LEGISLATIVE COUNCIL

COVID-19 RESPONSE COMMITTEE

Plaza Room, Parliament House, Adelaide

Thursday, 28 May 2020 at 11:15am

BY AUTHORITY OF THE LEGISLATIVE COUNCIL

WITNESSES

MEMBERS:

Hon. T.A. Franks MLC (Chairperson)
Hon. C. Bonaros MLC
Hon. E.S. Bourke MLC
Hon. N.J. Centofanti MLC
Hon. D.G.E. Hood MLC
Hon. K.J. Maher MLC

WITNESSES:

POPE, DAVID, President, South Australian Salaried Medical Officers Association

MULHOLLAND, BERNADETTE, Senior Industrial Officer, South Australian Salaried Medical Officers Association

424 The CHAIRPERSON: Welcome to the meeting. The Legislative Council has given the authority for this committee to hold public meetings; however, due to the current situation concerning the COVID-19 pandemic, the committee has resolved to exclude strangers from the gallery. A transcript of your evidence today will be forwarded to you for your examination for any clerical corrections. The uncorrected transcript of your evidence today will be published immediately upon receipt from Hansard, but the corrected transcript, once received from you, will replace the uncorrected transcript.

I advise that your evidence today is being broadcast by the Parliament of South Australia website. Should you wish at any time to present confidential evidence to the committee, please indicate and the committee will consider your request. Parliamentary privilege is accorded to all evidence presented to a select committee; however, witnesses should be aware that privilege does not extend to statements made outside this meeting. All persons, including members of the media, are reminded that the same rules apply as in the reporting of parliament.

We would like to acknowledge that the land we meet on today is the traditional lands for the Kaurna people and that we respect their spiritual relationship with their country. We also acknowledge the Kaurna people as the traditional custodians of the Adelaide region and that their cultural and heritage beliefs are still as important to the living Kaurna people today.

We are currently still not broadcasting through the intranet so I will still do the introductions but we will leave yours until we go live. My name is Tammy Franks and I am the Chair of this COVID response select committee of the Legislative Council. To my left is the Hon. Kyam Maher and Hon. Emily Bourke. To my right is the Hon. Nicola Centofanti and the Hon. Connie Bonaros. The other member of the committee who is an apology today due to being at another committee is the Hon. Dennis Hood.

With the formalities out of the way, if you would like to introduce yourselves. If you have an opening statement, please deliver that, and then we will move into questions.

Dr POPE: My name is Dr David Pope. I am President of the South Australian Salaried Medical Officers Association.

Ms MULHOLLAND: And my name is Bernadette Mulholland. I am the Senior Industrial Officer of the South Australian Salaried Medical Officers Association. I would like to thank you for inviting us here today. I will do a very brief introduction. Really, what we are focusing on from a SASMOA point of view is what we have done well and what we haven't done so well in our own observations and the feedback from our membership.

Quite clearly, what we have observed that has been done particularly well is allowing the health professionals to lead the COVID response. Up until that opportunity was given, it was SASMOA's view that there had been a disparity or a disrespect in the job and the professionalism of

health workers to be able to lead such a response and indeed lead Health in particular. We also thought that the job done by SA Pathology and its team was done very well. That should have been recognised by government, and the leadership of SA Pathology was done very well.

What was not so good, from our point of view, was more back of house, was more the response to health workers and in particular our doctors and what their actual needs were during that response: issues around protective equipment; issues around social distancing; issues around equipment, such as desk space; response to the needs of vulnerable workers, particularly pregnant doctors, continues to be a concern for SASMOA in relation to what is happening; crowding behind the scenes.

The disparity in leave opportunities of some doctors—for example, casual doctors and visiting medical specialists—continues to be a concern. We certainly wrote to the government about workers comp and the ability for it to be deemed that, should a doctor contract the disease, it would be automatically a workers compensation claim. We are yet to receive a response to that correspondence.

425 The CHAIRPERSON: Interesting.

Ms MULHOLLAND: Although we do understand that that is in the pipeline. But that was very concerning for our doctors. What was also concerning was the ability to implement welfare officers on the ground. What we also saw, with the removal of some vulnerable doctors within particular services, was that there became a shortage of resourcing for those particular services. Should we have seen a worse response or indeed a greater number of people contracting COVID as well as health workers, then that would have been a desperate situation for us all.

Other issues the light was shone on was the competency of some LHNs to respond. Some did really well and were very interactive and consultative with the unions and indeed with SASMOA. Others lagged behind considerably and used the term 'business as usual' when we all knew very well it wasn't business as usual. Certainly, from our point of view, in the public arena things were good, but behind the scenes there were ongoing difficulties for us to actually access the needs of doctors, which was problematic.

Dr POPE: Just further on the protective equipment for medical staff, there were clearly some logistic and supply issues there that went to the safety and welfare of medical staff and also patients presenting to the hospitals. Unfortunately, most of the acute areas of our hospitals operate at a very high level of crowding, where it's not possible to socially distance at all. This means that the risk of transmission is very high in those environments, and it's an environment where you've got not only staff who are at risk but also high-risk patients being put at risk, and despite us raising this as a concern multiple times that risk was simply ignored.

There was no provision to use anything in lieu of social distancing. Social distancing is very important. We are doing it here today, but in the hospitals and most parts of the clinical areas of the hospitals it's not possible to do and yet there is no attempt to mitigate that risk. We believe it is certainly possible to mitigate that risk, but that didn't occur, which remains a concern as we go forward and as we start to open things up, and that could be a problem.

The other thing I would say about protective equipment, just at the onset, is that there was a big focus on masks, but we had shortages in the other parts of that equipment, like face shields, like gowns, and big deficits in the supply of hand sanitiser such that in the hospitals our normal routine hand hygiene procedures to limit the spread of infection were not possible because there was no longer the sanitising hand gel available in the hospitals. They are things which the supply chain is now catching up with largely because I think some of the demand has lessened as the number of cases in the community has lessened, but we still are not fully back to a situation where we can use our normal hygiene measures in the hospitals to limit all forms of transmission.

426 The CHAIRPERSON: I would like to turn to one of the specific things you raised in your opening statement to start with. When did SASMOA write to the government with regard to presumptive treatment of COVID transmission for front-line workers?

Ms MULHOLLAND: I couldn't give you a definitive date. I'm happy to provide the correspondence, but I would say in about late March.

427 The CHAIRPERSON: If you could take on notice a copy of that correspondence, it would be most appreciated. Which minister did you write to, or ministers?

Ms MULHOLLAND: I wrote to the Premier, I believe.

428 The CHAIRPERSON: Did you receive an acknowledgement of that correspondence?

Ms MULHOLLAND: I recently received an acknowledgement a couple of days ago.

429 The CHAIRPERSON: Who was that acknowledgement from?

Ms MULHOLLAND: That was from the Treasurer's office.

430 The CHAIRPERSON: When did the Treasurer receive the correspondence?

Ms MULHOLLAND: I can't specifically say, but I would have emailed that at the time that I had sent it through to the Premier.

431 The CHAIRPERSON: Again, if you want to take that on notice in terms of the response received so far from the Treasurer. You are quite right in that the Treasurer has raised this issue in parliament in terms of a bill that we do have before the parliament; in fact, there are two bills before the parliament looking at presumptive treatment of COVID in people-fronted worksites. The Treasurer didn't mention SASMOA in his speech to the previous bill. Perhaps he will in the coming week. Do other members have questions?

432 The Hon. E.S. BOURKE: I want to expand on a bit on what the Hon. Ms Franks just mentioned with regard to communication with the government. Have you had regular conversations with the minister or the Premier or the Chief Public Health Officer?

Ms MULHOLLAND: We had regular conversations with department representatives later on. That was later on, and I think the agitation by the unions to get some formal discussions happening happened about the third or fourth week in. Certainly, from our point of view, we started raising concerns. We have a lot of doctors doing professional development overseas, and our concerns were raised probably late February, when we started to see internationally what was happening—are we going to put in place some supports and have some discussions about these doctors coming back?

There seemed to be a disparity in the knowledge that we had or the potential risk in what our doctors knew and what was happening on the ground within the administration and the bureaucracy wasn't lining up. It almost looked like desperation from ourselves to say, 'Hey, this is going to happen. What are we going to do? Do you want these doctors to isolate when they come back from overseas?'

From there, we started to have planned union meetings, probably about the third or fourth week in. I would be able to give you those dates when it started because what was really coming to the fore were issues at local health networks that weren't being addressed. Some LHNs were exceptional, so we were seeing some that were doing really well. We were also seeing the anxiety and stress of our medical workforce and that discussion not happening. There was certainly a breaking down, or a catch-up really, to address some of the concerns that they had. It improved as time went on, but certainly earlier on there was some frustration with it.

433 The Hon. E.S. BOURKE: But just to highlight, would you describe your relationship as having a direct line to the minister or to the Chief Public Health Officer?

Ms MULHOLLAND: Did I think that we couldn't have that direct line and couldn't pick up the phone to have that conversation? I would assume I could. I would be comfortable in thinking that. I don't recall if we met with government at that stage.

Dr POPE: No, we had no formal meetings, but we certainly had the occasional phone call into the minister's office and speaking to a minister's staff about how things were going on the front line and the odd suggestion about how government might respond to that.

Ms MULHOLLAND: The difficulty we were having initially was who actually was going to control the response: was it the department or was it the local health networks? There was certainly confusion with some local health networks. I'm certainly happy to say that with—well, not

happy, but NALHN certainly presented a difficulty because their view was that it was business as usual and the department would tell us what to do, and they were always about two to three weeks back.

Then you had SALHN, who was on the front foot implementing things, doing their own thing really in regard to their response, so there was no clarity on roles right from the commencement as to who was doing what—so, when there were shortages of PPE, who do we speak to? I think that's something that certainly can be improved, in terms of the response to the employees on the ground, and needs to be.

434 The Hon. E.S. BOURKE: Similar information was provided by the AMA, that they took steps to provide their own information and guidelines. They mentioned also that SALHN were ahead of the game. Looking forward, would it be better to be looking at a centralised message to be going out? Is it working having the individual LHNs?

Ms MULHOLLAND: It's probably a combination of both—that we actually all need to work together, we all need to be in the room, to bring up those local health networks that weren't achieving what should have been achieved with the employees so they could see what the other LHNs were doing.

I think you have to have a centralised process—and Dave will talk more to this. You have to have a command and control almost for that to happen to respond to the pandemic. But what was really concerning was that we didn't have that. We still don't have that in terms of seeing what each of the LHNs are actually doing. That's still concerning for us. We are not seeing comparable responses across the networks. Is that then something the department should take up to achieve that? Possibly, yes.

Dr POPE: The declaration of a public health emergency was interesting because it was clear from our discussions with the department and some of the LHNs that they had no idea what that meant in terms of the command and control structure, who was making what decisions. SALHN was well aware of this. I think they had the advantage of having some very skilled people working within the LHN who knew their stuff very well, and the department and the other LHNs were really looking around for instructions when they didn't know where those instructions were going to come from.

SALHN did very well because they just took the initiative and did all the things that needed to be done at the LHN level and just went off and did them. They were certainly well ahead of the game from that point of view. But even the messaging around the declaration of the emergency was very poor because you would turn up to work and find that nobody even knew about it.

Ms MULHOLLAND: The other thing is you also have to note why there was a difference between something like SALHN and NALHN. Quite clearly, SALHN is resourced well to have the communication officers. They are well resourced in their HR and their IR and that response. NALHN is not well resourced. They lost a very good EDMS to the city, who was Mike Cusack. I still don't think they actually have the resources or the maturity in those resources to address a pandemic, and that was reflected. You saw within SALHN and, to a degree, within CALHN that they have those resources to be able to allocate to a pandemic, whereas NALHN don't have those resources to be able to do that, and that was also very clear.

435 The Hon. E.S. BOURKE: When there was such a significant difference between what was happening on the ground at the front line, what did that mean for those communities? What did it mean for those doctors, employees, staff?

Ms MULHOLLAND: David can speak to this because he works out there. We saw a much greater anxiety level in NALHN, and to a degree in CALHN because that was the COVID hospital, compared to the other areas. That is because internationally doctors are very well linked. They knew the dangers of the disease and they weren't seeing the response to those dangers and that increased the level of anxiety and stress, particularly when we didn't see enough PPE.

At one stage, I got a call on a weekend saying, 'Bernadette, we are about to run out of masks in the ICU in the Royal Adelaide Hospital. We are desperate.' That led to me doing a safety inspection having had that discussion with them. So the anxiety levels, the ongoing deaths overseas of their colleagues and the inability for something like NALHN to be able to respond to those concerns

just removed the focus from what we should have been focusing on, and there was enormous distress.

At one stage, out at NALHN, they were looking to commence the build of the emergency department which caused enormous distress. We had to intervene in that to stop them. That was very early on in the COVID response. The concerns were if you start this build and we are overwhelmed, and I think it was very close to the breakout in the Barossa Valley that they thought to then implement this build, and that caused enormous agitation. What should have happened is that should have ceased without that agitation occurring, so there was a lack of maturity and thought because at NALHN they literally put out communication that it was business as usual.

Dr POPE: The medical staff at NALHN were really, frankly, very scared because they could see that there were no workable plans in place, that the narrative coming from the hospital executive just didn't match the reality. They were claiming that this is nothing more than a flu and your standard precautions will be enough, whereas at exactly the same time SALHN had put in place extremely detailed plans as to how they were going to respond at every stage.

436 The CHAIRPERSON: I will just interrupt there. When you say 'they were claiming', who was claiming and in what form were they making this claim?

Dr POPE: This was coming from the chief executive in some of their communications.

437 The CHAIRPERSON: In written communications?

Dr POPE: In some of them, yes.

438 The CHAIRPERSON: Again, if you could provide those to the committee, that would be appreciated.

Dr POPE: There were other communications from other levels of that organisation as well. So staff would raise concerns that we needed to have some detailed plans to make it safe for everybody, including patients, and that was met with just derision and an approach which sort of assumed that you're anxious and panicking for no particular reason, but the lack of proper planning led to enormous anxiety.

Ms MULHOLLAND: Can I just add there is a specific example of this very early on in the gastroenterology department, where they of course were very much in line of airborne droplets. They had internationally taken it on board to wear masks, had put in place a process, had agreed a process, were very concerned because of the speciality they were doing, and were then the following day directed the following day to take those masks off. That caused enormous distress, incredible distress and tension, in which SASMOA then had to write and say, 'These people are health workers. They understand the concerns and what potentially may happen. Could you please allow them to wear their masks?'

That wearing of masks and not having that ability to socially distance became a huge conflict behind the scenes between SASMOA, the department and the local health network in that they weren't able to socially distance. We didn't know then which way the disease was going to go and people wanted to wear masks. They were getting a lot of pushback from the administration about wearing masks, and we reached the point via an email where we provided to them what—I'm not sure what they're called—Health and Safety Australia had actually come out and given a response: 'You cannot tell health workers to remove their masks.'

439 The CHAIRPERSON: Is this the AHPPC?

Ms MULHOLLAND: Yes. It was only when we provided that that they agreed that health workers could bring in their own masks—but they weren't making them.

440 The Hon. E.S. BOURKE: Was there a required standard of the mask that they were able to bring in, or could it just be any mask?

Ms MULHOLLAND: Very early on, I know within the north they had gone to Bunnings to actually purchase their own PPE, so we were seeing this real disparity between one group—

441 The Hon. E.S. BOURKE: Do you have any evidence of them having to go to Bunnings to buy their own?

Ms MULHOLLAND: I certainly have emails of the membership coming to me, saying, 'We're off to Bunnings to purchase it.' Whether they would want me to table it—

442 The CHAIRPERSON: In terms of that, there are some formal communications that you have alluded to, so you could provide that to the committee, and if you could check with some of those people if they are happy for the committee to be aware. Perhaps we can de-identify some of that data.

Ms MULHOLLAND: There's a good example of how will we do things better in the future? I understand about the shortage of personal protective equipment, but there's clearly a way to improve things in the future.

443 The Hon. E.S. BOURKE: Just expanding from that, you've already mentioned there is workplace fatigue and anxiety but then also I think the public would have been under the illusion that there was an automatic cover for doctors if they were to get COVID-19 or to be confronted with these ongoing anxieties in the workplace. Are you surprised that there was no automatic workers compensation available?

Ms MULHOLLAND: Very surprised. Given what our doctors were witnessing overseas, and a lot of Twitter was going on, they were very concerned that they would catch the disease and die. They were ringing us up and saying, 'What will be the benefit to our families should we catch the disease and die?' A lot of our doctors hadn't been involved in workers comp legislation, so we basically had to put something out to them about what that would actually mean for them.

They were very concerned and had an automatic realisation that potentially their families would have to instigate court action to be able to demonstrate that that disease was caught at work and that caused a great deal of concern for them. There was no hesitation of them being on the front line—none whatsoever. There was no hesitation from them and some of them did go and stay in other areas. The real concern and anxiety was what that meant for their family should they catch COVID and die, and that was where we were at.

