PARLIAMENTARY INQUIRY QUESTION ON NOTICE

Department of Health

Senate Select Committee on COVID-19

Australian Government's Response to the COVID-19 Pandemic

Thursday 23 April 2020

PDR Number: IQ20-000062

Question Number: 01

Question Subject: Briefing Cabinet

Type of Questions: Hansard, page 3, 23 April 2020

Questioner: Senator Gallagher

Question:

CHAIR: When were you first asked to brief the cabinet?
Prof. Murphy: Let me just have a look. I think I briefed the National Security Committee of cabinet that weekend. I'd have to go back and check that. I'd better take it on notice. We certainly raised the travel advisory, because we'd made recommendations through cabinet around 22 to 23 January. I don't have a record here of when I formally first briefed cabinet. Most of my briefings have actually been to the National Security Committee of cabinet. I've briefed the full cabinet on three or four occasions, but I've probably briefed the National Security Committee of cabinet two or three times a week since that pandemic situation evolved in late January.

Answer:

Please refer questions regarding the National Security Committee to the Department of the Prime Minister and Cabinet.

PARLIAMENTARY INQUIRY QUESTION ON NOTICE

Department of Health

Senate Select Committee on COVID-19

Australian Government's Response to the COVID-19 Pandemic

Thursday 23 April 2020

PDR Number: IQ20-000064

Question Number: 03

Question Subject: Number of children infected

Type of Questions: Hansard, page 7, 23 April 2020

Questioner: Senator Paterson

Question:

Senator PATERSON: Thank you. Could you, on notice, provide the number of children who have been infected, any confirmed cases of children-to-children infection and any confirmed cases of children-to-adult infection?
Prof. Murphy: Yes.

Answer:

As of 0600hrs on 27 April 2020, there have been 203 cases in children aged 0-18 years old reported to the National Notifiable Diseases Surveillance System. Of the 203 cases, 22% were 0-4 years old and 78% were 5-18 years old (school-aged). Overall the cases reported in children 18 years and under make up 3.5% of the total cases reported nationally.

A third of cases reported in children were considered to have been overseas acquired.

Data regarding the transmission of COVID-19, specifically between children and from children to adults, is not currently captured in the National Notifiable Diseases Surveillance System.

Evidence globally highlights that infections are less frequently observed in children, with their odds of infection being much lower compared with adults. Additionally, child-to-adult transmission appears to be uncommon.

Preliminary research undertaken by the National Centre for Immunisation Research and Surveillance has shown that there has been very limited transmission of SARS-CoV-2 among children in primary and high schools in New South Wales. Adult staff (teachers)

appear to play a role in both the introduction and, to a greater extent than children, transmission of the virus in education settings. However, as these are currently preliminary findings, ongoing investigations will provide more detail, including on the role of transmission by infected staff and students who have minor or no symptoms, including pre-symptomatic cases. The preliminary report issued on 9 April 2020 is provided at Attachment A and the final report published on 26 April 2020 is provided at Attachment B.

Attachments

A NCIRS NSW COVID-19 School Investigations Summary Report dated 9 April 2020

B NCIRS/NSW Health - COVID-19 in schools – the experience in NSW dated 26 April 2020

NSW COVID-19 School Investigations Summary Report

9th April 2020: Report 4 to NSW Health, modified for CDNA/AHPPC

Prepared by the National Centre for Immunisation Research and Surveillance (NCIRS)

Overview

The National Centre for Immunisation Research and Surveillance (NCIRS) in conjunction with NSW Departments of Health and Education and NSW Health Pathology, Westmead are undertaking enhanced investigations of education-setting related COVID-19 transmission. A summary of findings from this investigation as at 6 April 2020 is included below. A separate detailed report on the childcare centre (CCC) related outbreak has also been submitted.

Enhanced investigation and analysis of education setting related COVID-19 in NSW

Enhanced investigations in NSW educational settings include:

a) Detailed analysis of COVID-19 data collected from case schools and child care centres via standard NSW Heath public health staff follow-up, using data on cases and contacts recorded in NCIMS;

b) Enhanced investigations in selected schools and CCC's that includes:

- Detailed case and contact data collection via questionnaires by week 1 and 4 post-case diagnosis and last exposure in symptomatic and asymptomatic close contact children and teachers
- Additional biologic samples [nasopharyngeal (NP) swab for virus and serum for antibody to SARS-CoV-2]) obtained via home and/or school visits in all consenting close contacts. This includes both symptomatic and asymptomatic contacts at approximately 1 and 4 weeks post case diagnosis/last contact, where possible.

Summary of findings

21 educational settings where one or more cases of COVID-19 have been diagnosed in a staff or student have been identified to date. At 6 April, 903 children and 179 staff from 17 sites (contact lists are pending for 4 sites) have been identified as close contacts. For more details see Table 1.

- Of the sites under investigation, there are 11 secondary schools, 2 primary school, and 8 CCC's.
- Index cases have been adult staff in 10 sites and children in 11 sites. Enhanced investigation is underway in 5 sites, with 3 additional sites in planning stage.
- Of the 16 sites where NP virus PCR test data was available (361 children close contacts and 84 staff close contacts in total tested), 7/361 children and 7/84 adults have tested positive for SARS-Cov-2.

- Evidence of *potential* transmission of SARS-CoV-2 has been seen in 3/21 settings to date:
  a) from a teacher to 1 student in a primary school;
  b) from two co-primary index student cases in a high school to another student; and
  c) among 5 children and 7 staff from a CCC in a cluster, noting 2 year old child index case from the CCC was not the primary case (primary case/s were possibly two teachers).
- To date 75 blood samples have been collected for serologic testing on Day 26 (1 April 2020) from both symptomatic and asymptomatic close contacts at one high school. Of these, 74 were negative and 1 (student) was antibody positive, consistent with past infection to SARS-CoV-2 (described in **b)** above and below). Additional serologic testing from other sites is pending.

