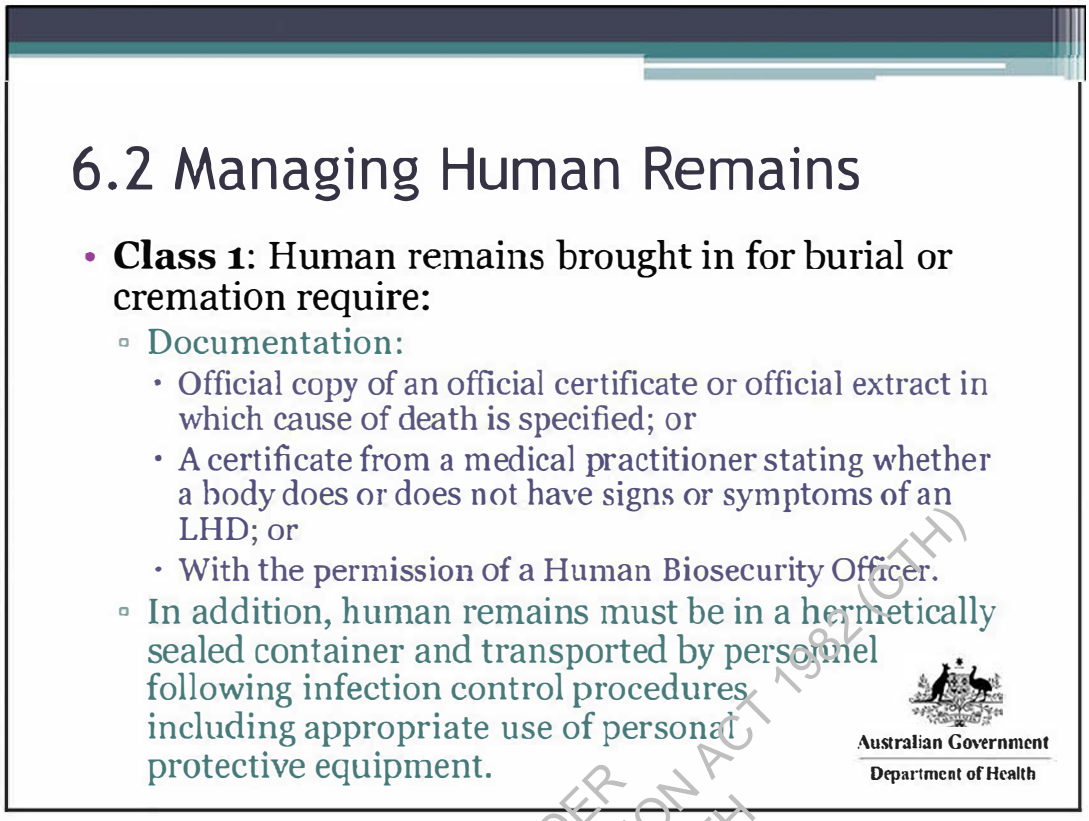


To import human remains under the *Biosecurity Act 2015* and the *Managing Human Remains Instrument 2016,* documentation other than a death certificate stating cause of death will be accepted.

Powers have also been established under the *Biosecurity Act 2015* and the *Managing Human Remains Instrument 2016,* to facilitate management of deaths in transit or on arrival in Australian territory without a standing import permit or case-by-case import permit. Permits are no longer required.

I'll now run you through how human remains and deaths in transit or on arrival will be managed under the *Biosecurity Act 2015*.

Under the *Biosecurity Act 2015,* the importation of human remains into Australian territory is not prohibited provided requirements are met as set for classes of human remains in the *Managing Human Remains Instrument 2016.* There are four classes of human remains as follows:



Human remains for burial or cremation can be imported into Australia if they meet one of the following requirements:

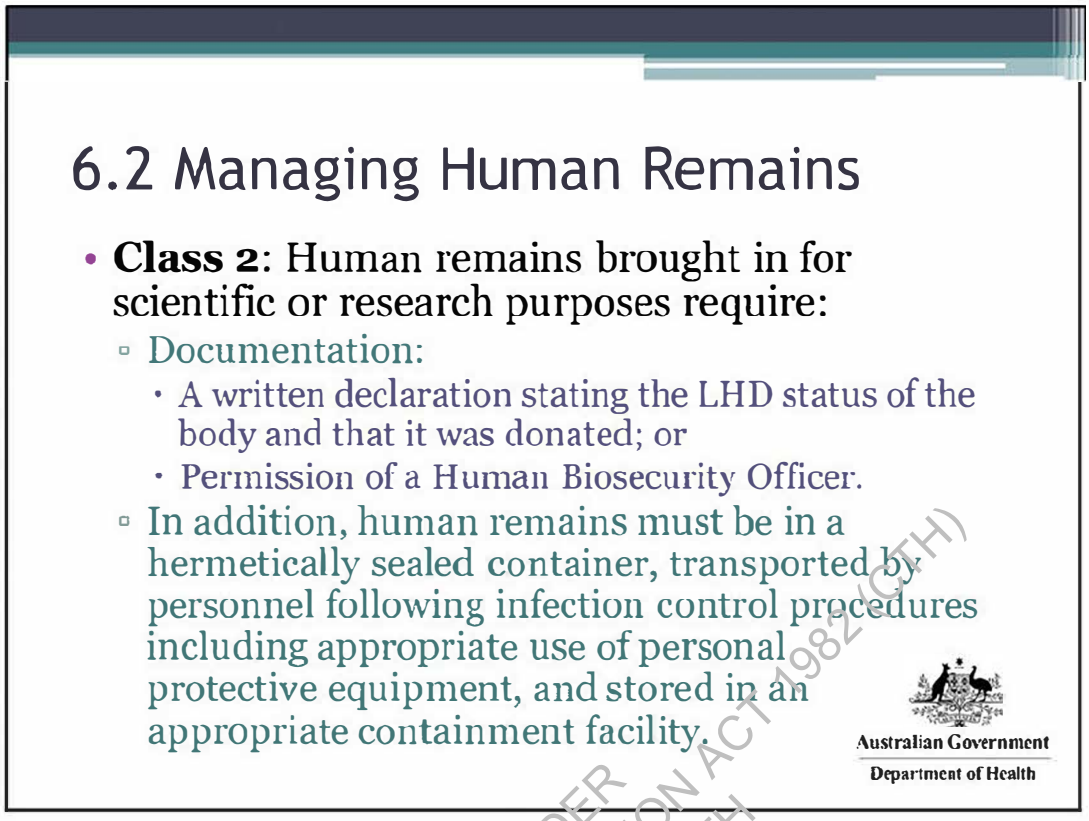
- they are accompanied by an official copy of an official certificate or official extract from an entry in an official register, in which the cause of death is specified (an example of this would be a death certificate), or
- they are accompanied by a statement from a medical practitioner certifying that the human remains do not, or did not before death, have signs or symptoms of a Listed Human Disease (LHD) (an example of this would be a letter from a hospital, signed by a doctor, stating that the individual did not die of a communicable disease), or
- with the permission of a commonwealth HBO.

To obtain permission from a commonwealth HBO, Biosecurity Officers will contact Health with all available information and documentation via the Human Quarantine Inbox s22 , or in urgent situations phone the Border Health Section. Health will facilitate the commonwealth HBO in undertaking a risk assessment to analyse the communicable disease risks associated with importing the human remains and grant permission in writing if appropriate.

In addition to one of the requirements I've just mentioned, the human remains must:

- be brought into Australian territory in a hermetically-sealed container,
- be transported in a hermetically-sealed container from the landing place or port where it first enters Australia to another place under the direction or control of a coroner or funeral director, and
- be handled following appropriate infection control procedures and the use of

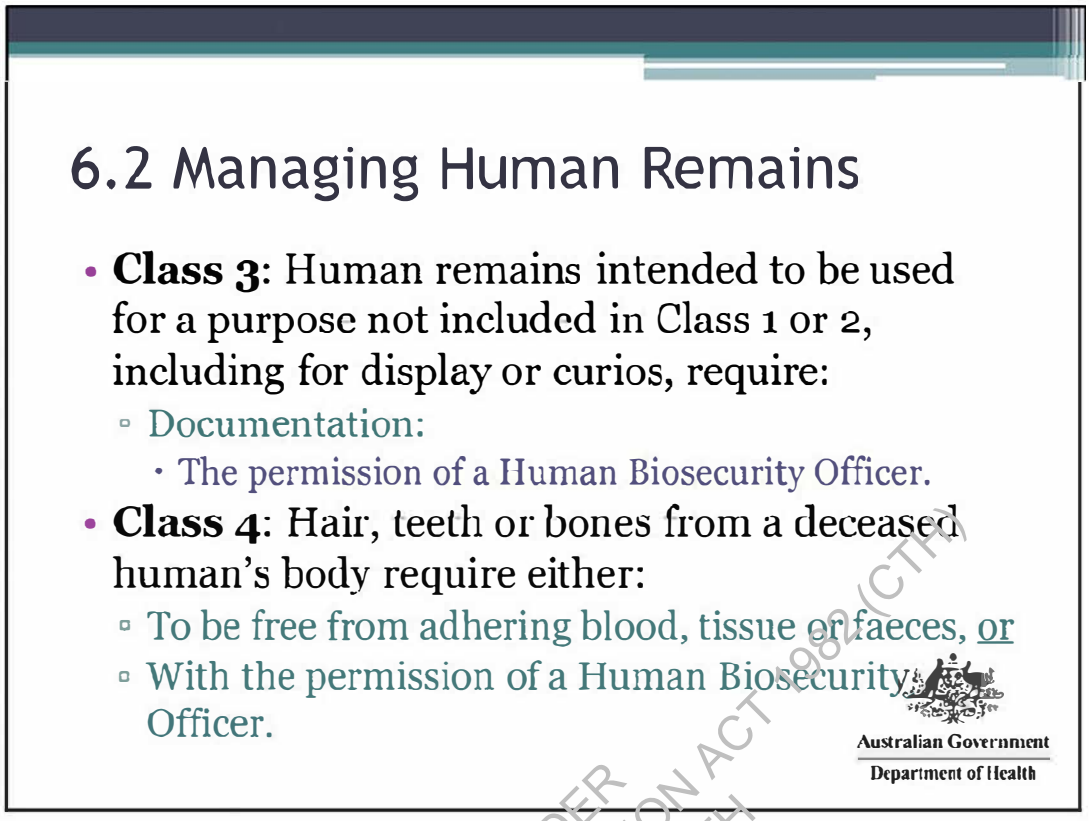
personal protective equipment.