444 The Hon. E.S. BOURKE: Especially when they are wearing a mask from Bunnings. I just wanted to also touch on some corridor chatter that has been going around regarding the Lyell McEwin and the Modbury Hospital about the possibility that the theatres could be privatised. Is that just corridor chatter or is there something that you have heard along the grapevine too?

Ms MULHOLLAND: We initially had a discussion, probably about three months ago when it was raised with us, in very middle management ranks about the potential to hive outpatients into a build. At first, we found that challenging for anyone who wanted to do it given the legislation, but it wasn't going away. We were consistently hearing that chitter chatter after that discussion and then we heard even more of it at CALHN, which sometimes go to the NALHN to actually provide services.

Certainly, the discussion was being had. We were reassured it was just discussion when we made inquiries. As we move further along and we move from only closing two theatres to closing four theatres, emails were moving between our medical workforce and senior people talking about the potential for outsourcing, asking, 'Could we have a clear understanding that we would be returning back to Modbury once we moved to the Lyell McEwin Hospital?' We still hadn't got clarity around that and even with a meeting with employer representatives last week, there was a disparity of views on whether that would happen or not. It was really clear from one of the participants and not so clear from one of the other participants.

There was so much discussion and there was no transparency or outright ruling out by the hospital management that we wrote. Those letters have been backwards and forwards. It was not until last night that we got some clear indication from the minister that there is not going to be any outsourcing of those surgical services. Initially, it started with outpatients, then we heard it was theatres, and that caused us a great deal of problems.

I understand, in conversations that I have had with local members out there, that because SASMOA didn't seemingly take it seriously, because it didn't seem to be something that was moving forward, they started to go to the local MP, who was ringing us asking about clarity. Then

we started to see the emails and we went, 'We need to have some reassurance here.' Do I think that was a government policy that was being put in place? No, I don't. Certainly, with COVID, I think it would be a silly move. But, certainly, it was unclear from hospital management whether the intent was to move policy along those lines.

445 The Hon. C. BONAROS: Given the evidence that you have provided so far today, the issue with when we first had the declaration of a public health emergency, what that actually means, do you think that there was an over-reliance or a general reliance by the government and SA Health on peak bodies, unions, to effectively step up and fill the gaps in terms of providing policies, providing information to their members, who were clearly coming to you and asking questions? Do you think that's appropriate, or should there have been a framework around that? Is it appropriate for those members to have to come to the peak bodies for that sort of information, or should that have existed?

Dr POPE: I have to say that, as I mentioned, the knowledge about what the declaration meant was almost non-existent. I had some idea because I had been involved with emergency management in the past. There was no communication at any level from government to LHNs as far as I could tell, and certainly amongst SA Health more broadly, as to what that actually meant. It is only very recently that SA Health have started to have sessions and webinars about what it means under that declaration.

446 The Hon. C. BONAROS: If we just tie that back to your opening comments, Ms Mulholland, about the disparity and disrespect that has been shown towards clinicians and doctors leading up to COVID, is that one of the lessons that has been learned: that they need to be front and centre in the decision-making process? Do you think that the government has now acknowledged that and that there is a plan going forward where doctors and clinicians are going to be front and centre, not just in a COVID-19 situation but generally across the board in Health?

Ms MULHOLLAND: Certainly, there is some recognition of the importance of clinicians, in particular doctors, leading some of these processes in this environment. Up until the pandemic happened that wasn't happening. Do I think we are going to slide back into old ways? Yes, I do, and we are already seeing that. As we move away and people think it's a bit more controlled, we are now seeing the administration trying to claw back what they have lost.

What they should be seeing and I think what I have said publicly is that you should be able to see the benefits—the efficiencies that were achieved—of having those front-line doctors stepping up, taking a bit of control, having a bit of trust in them and, look, what a great result. But we have seen that on many occasions. The frustration, I think, for front-line doctors is that no-one wants that to happen. I can't speak for other health workers, but it has always been a frustration.

Coming back to the other part of your question, yes, we did lead a lot of responses for our front-line doctors and we did have to provide them a lot of information but, as we all started to work together and SA Health started to step up—I am talking about all the LHNs—there was certainly a benefit in all of us working together, listening to one another and listening to the clinicians to try to achieve a good outcome. I think we eventually did that with the public. I am not sure we are yet there with the health workers.

447 The Hon. C. BONAROS: The reality is that we are not quite out of the woods yet.

Ms MULHOLLAND: We're not.

448 The Hon. C. BONAROS: We are far from it.

Ms MULHOLLAND: We are.

449 The Hon. C. BONAROS: So there is every possibility that we could step back into a much more dire situation.

Ms MULHOLLAND: Yes.

450 The Hon. C. BONAROS: If we didn't have those front-line clinicians and doctors leading the way then we potentially could have been in a much worse situation than we are, and we still run that risk. Do you think that's a fair analysis?

Ms MULHOLLAND: I think so. Where we have seen health workers put up as heroes, I think eventually we will start to see that slide—well, actually, the linguistics will change.

451 The Hon. C. BONAROS: Following on from that then, and in terms of those front-line doctors and clinicians who have done an amazing job, and we are all extremely grateful for what they have done, I imagine that you are particularly concerned about the psychological impact and the mental health impacts that this has had on your members.

I note that there is a survey that was just updated last year from Beyond Blue that says that doctors are already at the top of the list of those individuals who are significantly impacted by mental health, by suicide and so forth. How much has that played on your mind and how concerned are you about post-traumatic stress and the mental health of those doctors who have been at the front line?

Ms MULHOLLAND: Certainly, I met with a number of what I would call vulnerable doctors, that is, older doctors within our workforce, that were incredibly upset about what was happening and whether they can continue on in their role. That was something that I recognised and the anxiety of doctors was a great deal more than I expected, particularly overseas doctors, who were seeing what was happening in their previous homes. That exacerbated that anxiety in an already incredibly difficult environment for them and what they work in. It really does become absolutely necessary that we need to start to do some focusing—particularly because, like you say, COVID is not going away—on the wellbeing of our doctors at the different sites.

452 The Hon. C. BONAROS: Have there been additional mental health services—telephone support services, online services, anything—made available to doctors and clinicians during this period to help cope?

Dr POPE: Nothing over and above what's there in normal business, which, quite frankly, is inadequate. I would say it would go a long way to alleviating a lot of the psychological trauma if clinicians are able to do their job properly and aren't impeded by bureaucrats and others who seem to impose a certain will on the clinicians. That's a key source of stress.

453 The Hon. C. BONAROS: In relation to patient presentations, particularly in EDs, have you had any reports back in relation to mental health presentations, for instance, at ED? Are those numbers up? Are they down? Do you think people have been kept away because they have been worried about COVID? Are you concerned that they haven't had access to appropriate mental health treatment because they have been too scared to present to a hospital?

Dr POPE: There are many things going on there. Probably most of the things you mentioned are true. In terms of numbers, I haven't seen any official numbers, but we didn't really see mental health presentations fall that much.

454 The Hon. C. BONAROS: Do you think there was a decline compared to previously?

Dr POPE: Overall, the numbers presenting to hospitals were way down for a number of weeks. They are now bouncing back up. I haven't seen any numbers about mental health issues specifically, but I would say that the percentage of people presenting to hospitals, the number that have mental health problems as a percentage, is growing, and it's growing quite fast.

455 The Hon. C. BONAROS: In relation to those vulnerable workers and high-risk workers, I note that you had put together a number of fact sheets and help sheets in terms of making sure that your members know what their rights are, what rights they have to paid leave, special paid leave, and so forth. Do you think that part of this has been dealt with appropriately? Do you think there's been an appropriate level of flexibility regarding pay matters generally? If you've got a vulnerable worker or a high-risk worker and they haven't been able to go to work, do you think they have been addressed appropriately?

Ms MULHOLLAND: It's been patchy. Certainly, with pregnant doctors there was real concern. It almost came down to a hostility towards pregnant women, that they couldn't go off the job. It became a debate, a medical debate, as to whether they were in jeopardy or not. Certainly, there were a number of articles. If pregnant women are anxious for themselves and for their child and they are not classed as a vulnerable worker, and we are waiting to see what the data is on it, I think that was a tragedy because that increased the anxiety of those particular women, and we should have been pragmatic. There was no pragmatism there.

Certainly, one of our industrial officers was given the work to look after that cohort of doctors and found it incredibly difficult to get support for pregnant front-line doctors to be able to remove themselves from that front line for fear and anxiety for themselves and their child. Certainly, there was concern for casual doctors and what we call our visiting medical specialists, who had no access—and they were very clear when they raised this with the Commissioner for Public Sector Employment—to COVID leave, and that was a real concern for them.

It was also a concern: if things had got worse, why would these doctors then present themselves to assist in the public sector if they weren't going to be provided any leave should they get sick? I think that's something that can be improved as we move forward as well.

456 The Hon. C. BONAROS: In relation to casual doctors, has it been a particular problem as well, in relation to the special leave?

Ms MULHOLLAND: Yes, certainly. They couldn't access it. They were very clear with us that there would be no access to that and very clear with visiting medical specialists, some of whom have worked for years for the hospital sector, that because the award provides that they are given a loading for that they wouldn't have access to that leave. It doesn't endear themselves to the public sector when we are most in need, potentially.

457 The Hon. C. BONAROS: I'm going to end because I'm mindful of time, but there have been some alarming articles recently and debates around vaccination rates and I want to get some clarity. I understand that front-line staff do have access to vaccinations, and in some areas it is a mandated requirement. Is that the same with doctors and clinicians? Is there a mandated requirement for doctors and clinicians to be vaccinated, and are there any concerns around vaccinations generally and vaccination rates?

Dr POPE: No. It's probably not mandated in a strict sense, but it's strongly encouraged.

458 The Hon. C. BONAROS: It's made available to all?

Dr POPE: It's made available to all.

459 The CHAIRPERSON: Are we talking about flu vaccinations?

460 The Hon. C. BONAROS: Yes. Is there a requirement that everyone be vaccinated as such?

Dr POPE: No. There has been discussion many times that there should be a requirement, but there are always cases where that can be quite difficult to achieve, so it hasn't been pushed that far, but it's strongly encouraged.

461 The Hon. N.J. CENTOFANTI: Thank you for joining us this morning. I just have one question. In regard to personal protection equipment, have you had any feedback on how the establishment of the PPE vending machines has gone in hospitals?

Dr POPE: Yes. Where to start? The vending machines arrived in the hospitals. In the particular hospital where I work the vending machines are placed in an area where there is no power, so the vending machines do not operate. They are full of equipment that no-one can access because there is no power and there is no attempt, it seems, so far to supply power to those machines.

462 The Hon. N.J. CENTOFANTI: Who makes the decision as to where those vending machines are placed?

Dr POPE: That would be made, I imagine, at the local unit level, but the options available in very limited space are fairly limited, so they found a spot where they would physically fit. Unfortunately, that is not a spot that has any power outlets.

463 The Hon. N.J. CENTOFANTI: Do you know how many hospitals that is happening in? Do you have any evidence, or is it sort of anecdotal?

Ms MULHOLLAND: I know it's happening at Flinders Medical Centre. I think Flinders had it, but I may be getting confused. I'm not clear as to the—

Dr POPE: I understand that they have rolled out vending machines to most hospitals. How it has worked in each hospital I imagine is quite different. I haven't got specific feedback from other sites.

464 The CHAIRPERSON: Again, if there is any further information on that, we will take that on notice and would much appreciate it. I have just a couple of very small things. We apologise that we have run behind on time, and I am aware that we have two more witnesses today. In your evidence, you talked about how only recently SA Health started having webinars about what a public health emergency means. On notice, could you give us the dates of those particular webinars? My question actually is: how was SASMOA informed that there was a public health emergency?

Dr POPE: It was announced on a weekend, on a Saturday, so we became aware of it through media reports, but I think other states' declarations of emergencies got more media coverage than our own here in South Australia. I know many medical staff became aware of declarations in Victoria, not knowing that South Australia had made a very similar declaration.

465 The CHAIRPERSON: So there was a reliance on the media or social media for that information. There were no official emails sent?

Dr POPE: It was delayed. In fact, that was something that I did raise with the minister's office to essentially ask: is there any messaging that is coming out about this because nobody knows about it? Shortly thereafter, I think that evening, some messaging did come from the Chief Executive of SA Health.

466 The CHAIRPERSON: Any of that data or email or mail trail on notice would be much appreciated. My final question is one from the perspective of a family member of a patient. I think many members of this committee—and we have now received it officially—have been contacted. I will read this out in part that, having only one visitor a day for an 87-year-old, possibly terminally ill grandfather, is putting enormous emotional distress on both him in his last days potentially and this family. I know that this is quite widespread. There are many in the community who have sick, suffering and dying loved ones in hospitals, and they can only have one visitor a day, yet we can have 80 people in the pubs on the weekend. How is that impacting on your workforce watching that happen?

Dr POPE: It's extremely distressing because the staff take on the distress of the patients and their families. To have to tell people that they can only have one relative at a time in a situation of a health crisis is just devastating for all concerned. I think there has to be a different way to approach this. There is crowding in our hospitals as it is. There is no limit on the number of staff confined to very small workspaces, so it doesn't make a lot of sense to limit visitors in those circumstances, in my view as a clinician.

Ms MULHOLLAND: Can I just add that it has been an ongoing discussion in the Royal Adelaide Hospital and The QEH. Dr Pope is quite right that it is left up to the doctors and the nurses to be able to tell families. It is not done at the entrance. They come in, quite agitated, to the service where doctors then have to say that they have had ongoing discussions over the last couple of weeks on this particular issue. If it is a one visitor policy, then why is it being left up to them in a very sensitive circumstance when four or five people come into the unit and they have to say, 'Sorry we can only have one person,' so there is that particular issue.

The other area is that if we start to see COVID increase in that sort of environment, the advice is coming back to me, 'How do we then control it?' We don't want to see what is happening in elderly homes. If one person comes in, and they have the disease, that potentially is dangerous. They are being left to make these decisions. No-one from the administration is actually policing it. It has been an ongoing discussion at quite high levels within the Royal Adelaide Hospital and The QEH between the doctors and the chief executive and the executive as to whose responsibility it is.

If you have a rule that only one member of the family is allowed in the very sensitive circumstances that you have talked about, and that rule is there but you are not managing it and you are leaving it to us to manage, where do we stand in all of this? There is no clarity over this and it is causing a great deal of distress, particularly in palliative care at The Queen Elizabeth Hospital and the Royal Adelaide Hospital. They are very distressed about it.

467 The CHAIRPERSON: Is that rule blanket across the state—one visitor per 24 hour period—or does it apply differently?

Dr POPE: It seems to be, unfortunately.

Ms MULHOLLAND: It's not managed.

Dr POPE: Yes, it's not well managed. The public aren't aware of it. It comes as a shock. They are extremely angry, as you can imagine, quite rightly, so it puts an enormous amount of stress on staff. It is certainly one of the things that can contribute to that post-traumatic stress. If you are someone who is in the last throes of life and you are left with that situation, it just leads to stress.

468 The CHAIRPERSON: If there are two family members wanting to visit an elderly man in hospital, who decides which family member takes priority?

Dr POPE: That's right, and then you have conflict within the family about who that is going to be.

469 The CHAIRPERSON: Who may all be coming from the same household.

Ms MULHOLLAND: And it causes enormous distress to those front-line health workers who have to manage that with no support coming from the hospital administration to identify how they would like to frame exactly the questions that you are putting.

Dr POPE: There's no alternative presented. So it's not as though, 'We limit the numbers of people but we do something instead.' There's no thought to that, there's no planning for that, and I think that's a huge hole.

470 The Hon. C. BONAROS: Has that included—and I imagine it has—confrontations between family members and medical staff?

Dr POPE: Absolutely; I have had personal experience.

471 The Hon. C. BONAROS: Which is not a pleasant situation for anyone to be in.

Dr POPE: No, and it's completely opposite to the way that we would normally manage grief and dying.

472 The CHAIRPERSON: Indeed. If there are no further questions, we thank you for your time today and also for the extraordinary circumstances in which you have been working and supporting your members. As you know, the transcript will be forwarded to you for any clerical corrections, but I remind you that it will in fact go live as soon as we have the uncorrected transcript today.

Ms MULHOLLAND: Thank you.

Dr POPE: Thank you very much.

THE WITNESSES WITHDREW

Bernadette Mulholland

From: Kaharevic, Melisa (Health) <Melisa.Kaharevic2@sa.gov.au>
Sent: Tuesday, 14 April 2020 9:04 AM
To: Katharine Webster; Bernadette Mulholland
Cc: White, Kelly (Health)
Subject: RE: Vulnerable Persons - COVID-19
Attachments: COVID-19 UPDATE | Protecting Vulnerable Staff; COVID19 +Fact+Sheet+Information+for+vulnerable+SA+Health+staff.pdf

Hi Bernadette and Katharine,

Thank you for the information you have provided.