Summary of 3 settings where evidence of potential transmission documented

a) Summary of secondary transmission (single case) in primary school (Table 1, Site 12)

Index case is a Year 2 school teacher at a primary school who was at work while symptomatic on Monday 16, Thursday 19 and Friday 20 March. The teacher was tested on Monday 23 March. The teacher's entire class was identified as close contacts and requested to self-isolate for 14 days from 20 March. The secondary case is a student of the class who was at school on Monday 16 March only, before being sent home with vomiting. The student did not return to school for the week. He was tested on Thursday 26 March (D10 post last exposure to index case) as part of enhanced investigation undertaken by NCIRS. At the time of the positive test for SARS-CoV-2, he was asymptomatic, but subsequently reported symptoms including fever, rigors, conjunctivitis, fatigue, headache, nausea, vomiting, rhinorrhoea and sore throat.

b) Summary of close contact with positive serology in high school (Table 1, Site 2)

A 15 year old male had serology consistent with past infection with SARS-CoV-2 following testing on 1 April. The boy was a contact of the female index case at a high school, with his last day of exposure to the case on Friday 6 March (after which he was in quarantine for 14 days to 20 March). There was a co-primary male index case in this school, but there was no contact between the two boys. His only contact with the female case was 1 shared class. He reported no other social or extracurricular contact with the female index case, and no direct physical contact. He reported no overseas or interstate travel. He was not aware of any exposure to any other confirmed case of COVID-19. He was symptomatic with a mild respiratory illness from approximately 6–12 March and was PCR tested for SARS-CoV-2 on 10 March, which was negative. A sibling tested positive for another respiratory virus at that time. The boy was then well during the following 3 weeks. Serological testing on 1 April 2020 (day 26 post last exposure) demonstrated that the boy was antibody positive, consistent with past infection to SARS-CoV-2. Serological testing and more detailed data collection from his family are planned.

c) Brief summary of transmission in CCC and associated cluster (Table 1, Site 18)

A 2 year old child index case from this CCC was diagnosed on 17 March 2020, but on detailed investigation found to not be the primary case. The primary cases were possibly two teachers. One of these teachers also worked at, and had teenage children who attended, a nearby high school. Her two children were both also infected but despite their attendance at school while symptomatic, there has been no documented secondary infections in that high school (Site 7, Table 1). In total, 13 attendees (5 children and 7 staff) from this CCC were infected, with an additional 13 cases of onward transmission documented in this cluster. Some cases were mildly or pre-symptomatic at time of testing during NCIRS enhanced follow-up. More detail on this CCC cluster is contained in a separate report to NSW Health.

Preliminary conclusions

These enhanced investigations provide evidence of very limited transmission of SARS-CoV-2 in primary and high schools. The large childcare outbreak was complex and warrants separate consideration. In only 1 school is there evidence of potential student to student transmission. Adult staff (teachers) appear to play a role in both the introduction and, to a greater extent than children transmission of, the virus in education settings. Ongoing investigations will provide more detail, including on the role of transmission by infected staff and students who have minor or no symptoms, including pre-symptomatic cases.

Acknowledgements

Thanks go to all the schools, staff, children and families who have participated in the enhanced investigations.

The following people have contributed to the COVID-19 schools transmission investigation project:
NCIRS core clinical and epidemiological team: Kristine Macartney, Nick Wood, Noni Winkler, Helen Quinn, Archana Koirala, Lucy Deng, Catherine Glover and Alexis Pillsbury
NCIRS interview and home visit team: Rosemary Joyce, Deidre Brogan, Nicole Dinsmore, Ajay Jadhav, Andrew Dunn, Laura Rost, Gemma Saravanos, Lisa Pelayo, Rama Kandasamy
ICPMR/NSW Pathology: Kerri Basile, Jen Kok, Matthew O'Sullivan, Dominic Dwyer
NSW Health: Caroline Sharpe, Craig Dalton, Paula Spokes
Western Sydney PHU: Anthea Katelaris, Shopna Bag, Stephen Corbett ; Northern PHU: Michael Staff; South West Sydney PHU: Stephen Conaty, Christine Harvey, Kate Alexander; Hunter-New England PHU: Craig Dalton and Kate Leadbeater; Nepean-Blue Mountains PHU: Brad Forssman

Table 1: Summary of educational settings, contacts and case data and findings as at 6 April 2020

No.	Suburb/Town	Index case/s	Last exposure (Day 0)	Close contacts (N with PCR and serology testing)	Enhanced investigation	Findings in close contacts
Secondary school						
1	Epping	1 student (16 yo)	5 Mar	N= 69 Students = 58; Staff = 11 21 (30.4%) SARS_CoV-2 PCR tested; 7 (10.1%) tested between D5-D14	N	SARS_CoV-2 PCR: 0/21 positive
2	Dundas	2 students, family friends (14 and 15 yo)	6 Mar	N = 210 Students = 191; Staff = 19 129 (61.4%) SARS_CoV-2 PCR tested; 52 (24.8%) tested between D5-D14 75/210 (35.7%) D26 serum samples obtained	Y	SARS_CoV-2 PCR: 0/129 positive Serology: 74/75 negative, 1/75 positive
3	Willoughby	1 student	6 Mar	N=74 Students = 63, Staff = 11 25 (33.8%) SARS_CoV-2 PCR tested; 10 (13.5%) tested between D5-D14	N	SARS_CoV-2 PCR: 0/25 positive
4	Katoomba	1 staff	9 Mar	N=57 Students = 46; Staff = 11 21 (36.8%) SARS_CoV-2 PCR tested; 18 (31.6%) tested between D5-D14	N	SARS_CoV-2 PCR: 0/21 positive
5	Ashcroft	1 staff	23 Mar	N=10 Students = 4; Staff = 6 6 (60.0%) SARS_CoV-2 PCR tested; 1 (10.0%) tested between D5-D14	N	SARS_CoV-2 PCR: 0/6 positive
6	Bankstown	1 student (21 yo)	23 Mar	TBC	N	Pending NCIMS data*
7	Blacktown**	2 student siblings (13 and 15 yo)	20 Mar 24 Mar	N=73 Students = 64; Staff = 9 12 (16.4%) SARS_CoV-2 PCR tested; 12 (16.4%) tested between D5-D14	Planning	SARS_CoV-2 PCR: 0/12 positive
8	St. Mary's	1 student (16 yo)	24 Mar	N=139 Students = 132; Staff = 7 8 (5.8%) SARS_CoV-2 PCR tested; 5 (3.6%) tested between D5-D14	Planning	SARS_CoV-2 PCR: 0/8 positive