Human remains brought in for scientific or research purposes must be accompanied by appropriate documentation, stating whether the body has an LHD and that it was freely donated. If this statement is not available, permission of a Commonwealth HBO will be required.

The normal standards for transportation and storage of the human remains also apply.

To obtain permission from a Commonwealth HBO, Biosecurity Officers should contact Health with all available information and documentation via the Human Quarantine Inbox s22 , or in urgent situations phone the Border Health Section. Health will facilitate the commonwealth HBO in undertaking a risk assessment to analyse the communicable disease risks associated with importing the bones or teeth from a deceased human's body and grant permission in writing if appropriate.



Human remains for purposes other than burial and cremation, including for use as jewellery, curios or for display purposes, may be imported into Australia with the permission of a commonwealth HBO.
It should be noted that this class excludes human remains for scientific and research purposes, for which there is a separate class.

Hair, bones or teeth of a deceased human's body for use as curios or jewellery may be imported into Australia if they are clean and have no adhering tissue, blood or faeces. If the hair, bones or teeth of a deceased human's body are not clean or have adhering tissue, blood or faeces, the permission of a commonwealth HBO must be obtained.

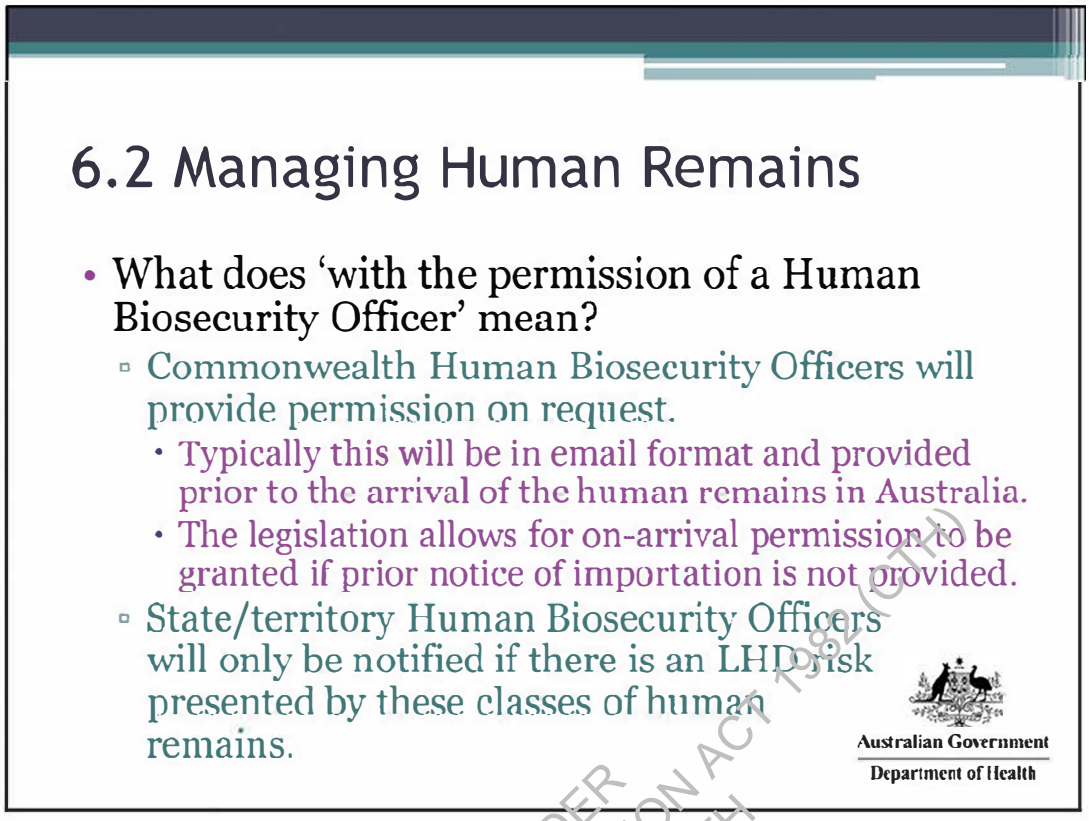
To obtain permission from a commonwealth HBO, Biosecurity Officers should contact Health with all available information and documentation via the Human Quarantine Inbox s22 , or in urgent situations phone the Border Health Section. Health will facilitate the commonwealth HBO in undertaking a risk assessment to analyse the communicable disease risks associated with importing the hair, bones or teeth from a deceased human's body and grant permission in writing if appropriate.

Individuals who have died in transit or on arrival are recognised as a separate category under the *Biosecurity Act 2015* and are required to be assessed for the presence of an LHD by a Biosecurity Officer. The process for managing deaths in transit or on arrival in Australian territory includes:

- the operator of the aircraft or vessel submits a pre-arrival report, as set out in the

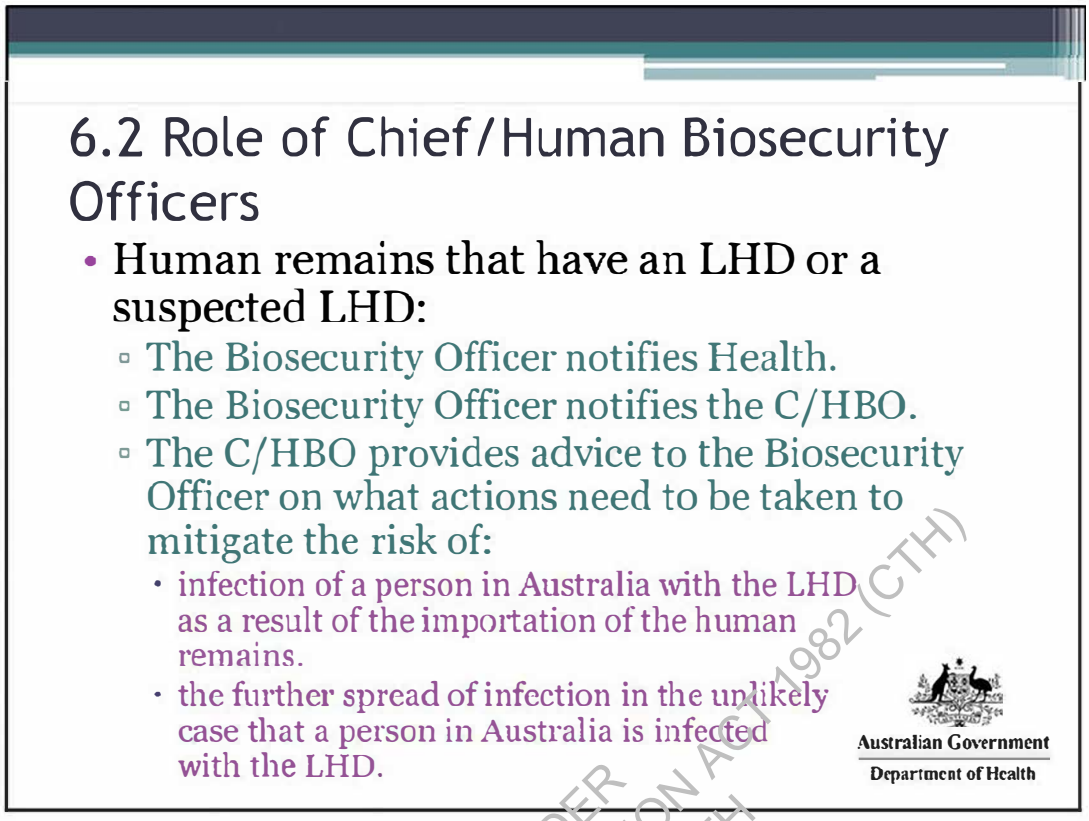
Pre-Arrival Notices and Reports Regulation 2015, advising of the death in transit,

- the Biosecurity Officer notifies the relevant air or sea port authority. The air or sea port authority contacts the police and coroner,
- the aircraft or vessel falls into a negative pratique class as set out in the *Negative Pratique Instrument 2015* and positive pratique will not be granted until such time as permission is given by the Biosecurity Officer or (C)HBO,
- the Biosecurity Officer undertakes the Death in Transit Report (DTR). This can be done prior to the aircraft or vessels arrival with information obtained from the crew or accompanying travellers,
- if the completed DTR does not indicate a suspected LHD, the Biosecurity Officer grants positive pratique and passengers may disembark from the aircraft or vessel on arrival, and
- when the police are satisfied that the removal of the body is appropriate, the body is handed over to the coroner or their agent.