Please see the ***attached*** Chief Executive update (hyperlinked Fact Sheet also attached) regarding Protecting Vulnerable Staff that was distributed to SA Health staff late last week. I trust that you have already received copies via the usual channels and that this provides some clarification to your enquiries.

Should you have specific examples of concerns which cannot be addressed by the attached information, please refer them to myself or Human Resources within the respective LHN.

Kind Regards

Melisa Kaharevic | Director Workforce Services
Corporate and System Support Services | SA Health

Address: Level 7, Citi Centre Building, 11 Hindmarsh Square ADELAIDE SA 5000
Phone : 8226 6837 | **Mobile:** 0401 285 102
Email: melisa.kaharevic2@sa.gov.au

From: Katharine Webster <katharine@sasmoa.com>
Sent: Monday, 6 April 2020 3:04 PM
To: Bernadette Mulholland <bernm@sasmoa.com>; Kaharevic, Melisa (Health) <Melisa.Kaharevic2@sa.gov.au>; Ranieri, Erma (OCPSE) <Erma.Ranieri@sa.gov.au>
Subject: Vulnerable Persons - COVID-19

Thank you Bernadette

The issues are:

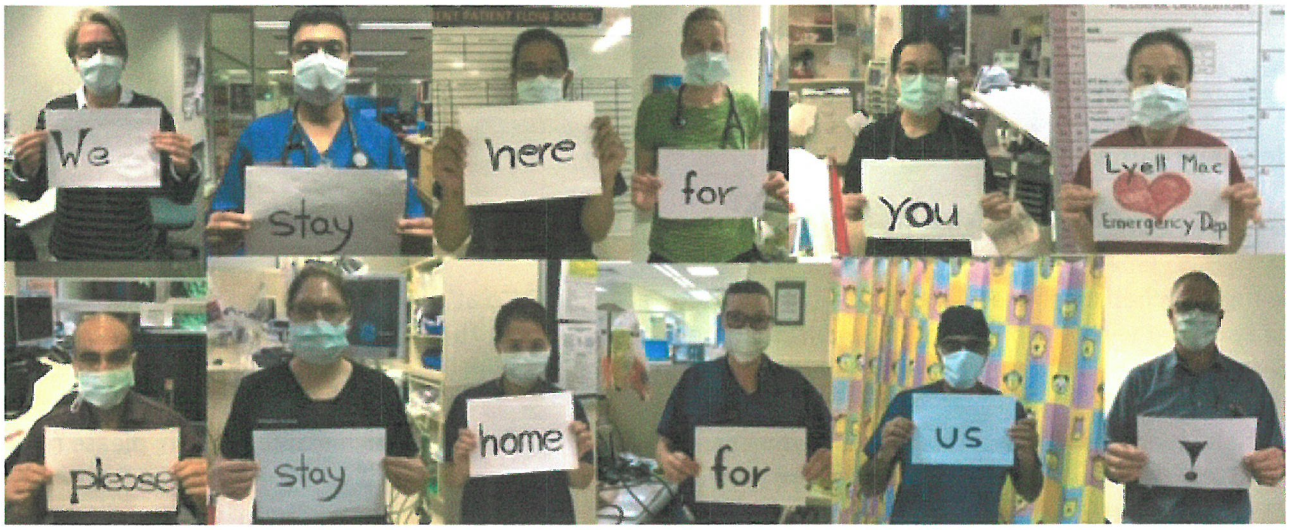
1) Inconsistent information about whether pregnancy should be treated as a high risk category (see RANZOG guidelines which suggest they are - https://ranzcog.edu.au/statements-guidelines/covid-19-statement/information-for-pregnant-women)
2) In some cases, inconsistent treatment of pregnant workers vs other workers who have been told by treating practitioners to stay home (in terms of accessing leave)
3) Lack of clarity re: whether the 15 days special leave is available to people who are required to stay at home because they are vulnerable or at high risk

Your urgent advice, in particular regarding (3) would be greatly appreciated.

Kind regards

Katharine Webster
Katharine Webster
South Australian Salaried Medical Officers Association (SASMOA)
161 Ward Street | North Adelaide SA 5006

M: 0477 779 594
E: katharine@sasmoa.com



From: Bernadette Mulholland <bernm@sasmoa.com>
Sent: Monday, 6 April 2020 2:37 PM
To: Melisa.Kaharevic2@sa.gov.au; Erma.Ranieri@sa.gov.au
Cc: Katharine Webster <katharine@sasmoa.com>
Subject: Vulnerable Persons - COVID-19

Dear Melisa and Erma

I understand that consideration is being given for a direction for vulnerable persons (age related, illness, pregnancy etc.) working in environments such as hospitals due to COVID-19.

SASMOA has had some problems in some services and LHNs, given the little direction on this issue, particularly around pregnant doctors. We are advised that there is no evidence to suggest that COVID-19 will cause any complication for the unborn child but this fails to take into account the anxiety and concerns and changed environment the pregnant doctor is required to work. Particularly high risk areas such as ICU, EDs and MER. .

There are also those doctors who raise their vulnerability or their vulnerability is known to the employer and are told their only option is to take leave and go home, take leave without pay, threatened that if they didn't take leave or resign would be referred to AHPRA or threatened to be left on the frontline in they don't retire. These are but a few of the examples we are provided.

Our Katharine Webster has done a great deal of work members who are pregnant over the last few weeks and I will ask her to make any further comment that are necessary to inform this conversation.

It would be really useful to have some direction on this matter.

Kind Regards

Bernadette Mulholland

Bernadette Mulholland

From: Ranieri, Erma (OCPSE) <Erma.Ranieri@sa.gov.au>
Sent: Friday, 17 April 2020 11:04 AM
To: Bernadette Mulholland
Cc: Katharine Webster
Subject: FW: Vulnerable Persons - COVID-19

Hi Bernadette

Thank you for your email on 6 April 2020 in which you sought clarification regarding "vulnerable persons" and the working arrangements that are to apply.

The revised Supplementary Determination I issued on 8 April and the Information for Vulnerable Staff Health issued by the Chief Executive, SA Health on 9 April do provide guidance on this matter.

My expectations for all Local Health Networks and the Department for Health and Wellbeing in respect to the issues you have raised is that the Chief Executive, or their delegate will mitigate the risk to vulnerable staff and that a risk assessment is undertaken. This ensures that the individual's circumstances are given due consideration and that the risk is mitigated.

When it comes to our vulnerable staff, it is important to me that individual employees are not treated indifferently and inconsistently across the public sector.

I am very aware that the advice and directions that are being given in relation to the management of COVID-19 both in this State and across Australia can change. I will continue to rely upon the medical advice that is being provided in relation to vulnerable people and how the South Australian public sector Chief Executive and HR Leaders need to respond to that advice to ensure the wellbeing of the public sector employees.

If it assists I support this email being provided in the resolution of any member issues that SASMOA is currently involved in.

Further assistance is available in my Office from Jan Summerton, Principal Adviser who may be contacted by email jan.summerton@sa.gov.au or on 0401 125 869.

Kind regards
Erma

Erma Ranieri
Commissioner for Public Sector Employment
Office of the Commissioner for Public Sector Employment | publicsector.sa.gov.au

My executive support is provided by Angela Corletto
T +61 (8) 8226 2721 | **E** angela.corletto@sa.gov.au

Government of South Australia
Office of the Commissioner
for Public Sector Employment

From: Bernadette Mulholland <bernm@sasmoa.com>
Sent: Monday, 6 April 2020 2:37 PM
To: Kaharevic, Melisa (Health) <Melisa.Kaharevic2@sa.gov.au>; Ranieri, Erma (OCPSE) <Erma.Ranieri@sa.gov.au>
Cc: Katharine Webster <katharine@sasmoa.com>
Subject: Vulnerable Persons - COVID-19

Dear Melisa and Erma

I understand that consideration is being given for a direction for vulnerable persons (age related, illness, pregnancy etc.) working in environments such as hospitals due to COVID-19.

SASMOA has had some problems in some services and LHNs, given the little direction on this issue, particularly around pregnant doctors. We are advised that there is no evidence to suggest that COVID-19 will cause any complication for the unborn child but this fails to take into account the anxiety and concerns and changed environment the pregnant doctor is required to work. Particularly high risk areas such as ICU, EDs and MER. .

There are also those doctors who raise their vulnerability or their vulnerability is known to the employer and are told their only option is to take leave and go home, take leave without pay, threatened that if they didn't take leave or resign would be referred to AHPRA or threatened to be left on the frontline in they don't retire. These are but a few of the examples we are provided.

Our Katharine Webster has done a great deal of work members who are pregnant over the last few weeks and I will ask her to make any further comment that are necessary to inform this conversation.

It would be really useful to have some direction on this matter.

Kind Regards

Bernadette Mulholland
SASMOA, Senior Industrial officer

SA Salaried Medical Officers Association

Serving Salaried Doctors

1st Floor, 161 Ward St
(PO Box 64)
North Adelaide
South Australia 5006

Telephone: (08) 8267 5151
Email: sasmoa@sasmoa.com
Website: www.sasmoa.com
ABN: 60 932 342 397

14 April 2020

Erma Ranieri
Commissioner for Public Sector Employment
GPO Box 2343
Adelaide SA 5001

Via Email: Erma.Ranieri@sa.gov.au

Dear Ms Ranieri,

Thank you for providing greater clarity to our members through the updated *Commissioner's Determination 3.1: Employment Conditions – Hours of Work, Overtime, Leave: Supplementary Provisions for COVID-19*, released last week.

South Australian doctors, nurses, health care and emergency workers stand ready with their communities to face COVID-19 and save lives. They cannot, however, do this without appropriate support from their employer, including access to appropriate leave during the current pandemic.

Inconsistencies and abnormalities

SASMOA welcomes a number of the initiatives available within the Determination but has identified several inconsistencies and abnormalities which we are concerned will create unfairness and confusion.

We would like to bring the following to your attention:

- When an employee is caring for a family member who is sick or isolating, they are automatically entitled to COVID-19 special leave after exhausting their sick (carer's) leave entitlement. However, when the employee is sick themselves with COVID-19, then COVID-19 special leave is discretionary on application to the Chief Executive.

- When an employee is living with a vulnerable family member, they can access sick leave (as carer's leave) until it runs out. However, it is not clear whether vulnerable employees themselves are entitled to take accrued sick leave once COVID-19 special leave is exhausted.

- When the workplace shuts down temporarily due to COVID-19 the employee must take their own leave entitlements - however if the workplace shuts down in other circumstances the employee is not deducted any leave entitlements.

- New employees on fixed-term contracts can access COVID-19 special leave, however long-term casuals/VMOs who have worked for the Government for a number of years receive no paid leave.

- It is not clear whether COVID-19 special leave is available in all circumstances where an employee has been directed to self-isolate.

SASMOA would appreciate clarifications regarding the Government's intent on those matters.

Fairness and workforce wellbeing

In addition, SASMOA is concerned that any ambiguity will create a risk that some health units will use the COVID-19 pandemic as an excuse to make unfair and unreasonable demands on their workforce, including to discriminate against, intimidate or bully staff.

To assist in preventing this, we would welcome statements from you confirming that:

- Existing conditions of employment as provided for under relevant industrial instruments will continue to apply to employment arrangements during a health pandemic.
- Employers must comply with all legal obligations to provide a safe working environment and to avoid placing excessive or onerous workloads on their employees.
- Leave entitlements and requests should be applied as consistently as possible across the health sector.
- The consultation requirements contained in the industrial instruments have not changed.
- The precise date and time that the isolation requirements were applied to doctors returning from interstate and under what instruments/authorities.

Interstate comparisons

SASMOA has compared the Determination against supports available to the public sector workforce across Australia, and it appears that South Australian COVID-19 entitlements fall well below interstate standards. The following table provides comparisons:

	SA	WA	NSW	QLD	TAS	ACT	VIC
Special Leave (days)	15	20	20	20	Uncapped	Uncapped	Case by case
Special leave: school closures	sick/carers only	Yes	-	Yes	sick/carers only	Yes	Yes
Paid leave: regular casuals	No	Yes	Yes	Case by case	Yes	Yes	Case by case
Workplace closures: Special leave/ absent on duty	No	Yes	Yes	Yes	Yes	Yes	-

We are not aware of any reason why doctors in South Australia should not have access to comparable supports and entitlements as their colleagues over the border.

To this end, SASMOA is strongly recommending further supplementary provisions be adopted to include:

1. **An increase of COVID-19 Special Leave entitlement from 15 days to 20 days**
2. **Extension of the application of COVID-19 special leave to school closures**
3. **Extension of paid leave entitlements to regular casuals and VMO employees**
4. **Maintenance of current industrial entitlements in relation to workplace closures**

Thank you for your consideration of the above questions and requests. We look forward to your response by COB 28 April 2020.

Your sincerely

Bernadette Mulholland

cc: Melisa Kaharevic, Director Workforce Services

Bernadette Mulholland

From: Bernadette Mulholland
Sent: Monday, 20 April 2020 10:59 AM
To: Erma.Ranieri@sa.gov.au; Kaharevic, Melisa (Health)
Cc: Cusack, Michael (Health); Katharine Webster; Tea Boromisa; Ed Grue
Subject: Pregnant workers and Covid19
Attachments: 2020-03-30-occupational--health--advice--for--employers-and--pregnant-women-during-the-covid-19-pandemic-200409.pdf

Dear Erma and Melisa

Further to the concerns raised by SASMOA regarding pregnant women employed in the health sector I provide you the attached guidelines provided by the UK/NHS in regards to COVID-19 and OH&S advice on this matter.

Regards

Bernadette Mulholland

SASMOA, Senior Industrial Officer

https://www.rcog.org.uk/globalassets/documents/guidelines/2020-03-30-occupational--health--advice--for--employers-and--pregnant-women-during-the-covid-19-pandemic-200409.pdf

Royal College of Obstetricians & Gynaecologists

COVID-19 virus infection and pregnancy

Occupational health advice for employers and pregnant women during the COVID-19 pandemic

Version 2.1: Published Monday 30 March 2020

Updates

Please note that version 1 of this occupational health guidance was published as a chapter in the RCOG's general Coronavirus (COVID-19) Infection in Pregnancy guidance. The occupational health guidance will now be published as a separate document given the audiences for each document are distinct. It is hoped that this will make it easier for all healthcare professionals to stay updated as new versions of each document are published in line with emerging evidence.

The occupational health guidance will continue to be referenced in the general Coronavirus (COVID-19) Infection in Pregnancy guidance.

Version	Date	Summary of changes
2.1	30.3.20	**2.2:** Update - Assessment of the risk of vertical transmission has been changed to 'probable', in line with a single case report published 26.3.20 that showed the first convincing evidence of COVID-19 being transmitted to the baby during pregnancy.

1. Introduction

Everyone in the UK is advised to follow guidance from the Government to lessen the spread of COVID-19. As of 23 March 2020, this has been updated to guidance to stay at home, with the exception of a limited number of circumstances, detailed here.

However, for individuals in key professions, travelling to and participating in work remains essential in this national emergency.

For pregnant women in these key professions, and in particular for pregnant healthcare professionals, the following information may be helpful when discussing how best to ensure health and safety in the workplace with their occupational health teams.

2. Available information about risks of contracting COVID-19 in pregnancy

COVID-19 poses a risk to all members of the population, particularly to people with co-morbidities. The groups who appear to be at the lowest risk of developing severe disease are children and healthy adults. It is reassuring that there is as yet no robust evidence that pregnant women are more likely to become infected than other healthy adults.

2.1 Risk to pregnant women

It is known from other respiratory infections (e.g. influenza, SARS)[1,2] that pregnant woman who contract significant respiratory infections in the third trimester (after 28 weeks) are more likely to become seriously unwell. This may also lead to preterm birth of the baby, intended to enable the mother to recover through improving the efficiency of her breathing or ventilation.[3,4]

Given these additional considerations for pregnant women who become seriously unwell in the later stages of pregnancy, the Government has taken the precautionary approach to include pregnant women in a vulnerable group. This is so that pregnant women are aware of the current lack of available evidence relating to this virus in pregnancy; and particularly, to encourage awareness that pregnant women in later stages of pregnancy could potentially become more seriously unwell.

2.2 Risk to the baby

Currently, there is no evidence to suggest that COVID-19 causes problems with the baby's development or causes miscarriage. With regard to vertical transmission (transmission from mother to baby antenatally or intrapartum), emerging evidence now suggests that vertical transmission is probable. There has been a report of a single case in which this appears likely, but reassuringly the baby was discharged from hospital and well. In all previously reported cases, infection was found at least 30 hours after birth. The proportion of pregnancies affected by vertical transmission and the significance to the neonate is not yet known. [4-11]

No previous coronavirus has been shown to cause fetal abnormalities; and, while COVID-19 is new, the absence of reports of an increased incidence of fetal abnormality at routine scans in Asia indicates this is likely to be the same for the novel coronavirus.