No.	Suburb/Town	Index case/s	Last exposure (Day 0)	Close contacts (N with PCR and serology testing)	Enhanced investigation	Findings in close contacts
9	Kincumber	1 student (18 yo)	25 Mar	N=15 Students = 8; Staff = 7 15 (100%) SARS-CoV-2 PCR tested; 15 (100%) tested between D5-D14	N	SARS_CoV-2 PCR: 0/15 positive
10	Rose Bay	1 staff	25 Mar	N=10 Students = 10 0 SARS-CoV-2 PCR tested	N	Nil tested to date
11	Wiley Park	1 staff	26 Mar	N =34 Students = 19; Staff = 15 1 (2.9%) SARS-CoV-2 PCR tested; 1 (2.9%) tested between D5-D14	N	SARS-CoV-2 PCR: 0/1 positive
Primary school						
12	Normanhurst	2 staff (independent index cases)	10 Mar 20 Mar	N=31 Students = 24; Staff = 7 26 (83.9%) SARS-CoV-2 PCR tested; 24 (77.4%) tested between D5-D14	Y	SARS-CoV-2 PCR: **1**/26 positive (3.8%), 1 child Serology collection planned for 15 and 16 April
13	Belfield	1 student (10 yo)	23 Mar	TBC	N	Pending NCIMS data*
Childcare centres						
14	Newcastle	1 staff	10 Mar	N=15 Children = 15 15 (100%) SARS-CoV-2 PCR tested; 15 (100%) tested between D5-D14	Y (HNE PHU)	SARS-CoV-2 PCR: 0/15 positive
15	Camden	1 staff	16 Mar	N=174 Children = 149; Staff = 25 92 (52.9%) SARS-CoV-2 PCR tested; 90 (51.7%) tested between D5-D14	Y	SARS-CoV-2 PCR: 0/92 positive Serology collection planned for 8 and 9 April
16	Vaucluse	1 staff	16 Mar	N=40 Children = 31; Staff = 9 15 (37.5%) SARS-COV-2 PCR tested; 14 (35.0%) tested between D5-D14	N	SARS-CoV-2 PCR: 0/15 positive
17	Erina	1 child (3 yo)	16 Mar	TBC	N	Pending NCIMS data*

No.	Suburb/Town	Index case/s	Last exposure (Day 0)	Close contacts (N with PCR and serology testing)	Enhanced investigation	Findings in close contacts
18	Blacktown**	1 child (2 yo): not primary case	Ongoing from 17 Mar	N=39 Children = 26; Staff = 13 34 (87.2%) SARS-CoV-2 PCR tested	Y	SARS-CoV-2 PCR: **13**/34 positive (38.2%) in total (including index case and 2 co-primary cases). 7 staff and 6 children. Serology collection planned for week beginning 13 April
19	Newtown	1 child (2 yo)	20 Mar	TBC	N	Pending NCIMS data*
20	Narellan Vale	1 child (1 yo)	24 Mar	N=13 Children = 8; Staff = 5 5 tested (38.5%), all D3	N	SARS-CoV-2 PCR: 0/5 positive
21	Penrith	1 staff	24 Mar	N=79 Children = 55; Staff = 24 20 (25.3%) SARS-CoV-2 PCR tested; 19 (24.1%) tested between D5-D14	Planning	SARS-CoV-2 PCR: 0/20 positive

*Close contacts list to create NCIMS cluster for data extraction is pending

** See separate detailed report on this CCC and related school cases (noting 2 students at high school had parent who was teacher at CCC)

COVID-19 in schools – the experience in NSW

Prepared by the National Centre for Immunisation Research and Surveillance (NCIRS)
26 April 2020

Overview

- This report provides an overview of investigation into all COVID-19 cases in New South Wales (NSW) schools.
- In NSW, from March to mid-April 2020, 18 individuals (9 students and 9 staff) from 15 schools were confirmed as COVID-19 cases; all of these individuals had an opportunity to transmit the COVID-19 virus (SARS-CoV-2) to others in their schools.
- 735 students and 128 staff were close contacts of these initial 18 cases.
- No teacher or staff member contracted COVID-19 from any of the initial school cases.
- One child from a primary school and one child from a high school may have contracted COVID-19 from the initial cases at their schools.

Background

Globally, the control of COVID-19 (caused by the virus, SARS-CoV-2) has been focused on public health measures, including improving hygiene and ensuring social distancing. Some countries have closed schools as part of their response. The strategy of closing schools has previously been recommended to assist in the control of influenza pandemics[1] because we know children with influenza are likely to spread the infection and become ill from influenza. However, COVID-19 appears to be a less common infection in children than is influenza and in studies done overseas, many of the infected children had only mild symptoms. It has been suggested that children are also less likely to spread the virus. Thus, it has not been clear how common it is for SARS-CoV-2 to transmit among school children or school staff, and if school closures are an effective measure to control COVID-19. Prolonged school closures can have negative consequences for the community and for children.

The emergence of COVID-19 and early spread globally coincided with the start of school term 1 in Australia. The first NSW school with a COVID-19 case was identified on 5 March 2020. The National Centre for Immunisation Research and Surveillance (NCIRS), with the support of the NSW Ministry of Health and NSW Department of Education, started this schools investigation in early March. Through this investigation, we aimed to understand the transmission of SARS-CoV-2 in schools and childcare centres in NSW. This report summarises the preliminary findings (to 21 April 2020) of this work in NSW primary and high schools.