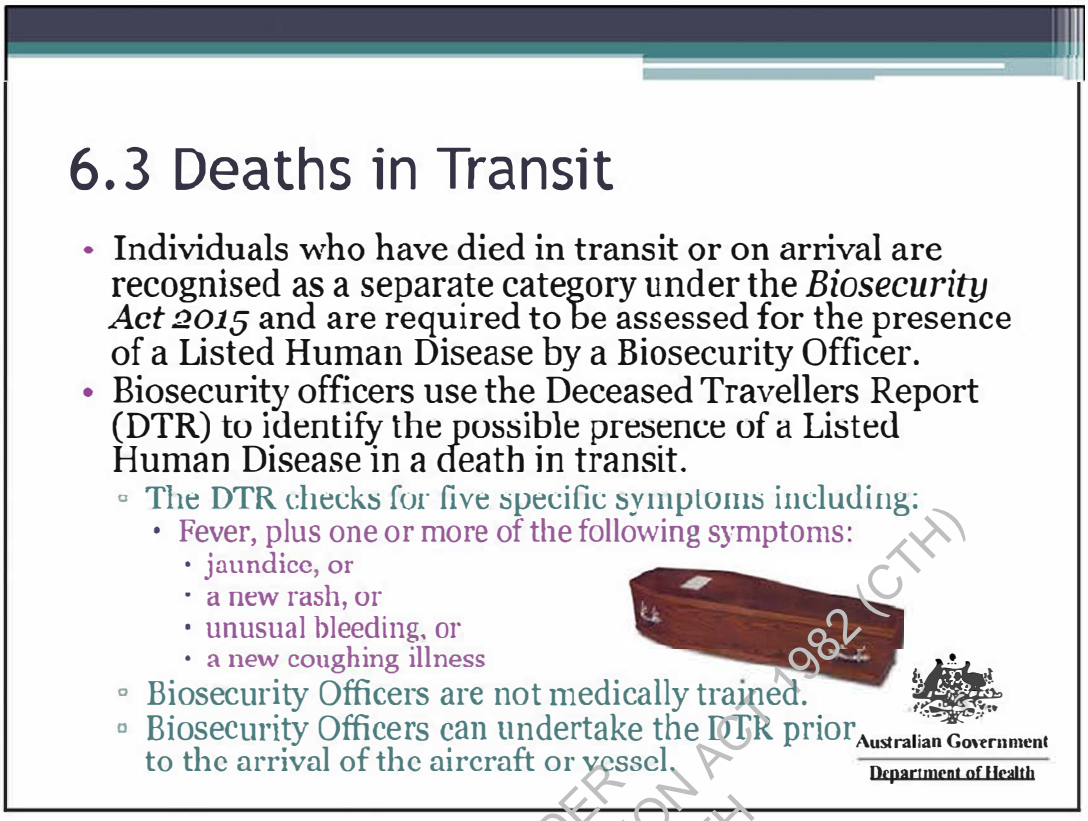
Providing permission to bring in human remains is a function of Commonwealth Human Biosecurity Officers. Within business hours this process is managed by Border Health Section, and outside of business hours the National Incident Room Duty Officer will facilitate permission.

State and territory human biosecurity officers will be notified if there is concern regarding an LHD risk.



When human remains are imported into Australian territory and they have an LHD or suspected LHD (i.e. the accompanying documentation states that the individual died of an LHD or suspected LHD), the following process should be followed:

- the Biosecurity Officer notifies Health via the Human Quarantine Inbox s22 ,
- the Biosecurity Officer notifies the (C)HBO,
- the (C)HBO provides advice to the Biosecurity Officer on what actions need to be taken to mitigate the risk of:
    - infection of a person in Australia with the LHD as a result of the importation of the human remains, and
    - the further spread of infection in the unlikely case that a person in Australia is infected with the LHD.



Individuals who have died in transit or on arrival are recognised as a separate category under the *Biosecurity Act 2015* and are required to be assessed for the presence of an LHD by a Biosecurity Officer. The process for managing deaths in transit or on arrival in Australian territory includes:

- the operator of the aircraft or vessel submits a pre-arrival report, as set out in the *Pre-Arrival Notices and Reports Regulation 2015*, advising of the death in transit,
- the Biosecurity Officer notifies the relevant air or sea port authority. The air or sea port authority contacts the police and coroner,
- the aircraft or vessel falls into a negative pratique class as set out in the *Negative Pratique Instrument 2015* and positive pratique will not be granted until such time as permission is given by the Biosecurity Officer or (C)HBO,
- the Biosecurity Officer undertakes the Death in Transit Report (DTR). This can be done prior to the aircraft or vessels arrival with information obtained from the crew or accompanying travellers,
- if the completed DTR does not indicate a suspected LHD, the Biosecurity Officer grants positive pratique and passengers may disembark from the aircraft or vessel on arrival, and
- when the police are satisfied that the removal of the body is appropriate, the body is handed over to the coroner or their agent.

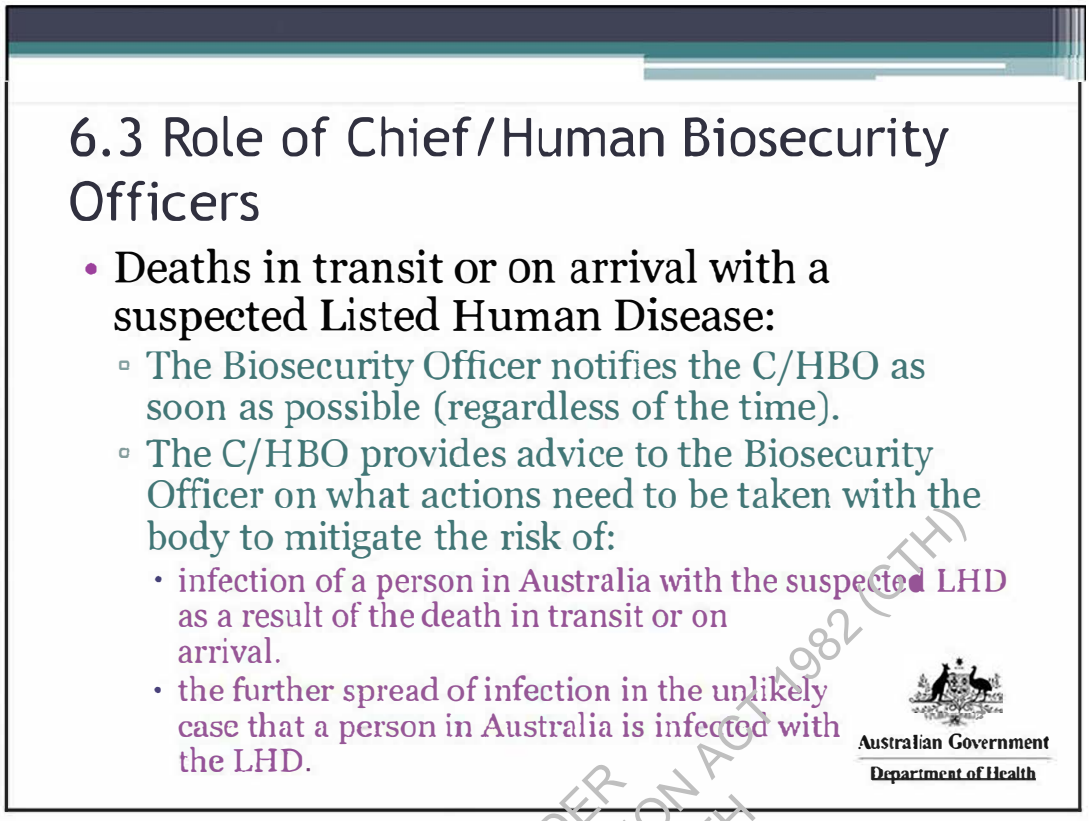
To identify the possible presence of an LHD in a death in transit or on arrival in Australian territory, Biosecurity Officers use the DTR to determine if the body had (prior to death), or has, any of the following five specific symptoms:

- fever, plus one or more of the following symptoms:

- jaundice, or
- a new rash, or
- unusual bleeding, or
- a new coughing illness.

Biosecurity Officers are not medically trained. The questions used in the DTR are therefore designed to make reporting requirements more practical for non-medically trained staff.

Biosecurity Officers can undertake the DTR prior to the arrival of the aircraft or vessel. Information needed to complete the DTR should be obtained from the crew of the aircraft or vessel and accompanying travellers. Biosecurity Officers do not need to assess or view the body when completing the DTR.