Although the evidence to date available offers no evidence of harm, it is not possible to give absolute assurance to any pregnant woman that contracting COVID-19 carries no risk to her baby and no risk to her over and above that experienced by a non-pregnant healthy individual. The information above combines the limited evidence from COVID-19 so far with evidence extrapolated from other similar viral illnesses. We are actively seeking more evidence and will update this guidance when this is available.

3. Recommendations for pregnant healthcare workers

In the UK, there already exist significant protections in law for pregnant workers. These must be followed in relation to COVID-19. NHS Employers should do everything possible to maintain the health of their pregnant employees. The central aspect of this protection is based on risk assessment of each individual pregnant worker's working environment and the role they play.

Acknowledging the evidence above and following discussion with the Government and UK Chief Medical Officers, the following recommendations should guide pregnant healthcare workers and occupational health teams in conducting this risk assessment.

3.1 Protection of all pregnant healthcare workers

In light of the limited evidence, pregnant women of any gestation should be offered the choice of whether to work in direct patient-facing roles during the COVID-19 pandemic. This choice should be respected and supported by their employers. Suitable alternative duties might include remote triage, telephone consultations, governance or administrative roles. This is in line with the national guidance that workers, including healthcare professionals, who are also identified by the Government as vulnerable to COVID-19 should be able to participate in their own risk assessment.

3.2 Choices for pregnant healthcare workers prior to 28 weeks' gestation

Pregnant women who choose to work in patient facing roles after occupational health risk assessment, prior to the third trimester of pregnancy, should be supported to do so by minimising risk of transmission through established methods.

It may not be possible to completely avoid caring for all patients with COVID-19. As for all healthcare workers, use of personal protective equipment (PPE) and risk assessments according to current guidance will provide pregnant workers with protection from infection. The arrival of rapid COVID-19 testing will significantly assist in organising care provision, and this guidance will be updated appropriately when such tests are commonly available.

Some working environments (e.g. operating theatres, respiratory wards and intensive care/high dependency units) carry a higher risk of exposure to the virus for all healthcare staff, including pregnant women, through the greater number of aerosol-generating procedures (AGPs) performed. These procedures are summarised in the PHE publication '**Guidance on Infection Prevention and Control**'. When caring for suspected or confirmed COVID-19 patients all healthcare workers in these settings are recommended to use appropriate PPE. Where possible, pregnant women are advised to avoid working in these areas with patients with suspected or confirmed COVID-19 infection.

3.3 Healthcare workers after 28 weeks' gestation or with underlying health conditions

For pregnant women from 28 weeks' gestation, or with underlying health conditions such as heart or lung disease at any gestation, a more precautionary approach is advised. Women in this category should be recommended to stay at home. For many healthcare workers, this may present opportunities to work flexibly from home in a different capacity, for example by undertaking telephone or videoconference consultations, or taking on administrative duties.

All NHS employers should consider how to maximise the potential for homeworking given current relaxation of NHS Information Governance requirements, wherever possible.

Staff in this risk group who have chosen not to follow government advice and attend the workplace must not be deployed in roles where they are working with patients. Services may want to consider deploying these staff to support other activities such as education or training needs (e.g. in IPC or simulation).

These measures will allow many pregnant healthcare workers to choose to continue to make an active and valuable contribution to the huge challenge facing us, whether at home or in the workplace, until the commencement of their maternity leave.

References

1. Critical illness due to 2009 A/H1N1 influenza in pregnant and postpartum women: population based cohort study. BMJ 2010;340:c1279. doi: 10.1136/bmj.c1279

2. Zhang J, Wang Y, Chen L, et al. Clinical analysis of pregnancy in second and third trimesters complicated severe acute respiratory syndrome. Zhonghua Fu Chan Ke Za Zhi 2003;38:516-20.

3. Liu Y, Chen H, Tang K, et al. Clinical manifestations and outcome of SARS-CoV-2 infection during pregnancy. Journal of Infection 2020;Online doi: https://doi.org/10.1016/j.jinf.2020.02.028

4. Dong L, Tian J, He S, et al. Possible Vertical Transmission of SARS-CoV-2 From an Infected Mother to Her Newborn. JAMA 2020 doi: 10.1001/jama.2020.4621

5. Chen H, Guo J, Wang C, et al. Clinical characteristics and intrauterine vertical transmission potential of COVID-19 infection in nine pregnant women: a retrospective review of medical records. Lancet 2020 doi: https://doi.org/10.1016/S0140-6736(20)30360-3

6. Chen Y, Peng H, Wang L, et al. Infants Born to Mothers With a New Coronavirus (COVID-19). Frontiers in Pediatrics 2020;8(104) doi: 10.3389/fped.2020.00104

7. Li N, Han L, Peng M, et al. Maternal and neonatal outcomes of pregnant women with COVID-19 pneumonia: a case-control study. . Pre-print doi: 10.1101/2020.03.10.20033605

8. Zhu H, Wang L, Fang C, et al. Clinical analysis of 10 neonates born to mothers with 2019-nCoV pneumonia. Transl Pediatr 2020;9(1):51-60. doi: http://dx.doi.org/10.21037/tp.2020.02.06

9. Wang L, Shi Y, Xiao T, et al. Chinese expert consensus on the perinatal and neonatal management for the prevention and control of the 2019 novel coronavirus infection (First edition). Annals of Translational Medicine 2020;8(3):47.

10. Chen S, Huang B, Luo DJ, et al. Pregnant women with new coronavirus infection: a clinical characteristics and placental pathological analysis of three cases. Zhonghua Bing Li Xue Za Zhi 2020;49(0):E005-E05. doi: 10.3760/cma.j.cn112151-20200225-00138

11. Fan C, Lei D, Fang C, et al. Perinatal Transmission of COVID-19 Associated SARS-CoV-2: Should We Worry? Clinical Infectious Diseases 2020 doi: 10.1093/cid/ciaa226

Disclaimer - Q&A for members of the public

The Royal College of Obstetricians and Gynaecologists (RCOG) provides this advice and guidance for your information purposes only. This information is not intended to meet your specific individual healthcare requirements and this information is not a clinical diagnostic service. If you are concerned about your health or healthcare requirements we strongly recommend that you speak to your clinician or other healthcare professional, as appropriate.

Disclaimer - Occupational Health Guidance

The Royal College of Obstetricians and Gynaecologists (RCOG) has produced this guidance for information purposes to support employers and pregnant women during the COVID-19 pandemic. This guidance is based on the best evidence available at the time of writing, and the guidance will be kept under regular review as new evidence emerges. Please be aware that the evidence base for COVID-19 and its impact on pregnancy and related healthcare services is developing rapidly and the latest data or best practice may not yet be incorporated into the current version of this document. The RCOG does not provide legal advice. If you are concerned about your employment rights or duties we strongly recommend that you speak to your trade union representative, legal adviser or other employment law consultancy.

@RCObsGyn @rcobsgyn @RCObsGyn

THE ROYAL COLLEGE OF MIDWIVES

Royal College of Obstetricians & Gynaecologists

Royal College of Obstetricians and Gynaecologists, 10-18 Union Street, London, SE1 1SZ

T: +44 (0) 20 7772 6200 E: covid-19@rcog.org.uk W: rcog.org.uk Registered Charity No. 213280

To the Executive Director, SafeWork SA

I provide the following report in accordance with the provisions of section 117 (6) of the Work Health and Safety Act 2012 (SA) and regulation 28(2) of the Work Health and Safety Regulations 2012 (SA).

I am aware that this report, either in part or in full, may be published on the SafeWork SA website.

ENTRY PERMIT HOLDER (EPH) DETAILS

Name:	**Bernadette Mulholland**
Contact number:	**08 8267 5151**
Permit No:	**ET-19-00307**
Name of union represented:	**South Australian Salaried Medical Officers Association (SASMOA)**
Workplace Name:	**The Queen Elizabeth Hospital/Palliative Care Service**
Street Address:	**28 Woodville Road Woodville South, SA**
Date:	**Friday, 29 May 2020**

DETAILS OF ALLEGED CONTRAVENTION: in my opinion the following provision/of the Work Health and Safety Act 2012 (SA) has or have been contravened:

The EPH has recently received several safety concern from doctors situated in the Palliative Care Hospice at the Queen Elizabeth Hospital (TQEH), stating that the PCBU was failing to provide the staffing and processes required to ensure the safety of patients, visitors and staff by implementing both the PCBU COVID-19 visitor management policy and the PBCU OWI for management of interstate visitors. The EPH initially sought to work directly with the PCBU after receipt of emails documenting the safety concerns raised by doctors in the unit, but this did not resolve or address these concerns. (see email attached)

The EPH understand there are four concerns relating to the health and safety of patients, visitors and staff in the unit resulting from COVID-19. The first is the inadequate process provided by the PCBU for screening and control of visitor numbers at the hospital entrances prior to their arrival on the ward; second, the infection risk posed by interstate visitors who attend the hospital upon receiving an exemption on compassionate grounds to cross the SA border and visit a family member when the

OWI for interstate visitors has not been enforced; third, the PCBU instructing medical staff that it is their responsibility to manage visitor numbers in the ward environment, and; fourth, the PCBU knowingly instructing workers to socially distance when it is difficult, and frequently impossible to do so.

The failure by the PCBU to address the concerns that have been repeatedly identified and escalated increases the risk to patients, visitors and staff, creates anxiety and stress for all concerned, and places the workers in harm's way in the event that a distressed relative reacts aggressively to being asked to comply with the COVID-19 policy requirements for visitors. The doctors' concerns were heightened following the recent interstate visitor who tested COVID-19 positive on arrival to South Australia.

The doctors reported to the EPH that they have advised the PCBU that they support the provision of compassionate access for persons who are close to dying patients, but have requested the PCBU provide a reliable mechanism for visitor control at the hospital entrances to allow this access to be negotiated in a safe and controlled manner.

Given these concerns, on Friday 29 May 2020, at approximately 11.00 am, the EPH advised SafeWork SA that the EPH intended to visit the site as a matter of urgency.

On arrival at North East (N/E) Entrance of The Queen Elizabeth Hospital, I noted several posters on the door advising that only one visitor per patient is allowed on site each day (photos of the posters attached). I presented to the women at the entrance who were asking questions of visitors for COVID-19 screening purposes. This was clearly signed at the entrance of the building. The women asked whether I was presenting as a visitor or for an appointment. I advised I was presenting to conduct a safety inspection and provided my EPH identification. I asked where the palliative care unit was situated as I had a vague idea but was not quite clear. I was told by the individual they did not know where the palliative care unit was situated and that perhaps I was in the wrong building. I believed the advice to be incorrect and proceeded to walk down the corridor. I was not asked screening questions.

I initially entered ward NGA, preceding the palliative care unit, presenting at what I believe to be the nurse station and was redirected through an open door connecting to the palliative care ward (NGB). On arrival at the first ward and then at the palliative care ward, the EPH noted there was an inability

for those in the area to socially distance given the size of the space and number of health workers and patients present in these areas. The doctors advised the EPH that the difficulty in social distancing is increased because the areas where they all work are often cluttered and congested, with considerable space taken up by "WOWs" (Workstations on Wheels) and other equipment. The EPH was advised the workers in the area have tried to socially distance and have rearranged work where possible, but it is clear that safe distancing is not routinely achievable. The doctors advised that the PCBU has been advised that the social distancing directive cannot be achieved in many areas of the hospital.

The EPH was advised by doctors that the process for the screening of visitors at both hospital entrances is manifestly inadequate, with numerous instances of groups of up to 5 or 6 visitors arriving all at once on the ward to visit the same patient. The EPH was advised that health workers who have been asked to undertake the screening at the entrances have been told not to expose themselves to risk by attempting to obstruct entry or argue if visitors refuse to comply with the visitor policy. However, the doctors advised that this inevitably transferred the issue to the ward environment, where the nursing and medical staff are subjected to the same risks, and face engaging in stressful discussions with visitors on the ward, with a high risk of conflict. The doctors advise that where other families and patients witness other visitors in the ward not complying with the one visitor rule, or failing to socially distance, they are getting angry and distressed, raising concerns with the hospital staff in the ward as to why they can't also have more visitors.

The doctors advised the EPH that they had escalated their concerns in written form on multiple occasions over at least two months, together with practical recommendations based on successful processes employed at other SA Health institutions. Escalation had been pursued through all available pathways, including emails directly to the PCBU CEO. This had resulted in some changes enacted in increments over two months. Firstly, a number of entrances were closed, and health screening instituted at two of the three remaining public entrances. The unscreened entrance was subsequently closed, and the screening protocol was modified to require the staff to identify visitors who intended to go to NGB, and call the ward to check whether the patient already had visitors present. While this resulted in some reduction in visitor flow, compliance with the protocol has been erratic and unreliable, and the doctors reported numerous instances of significant breaches, with as many as 7 persons in a group getting past the screening process and presenting to a ward. These breaches of the screening protocol have been reported to the PCBU through multiple escalation pathways, but this has not resulted in any effective change in the PCBU's process for enforcing its COVID-19 policy relating to visitors. The EPH was advised that the PCBU informed the doctors and

nurses in the palliative care unit that it was their responsibility to enforce the policy when too many visitors arrive at the ward.

The EPH was advised of at least two situations known to doctors in the palliative care ward where families who had already been authorised to have multiple visitors on compassionate grounds objected aggressively when their request for further visitors to attend was declined. The resulting conflict had escalated at the ward to near "code black" status, which was only averted by stressful, and time-consuming interventions by doctors and nursing leads. One doctor stated, "*I had never expected the visitors to be the most challenging and distressing issue we have to deal with in this pandemic*".

One doctor stated, "*why put a visitor policy in place if the Administration is not going to manage the process or take it seriously?*". The doctors and health workers within the palliative care unit are strongly of the view it should not be the frontline health workers in this service that are left to police this process. The doctors told the EPH "*it makes it hard to provide care and support to the patients and their families in the unit, when the first interaction with the treating doctor or nurse is conflict*".

The doctors also advised that each ward in TQEH had managed visitors differently, with some wards allowing more visitors than instructed by the PCBU, so when the patient required transfer to the palliative care ward there was an expectation by the family that this access would be continued. Other wards, because they have doors, can shut their doors to limit access, but the palliative care unit cannot do this as it does not have a door, and there are multiple access passages. The doctors advise that this allowed constant traffic of patients, family and health workers through the ward. Indeed, the EPH unknowingly accessed the ward through an open door from another ward.

The doctors advised the EPH that the palliative care service at TQEH seeks to comply with the PCBU COVID-19 one visitor rule, with appropriate flexibility on compassionate grounds, to protect patients and workers from potential harm of the disease. Under this policy, staff on the ward have the ability to increase the number of visitors seen by a patient for compassionate reasons, for example, in the last few days to hours of the patient's life. Visitors under the age of 12 are prohibited from accessing the service, but access can be provided on compassionate grounds, and this has been negotiated on a case-by-case basis.

The doctors report that they consider these difficult negotiations around increased visitor access for compassionate reasons to be a legitimate part of their role, but they have repeatedly advised the PCBU that the uncontrolled flow of visitors is obliging them to engage in sensitive discussions in the midst of a crowded and busy ward, interrupting their rounds and diverting them from patient care. The doctors have repeatedly requested that the PCBU assume responsibility for controlling visitor numbers so that compassionate access can be managed in a safe and fair manner. The doctors report that the PCBU has responded with a written instruction that it is the doctors who are responsible for managing the visitor number issue on the ward.

The EPH was advised that visitor protocols have been enforced strictly in private hospitals, and in a safe and appropriate manner in other SA Health facilities, but that in CALHN it is not being managed by the PCBU. The EPH was told by doctors that they had repeatedly recommended to the PCBU that it follow the example of Modbury Hospital, which had ensured the safety of patients, visitors and staff by stationing a security guard with a nurse concierge at the hospital entrance to ensure reliable control of entry and allow compassionate access to be negotiated in a controlled and safe environment.

Doctors advise that they and other health workers are often not stopped at the hospital entrance and asked any COVID-19 screening questions.

In addition to the concerns about visitor numbers in general, the doctors advised the EPH that the PCBU was failing to ensure compliance with its OWI for the management of interstate visitors.

The EPH was advised that there is a two-step process to allow visitors to travel from interstate to South Australia to visit a loved one in the palliative care unit. The doctors are not involved in the first step of the exemption/approval process to cross the border into South Australia, as this is managed via the SA Health COVID Hotline. They have, however, written letters of support. The PCBU OWI then requires the Nurse Unit Manager of the unit to escalate a request to visit to the program manager a request for approval, although in practice this function is mainly performed by the doctors.

The EPH was advised that as part of the conditions of an interstate visitor entering the hospital they must self-isolate for 14 days and are allowed exemption only to attend the hospital. On leaving the hospital they are required to return to their accommodation and adhere to the isolation rules. While

at the hospital, the visitors are required to wear masks, wash their hands and abide by any other rules applied at the hospital to minimise the risk of transferring COVID-19. Interstate visitors are also supposed to record their movements, but it is unknown whether this occurs or is policed.