Methods

COVID-19 is a notifiable disease in Australia. When a person is diagnosed with COVID-19 a public health response is initiated that involves follow up of each case to identify the person's close contacts and when these contacts may have last been exposed to the person (case) while infectious. A 'close contact' is defined as a person who has been in face to face contact for at least 15 minutes or in the same room for two hours with a case while infectious. In

[1] Cauchemez S, Ferguson NM, Wachtel C, Tegnell A, Saour G, Duncan B, Nicoll A. Closure of schools during an influenza pandemic. The Lancet Infectious Diseases. 2009;9(8):473–481.

schools, close contacts of cases were usually found either to be students and teachers who shared the same class/classes or extracurricular activities as the case or in their close circle of friends.

Once the close contacts are identified, they are required to isolate themselves at home for 14 days from the date of last exposure to the infectious case, watch for any symptoms and if they become unwell, go to the doctor or a fever clinic to get a nose/throat swab to test for COVID-19. NSW Health and NCIRS followed up all close contacts of COVID-19 cases in the 10 high schools and five primary schools for which a person with COVID-19 had attended while infectious by collecting data on all tests done on close contacts (positive and negative). For schools, staff and students that agreed to participate in enhanced surveillance all close contacts also: a) had a symptom questionnaire; b) were swabbed for COVID-19 testing at between 5-10 days after the last contact with the case, and; c) had a blood sample taken to detect antibodies to the virus (which is evidence of an immune response to infection with the virus).

Results

In the 15 schools (10 high school and 5 primary schools) a total of 18 COVID-19 cases (9 students and 9 staff) were identified between 5 March 2020 and 3 April 2020 (refer to Figure 1). The public health staff identified 863 close contacts in these 15 schools. Of the 863 close contacts, only two students have been identified as secondary cases. One of these was diagnosed by nose/throat swab testing and one had a positive antibody test 4 weeks after their exposure. A review showed that it was most likely, but not certain, that these two children were infected by transmission in the school environment.

High schools

A total of 12 COVID-19 index cases (8 students and 4 staff) were identified who had attended 10 high schools while infectious. The total number of close contacts in these 10 high schools was 598 students and 97 staff (total of 695 contacts). Nose/throat swabs were taken from one third (n=235) of contacts, all of which tested negative. In one high school, of the 75 close contacts who underwent blood testing at approximately 1 month after contact with the initial cases while infectious, only 1 student had antibodies detected, indicating infection had occurred.

Overall, as shown in Figure 2, only one of 695 individuals was identified to have been infected following close contact with a school case in these 10 high schools.

Primary schools

A total of six initial cases (comprising one student and five staff) were identified in five primary schools. The total number of close contacts in these five primary schools was 137 students and 31 staff (total of 168 contacts). Nose/throat swabs were taken from one third (n=53) of contacts. Only one secondary case (nose/throat swab positive) was identified in the 168 close contacts. In the same primary school that had this secondary case, 21 close contacts underwent blood testing. The same student whose nose/throat swab tested positive also had antibodies detected through serology testing, consistent with their known recent infection.

Overall, as shown in Figure 3, only one of 168 individuals was identified to have been infected following close contact with a school case in these five primary schools.

Figure 1: NSW primary and high schools with a COVID-19 index case/s from March – mid April

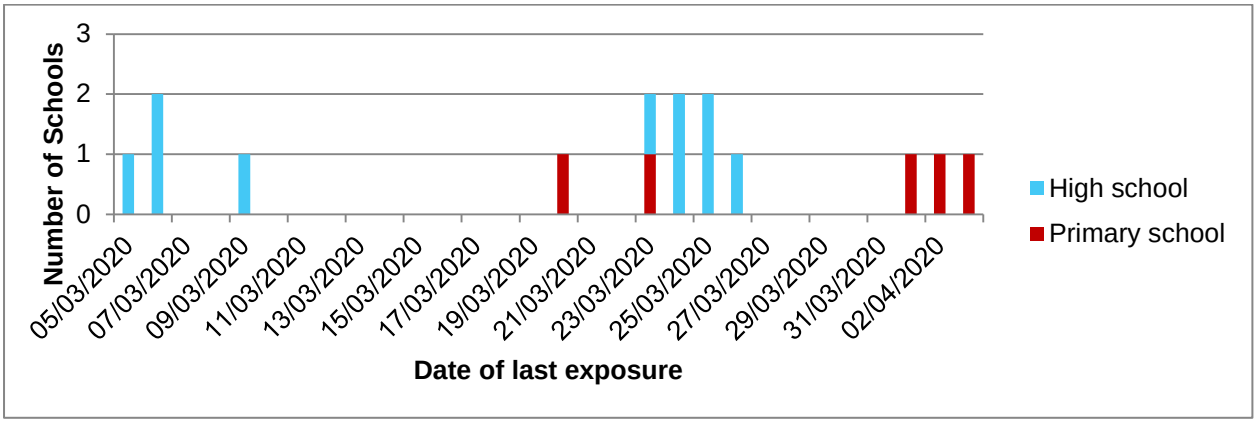


Figure 2: Cases and close contacts among teachers and students in 10 NSW high schools showing one secondary case in a student