When the DTR indicates a suspected LHD, the following process should be followed:

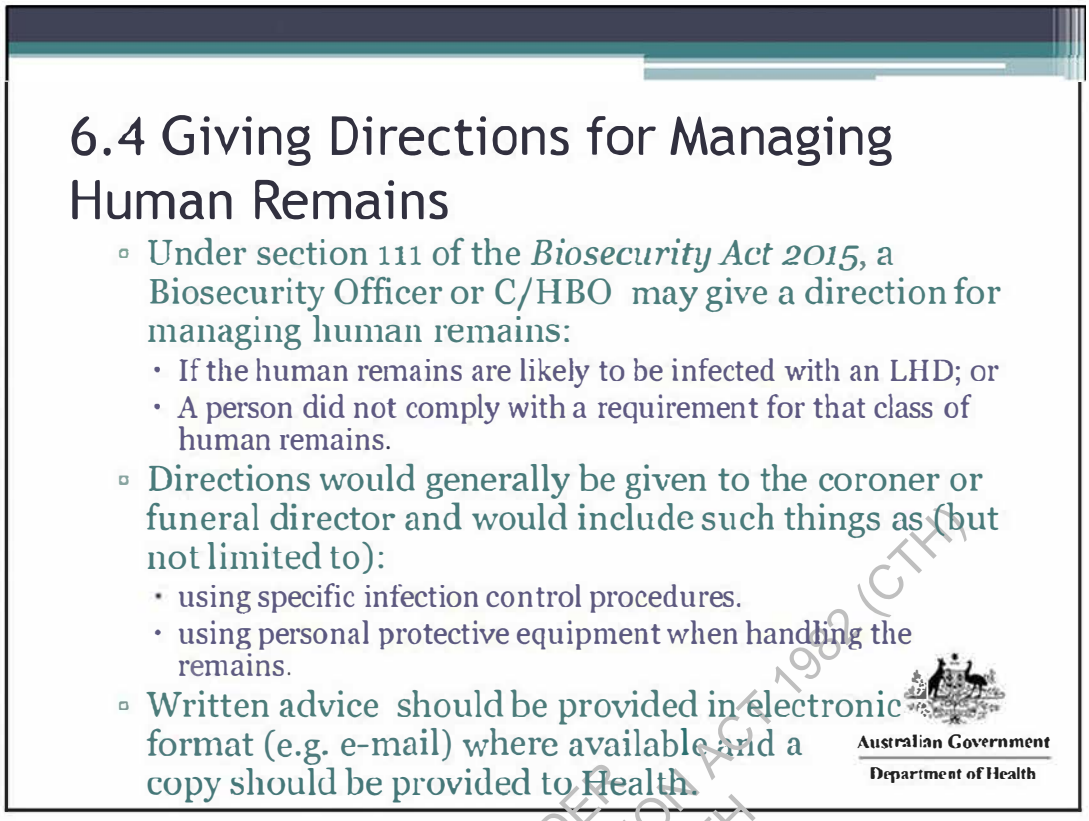
- the Biosecurity Officer notifies the (C)HBO as soon as possible (regardless of the time),
- the aircraft or vessel is met on arrival by the Biosecurity Officer,
- the (C)HBO provides advice to the Biosecurity Officer on what actions need to be taken with the body to mitigate the risk of:
    - infection of a person in Australia with the suspected LHD as a result of the death in transit or on arrival, and
    - the further spread of infection in the unlikely case that a person in Australia is infected with the LHD,

6.3 Role of Chief/Human Biosecurity Officers

- The Biosecurity Officer administers the Traveller with Illness Checklist (TIC) to any other ill individuals on the aircraft or vessel.
- The C/HBO advises the Biosecurity Officer if positive pratique can be granted and passengers may disembark.

Australian Government
Department of Health

- the Biosecurity Officer administers the Traveller with Illness Checklist (TIC) to any other ill individuals on the aircraft or vessel, and
- the (C)HBO advises the Biosecurity Officer if positive pratique can be granted and passengers may disembark.



Under section 111 of the Act, a Biosecurity Officer or (C)HBO may give a direction in writing for managing specified human remains if the officer is satisfied that those remains are likely to be infected with an LHD. Written directions would generally be given to the coroner or funeral director and would include such things as (but not limited to):

- using specific infection control procedures, or
- using personal protective equipment when handling the remains.

The Biosecurity Officer (largely under advice from the (C)HBO) or (C)HBO should provide the written advice in electronic format (e.g. e-mail) where available and a copy should be provided to Health via the Human Quarantine Inbox

s22

Topic Seven:

Vector Management

Australian Government
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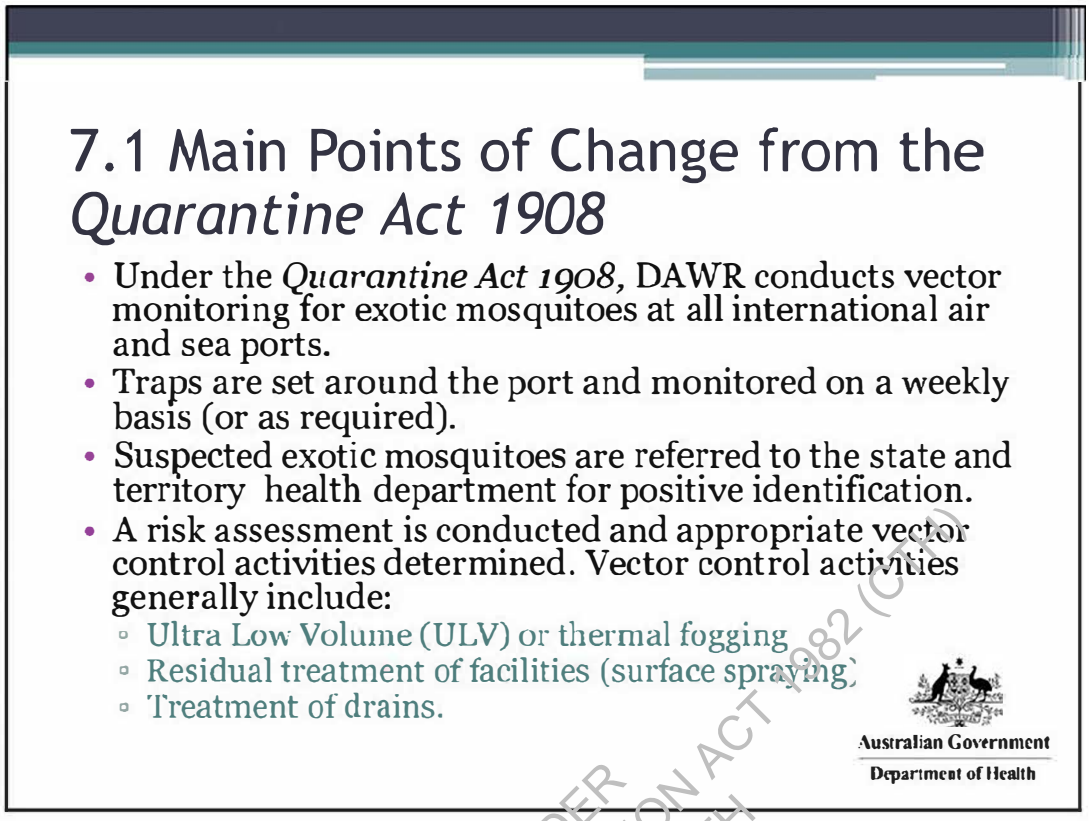


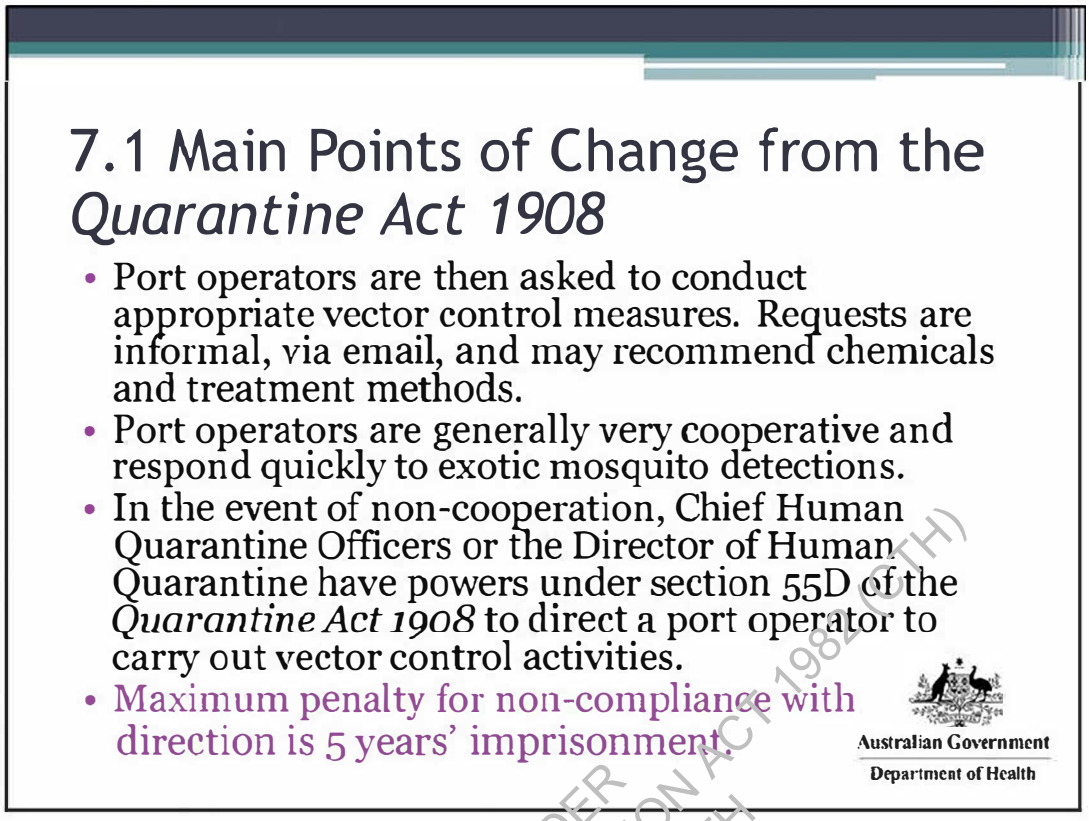
The entry of mosquitoes and mosquito-borne diseases into Australia is considered a threat to public health and warrants control measures at the border. Australia is largely free of vectors that carry such diseases as dengue, Zika virus and yellow fever and wants to remain so. All of Australia's international air and sea ports are monitored for exotic mosquitoes.