The doctors in the service state they are aware of at least one family who travelled over the border and arrived on the adjacent ward with no letter, no exemption and no mask. There have also been multiple instances of interstate visitors who have been granted exemptions not receiving a mask at the hospital entrance as they were not screened and identified, and of others declaring themselves as interstate visitors, but being informed there were no masks available or that they did not need a mask by the screening staff at the entrance. The EPH was advised that doctors were aware of examples of interstate visitors to the palliative care ward removing their masks when with patients, and another interstate visitor had been witnessed without a mask getting a coffee in TQEH canteen, which was a clear breach of their quarantine requirements

The EPH was advised by the doctors that interstate visitors continue to report inconsistencies in advice they are receiving with regard to requirements for quarantine, with some being advised that no quarantine was required. Some families have chosen to follow this incorrect advice rather than the information and documents provided to them by the medical team. The doctors reported that, in the past, the COVID Hotline itself had contributed to confusion by providing incorrect information. The doctors are aware of instances where interstate visitors, who are supposed to be in self-isolation, are staying with families, and these family members are also coming in to see the patients.

There will be ongoing requests for interstate families to visit patients in the hospice.
The EPH was advised by doctors that because numbers of COVID-19 positive patients in S.A. are currently low, it is likely that general visitor restrictions will be relaxed or lifted. While recognising that this is consistent with the risk level in the general community, the doctors consider that the continuing presence of compassionate-exemption visitors from interstate (and overseas), combined with inadequate control of visitor numbers overall, will continue to place patients, visitors and staff in the palliative care service at risk for transference of the disease.

The EPH was advised by doctors that if a potential or actual transmission event were to occur, the combination of illness and quarantine requirements would *"wipe out the ward, both workers and patients"*.

The EPH was advised that the management had made some attempts to resolve the safety concerns raised by the health workers situated in the palliative care unit, but the measures put in place had not succeeded in preventing excessive numbers of visitors arriving into the ward.

The EPH was satisfied on speaking to doctors and attending the palliative care service at the Queen Elizabeth Hospital that:

- The PCBU is knowingly failing to comply with its own policy regarding visitor numbers and the OWI regarding management of interstate visitors.

- The PCBU knowingly continues to allow an unsafe environment to exist in the Hospice ward because the measures it has put in place to screen and control visitor numbers have proven inadequate.

- The continued presence of visitors in numbers well outside the PCBU's policy, combined with a continuous flow of interstate visitors poses a real and significant COVID-19 infection risk to patients, visitors, doctors and other staff.

- In spite of repeated requests, and the provision of clear advice regarding successful measures employed in other SA Health hospitals, the PCBU has not addressed the safety concerns raised by doctors in the palliative care ward, and has not instituted a reliable process for controlling visitor numbers.

- The PCBU knowingly is aware that due to the configuration and size of the ward, the workers and visitors cannot reliably practice physical distancing as instructed and directed by the PCBU.

Work Health and Safety Act, 2012

On conducting this inspection, the following contraventions have occurred and continue to occur by the PCBU and its Officers in relation to the *Work Health and Safety Act, 2012*.

The EPH is of the view that the PCBU responsible for the Queen Elizabeth Hospital, Palliative Care Service has contravened the following sections of the *Work Health and Safety Act 2012 (SA)* 2012, Section 17, 19, 20 and its officers who have failed to implement an appropriate or reasonable response to eliminate or remove the risk to health, safety and welfare of workers at the site.

4	Signature of EPH:		Date 12-6-2020

5	**SAFEWORK SA USE ONLY:**	**InfoNET File No.:**	**Report triaged by:**	**Names redacted:** ☐
				Report saved on Q:/: ☐
		Report saved on InfoNET: ☐	*Further action required Yes / No*	**Report sent to Comms Unit:** ☐
			Date / /20	**EPH s/sheet updated:** ☐

Bernadette Mulholland

From: Bernadette Mulholland
Sent: Wednesday, 29 April 2020 1:17 PM
To: Dwyer, Lesley (Health); Ramsay, Gabby (Health)
Subject: Occupational Health and Safety Risk at the TQEH - COVID 19

Dear Lesley and Gabby

I am wondering if you can assist me and minimise the requirement for me to conduct a health and safety inspection.

Members at the TQEH have confirmed they have attempted to resolve this matter locally and these processes have now been exhausted.

CALHN has a single visitor policy at ward level. This has been implement as part as health's response to COVID-19 ensuring the safety of patients, staff and the community.

Due to the lack of monitoring of this policy at the TQEH safety and clinical care of patients, staff and the public is compromised, exposing these groups to avoidable risk, and the distress of patients and families facing terminal illness is needlessly exacerbated.

There are three access entry points at the QEH, at two of these entry points CALHN has allocated clinical staff to run through a list of checks to determine whether there is a safety threat to the patients and staff in the hospital (COVID-19) should you enter. There is no criticism pertaining to the monitoring or precautions taken by the QEH to determine and restrict visitors to the QEH to see a patient.

However, the implementation and resourcing of the policy is flawed and should be escalated and dealt with by both the CALHN Executive and COVID Command Team.

Many of the patients residing at the QEH are considered in the vulnerable category regarding COVID-19.

The writer understands that clinical staff from a number of Units at the QEH sought a single entry for visitors to be screened temperature checked and ensuring compliance of visitor restrictions. The problem I am advised appears particular to North Ground B where the arrangements for access are very loose and not in accordance with the directive. There is no signage or advice to visitors as far as I am aware and visitors are congregating in a confined area not respecting the social distancing rules. There are three entries to North Ground B. I understand there are two other accesses to North Ground B providing three entries and exits. There are already significant resources devoted to the other access points.

There are a number of visitors failing to comply with the policy with greater numbers visiting patients than is safe and appropriate. However, rather than this being managed at entry it is left to the clinical staff on the ward leading to inappropriate and negative behaviour toward the clinical staff. The best option to ensure compliance with the instructions of the public health officers and protecting staff and vulnerable patients is as follows;

1. Restrict entry to a single point, the main tower block entrance, with clear signage in the carparks and pedestrian access points redirecting visitors there
2. Screening by clinicians and entry control by security staff, with a list of current patients and a clock-in clock-out process
3. Manage the queuing issue by providing a waiting area in the undercroft with signage and space markers as at testing sites
4. Signage and the provision of information to patient representatives at ward level encouraging them to co-ordinate visiting within their network
3. A defined communication pathway for escalation of requests for exemptions to the single visitor rule on compassionate grounds, as consistent with the OWI

It is clear given the restrictions to hospitals are still in place that these are complied with, a half hearted response by CALHN sends mixed messages and confusion regarding the necessity to maintain safe practices.

Can you advise CALHN's position.

Thank you

Bernadette

Bernadette Mulholland

From: Health:CALHN Covid19 <Health.CALHNCovid19@sa.gov.au>
Sent: Wednesday, 20 May 2020 5:27 PM
Subject: CEO Bulletin - COVID-19 Update | 20 May 2020

COVID-19 CEO Bulletin

20 May 2020

Hi everyone,

In South Australia our COVID-19 position continues to look positive with no new cases identified in almost a fortnight. This is a great result and really shows what good social distancing, an amazing testing regime and good public health messaging can do – oh and don't forget a community that continues to do the right thing!

Due to our current success in limiting the spread of COVID-19, the government today announced that some Stage 2 restrictions will be eased from Friday 5 June. This is earlier than planned and will come into place before the long weekend. I know that many of you will welcome this as I am sure that businesses will as well.

Gate review
Yesterday the Command Centre conducted the weekly gate review and assessed the current COVID-19 situation both here and interstate.

This was our 6th gate review and it again recommended that we should remain at CoSTAT 2 for the time being, as we are conscious of recent clusters identified interstate, and to be honest, the less than encouraging uptake of the flu vaccine here at CALHN – more on that on Friday!

Remaining at this status also allows us to continue to reduce the number of people on our campuses to enable us to sustain our social distancing practices – this is not just about patients and visitors but also that the social distancing rules mean that if you can work from home...then please continue to do so!

This also means that our one visitor per patient per day policy remains in place. I encourage ALL staff to ensure this is complied with for all patients unless on compassionate grounds. We have an obligation to ensure that patients and their visitors get consistent messages from us.

The review also approved a number of services to recommence in June including an increase to the surgical bed footprint to match our increased capacity.

Given the current COVID-19 activity across the state and nation, we will now conduct our gate reviews fortnightly rather than weekly.

BRACE trial

Last Friday I shared with you details about the BRACE trial which is investigating whether the BCG vaccine that's traditionally used to prevent tuberculosis can help reduce the impact of COVID-19.

If you are interested in participating in the trial, you can find out more or register through the SAHMRI website https://www.sahmri.org/brace/. Staff who have already had their influenza vaccine can participate in this trial.

The trial is being run by the Murdoch Children's Research Institute in collaboration with SAHMRI and SA Health as well as other partners across Australia and internationally.

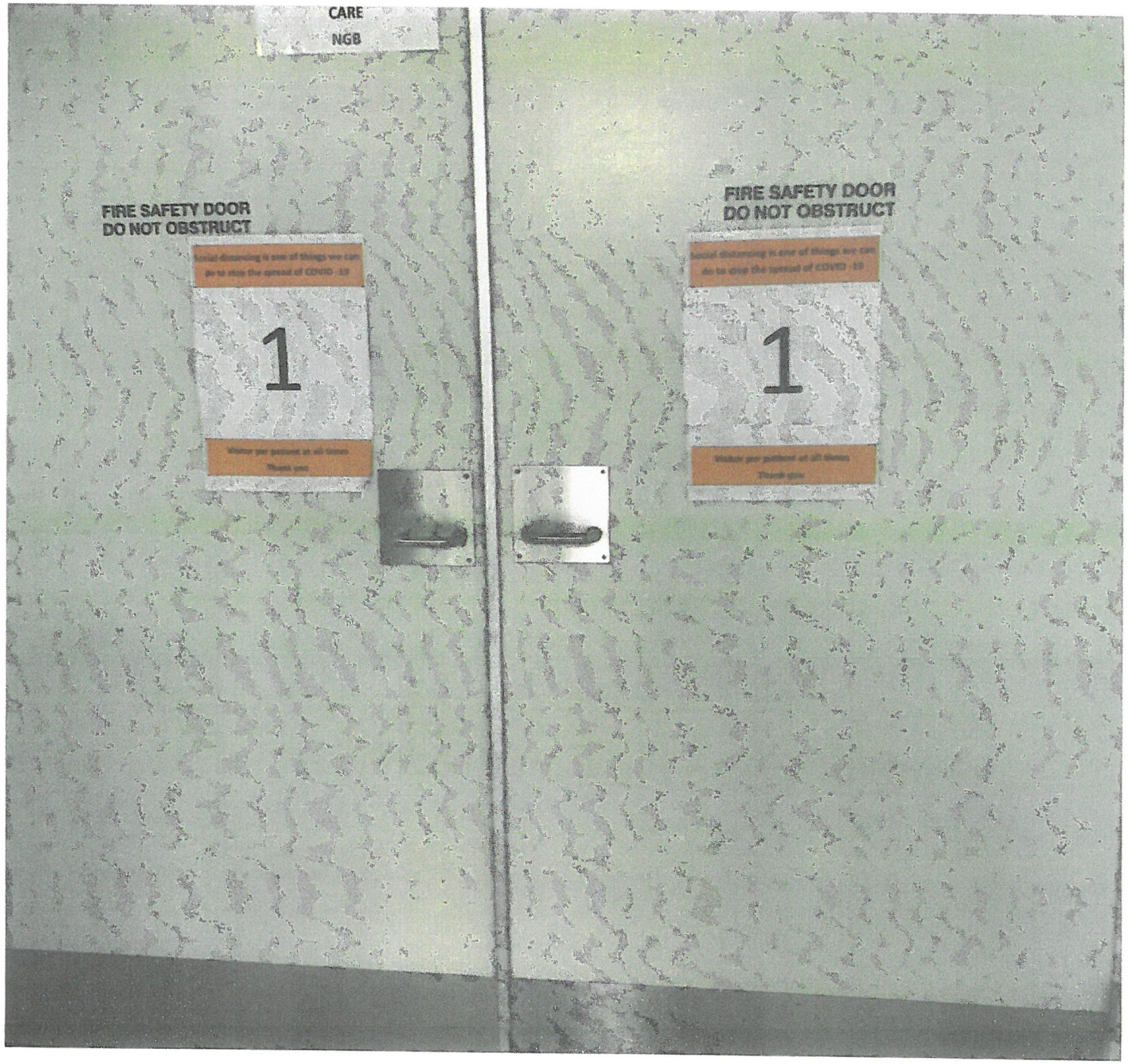
COVID-19 status update
Yesterday RAH COVID-19 clinic assessed 93 people. Since the clinic opened in early March it has assessed more than 5,507 patients.

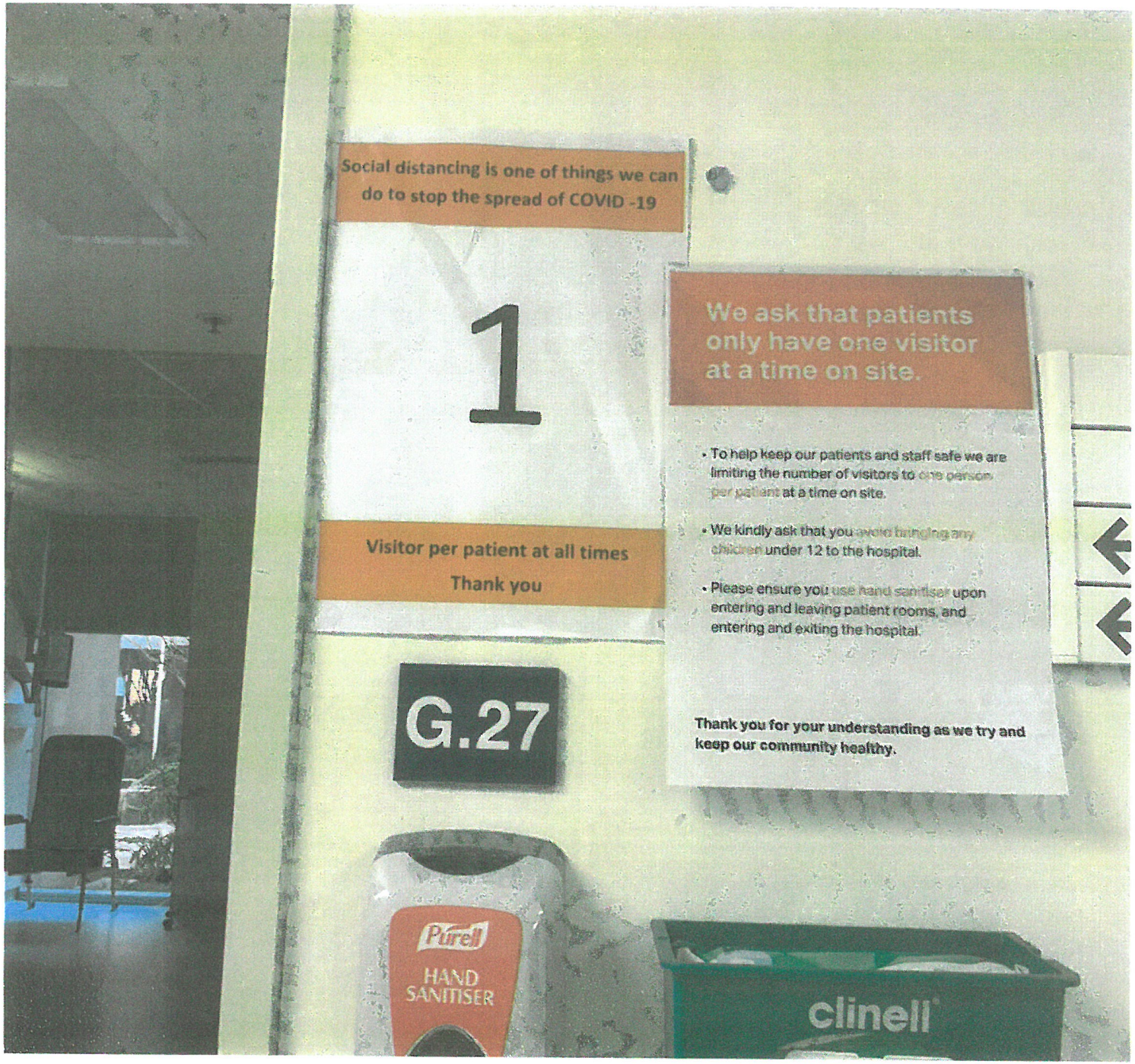
With the decrease in COVID-19 related activity, we will now release our COVID-19 Bulletin once per week on a Tuesday (unless something critical occurs) and you'll continue to receive my weekly CEO message as usual on a Friday. I hope that this is ok, but I am conscious of not wanting to fill up your inbox with a repeat of information.