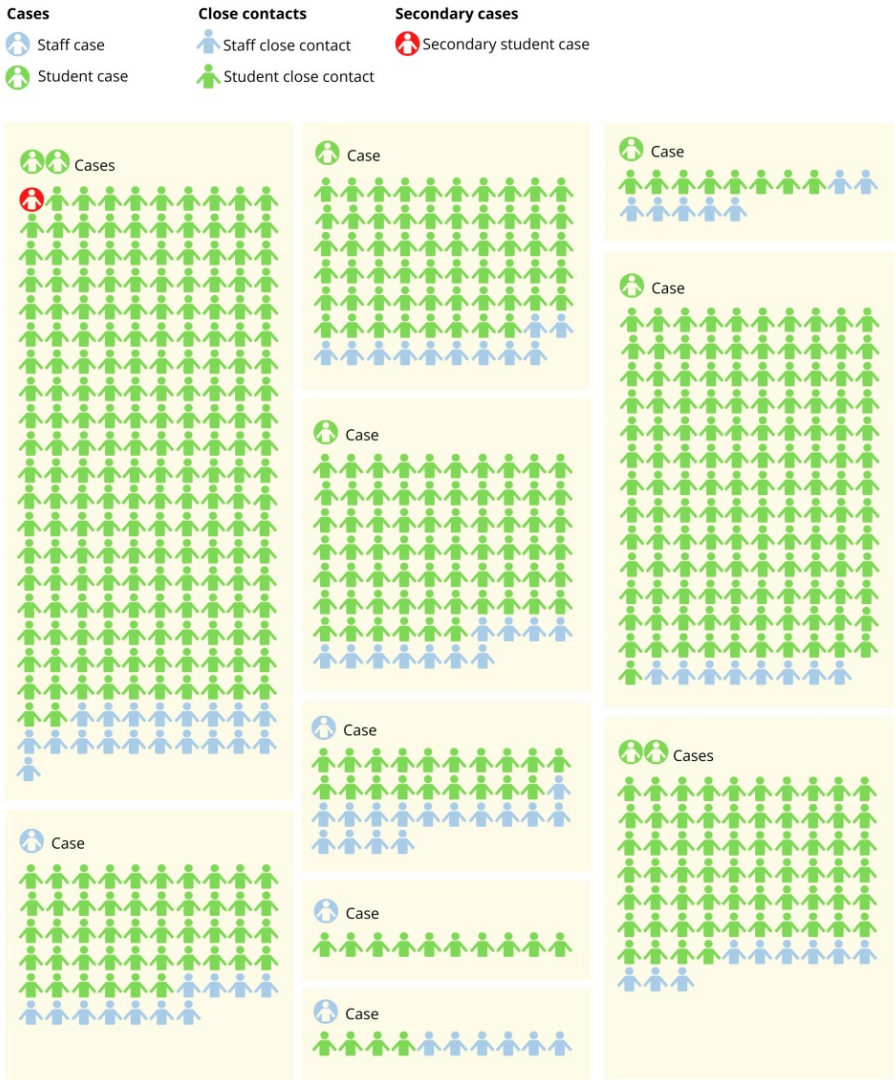
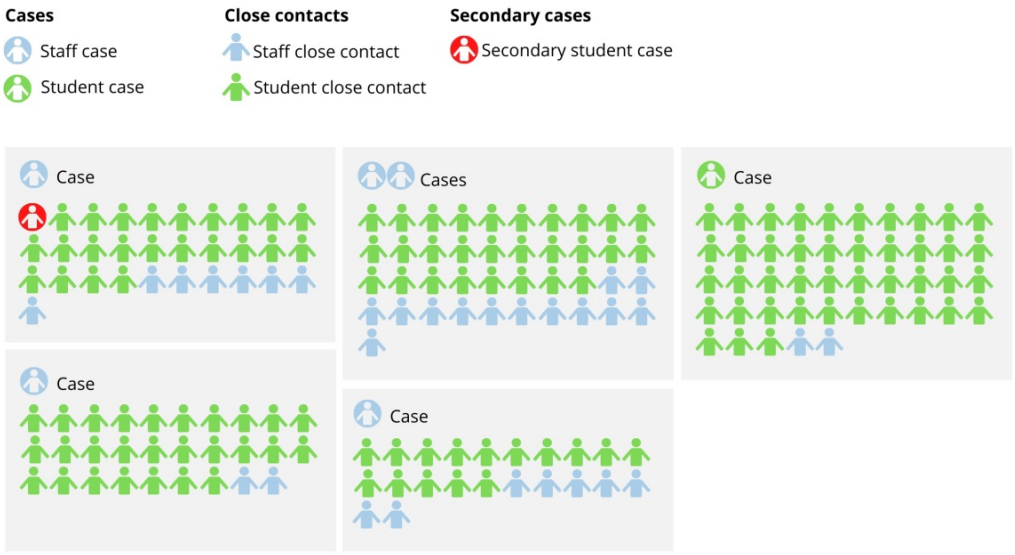


Figure 3: Cases and close contacts among teachers and students in 5 NSW primary schools showing one secondary case in a student



Conclusion

Our detailed investigation of COVID-19 cases in 15 NSW primary and high schools found only two secondary cases, both in students. This was despite initial cases occurring in 9 students (including two students in two schools) and 9 teachers. Very detailed follow-up, including additional testing for the presence of the virus and for antibodies to the virus, occurred in a proportion of the total 863 close contacts identified from the school setting.

Our investigation found no evidence of children infecting teachers. One secondary case (in the child in a high school) was presumed to have been infected following close contact with two student cases. The other secondary case was presumed to have been infected by a staff member (teacher) who was a case.

It is notable that half of the initial cases that occurred in schools were in staff. This is consistent with the higher rate of COVID-19 seen in adults than in children. This reinforces the need for both adults and children to ensure they do not attend school when ill and if they become ill to promptly isolate themselves and seek medical attention. It is also important for all adults, including teachers, to follow recommended social distancing practices while at school and in the community.

The findings from this detailed investigation are preliminary. However, they do suggest that spread of COVID-19 within NSW schools has been very limited.

SARS-CoV-2 transmission in children in schools appears considerably less than seen for other respiratory viruses, such as influenza. In contrast to influenza, data from both virus and antibody testing to date suggest that children are not the primary drivers of COVID-19 spread in schools or in the community. This is consistent with data from international studies showing low rates of disease in children and suggesting limited spread among children and from children to adults.[2,3,4] Data from the whole of NSW also demonstrate children (aged <19 years) represent 4% of all cases of COVID-19 despite being approximately 23% of the population.

[2] World Health Organization (WHO). Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19). 16-24 February 2020. https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf

It is notable that on 23 March 2020 the NSW Premier advised that although schools remained open, parents were encouraged to keep their children at home for online learning. After this date face-to-face attendance in schools decreased significantly and this may have impacted the results of this investigation. Furthermore, school holidays commenced in NSW on Friday 10 April for two weeks.