DAWR is responsible for vector monitoring at all Australian first points of entry. Traps are generally monitored weekly and more frequently following a detection. Following a detection, traps are generally monitored on a daily basis and scaled back if no further detections occur.

Once a suspected mosquito is discovered, identification confirmation is carried out by the state or territory health department.

Once a positive identification has been made and a risk assessment conducted, the air or sea port operator is contacted regarding relevant vector control activities.

Vector control activities are usually all of the ones listed here with thermal fogging generally being preferred over ultra low volume fogging. Fogging is used to knock down adult mosquitoes that may be harbouring in or around the facility and is generally the first vector control measure in response to a detection.



In general, port operators are cooperative and conduct vector control measures when requested.

Historically, with 5-6 detections of exotic mosquitoes seen at first points of entry in Australia, vector control measures have been limited. However over the past two years there has been a significant increase in detections with over 50 instances this season where exotic mosquitoes have been detected at air and sea ports, primarily airports, and there has been some resistance to conducting vector control activities that can be quite disrupting in response to ongoing detections.

Section 55d of the Quarantine Act allows for a CHQO or the Director of Human Quarantine to issue a direction to a port operator to conduct vector control activities. Should a port operator be non-cooperative or refuse outright to conduct vector control measures in response to a detection, a direction can be issued. Non-compliance with a direction issued under section 55d carries a maximum penalty of 5 years in prison.

There has only ever been the need to use the powers described under section 55d once directing a port operator to conduct vector control measures.

7.1 Main Points of Change from the *Quarantine Act 1908*

- Under the *Biosecurity Act 2015*, DAWR conducts vector monitoring within permanent monitoring zones around First Points of Entry.
- Suspected exotic mosquitoes are referred to the state and territory health department for positive identification and risk assessment.
- A request is made to the port operator to conduct appropriate vector control activities.
- Essentially the same process as under the *Quarantine Act 1908*.

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Department of Health

Under the Biosecurity Act, the aim is to maintain the status quo - to keep things operating as they are.

DAWR continues to remain responsible for vector monitoring at first points of entry and in the event of an exotic mosquito being detected, state and territory health departments are called on to confirm the identification and conduct a risk assessment.

Again, a request will be made to port operators to conduct vector control activities as determined necessary by the state and territory experts.

Essentially nothing changes except in the case where a port operator is non-cooperative or refuses to comply with a request to spray, then things are slightly different.

7.2 New Vector Control Arrangements – Failure to Comply with Request

- There is currently no section 55D equivalent, and no means for the Director of Human Biosecurity or Chief Human Biosecurity Officers to legally compel a port operator to conduct vector control activities.
- The intent remains for Health and the state and territory health departments to have the power to direct a port operator to conduct vector control activities.
- Health and DAWR intend to amend the *Biosecurity Act 2015* to introduce equivalent powers to section 55D of the *Quarantine Act 1908*, however this may take some time.

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Under the Biosecurity Act, there is no equivalent to section 55d. As such there is no means available for the Director of Human Biosecurity or chief human biosecurity officers to legally compel a port operator to spray.

Health and DAWR have agreed in principle that the power to direct a port operator to conduct vector control activities should sit with the DHB and CHBOs. Therefore, Health and DAWR intend to amend the *Biosecurity Act 2015* to include equivalent powers to section 55D of the *Quarantine Act 1908*. All going well, the amendment will be tabled during the spring sitting of parliament.

7.2 New Vector Control Arrangements – Failure to Comply with Request

- In the meantime, DAWR will issue a Biosecurity Control Order (BCO) in place of a direction, that requires vector control measures be carried out.
- Penalties of up to 5 years jail and 300 penalty units apply for non-compliance with a BCO.

Australian Government
Department of Health

As mentioned, only once have we ever needed to legally compel a port operator to carry out vector control measures. Until the *Biosecurity Act 2015* is amended, however unlikely it might be, should an air or sea port refuse to conduct vector control activities that are deemed necessary, DAWR will issue a biosecurity control order that will legally require a port operator to conduct treatment. DAWR will only issue a BCO under advice from the relevant state or territory health department and the Department of Health.

DAWR and Health have agreed to more stakeholder engagement with air and sea port operators in the lead up to next season looking towards cooperative compliance regarding vector control at first points of entry.

Topic Eight:

Human Biosecurity Emergencies

Australian Government
Department of Health

8.1 What is a Human Biosecurity Emergency?

- A human biosecurity emergency may be declared in relation to a Listed Human Disease:
  - If the LHD is posing a severe and immediate threat, or is causing harm on a nationally significant scale; and
  - The declaration of an emergency is necessary to prevent or control the entry of an LHD into Australia, or the emergence, establishment and spread within Australia.
  - Can be established for up to three months (may be extended if required).

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The human biosecurity emergency power is exactly that – a power that is available in emergencies to manage a Listed Human Disease, should the situation be serious enough to require activation of these powers. If there is a new or emerging disease threat, that disease would have to be determined as an LHD by the Director of Human Biosecurity prior to the human biosecurity powers being used. When an emergency is declared, it is for a specified time of up to three months, though this may be extended if it continues to be necessary. The Department of Agriculture and Water Resources also have emergency powers available for emergencies related to animal and plant health, the environment, and economic activities related to animals, plants and the environment. We are going to focus on the human biosecurity emergency powers only.

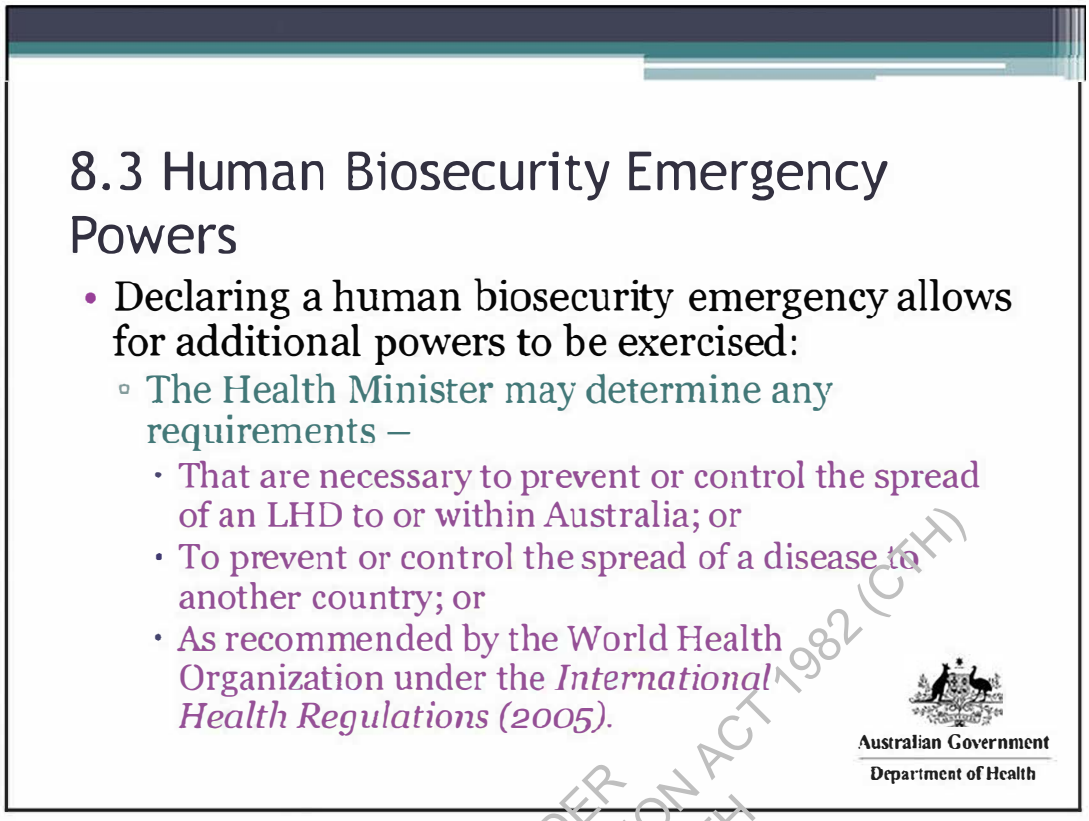
8.2 Who Declares an Emergency?

- The Governor-General, on advice from the Health Minister, may declare a Human Biosecurity Emergency if the Health Minister is satisfied it is necessary to manage the risk of an LHD.
  - Existing consultation mechanisms, such as the Australian Health Protection Principal Committee, will continue to be an important factor in managing public health threats.