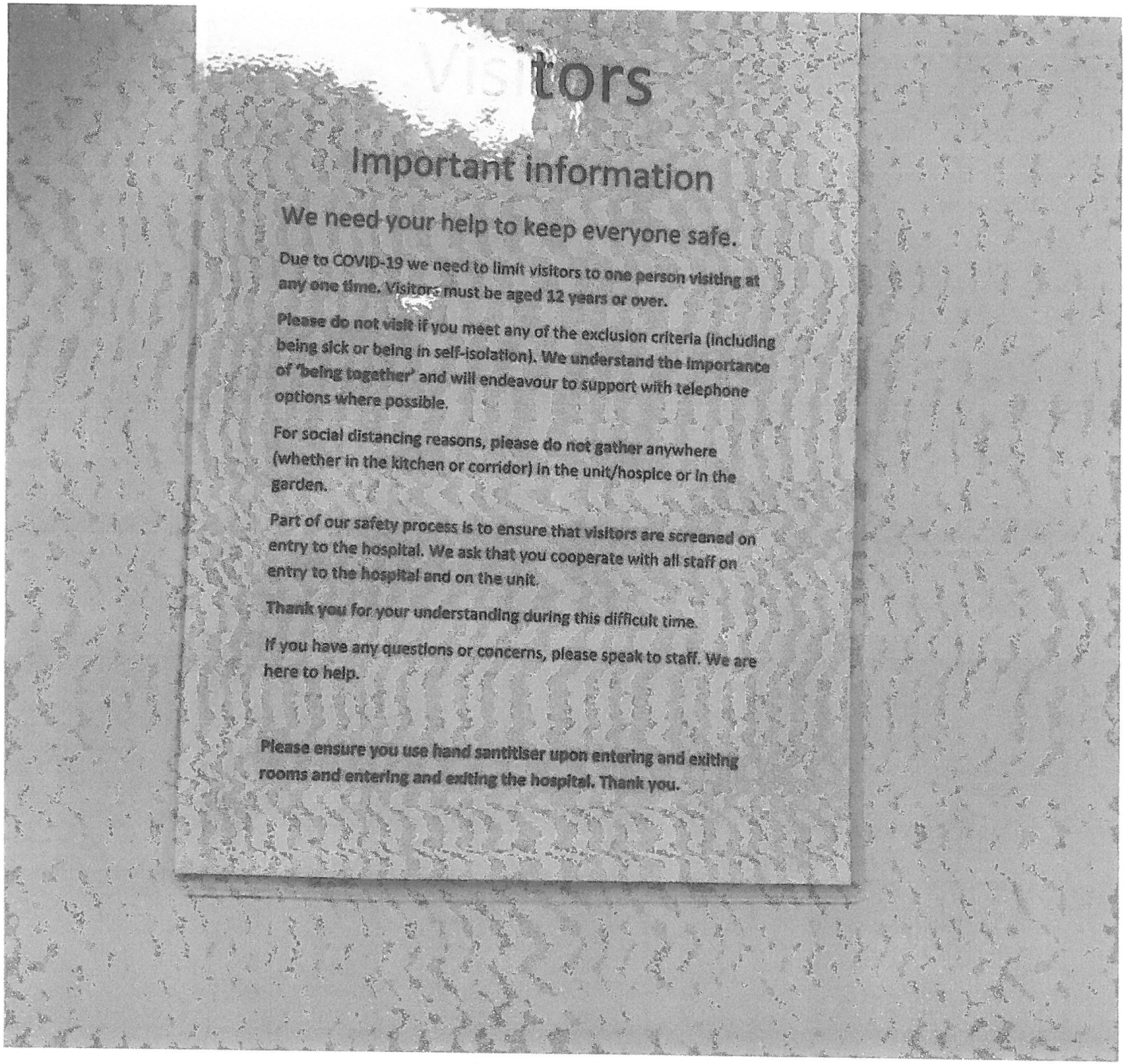
I encourage you all to continue to do the right thing when it comes to social distancing and remain in a state of readiness. We need to remain vigilant and prepared should we see an increase in cases following the easing of restrictions and as our community takes a more relaxed stance on social distancing.

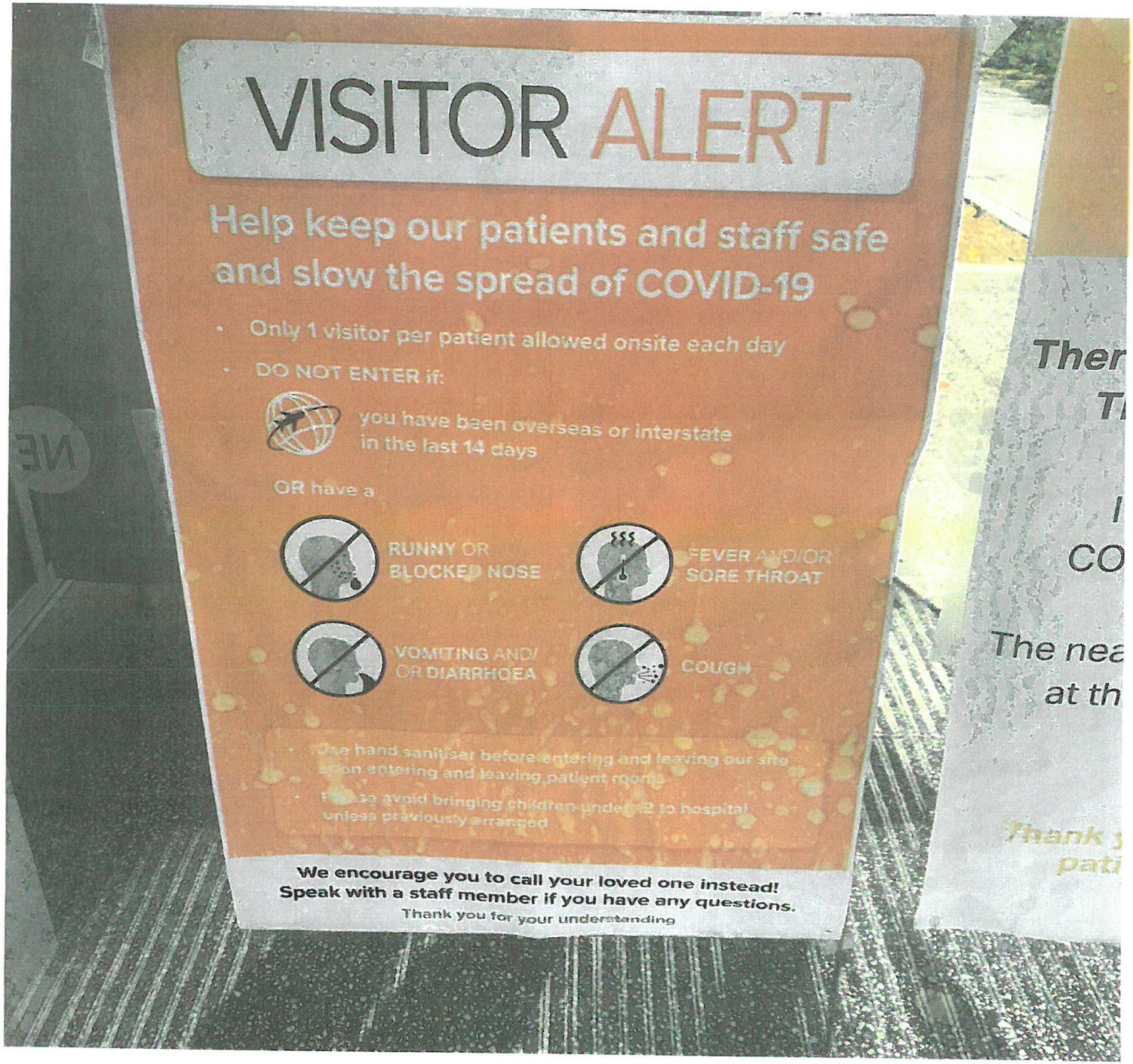
As I always say... **'If not us...then who?'.**

Lesley Dwyer
Chief Executive Officer
Central Adelaide Local Health Network

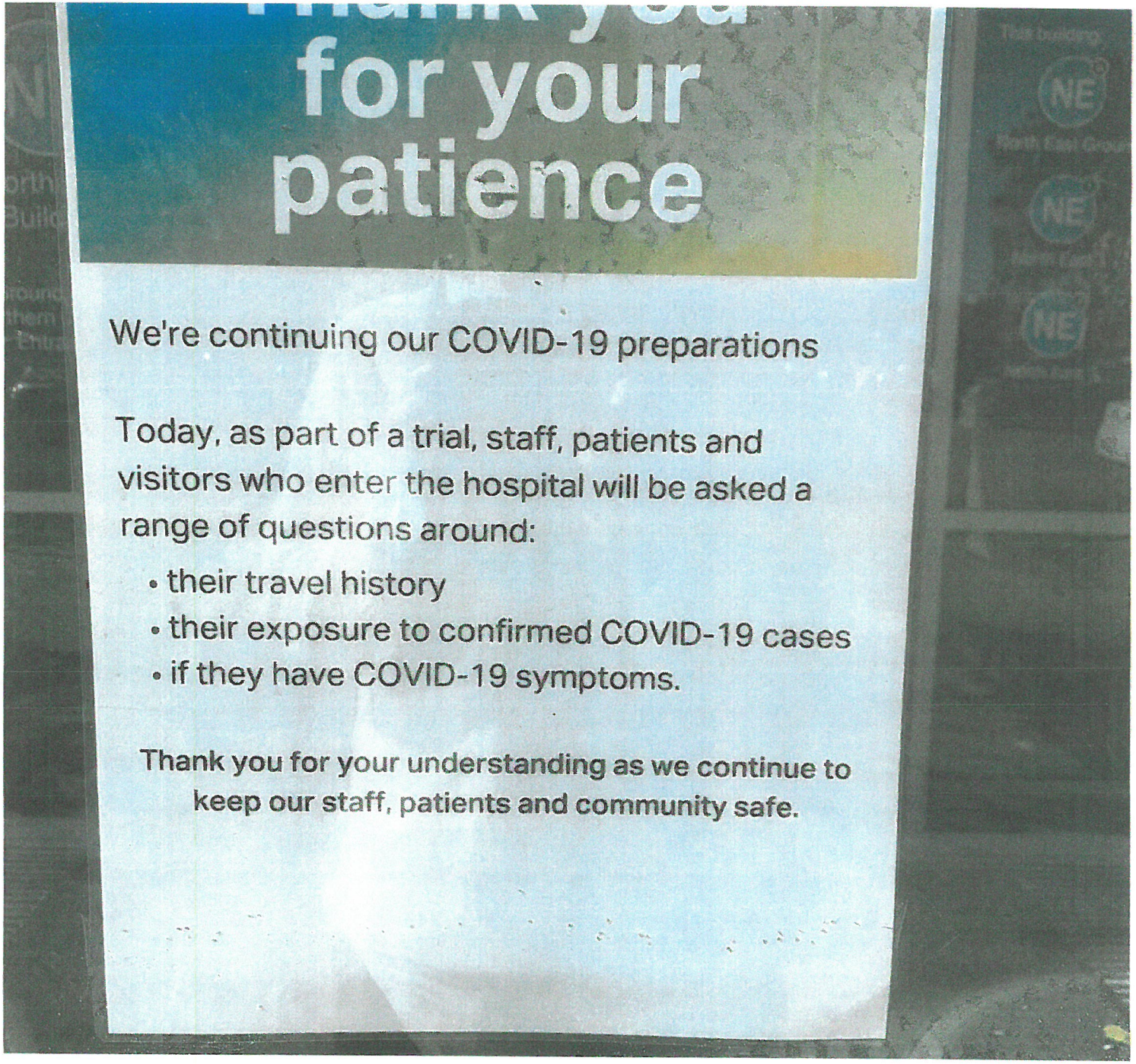

CARE
NGB
FIRE SAFETY DOOR
DO NOT OBSTRUCT
1
FIRE SAFETY DOOR
DO NOT OBSTRUCT
1


Social distancing is one of things we can do to stop the spread of COVID -19
1
Visitor per patient at all times
Thank you
We ask that patients only have one visitor at a time on site.
• To help keep our patients and staff safe we are limiting the number of visitors to one person per patient at a time on site.
• We kindly ask that you avoid bringing any children under 12 to the hospital.
• Please ensure you use hand sanitiser upon entering and leaving patient rooms, and entering and exiting the hospital.
Thank you for your understanding as we try and keep our community healthy.
G.27
Purell
HAND SANITISER
clinell


Visitors
Important information
We need your help to keep everyone safe.
Due to COVID-19 we need to limit visitors to one person visiting at any one time. Visitors must be aged 12 years or over.
Please do not visit if you meet any of the exclusion criteria (including being sick or being in self-isolation). We understand the importance of 'being together' and will endeavour to support with telephone options where possible.
For social distancing reasons, please do not gather anywhere (whether in the kitchen or corridor) in the unit/hospice or in the garden.
Part of our safety process is to ensure that visitors are screened on entry to the hospital. We ask that you cooperate with all staff on entry to the hospital and on the unit.
Thank you for your understanding during this difficult time.
If you have any questions or concerns, please speak to staff. We are here to help.
Please ensure you use hand santitiser upon entering and exiting rooms and entering and exiting the hospital. Thank you.


VISITOR ALERT
Help keep our patients and staff safe and slow the spread of COVID-19
Only 1 visitor per patient allowed onsite each day
DO NOT ENTER if:
you have been overseas or interstate in the last 14 days
OR have a
RUNNY OR BLOCKED NOSE
FEVER AND/OR SORE THROAT
VOMITING AND/OR DIARRHOEA
COUGH
We encourage you to call your loved one instead!
Speak with a staff member if you have any questions.
Thank you for your understanding


SURVEILLANCE
NO SMOKING
This is a smoke-free health site
VISITOR ALERT
Help keep our patients and staff safe and slow the spread of COVID-19
We encourage you to call your loved one instead! Speak with a staff member if you have any questions.
Thank you for your understanding
COVID-19 Testing
There is no COVID-19 testing clinic at The Queen Elizabeth Hospital.
If you want to be tested for COVID-19 please do not enter
The nearest COVID-19 testing clinic is at the Royal Adelaide Hospital


for your
patience
We're continuing our COVID-19 preparations
Today, as part of a trial, staff, patients and visitors who enter the hospital will be asked a range of questions around:
• their travel history
• their exposure to confirmed COVID-19 cases
• if they have COVID-19 symptoms.
Thank you for your understanding as we continue to keep our staff, patients and community safe.

Bernadette Mulholland

From: Bernadette Mulholland
Sent: Thursday, 9 April 2020 9:15 AM
To: McGowan, Chris (Health)
Cc: (Health); TePohe, Julienne (Health); Kaharevic, Melisa (Health); Katharine Webster; Tea Boromisa; Ed Grue
Subject: Masks PPE

Dear Chris

There seems to be some confusion regarding the mandatory PPE Matrix released last night and what it does not include.

Our members are very concerned that SA Health is not following Safe Work Australia direction please see below. SASMOA Council will meet tonight and therefore your response would be useful prior to this meeting. If frontline doctors are therefore being instructed not to wear masks then the instructions is considered unreasonable and for the health and safety of the SASMOA membership this will be escalated if not amended.

https://www.safeworkaustralia.gov.au/covid-19-information-workplaces/preparing-workers-covid-19#can-a-worker-be-directed-not-to

Bernadette

Can a worker be directed not to wear a mask?

Some workers may want to wear a mask even though it does not offer protection, such as a surgical mask, and even if the employer has considered that it is an unnecessary control measure.

This is a stressful time for all Australians and some workers may be wearing the mask because they feel unsure or anxious about their health. Employers should consult with workers on this issue and find out why they want to wear a mask at work. Employers should also inform workers of the control measures that have been implemented in the workplace to minimise the worker's exposure to the COVID-19 virus.

Whether an employer can direct an employee not to wear a mask will depend on whether the direction is permitted by the model WHS laws or is otherwise lawful and reasonable. This will need to be determined on a case by case basis depending on the circumstances.

However, if a worker was working on their own at home and using their own masks, it would be unlikely the direction would be reasonable. Similarly, if the worker was a frontline health worker, a direction of this kind would also be unreasonable.

The important thing is that the employer has actively considered whether a mask is an appropriate control measure in minimising exposure to the COVID-19 virus and has done so in consultation with workers, and in combination with other reasonably practicable, known control measures such as physical distancing – keeping everyone at the workplace at least 1.5 metres physically apart.