Analysis of data collected here is ongoing and a full peer reviewed report is being prepared for publication. As a phased re-introduction of face-to-face learning in schools is planned for early Term 2 from 11 May 2020, it will be important to continue these detailed investigations to monitor the transmission of COVID-19 in schools.

Acknowledgements

We would like to thank all schools, staff and student contacts and their families who participated in this investigation, especially those who assisted with the enhanced investigation.

The following people have contributed to the COVID-19 schools transmission investigation project:
NCIRS core clinical and epidemiological team: Kristine Macartney, Nicholas Wood, Noni Winkler, Helen Quinn, Archana Koirala, Lucy Deng, Catherine Glover and Alexis Pillsbury
NCIRS interview and home visit team: Rosemary Joyce, Deidre Brogan, Nicole Dinsmore, Ajay Jadhav, Andrew Dunn, Laura Rost, Gemma Saravanos, Lisa Pelayo, Rama Kandasamy
ICPMR/NSW Pathology: Kerri Basile, Jen Kok, Matthew O'Sullivan, Linda Hueston, Dominic Dwyer
NSW Health: Caroline Sharpe, Craig Dalton, Paula Spokes
Western Sydney PHU: Anthea Katelaris, Shopna Bag, Stephen Corbett; **Northern PHU:** Michael Staff; South West **Sydney PHU**: Stephen Conaty, Christine Harvey, Kate Alexander; **Hunter New England PHU**: Craig Dalton and Kate Leadbeater; **Nepean-Blue Mountains PHU**: Brad Forssman

[3] Children and COVID-19. National Institute for Public Health and the Environment, Ministry of Health, Welfare and Sport, The Netherlands. https://www.rivm.nl/en/novel-coronavirus-covid-19/children-and-covid-19

[4] Gudbjartsson DF et al. Spread of SARS-CoV-2 in the Icelandic population. New England Journal of Medicine. 14 April 2020. https://www.nejm.org/doi/full/10.1056/NEJMoa2006100

Australian Government

Department of Health

Acting Secretary

Senator Katy Gallagher
PO Box 6100
Parliament House
CANBERRA ACT 2600

Dear Senator Gallagher

On 6 May 2020, as a member of the Senate Select Committee on COVID-19 (the Committee), Senator Keneally asked about advice provided to the Minister for Health, the Hon Greg Hunt MP, prior to the enactment of the Determination on 18 March 2020 regarding the entry of foreign flagged ships carrying Australians to Australia.

In response, Minister Hunt proposes to table two letters from the Chief Medical Officer, Brendan Murphy, dated 16 and 27 March 2020, respectively.

A redaction has been made in the letter dated 27 March as it has the potential to disclose the deliberations of Cabinet.

Ordinarily, consideration would have been given to making a claim for Public Interest Immunity in relation to both documents. However, in light of the significance of the work of the Committee, the decision has been made to provide the documents in full, apart from the minor redaction mentioned above.

In doing so, Minister Hunt does not intend to set a precedent as to whether Public Interest Immunity will be considered and potentially claimed in relation to other future questions or requests for production of documents. Such considerations will be made by Minister Hunt on a case by case basis.

Yours sincerely

Caroline Edwards

6 May 2020

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PARLIAMENTARY INQUIRY QUESTION ON NOTICE

Department of Health

Senate Select Committee on COVID-19

Australian Government's Response to the COVID-19 Pandemic

Thursday 23 April

PDR Number: IQ20-000065

Question Number: 04

Question Subject: Biosecurity Act written advice

Type of Questions: Hansard, page 9, 23 April 2020

Questioner: Senator Keneally

Question:

Senator KENEALLY: On 15 March the Prime Minister banned foreign flagged cruise ships from arriving in Australia and he announced an explicit exemption for some of the foreign flagged cruise ships carrying Australians on board. On 18 March the federal Minister for Health made a determination under the Biosecurity Act that gave effect to that announcement. Can you confirm that you gave advice to the Minister for Health regarding that directive?
Prof. Murphy: I did.
Senator KENEALLY: Are you able to table for the committee the written advice that you provided?
Prof. Murphy: We could take that on notice. There's a letter that I wrote to the minister that I'm sure we can table.

Answer:

The Chief Medical Officer and Director of Human Biosecurity has written two letters to the Minister for Health on cruise ships (copies attached).

On 16 March 2020, the Chief Medical Officer and Director of Human Biosecurity wrote to the Minister for Health recommending he make a declaration of a human biosecurity emergency under the *Biosecurity Act 2015* (Cth). This recommendation was based on a number of factors, including the 30 January determination by the World Health Organization (WHO) that the COVID-19 outbreak was a Public Health Emergency of International Concern, the 11 March WHO declaration of a pandemic, the number of cases of COVID-19 nationally and internationally, and the importance of acting quickly to reduce further spread.

On 27 March 2020, the Chief Medical Officer and Director of Human Biosecurity wrote to the Minister for Health to provide further advice including recommending the extension of the restrictions on cruise ships. Paragraph 2 of that letter, which was classified PROTECTED, has been redacted to allow it to be tabled.

Attachments

A Letter from Chief Medical Officer and Director of Human Biosecurity of 16 March 2020

B Letter from Chief Medical Officer and Director of Human Biosecurity of 27 March 2020

Australian Government
Department of Health

Chief Medical Officer

The Hon Greg Hunt MP
Minister for Health
PO Box 6022
Parliament House
CANBERRA ACT 2600

Dear Minister Hunt

I am writing to recommend the declaration of a human biosecurity emergency under section 475 of the *Biosecurity Act 2015* (the Act).

The ongoing management of the virus outbreak is based on the expert medical advice of the Australian Health Protection Principal Committee with proportionate steps escalated as necessary to contain and slow the spread of the Coronavirus Disease 2019 (COVID-19) caused by the novel coronavirus SARS--CoV-2 throughout China.