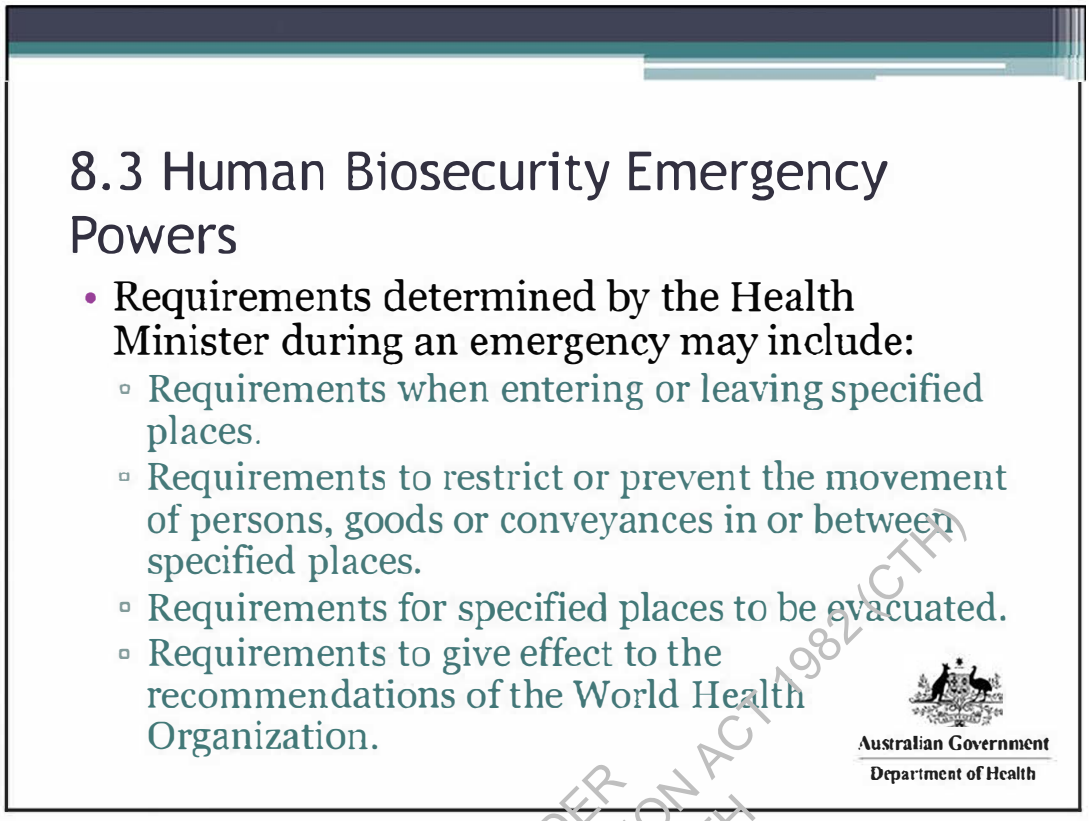
Australian Government
Department of Health

The declaration of a human biosecurity emergency is a function of the Governor-General, on advice of the Health Minister.

Supporting this advice will be the Department of Health, including the Director of Human Biosecurity and existing consultation mechanisms such as AHPPC. While not specifically mentioned in the legislation, AHPPC continues to be a key mechanism to ensure engagement with state and territory colleagues in emergency situations.



Human biosecurity emergency powers are flexible in order to meet the circumstances of that emergency. The Health Minister may determine requirements that are necessary to stop or control the spread of the disease within Australia, to other countries, or to give effect to recommendations made by the WHO under the IHRs.



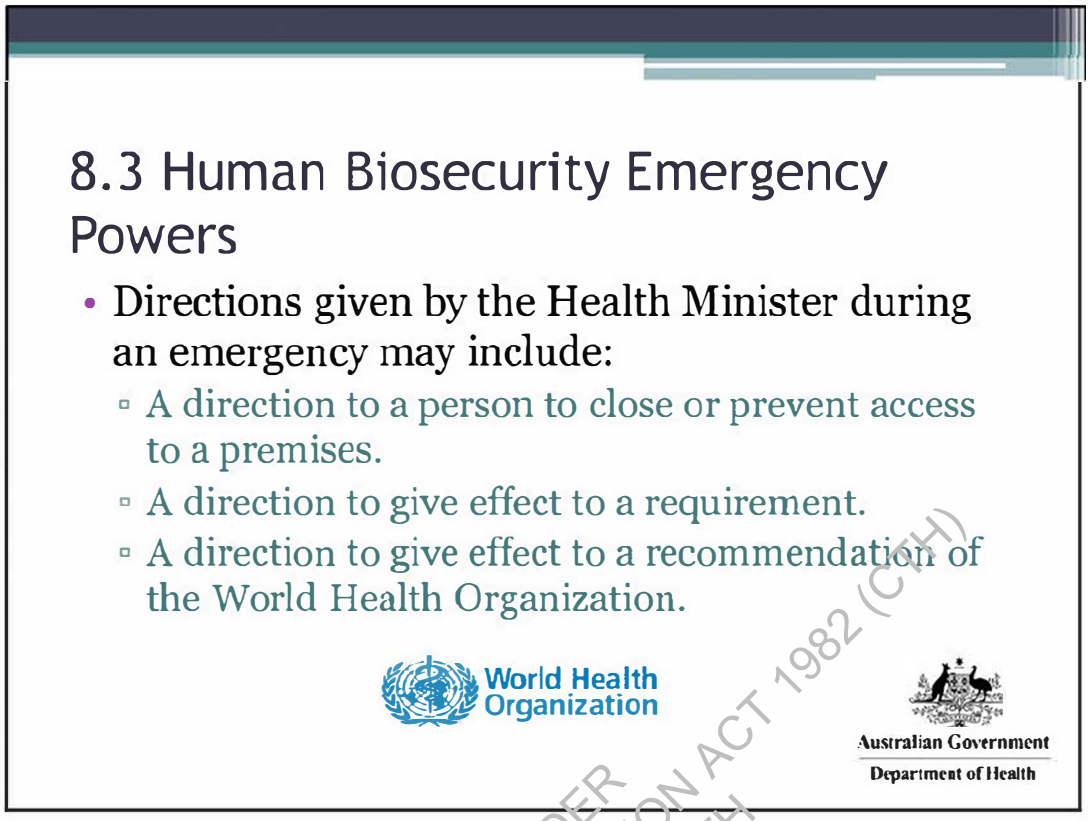
Some examples of things we might do in a human biosecurity emergency include determining requirements for entering and leaving specified places, like wearing personal protective equipment. We may also prevent people from entering or leaving particular places, for example, if a hospital or township becomes the location of an outbreak we could ensure that only medical professionals can enter the area. In extreme circumstances, we may evacuate areas, again, this could be entire towns, hospitals, first points of entry etc. If there are recommendations made by the WHO to require particular things be done, the Health Minister can enshrine this in law through the human biosecurity emergency requirements power.

8.3 Human Biosecurity Emergency Powers

- The Health Minister may provide directions -
  - That are necessary to prevent or control the spread of an LHD to or within Australia; or
  - To prevent or control the spread of a disease to another country; or
  - As recommended by the World Health Organization under the *International Health Regulations (2005).*

Australian Government
Department of Health

The Health Minister can also give directions to control or prevent the spread of disease within Australia and to other countries, and as per recommendations of the WHO.



These directions may be given to a person who is able to give effect to the requirements, such as people in charge of specified places that have been ordered to be evacuated, for example. It is important to note that the Health Minister can not direct officers or employees of a state, territory, or state or territory body unless there is an agreement between the Commonwealth and that state/territory/body.

8.3 Human Biosecurity Emergency Powers

- Directions and requirements **must** be fit for purpose!
- Powers available under a human biosecurity emergency are intended for the large scale direction of people, rather than the management of individuals.
- Human Biosecurity Control Orders are the most appropriate way to manage individual disease threats.

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Department of Health

There are some limitations on the use of the emergency powers. As mentioned on the previous slide, the Health Minister cannot direct everyone to anything at his or her whim. The requirement or direction must be fit for purpose – that is, it must be likely to be effective in controlling or preventing the spread of disease, or in giving effect to WHO recommendations. It must also not be more restrictive or intrusive than necessary, and the direction or requirement can only be in place for as long as is necessary to manage the risk. Failure to comply with emergency requirements and directions can result in a fault-based offence.

The emergency powers are intended to be used for large scale activities, such as the mass movement of people or bigger geographical locations. Human Biosecurity Control Orders are the most appropriate way to manage human biosecurity risks posed by individuals.

8.4 Role of Human Biosecurity Officers

- Human Biosecurity Officers and Chief Human Biosecurity Officers may be requested to assist in giving effect to directions and requirements set by the Health Minister.
  - Each human biosecurity emergency will differ, and therefore your involvement will vary depending on the particular circumstances of the emergency.
  - We will continue to consult with Chief Human Biosecurity Officers in managing border response during emergencies.