Bernadette Mulholland

From:	Bernadette Mulholland
Sent:	Thursday, 9 April 2020 10:15 AM
To:	Geraghty, Maree (Health); Health:NALHN - OCEO; Dwyer, Lesley (Health); O'Neill, Sue (Health)
Cc:	McGowan, Chris (Health); Stevens, Helen (Health) (Helen.Stevens@sa.gov.au); Kaharevic, Melisa (Health); TePohe, Julienne (Health); Maddison, John (Health); Cusack, Michael (Health); O'Callaghan, Gerry (Health); Lawrence, Diana (Health); Katharine Webster; Ed Grue; Tea Boromisa
Subject:	Use of surgical masks

Dear LHN Chief Executive Officers

Since the release of the COVID-19 PPE Assessment Matrix last night, SASMOA has been contacted by three medical officers, two in NALHN and one in CALHN being directed by nursing staff on the floor to remove their surgical masks as the wearing of these surgical masks do not comply with the Matrix. One of these matters impacts a junior medical officer.

SASMOA does not agree with the removal of surgical masks if this pertains to the health and safety of the individual doctor. SASMOA would like you to know that this behaviour is increasing the anxiety and anger not only of the individuals concerned but the medical workforce as a whole and should a satisfactory response that ceases this behaviour not be forthcoming then SASMOA will escalate this issue.

SASMOA has also been asked by frontline doctors will they be stood down if they do not comply with the direction of the nurses for failing to comply. SASMOA's advice is that they will not be stood down but that this behaviour amounts to bullying and harassment and should be called out. Any direction, in any event, of this kind should be coming from the individual's medical line manager which in these circumstances is not the nurse manager.

Please see below the Direction provided by Worksafe Australia which has been provided to our members, if this is not complied with by the PCBUs, the writer will request SafeWork SA to become involved.

COVID-19 - **Preparing workers for COVID-19**

https://www.safeworkaustralia.gov.au/covid-19-information-workplaces/preparing-workers-covid-19#can-a-worker-be-directed-not-to

Worksafe Australia

Can a worker be directed not to wear a mask?

Some workers may want to wear a mask even though it does not offer protection, such as a surgical mask, and even if the employer has considered that it is an unnecessary control measure.

This is a stressful time for all Australians and some workers may be wearing the mask because they feel unsure or anxious about their health. Employers should consult with workers on this issue and find out why they want to wear a mask at work. Employers

should also inform workers of the control measures that have been implemented in the workplace to minimise the worker's exposure to the COVID-19 virus.

Whether an employer can direct an employee not to wear a mask will depend on whether the direction is permitted by the model WHS laws or is otherwise lawful and reasonable. This will need to be determined on a case by case basis depending on the circumstances.

However, if a worker was working on their own at home and using their own masks, it would be unlikely the direction would be reasonable. Similarly, if the worker was a frontline health worker, a direction of this kind would also be unreasonable.

The important thing is that the employer has actively considered whether a mask is an appropriate control measure in minimising exposure to the COVID-19 virus and has done so in consultation with workers, and in combination with other reasonably practicable, known control measures such as physical distancing – keeping everyone at the workplace at least 1.5 metres physically apart.

Regards

Bernadette Mulholland
SASMOA, Senior Industrial Officer

EPH – Permit No. ET-19-00307

SA Salaried Medical Officers Association

Serving Salaried Doctors

1st Floor, 161 Ward St
(PO Box 64)
North Adelaide
South Australia 5006

Telephone: (08) 8267 5151
Fax: (08) 8267 1891
Email: sasmoa@sasmoa.com
Website: www.sasmoa.com
ABN: 60 932 342 397

9 April 2020

Ms Maree Geraghty
CEO – NALHN
Lyell McEwin Hospital
Haydown Rd
ELIZABETH VALE SA 5112

Via email: Maree.Geraghty@sa.gov.au

Dear Ms Geraghty,

RE: Postponement Emergency Department redevelopment works at Lyell McEwin Hospital

We refer to previous communications regarding this matter.

As has been noted on a number of occasions previously, including the meeting on Monday 30 March 2020, formal correspondence to officially commence consultation with the Unions and their members regarding the Lyell McEwin Hospital Emergency Department Redevelopment has not occurred.

The complete lack of formal correspondence can be contrasted to the approach taken by NALHN in relation to the Modbury Hospital Redevelopment in November 2019.

For information, Clause 5 of the Salaried Medical Officers Enterprise Agreement 2017 ("SMOEA") states:

"5. CONSULTATION

5.1 The parties commit to the following consultative principles.

5.1.1 Consultation involves the sharing of information and the exchange of views between the employing authority and

employees and their representatives and the genuine opportunity for them to contribute effectively to any decision-making process.

5.1.2 *The employing authority will consult in good faith, not simply advise what will be done.*

5.1.3 *It is an accepted principle that effective workplace relationships can only be achieved if appropriate consultation between the parties occurs on a regular basis.*

5.1.4 *Workplace change that will affect a significant number of employees should not be implemented before appropriate consultation has occurred with employee representatives.*

5.1.5 *Employee representatives will be given the opportunity to adequately consult with the people they represent in the workplace, in relation to any proposed changes that may affect employees' working conditions or the services employees provide."*

Given the current public health emergency associated with the COVID-19 pandemic and that it is not "business as usual" in South Australia's public hospitals, the impact of redevelopment works on a critical area such as the Emergency Department needs to be carefully considered, and the employer needs to ensure that it is consulting "in good faith", as it is obliged to do.

We await your response on this issue.

Yours sincerely

Edward Grue
SASMOA, Principal Industrial Relations Advisor

CC Australian Nursing and Midwifery Federation
Public Service Association
Ambulance Employees Association
Health Services Union
Professionals Australia

Bernadette Mulholland

From: Bernadette Mulholland
Sent: Monday, 6 April 2020 10:15 AM
To: premier@sa.gov.au
Cc: Ministerforhealth@sa.gov.au; Westenberg, Greg (Health)
Subject: Media Reports of Insurers Conduct and proposed changes to Workers Compensation
Attachments: Premier - WC- 05 April 2020.pdf

Dear Premier

Please find attached correspondence in relation to the above.

Kind Regards

Bernadette Mulholland
SASMOA, Senior Industrial Officer

05 April 2020

Hon. Steven Marshall MP
Premier of South Australia

BY EMAIL premier@sa.gov.au

Dear Hon. Steven Marshall MP,

Media Reports of Insurers Conduct re: Doctors and Covid-19 & Workers Compensation

It is with alarm and distress that SASMOA and its members have read media reports that insurers may be moving to exclude claims from health care workers resulting from the COVID-19 pandemic including, frontline doctors such as those working in our Emergency Departments and more specifically those who are working in the defined COVID-19 site, the Royal Adelaide Hospital.

It is SASMOA's strong position that such conduct, if it is occurring, is unconscionable and has the effect of significantly undermining the confidence of frontline medical staff at this critical time. We are confident we do not need to emphasise to your government that the need to support the medical workforce has never been higher and SASMOA members should not have to worry that they, or their families, will not be covered financially for the loss of income or medical expenses as a result of contracting the disease.

Further, a doctor (or indeed any health care worker) functioning on the frontline and their families should also be protected as much as possible under the State's workers compensation laws should they contract COVID-19. To protect frontline doctors will require amendments to the current workers compensation legislation, the *Return to Work Act, 2014.* These requested amendments would include that COVID-19 if contracted by a health care worker, would be presumed (deemed injuries) to have occurred when the health care worker was undertaking their duties whilst at the hospital.

Additionally, senior frontline doctors, earn above the current articulated average weekly earnings cap, and to adequately compensate frontline doctors for loss of income arising from contracted COVID-19 in their work setting, amendments to the necessary section will be required to ensure no disadvantage to the frontline doctor or their immediate family.

SASMOA members need to be assured that while they are supporting the people of South Australia, the government of South Australia will be doing

SA Salaried Medical Officers Association
ABN: 60 932 342 397

Australian Salaried Medical Officers Federation (SA Branch)
ABN: 23 172 174 608

1st Floor, 161 Ward Street
(PO Box 64)
North Adelaide
South Australia 5006

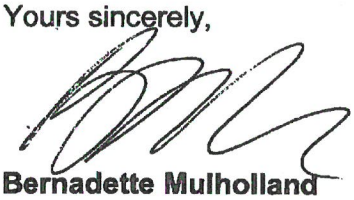
Telephone: (08) 8267 5151
Fax: (08) 8267 1891
Email: sasmoa@sasmoa.com
Website: sasmoa.com

everything in its power in supporting them. South Australian doctors in South Australian hospitals (or wherever they support our community) must know we are all united in supporting their vital role.

SASMOA calls on you, as Premier, to urgently address this matter and support South Australia's doctors.

The writer is available to meet with you and progress these changes as a matter of urgency.

Yours sincerely,



Bernadette Mulholland
SASMOA, Senior Industrial Officer

C.C. Minister for Health and Wellbeing

SA Salaried Medical Officers Association
ABN: 60 932 342 397

Australian Salaried Medical Officers Federation (SA Branch)
ABN: 23 172 174 608

27 March 2020

Ms Maree Geraghty
NALHN CEO
Lyell McEwin Hospital
Haydown Road
ELIZABETH VALE SA 5112

Dear Ms Geraghty

REDEVELOPMENT EMERGENCY DEPARTMENT LYELL MCEWIN HOSPITAL

Further to the email dated 17 March 2020, and recent telephone communication in relation to the above, the writer confirms that a SASMOA meeting was held this afternoon of members situated in the Lyell McEwin Hospital Emergency Department.

Arising from this meeting the following was determined;

> *"This meeting of SASMOA members are extremely concerned with the plan to proceed with the redevelopment of the NALHN Emergency Department in the midst of a pandemic.*
>
> *Our services are already disrupted as a result of COVID-19 and many of our colleagues are likely to get sick and die in significant part due to inadequate infrastructure and resources.*
>
> *To further disrupt our ability to provide care and to increase cross-infection is unacceptable.*
>
> *To misinterpret this as a lack of desire for this redevelopment of our undersized, outdated Emergency Department, would be untrue.*
>
> *Any change that might impair our ability to respond to an expanding disaster, with patients and relatives likely to need care beyond the physical confines of the Emergency Department walls is patently unwise.*
>
> *Any change that results in an increased risk of patients with potential infectious disease coming into contact with patients who have an*

1st Floor, 161 Ward Street
(PO Box 64)
North Adelaide
South Australia 5006

Telephone: (08) 8267 5151
Fax: (08) 8267 1891
Email: sasmoa@sasmoa.com
Website: sasmoa.com

alternate disease requiring care should be regarded as negligence by the hospital administration.

The car park where the redevelopment is to commence may be required for an emergency response for patients. The continuation of the redevelopment may also expose builders to the risk of COVID-19.

We therefore oppose the commencement of the redevelopment for a period of 4 weeks on the grounds of health, safety and welfare of staff, patients and community. At the end of the four-week period a further assessment can be made to determine if it is safe to proceed with the redevelopment building works."

If there is an unpreparedness by the employer to suspend the redevelopment of the Lyell McEwin Hospital Emergency Department for this period then SASMOA advises the matter is in dispute between the parties and status quo will be implemented until finalisation of the dispute. Could you please advise your position no later than 10.00 am, Monday 30 March 2020.

Yours sincerely

Bernadette Mulholland
SASMOA, Senior Industrial Officer

C.C. Dr Chris McGowan
SA Health, Chief Executive

Mr Stephen Wade
Minister for Health and Wellbeing

Attach. Email 26/03/2020

TRS20D1641

Government
of South Australia

Office of the
Treasurer
Level 8
State Administration Centre
200 Victoria Square
Adelaide SA 5000
GPO Box 2264
Adelaide SA 5001
DX 56203 Victoria Square
Tel 08 8226 1866
treasurer.dtf@sa.gov.au

Ms Bernadette Mulholland
Senior Industrial Officer
SA Salaried Medical Officers Association
PO Box 64
NORTH ADELAIDE SA 5006

sasmoa@sasmoa.com

Dear Ms Mulholland

On behalf of the Treasurer, the Hon Rob Lucas MLC, I acknowledge receipt of your letter referred to this office on 25 May 2020 by the office of the Premier, the Hon Steven Marshall MP, about workers compensation for health care workers.

Your correspondence is currently receiving attention and a response will be forwarded at the earliest opportunity.

Yours sincerely

Office Manager to the
Treasurer

26 May 2020

SA Salaried Medical Officers Association
ABN: 60 932 342 397

Australian Salaried Medical Officers Federation (SA Branch)
ABN: 23 172 174 608

17 March 2020

Dr Christopher McGowan
Chief Executive, SA Health
Office of the Chief Executive
Citi Centre Building
11 Hindmarsh Square
ADELAIDE SA 5000

Attention: **Ms Melisa Kaharevic**
Director, Workforce Services
Corporate and System Support Services

Dear Dr McGowan

COVID – 19 WORKFORCE PREPARATION

SASMOA writes following the meeting held today between the Department and SASMOA delegates regarding the above. SASMOA agrees that in order to meet this unprecedented health crisis all parties need to work in partnership, and SASMOA is committed to doing so.

SASMOA is, however, concerned that there appears to be a lack of action by SA Health regarding potential workforce issues that we have raised and which we believe must be addressed immediately to ensure workforce confidence and morale. SASMOA is especially concerned that communication to frontline clinicians requires improvement, and that transparent lines of governance must be made known to all health workers. This is essential.

SASMOA has forwarded the Department several emails over the last week regarding workforce planning, but agreed at the meeting to expand on the concerns raised in these and some potential solutions (where possible). Our clear aim is to assist the Department and Local Health Networks (LHNs) in their planning. For example, the issue regarding access by clinicians to showers has now been further clarified in the attached document. SASMOA has also highlighted in the attached document a prioritised list of matters for attention. SASMOA will contact the Department on a daily basis to determine progress on the attached matters.

SASMOA is also concerned that there appears to be minimal communication between the Department's Workforce Division and LHN Workforce Divisions, but understands the Department and representatives from the LHN Workforce

1st Floor, 161 Ward Street
(PO Box 64)
North Adelaide
South Australia 5006

Telephone: (08) 8267 5151
Fax: (08) 8267 1891
Email: sasmoa@sasmoa.com
Website: sasmoa.com

Divisions will be meeting tomorrow and more frequently over the next month to ensure clear communications and instructions regarding workforce issues.

SASMOA attaches the recently released ANZICS COVID-19 Guideline that, particularly for communication, workforce sustainability and staffing of services provides significant guidance.
https://mcusercontent.com/03cbd5b8a6d36c351c46c235e/files/86e36972-a552-45da-8eab-8fd8c52a788d/ANZICS_COVID_19_Guidelines_Version_1.pdf

Finally, SASMOA seeks confirmation the Department will include the Association on the staff communication distribution list for daily updates pertaining to COVID-19, as promised.