On 21 January 2020, I determined 'human coronavirus with pandemic potential' to be a listed human disease under section 42 of the Act in response to the identification and spread of COVID-19.

On 30 January 2020, the World Health Organization (WHO) determined the COVID-19 outbreak to be a Public Health Emergency of International Concern, reflecting the international spread of the disease to several regions of the world and limited evidence of human to human transmission outside of mainland China. Additionally, in recognition of the significant further international spread including increasing case numbers and increasing number of deaths as a result of COVID-19, the WHO declared a pandemic on 11 March 2020.

I believe, on the basis of international and national evidence, that COVID-19 poses a severe and immediate threat to human health on a nationally significant scale. Globally, as at 16 March 2020, there are 163,716 cases in 149 countries. There is now some evidence of community transmission of COVID-19 within Australia, with 298 cases being reported within Australia (as at 6am 16 March 2020), including 5 deaths. 40 of these cases, including 3 deaths, have no history of overseas travel. The global case fatality rate for COVID-19 is currently estimated at as high as 3.8%, with the risk of death reported to increase with age.

We have a time-limited opportunity to interrupt the transmission of the disease and reduce the number of cases and deaths within Australia, and the subsequent burden on the Australian health system. Based on this information I am formally

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recommending to you that the declaration of a human biosecurity emergency is necessary to support the containment the human biosecurity threat of COVID-19.

The declaration of a human biosecurity emergency will provide you with the power to set requirements and give directions as necessary to manage the risk of COVID-19. The declaration of an emergency now provides powers to give effect to requirements and directions over the coming days. Without limiting these powers, it is prudent to consider giving legal effect to recommendations to self-isolate for 14 days on arrival in Australia, banning mass gatherings (of 500 people or more), and restrictions on visitation to aged care facilities and remote communities. It is important to reduce the spread of the disease and in particular protect our vulnerable communities, while ensuring that our capacity to test and treat, not only COVID-19 patients but all Australians requiring health care, is sustainable.

I further advise that this recommendation I have given particular consideration to the potential human biosecurity risk posed by the movement of international flights and cruise vessels and have considered a letter on this issue from the Secretary of the Department of Home Affairs to the Acting Secretary of the Department of Health dated 15 March 2020. And again, without limited the requirements or directions that you may exercise pursuant to the declaration of a human biosecurity emergency, I consider that the declaration of a human biosecurity emergency will provide you, in relation to the issues associated with international cruise ships, the power necessary to prevent or control the emergence, establishment or spread of COVID-19 into Australia.

I note with concern that 10 cases, including one death, in Australia are associated with the Diamond Princess repatriation. Worldwide there are a number of cruise vessels that have experienced significant onboard transmission, and that have seeded onshore transmission, resulting in the identification of hundreds of additional COVID-19 cases. This appears to me to be a particularly significant risk warranting the suspension of such voyages at the current time. In my view this requirement should be put in place for 30 days in the first instance I think that this will ensure that it is no more restrictive or intrusive than required in the circumstances.

I am satisfied that the declaration of a human biosecurity emergency is necessary to enable powers to give effect to the clinical recommendations of the Australian Health Protection Principal Committee. I, in my capacity as Director of Human Biosecurity, recommend that the initial period of the emergency declaration be for three months to ensure the human biosecurity emergency declaration is in effect for an appropriate length of time to manage the immediate and medium term response requirements.

Yours sincerely

Professor Brendan Murphy
Chief Medical Officer and Director of Human Biosecurity

16 March 2020

Australian Government

Department of Health

Chief Medical Officer

The Hon Greg Hunt MP
Minister for Health
PO Box 6022
Parliament House
CANBERRA ACT 2600

Dear Minister Hunt,

I am writing to provide advice on further actions, as recommended by the Minister for Home Affairs on 23 March 2020 and agreed in-principle by the Prime Minister on 24 March 2020, to reduce the risk to Australia's health and quarantine capacity from cruise ship operations.

The Prime Minister's agreement is subject to the further actions having a sound legal basis, to you being satisfied of the necessary conditions for exercising your power to make an emergency requirement under the *Biosecurity Act 2015* (the Act),

On 18 March 2020, the Governor-General declared a human biosecurity emergency in relation to the global outbreak of the listed human disease 'Human coronavirus with pandemic potential' (COVID-19) under section 475 of the Act. At that time, I recommended to you that consideration be given to the risks posed by the international movements of aircraft and vessels, particularly cruise vessels, in recognition of the heightened risk posed by these movements.

In response, the Prime Minister provided in-principle agreement to restrict the entry of cruise ship vessels into Australia for 30 days.

On 18 March 2020, you considered my advice on these matters and made the *Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) (Emergency Requirements) Determination 2020* (the Emergency Requirements Determination) which allows for international cruise ships not to enter Australian ports before 15 April 2020.

COVID-19 continues to represent a severe and immediate threat to human health in Australia, and it has the ability to cause high level of morbidity and mortality and to

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disrupt the Australian community socially and economically. The number of confirmed cases of COVID-19 within Australia has reached 2,799 cases (as at 3pm on 26 March 2020), including 13 deaths.

Cruise ships may carry domestic or international travellers who pose human biosecurity risks. This may also lead to the spread of diseases to other travellers, particularly given the population density, the duration of cruises and the mixing patterns of people on board. It is therefore necessary to enhance control measures to:

- protect the health of travellers on vessels;
- minimise the likelihood of large numbers of infected people returning to Australia and further spreading COVID-19 among the community;
- manage the impact on the Australian health system; and
- prevent the spread of COVID-19 among populations in cruise voyage destinations.

To that end, I am advising an extension of the restriction of cruise ship vessel entry to Australia for a further two months from the end of the current 30 day restriction to 15 June 2020. Additionally, I suggest that:

- the restriction be extended to apply to any vessel undertaking domestic, overnight cruises including all Australian and international vessels;
- a review of the extension period should occur three weeks before its expiry, with the outcome notified to industry; and
- that all non-Australian flagged cruise ships currently in Australia be directed to depart Australian waters as soon as possible, excluding vessels that have previously been approved entry or were home porting in Australia should be permitted to re-provision to facilitate departure. Home ported cruise ships that wish to remain in Australia should seek approval from the Government and should remain with the minimal crew required to ensure maintenance and safe operation.