Australian Government
Department of Health

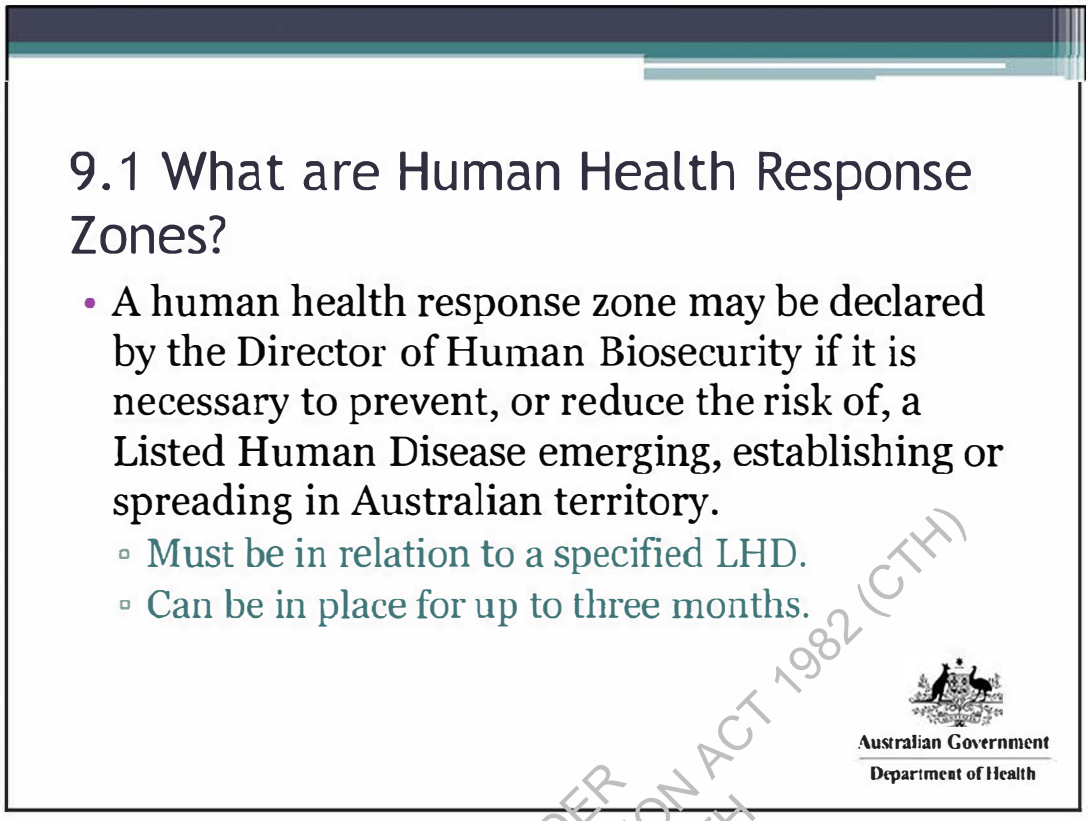
As noted previously, the Health Minister may only give directions to officers of state and territory agencies if there is an arrangement in place. The Commonwealth has a funding agreement with each state and territory health department to satisfy this requirement, so should there be an emergency, we are ready to go.

The role of a human biosecurity officer may vary in each emergency, depending on the specific circumstances of the disease outbreak. Your assistance may be requested in assessing individuals entering and leaving locations, providing advice on appropriate protective measures and so forth. Existing consultation mechanisms, such as our Chief Human Biosecurity Officer network, and the Australian Health Protection Principal Committee, will be used to discuss responsibilities and activities during an emergency.

Topic Nine:

Human Health Response Zones

Australian Government
Department of Health



Human health response zones are another tool to use in extreme circumstances to manage human health risks. Like the human biosecurity emergency powers, they are intended for larger scale direction of people, not for the management of individuals.

9.1 What are Human Health Response Zones?

- Designed to address isolated, short-term incidents or Listed Human Disease outbreaks.
- Intended to work with state/territory public health legislation.
  - If incident spreads beyond one jurisdiction, a human biosecurity emergency may be declared.

Australian Government
Department of Health

They are designed to address isolated disease outbreaks. They can only be used if the disease causing the outbreak is a Listed Human Disease, and are intended to supplement existing state public health legislation. It is important to note that in circumstances where both Commonwealth and State law operates, the Commonwealth will prevail, so consultation is a key factor here.

If the incident extends beyond one jurisdiction, the human biosecurity emergency powers may be a more appropriate way to manage the risks and lead a response.

9.1 What are Human Health Response Zones?

- A human health response zone may:
  - Specify requirements for individuals who are entering or leaving the Zone.
  - Specify classes of individuals who must not enter the Zone.
- Before determining a Zone, the Director of Human Biosecurity **must** consult with the relevant Chief Health Officer and the Director of Biosecurity.

Australian Government
Department of Health

A human health response zone allows the Director of Human Biosecurity to specify requirements for individuals leaving or entering the zone, and to specify classes of individuals who may not enter the dome. This means we can effectively control the movement of people in and out of the Zone, and set requirements to protect and monitor individuals.

As Zones can be established within jurisdictions, the Director of Human Biosecurity is required by law to consult with the Chief Health Officer of that jurisdiction, and the Director of Biosecurity. The DHB must also, in any many he or she sees as being appropriate, ensure that the determination of a response zone is made public. This may include a media release, providing information via the Health website, and so forth.

9.2 Role of Human Biosecurity Officers

- Not likely to have significant role in human health response zones.
- May be asked to assist in assessing the health of individuals leaving and entering the zone.
- Role of HBOs would be decided in consultation with CHBOs.

Australian Government
Department of Health

Similar to the human biosecurity emergency powers, each response zone will be different, and the role of human biosecurity officers will be determined by the situation.

There may be a requirement to assess the health of travellers entering and exiting the zone, or to provide advice to Biosecurity Officers who may also be assisting. Consultation with Chief Human Biosecurity Officers will be important in determining the role of human biosecurity officers in a response zone, and existing consultation mechanisms will be used.

9.3 Human Health Response Zones - Scenario

- There has been an unexpected increase in the number of cases of Ebola in Canberra.
- Initially, HBCOs were used to manage individuals:
  - Isolation.
  - Contact information for close contacts.
  - Risk minimisation interventions.
    - Too many HBCOs become difficult to manage and point to a broader issue.

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Our scenario here is that there have been an unexpected increase in the number of cases of Ebola identified in Canberra. HBCOs have been used on a few individuals to require them to isolate themselves, provide contact information for their family members who have recently been in close physical proximity to them, and – for individuals who are contacts but not themselves symptomatic – to wear personal protective equipment when outside the home.

9.3 Human Health Response Zones Scenario

- Director of Human Biosecurity, after consultation with ACT Chief Health Officer and Director of Biosecurity, has decided to declare the city of Canberra as a human health response zone.
  - Listed Human Disease: viral haemorrhagic fever.
  - What kinds of requirements might be effective?
  - Discuss!

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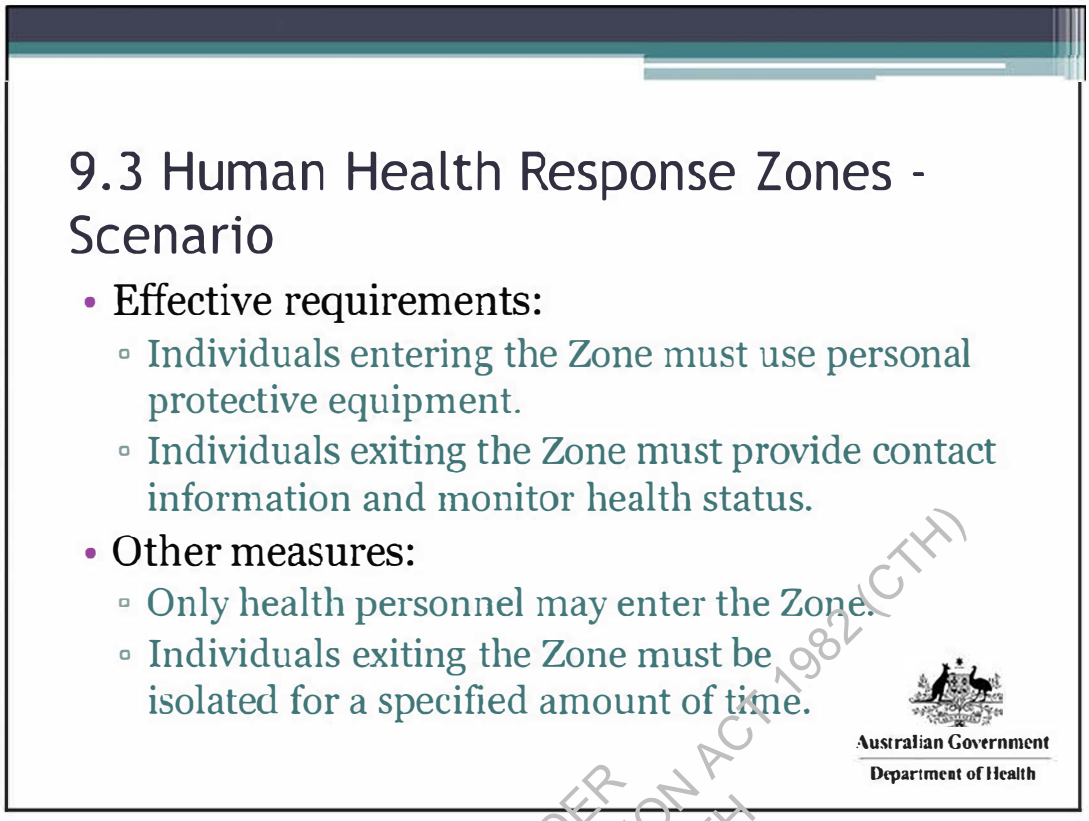
After discussion with the Director of Biosecurity and the ACT Chief Health Officer, the DHB has decided to declare Canberra as a human health response zone. The determination notes that the LHD in question is a viral haemorrhagic fever, but it also has to describe the requirements to be implemented. What sorts of things do you think we might effectively use for this situation?