Recent events have demonstrated that it is necessary to continue the control of cruise ships entering Australia. The illness of travellers on board the Ruby Princess, which did not enter a foreign port, shows that the biosecurity risks extend to domestic cruises. Non-Australian flagged cruise ships currently in Australian waters have large contingents of international crew on board (up to 1,000) which present a risk of the spread of COVID-19. Requiring these ships to depart Australian waters will alleviate this risk.

I, in my capacity as Director of Human Biosecurity, recommend that you consider amending the Emergency Requirements Determination to include the further actions outlined above to reduce the risk to Australia's health and quarantine capacity from cruise ship operations.

Yours sincerely

Professor Brendan Murphy
Director of Human Biosecurity and Chief Medical Officer
27th March 2020

PARLIAMENTARY INQUIRY QUESTION ON NOTICE

Department of Health

Senate Select Committee on COVID-19

Australian Government's Response to the COVID-19 Pandemic

Thursday 23 April 2020

PDR Number: IQ20-000068

Question Number: 07

Question Subject: PPE

Type of Questions: Hansard, page 13, 23 April 2020

Questioner: Senator Di Natale

Question:

Senator DI NATALE: Moving on, I might just ask: on notice, can you tell me what, in terms of numbers, we have of those other—I know you've got questions around masks, but gloves, gowns and shields. If you can just provide on notice the numbers in the medical stockpile.
Ms Edwards: I might just give some background to that. We'll provide on notice what we can. As Professor Murphy says, we haven't traditionally held any gloves, gowns or goggles in the stockpile. At the beginning of the process, there were none of those items. You are obviously very aware that the role of the national stockpile is limited. It's to provide assistance to states and territories, especially for public hospitals, in times of a particular health event. We have dramatically expanded our activities under PPE, including in relation to the stockpile, over the last few months, including procuring those additional items, some of which are arriving and some of which are scheduled to arrive. What we've been doing is trying to ensure appropriate supply of that over the next six-plus months.
In addition to that—that's only one of the things we've been doing—we've been working very carefully with states and territories to help their orders, to ensure that any international deliveries can come into Australia to work with the difficulties with the supply chains internationally. We've also been working with the department of industry to increase the capacity of local producers of masks but also other types of PPE.

Answer:

The National Medical Stockpile (the Stockpile) is a highly strategic reserve of drugs, vaccines, antivirals and personal protective equipment (PPE) for use in the national response to a public health emergency. Consistent with previous advice, the Commonwealth does not disclose actual stockpile numbers as they are considered sensitive.

The Stockpile exists to supplement holdings of drugs and PPE held by state and territory health authorities to support continuity of service provision. It is in addition to what states and territories maintain in preparation and support for their hospitals and not a national supply line for all health needs.

As part of historical decisions to delineate roles, states and territories have been responsible for stocking gowns, gloves and goggles in full from their own stockpiles rather than the Commonwealth. These lower cost, higher frequency use items have been managed by the states and territories to rotate stock and minimise potential wastage given the shelf life of such products.

The Commonwealth has nonetheless dedicated resources for masks and respirators as core PPE and has also invested in additional PPE as part of the emergency response to COVID-19. This has included significantly higher volumes of surgical masks and P2 masks, as well as gloves, gowns, goggles and face shields, and other essential medical equipment.

PARLIAMENTARY INQUIRY QUESTION ON NOTICE

Department of Health

Senate Select Committee on COVID-19

Australian Government's Response to the COVID-19 Pandemic

Thursday 23 April 2020

PDR Number: IQ20-000070

Question Number: 09

Question Subject: Department's involvement

Type of Questions: Hansard, page 24-25, 23 April 2020

Questioner: Senator Siewert

Question:

Senator SIEWERT: …across remote communities, in terms of price gouging?
Ms Edwards: I understand those issues are being dealt with, but they're being dealt with by the Department of Home Affairs, so I'm not across the detail of that.
Senator SIEWERT: I'll follow up with them. Can you outline very briefly how the interdepartmental processes are working on that particular issue?
Ms Edwards: I really think you should address those to the Department of Home Affairs. They have a large amount of work that is being done on it, of which we're only one bit, and I'm not intimately involved in it myself.
Senator SIEWERT: What I meant was: are you on that committee?
Ms Edwards: The Department of Health is on every committee at the moment, I feel. I'm not intimately involved in that issue, but I could take on notice how we're involved in that issue.

Answer:

Supermarkets Taskforce

The Department of Home Affairs established the Supermarket Taskforce (the Taskforce) on 18 March 2020 to respond to challenges facing supermarkets arising from the COVID-19 pandemic and to coordinate supermarket responses across Australia. The Department of Health was among a number of Australian Government participants in the Supermarket Taskforce and/or its subgroups.Food security, including ensuring supply to regional and remote communities, has been a high priority for the Taskforce. The Taskforce has, in collaboration with supermarkets and the National Indigenous Australians Agency, assisted in ensuring food supply to remote and rural areas including:

- Enabling supermarkets to work together to prioritise food supply in remote and regional areas.
- Raising awareness and calling for action on shortages of supplies to regional areas.

On April 9 2020, the Hon Ken Wyatt MP, Minister for Indigenous Australians and the Hon Peter Dutton MP, Minister for Home Affairs, co-sponsored a letter to key manufacturers about supporting remote supply of food and grocery items.

While supermarkets have advised that the situation in these areas has been improving, the Supermarket Taskforce and the National Indigenous Australians Agency are continuing to work with retailers to ensure supply to regional and remote communities, minimising panic buying in remote stores and supporting supply to remote communities in the medium term.

The Department of Health recommends directing specific food security and price gouging questions for Aboriginal and Torres Strait Islander people to Department Home Affairs and to the National Indigenous Australians Agency.