Requirements specified must be appropriate and proportionate for the management of the LHD.

Things we might think about doing include specifying that individuals entering the zone must wear full PPE, and that those exiting the zone must provide contact information and report changes in their health status.

If the situation escalated significantly and more extreme measures were required, we could specify classes of individuals, ensuring that only specified classes (such as medical professionals) can enter the zone, or that individuals exiting the zone must be isolated for a specified amount of time. This isn't dissimilar to the voluntary arrangements used by returning health care workers in the West Africa Ebola outbreak – many NGOs had a requirement that returning staff would isolate themselves for 28 days.

Even though the extreme powers are there if we need them, they must always be proportionate to the risk, appropriate for the management of the disease, and no more personally intrusive or invasive than is necessary.

Conclusion and Review

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In summary…

- *Biosecurity Act 2015* replaces *Quarantine Act 1908* on 16 June 2016.
- Listed Human Diseases to replace Quarantinable Diseases.
- New human health powers and positions:
  - Human Biosecurity Control Orders
  - Director of Human Biosecurity, Chief Human Biosecurity Officers, Human Biosecurity Officers.
- All training materials will be made available on govdex.
- 'Border Measures Guide' – coming soon.
- Border Health Section is here to help!

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Review Quiz… have you been paying attention?

- Introduction: Principles of General Protection
  - Which of the following is **not** a principle?
    - Exercising the power must be effective in contributing to or managing the risk?
    - The measure must not be more intrusive than is necessary?
    - The measure must be the most extreme measure possible for the circumstance?
    - The circumstances are sufficiently serious to justify use of the measure?

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- Correct answer is c. The principles of general protection state that the measure must be proportionate to the risk and must not be more invasive than is required.

Review Quiz… have you been paying attention?

- 1 . Chief/Human Biosecurity Officers
  - Which of the following is **not** an authorised position under the Act?
    - Director of Human Biosecurity?
    - Director of Enforcement?
    - Human Biosecurity Officer?
    - Biosecurity Enforcement Officer?

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The answer is b.

Review Quiz… have you been paying attention?

- 2. Listed Human Diseases
  - Which of the following is **not** a Listed Human Disease?
    - Middle East respiratory syndrome?
    - Smallpox?
    - Yellow fever?
    - Rabies?

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The answer is d.

Review Quiz… have you been paying attention?

- 3 . Assessing Travellers at the Border
  - When will a Biosecurity Officer call a Chief/Human Biosecurity Officer?
    - If a passenger is being really annoying?
    - If the Traveller Illness Checklist has been administered and symptoms of a Listed Human Disease identified?
    - If a deceased human has entered Australia with a death certificate?
    - If an individual has returned from a Yellow fever declared country but does not have a vaccination certificate?

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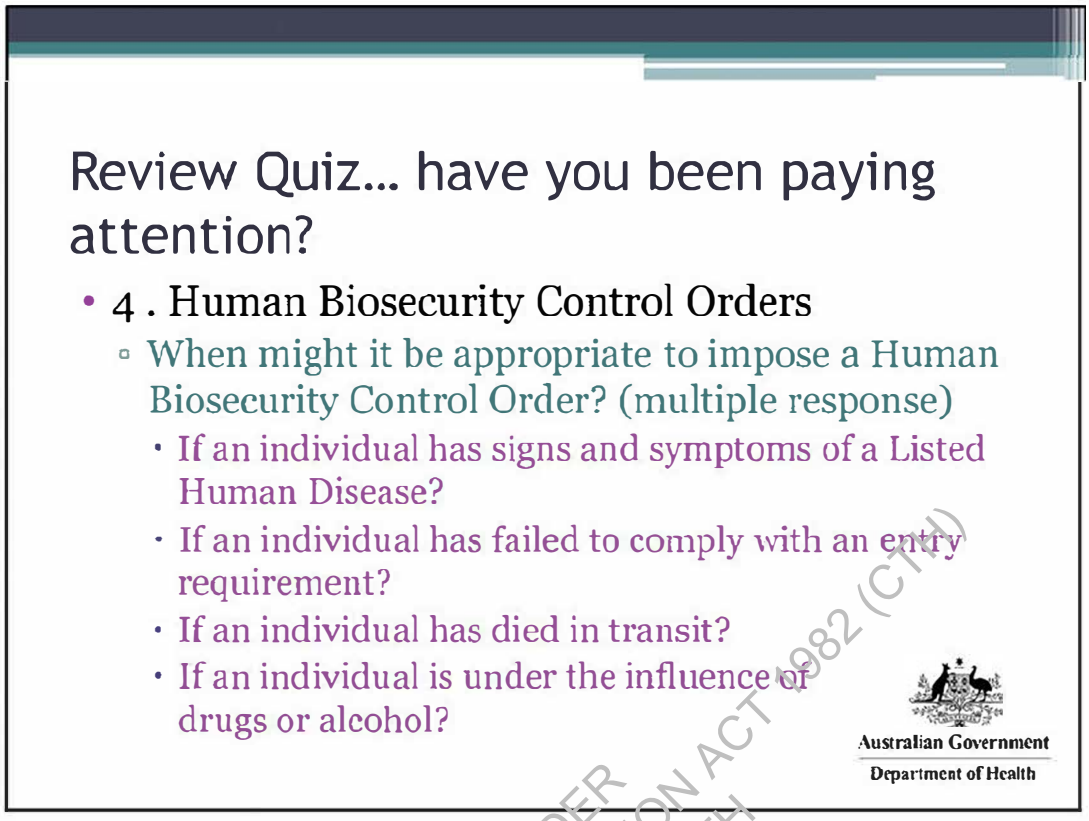
The answer is b.

The legislation requires that a death certificate, or other acceptable documentation, accompanies a body being imported for burial or cremation. If there are problems with this documentation, a Commonwealth HBO will be contacted.

Yellow fever vaccination certificate checking is generally undertaken by Border Force colleagues. Individuals who do not have a valid vaccination certificate undergo a short interview and are provided with information about signs and symptoms of yellow fever before being released. There is no need to involve HBOs in this process.



Possible answers include a and b.

Deceased individuals cannot provide consent to an HBCO and thus cannot comply with the requirements. Additionally, powers exist under section 111 to manage the risks of human remains suspected of infection with an LHD and this is the more appropriate power to use.

A death in transit will similarly be managed by BO processes, with advice from Commonwealth HBOs/using powers in section 111 if required.

Review Quiz… have you been paying attention?

- 5 . Pratique
  - When is negative pratique applied?
    - If the aircraft or vessel reports an ill passenger who may have signs and symptoms of a Listed Human Disease?
    - If there are human remains on board?
    - If an aircraft does not provide a pre-arrival report?
    - If the aircraft or vessel has illicit drugs on board?

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Correct answer is a.

Aircraft do not have to pre-arrival report unless there is an ill individual.

The Biosecurity Act does not manage illicit drugs.

Review Quiz… have you been paying attention?

- 6 . Human Remains
  - In what circumstances will an officer (health or DAWR) need to provide permission for human remains to enter the country? (multiple answers)
    - If the human remains are not accompanied by medical documentation?
    - If the bones are for display as curios, and are free from adhering blood/tissue/faeces?
    - If the human remains are brought into the country for purposes other than burial, cremation, display or curios?
    - If the teeth or hair have adhering tissue?

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Correct answers are a, b and c.

If bones are free from adhering blood, tissue and faeces there is no human health risk and therefore no additional requirements apply.

Review Quiz… have you been paying attention?

- 7 . Vector Management
  - What best describes the role of a Human Biosecurity Officer?
    - Undertakes treatment activity at points of entry?
    - Provides advice on appropriate treatments to be carried out by ports?
    - Directs Biosecurity Officers to undertake a treatment?
    - No role.

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Legislatively, until the amendments are made to reintroduce human health powers, HBOs have no formal role in vector management. Operationally, however, HBOs and relevant staff within state health departments (medical entomologists etc) will continue to provide advice on appropriate treatment and response activities.

Review Quiz… have you been paying attention?

- 8 . Human Biosecurity Emergencies
  - Who declares a Human Biosecurity Emergency?
    - The Director of Human Biosecurity?
    - The Health Minister?
    - The Chief Human Biosecurity Officer?
    - The Governor-General?

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Correct answer is d (on advice from the Health Minister)

Review Quiz… have you been paying attention?

- 9 . Human Health Response Zones
  - When is it **not** appropriate to impose a human health response zone? (multiple apply)
    - If the disease outbreak is a Listed Human Disease?
    - If it is necessary to manage the risk presented by a Listed Human Disease?
    - If it is a Human Biosecurity Emergency?
    - Without consultation with the relevant Chief Health Officer?

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Correct answers are d and potentially c.

The legislation requires that the DHB consult with the relevant CHO prior to implementing a human health response zone.

As the human health response zone is a new power, we have no practical experience regarding the interaction between human biosecurity emergencies and human health response zones. It is possible that the emergency powers would address LHD risks without using a response zone.

Any final questions?

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Thanks for coming!

Let us know if you have any questions, concerns, or would like further information.

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