Yours sincerely

Bernadette Mulholland
SASMOA, Senior Industrial Officer

C.C. Dr Michael Cusack
Minister for Health and Wellbeing
LHN Directors Workforce
SASMOA Members

SASMOA COVID-19 ISSUES REGISTER

Priority	Summary	Description	Status as at 17/3/20
System Plans			
Urgent	Protocols for withdrawing care	Members uncertain under what circumstances care can be denied to patients either with or without COVID-19 diagnosis. E.g. concerns of medicolegal implications of refusing to treat. The criteria for this will change as clinical need dictates and members will be protected under the activation of a state emergency – this needs clarifying with doctors.	Nil response
Urgent	Capacity building	What are the plans for building bed capacity in the system to treat influx of COVID-19 patients?	Nil response
High	Elective surgery	What are the plans regarding elective surgery in the short to medium term?	Nil response
High	COVID-19 testing clinics	Are there plans to open a Covid-19 testing clinic at TQEH and other secondary hospital given patients likely to present to ED.	Nil response
Urgent	OPD clinic operation.	Telemedicine or other ways of meeting OPD patients carve needs.	Nil response
Urgent	Communication to doctors	Clarification with communication to hospital doctors on command and control arrangements. Updates on reporting lines.	Nil response
Urgent	Telemedicine facilities	Telemedicine facilities for medical staff to communicate with patients and clinic staff	Nil response
Urgent	Identified Officers for workforce matters at LHNs	Clear identification lines who is accountable for workforce issues at local hospital levels for SASMOA and doctors	Nil response
Staff Wellbeing			
Urgent	Testing staff	Request for all doctors with COVID-19 like symptoms to have access to testing even though they may not have been overseas or in contact with known case	Nil response

SASMOA COVID-19 ISSUES REGISTER

Priority	Summary	Description	Status as at 17/3/20
		This needs fast turn around to return them to the work place if negative	
Urgent	PPA equipment and facilities	Members have requested the following at every hospital: 1. Access to scrubs and protective foot wear for all medical staff. 2. Adequate shower facilities for all staff to be able to shower before, during and after work as required. 3. Hospital laundering facilities to reduce risk of infection associated with laundering scrubs at home. 4. Access to adequate number of masks, PPE, Covid trolleys 5. Immediate fit testing for all doctors for masks 6. Training in use of equipment and guidelines	Nil response
Urgent	WHS and fatigue management	Members highlighted the need for the following at each hospital to support long working hours: - Onsite food and beverages - Adequate number of rest/sleeping quarters - Regular breaks	Nil response
Urgent	Protecting high risk staff	What happens when a doctor working in a high-risk area such as an ED is at high risk because of their medical condition e.g. cardiac condition. Can the doctor be placed on special leave with pay or alternative assignments – education etc	Nil response
Urgent	Psychological support and additional days off.	Psychological support for doctors regarding workloads, impact of working environment and family support.	Nil response
Urgent	Death of a clinician	In the event a doctor dies from COVID-a9 will their families be compensated by the employer?	Nil Response
Workforce Plans			
High	Childcare closures	What are the Department's plans to support the workforce in the event that schools/childcare centres close? What about the use of Carer's Leave?	Nil response

SASMOA COVID-19 ISSUES REGISTER

Priority	Summary	Description	Status as at 17/3/20
High	Managing illness	Will doctors who are ill with conditions other than COVID-19 be encouraged to attend work or stay home? E.g. cold/flu	Nil response
High	Movement of staff	Will direction about the movement of staff be a LHN or Department decision? What is the governance model for decision making?	Nil response
Leave, PD and training matters			
High	Leave arrangements	What is the Department's position on leave arrangements for: Staff who may be required to self-isolate, but not necessarily sick. E.g. Overseas travel • Returning from overseas travel commenced before 4 March • Returning from overseas travel commenced after 4 March but before 13 March • Returning from overseas travel commenced after 13 March • Cost associated with cancelled arrangements as part of a personal component of PD leave • Costs associated with cancelled annual leave Contact with known case • In the event a doctor is in contact (without adequate protection) with a patient testing positive to COVID-19 (both as part of the employment and not) • In the event a family member tests positive to COVID-19 Contact with quarantined individual • In the event a family member requires quarantine?	Various LHN, OPS and Department advice

SASMOA COVID-19 ISSUES REGISTER

Priority	Summary	Description	Status as at 17/3/20
Med	PD arrangements	Confirmation that doctors unable to obtain a refund costs associated with the PD booking from the provider, the PD entitlement will be reimbursed so that the employee's PD entitlement is not negatively impacted as a result of the direction to cancel interstate and interstate travel. What is the process if the doctor receives a credit rather than a refund (e.g. a flight credit)	Nil response Nil response
Med	Supporting insurance claims	Will the Department draft a standard letter to be sent to insurance companies to support individuals claiming personal travel expenses affected by decisions to cancel leave?	Nil response
Med	Training	Will the Department work with the Colleges to support doctors whose training may be affected? What will the Department do about training rotations – will these be put on hold?	Nil response
Low	PD and FBT	Confirmation that any FBT liability will not be passed onto the doctor for PD reimbursements refunded as a consequence of recent travel directives.	Nil response
Low	PD access	Extension of duration to claim PD funds from 2 years to 3 years where PD plans cancelled in current PD year.	Nil response
Other			
High	Building works	What are the plans for new building works currently commenced/planning at various hospital sites?	Nil response

Bernadette Mulholland

From: Bernadette Mulholland
Sent: Friday, 13 March 2020 10:55 AM
To: Kaharevic, Melisa (Health)
Cc: TePohe, Julienne (Health); McGowan, Chris (Health);

Subject: RE: COVID-19 Union Briefing with SA Health *teleconference details below*

Thanks for this Melisa and ongoing meetings are welcomed however from SASMOA's point of view I am unclear whether this forms part of a broader package or conversations will be limited to only theses meeting with Unions as this won't be enough from the Association's view.

It is also the view of frontline doctors that by 23 March many of the matters required to be discussed regarding medical workforce will be too late.

Can I request at our meeting this afternoon that we have a discussion re planning for medical workforce with the employer with meetings commencing next week.

I understand private schools will be meeting today regarding continued operation this decision will impact on health workforce.

Bernadette

-----Original Appointment-----
From: Michelle.Ralph@sa.gov.au <Michelle.Ralph@sa.gov.au> **On Behalf Of** Kaharevic, Melisa (Health)
Sent: Friday, 13 March 2020 10:04 AM
To: Bernadette Mulholland; 'rleaney@aeasa.com.au'; 'sandrews@professionalsaustralia.org.au'; 'nev@cpsu.asn.au'; 'Kiara.smith@unitedworkers.org.au'; 'zerebar@hsusant.org.au'; Woolcock, Jamin (Health); Spurrier, Nicola (Health); Health:Security CitiCentre Foyer; 'jackie.wood@anmfsa.org.au'; Katharine Webster; 'Lindy McAdam'; 'Leah Watkins'; 'tony.boyle@unitedvoice.org.au'; Tony Boyle; Huppatz, Rebekah (Health); Andrews, Andrea (Health); White, Kelly (Health)
Subject: COVID-19 Union Briefing with SA Health *teleconference details below*
When: Occurs every 2 week(s) on Monday effective 23/03/2020 until 31/12/2020 from 4:00 PM to 4:30 PM Cen. Australia Standard Time.
Where: CE's Boardroom (L9 Meeting room 2), level 9 CitiCentre Building, 11 Hindmarsh Square, Adelaide

Teleconference: Ph 1800 197 380; Guest Code 979 692 3260# ***(Host Code - Melisa Kaharevic - 121 248 7171#)***

Good morning

As agreed, fortnightly CoronaVirus Union Briefing meeting scheduled herewith for 4:00pm-4:30pm every second Monday, from 23 March 2020.

To be held in the CE's Boardroom, level 9 CitiCentre (LHS of foyer), or please dial in using the above teleconference numbers.

Upon arrival at the CitiCentre building please present photo ID to the ground floor security desk before making your way to level 9.

For security purposes please email the name & email address of any additional attendees to Michelle Ralph ahead of the respective meeting.

[redacted]

Kind regards,
Michelle

Michelle Ralph
Executive Assistant to Melisa Kaharevic, Director, Workforce Services
Workforce Services | Corporate and System Support Services
Department for Health and Wellbeing | SA Health | Government of South Australia

Address Citi Centre Building, 11 Hindmarsh Square, ADELAIDE SA 5000 | DX243 Adelaide
P +61 (0)8 822 66412 | **E** michelle.ralph@sa.gov.au | **W** www.sahealth.sa.gov.au

Bernadette Mulholland

From: Ed Grue
Sent: Thursday, 2 April 2020 11:09 AM
To: Sujeeve, Sanmuganatham (Health)
Cc: Stevens, Helen (Health); Bernadette Mulholland
Subject: Commissioner's Determination 3.1 - Supplementary Provisions for COVID 19
Attachments: doc29964520200401130856.pdf

Sujeeve,

SASMOA has been contacted by members concerned about requests to be absent from the workplace because of COVID 19 not being supported.

Please find attached the Supplementary Provisions specific to COVID 19 for Commissioner's Determination 3.1 - Employment Conditions – Hours of Work, Overtime and Leave.

These Supplementary Provisions are operative from 18 March 2020 and have been enacted following the declaration of a public health emergency on 16 March 2020 for the purpose of managing and minimising the impact of COVID 19.

The Determination provides for arrangements available to support absences from the workplace for COVID 19 situations.

Pursuant to the Determination, medical staff may seek flexible working arrangements such as "working from home" and such arrangements must be actively considered and must be implemented, within the constraints of maintain effective operations and essential services.

In addition, the Determination provides for uncapped carers leave to be accessed where there are caring responsibilities. Employees who request to work from home where they have caring responsibilities will be supported where practical and appropriate. In circumstances where it is impractical and inappropriate to work from home, carer's leave is to be provided (and subsequently Special Leave with Pay if the entitlement is exhausted).

As you would appreciate, given the current public health emergency, it is no longer "business as usual" and employees must be supported with flexible working arrangements where possible and, where there are caring responsibilities, the employer has provided for leave where working from home cannot be accommodated.

While the intent and purpose of the Determination is clear, if you have any concerns, I would encourage you to contact NALHN HR.

Please feel free to contact me should you wish to discuss any aspect of this matter.

Regards

Ed Grue

Ed Grue | Principal Industrial Relations Advisor

South Australian Salaried Medical Officers Association (SASMOA)
161 Ward Street | North Adelaide SA 5006

T: (08) 8267 5151
F: (08) 8267 1891

E: edgrue@sasmoa.com
W: www.sasmoa.com

Bernadette Mulholland

From: Knez, Andrej (Health) <Andrej.Knez@sa.gov.au> on behalf of Geraghty, Maree (Health) <Maree.Geraghty@sa.gov.au>
Sent: Wednesday, 29 April 2020 5:08 PM
To: Bernadette Mulholland
Cc: Stevens, Helen (Health); Maddison, John (Health); Ed Grue; Cusack, Michael (Health); Kaharevic, Melisa (Health); Woolcock, Jamin (Health)
Subject: Re: NALHN Update 3/4/20 CEO Bulletin

Dear Bernadette

NALHN adheres to social distancing as much as possible but obviously there are exemptions in the workplace where this is unavoidable. In addition, staff are actively encouraged to continue to practise social distancing and maintain high standards of personal hygiene and all staff have been reminded to complete the mandatory hand hygiene training.

In terms of PPE, we follow the SA Health matrix and there is currently no recommendation for staff to wear masks at all times.

Regards

Maree Geraghty
Chief Executive Officer
Northern Adelaide Local Health Network

SA Health – Government of South Australia
Address: Haydown Road, ELIZABETH VALE SA 5112, DX465580
Email: Maree.Geraghty@sa.gov.au **Email Correspondence:** Health.NALHN-OCEO@sa.gov.au
Telephone: 08 8133 2244 | **Mobile:** +61 413302549
Website: www.sahealth.sa.gov.au/nalhn **Twitter:** www.twitter.com/sahealth

From: Bernadette Mulholland <bernm@sasmoa.com>
Sent: Thursday, 23 April 2020 4:06 PM
To: Geraghty, Maree (Health) <Maree.Geraghty@sa.gov.au>; Health:NALHN - OCEO <Health.NALHN-OCEO@sa.gov.au>
Cc: Stevens, Helen (Health) <Helen.Stevens@sa.gov.au>; Maddison, John (Health) <John.Maddison@sa.gov.au>; Ed Grue <edgrue@sasmoa.com>; Cusack, Michael (Health) <Michael.Cusack@sa.gov.au>; Kaharevic, Melisa (Health) <Melisa.Kaharevic2@sa.gov.au>; Woolcock, Jamin (Health) <Jamin.Woolcock@sa.gov.au>
Subject: FW: NALHN Update 3/4/20 CEO Bulletin

Dear Maree

I note the reference to social distancing at the hospital site in the NALHN bulletin below.

I am interested to understand better, from a health and safety perspective, what process has been initiated in other areas of the hospital other than lifts and meetings for frontline health care workers to uphold the 1.5 metre policy, or at least identified written protections if the 1.5 metres cannot be implemented. When some doctors see the requirement to be 1.5 metres in a lift or in a meeting but no such safety measures is considered when they are providing care to patients they feel disappointed this has still not been addressed.

The employer obviously agrees there is a risk, noting when I go to the hospital sites there are clear restrictions in place about numbers of people getting into the lift and then required to stand 1.5 metres away. Even attending the Department there are restrictions in place for administration as to how closely we all sit, yet I have seen no advice provided to clinicians, in the conduct of their duties.

I understand it is difficult, if not impossible, in the provision of some health services to implement social distancing so I therefore request clarity as to what protection should be in place (e.g. masks) if frontline health workers (like those in the photo) cannot socially distance. I have gained a number of photos from LHNs identifying that social distancing to patients in some areas is not possible.

SASMOA has raised the issue with NALHN, CALHN, SALHN and the Department without response. We have raised in our health and safety reports which to date have not be responded to by the two LHNs. I would be keen to hear what the health and safety officers are saying at sites in relation to this issue. The observation is raised with SASMOA by clinicians but to date we have been unable to get a response. The matter is a notable absence in the matrix, which again SASMOA has raised but not given any response.

I have many articles provided to me by frontline doctors on this issue. I attach the latest https://kirby.unsw.edu.au/news/spatial-distancing-rules-health-workers-may-be-insufficient-review

What would be NALHN's advice on this matter. I have included the Department representative's perhaps a whole of health response would be appropriate.

It would be appreciated if a response is provided by someone to this ongoing issue. I will follow up on Monday.

Thank you

Bernadette

From: Evans, Michele (Health) <Michele.Evans@sa.gov.au>
Sent: Wednesday, 22 April 2020 5:14 PM
To: info@hsusant.org.au; Anne Ashwood <Anne.Ashwood@unitedvoice.org.au>; Ed Grue <edgrue@sasmoa.com>; krowney@professionalsaustralia.org.au; Louise Graham <Louise.Graham@anmfsa.org.au>; Rosie Ratcliff <rosie.ratcliff@cpsu.asn.au>; cody.hastings@unitedworkers.org.au; Bernadette Mulholland <bernm@sasmoa.com>
Subject: RE: NALHN Update 3/4/20 CEO Bulletin

Please circulate this information to staff in your area who do not have access to email and display on appropriate notice boards. Thank you.

Friday 3 April 2020

COVID-19 Planning Update

I acknowledge and appreciate that our staff both front line and behind the scenes are working tirelessly to ensure we are in the best position to respond to COVID-19 across the state. I want to assure you the extra efforts you are all putting in are appreciated and I remain proud of our NALHN staff.

NALHN is well prepared to support our colleagues across the health system, with COVID-19 positive patients being treated and cared for at the Royal Adelaide Hospital, Flinders Medical Centre and Women's and Children's Hospital as respective needs arise. We are here to support the designated COVID Networks manage capacity across the state, and I sincerely thank you all for your dedication and professionalism over recent weeks.

COVID-19 Updates

I would like to remind everyone the COVID-19 updates are regularly being circulated in an effort to keep you up-to-date with the changing situation.

In an effort to ensure everyone remains properly informed and to curb any misinformation, we will continue sharing the latest advice via COVID-bulletins which will be regularly uploaded to our intranet site.

I encourage all staff and disciplines to refer to this routinely, given the ever changing situation but also remind you of the importance of talking and listening to one another.

Planning and Preparation

Our dedicated Incident Management Team (IMT), chaired by Network Commander Karen Puvogel, is continuing to work through short term and long term response requirements for NALHN. Please click here to see how this structure looks.

Australian Defence Force and NALHN

We are pleased to welcome members of the Australian Defence Force (ADF) who have been invited to join our Planning Support Team to provide additional guidance and assistance in our response to the Coronavirus situation. I recognise it is a challenging time for all of our hardworking health staff. The ADF will be assisting us with planning, operational and communication support, including preparedness and other tasks depending on our needs for the times ahead.

ADF teams have also been established within other Local Health Networks and the State Command Centre, where they are expected to complement the work already being undertaken to prepare the health system.

The ADF will be based at Lyell McEwin Hospital. I am confident you will all help in making them feel welcome.

Social Distancing

Please be mindful of social distancing when meetings are required and remember to maintain your 1.5m distancing. It's fantastic to see staff embracing new ways of working and technology like Microsoft Teams. If you haven't already, I encourage you to take look at this interactive demo and guided tour of Teams:

Welcome to the Microsoft Teams Interactive Demo

Microsoft Teams is the hub for teamwork in Office 365. Jump in and experience how teams can achieve more together when all their chats, meetings, files and apps live in a single workspace.

In this interactive demo, you'll first get a guided tour of Teams to understand the app and learn about key features. You'll then try out some real actions and help a team make important decisions.

Let's get started

NALHN is also increasing their preventative measures in alignment with social distancing guidelines by limiting the number of people in our lifts. Posters and floor markings have been implemented to help communicate this change and assist staff, consumers and visitors in achieving the recommended distance.

COVID-19 Communications

Our Communications team are continuing to develop a mix of NALHN specific materials including posters, email footers and banners aimed at reminding staff to remain positive and providing tips about COVID-19 which will be made available on our intranet. Posters and videos are also in production to assist staff with education and helpful tips.

Please note the NALHN COVID-19 intranet page is in the process of being updated to ensure the information we are uploading is being communicated in the most effective manner.

NALHN Staff General Wellbeing

To best manage our anxiety during difficult times, we must first take heart in knowing we are all in this together. Being kind to ourselves and one another is essential to our wellbeing.

If you or anyone you know is feeling overwhelmed, distressed or in need of mental health support in relation to COVID-19, please contact the COVID-19 Mental Health Support Line which is being staffed by Lifeline counsellors.

This service can be accessed by calling **1800 632 753** and is available 8am – 8pm, 7 days a week.

A reminder EAP services are also available.

Further information about mental health support relating to COVID-19 can also be accessed via the SA Health website.

We are continuing to observe the benefits of our preparation and collaboration and I commend everyone for their hard work and dedication to our patients, the community and each other.

Maree Geraghty
Chief Executive Officer
Northern Adelaide Local Health Network

Missed a bulletin? Search here.

Regards

Michele Evans

Michele Evans | Manager Workforce Relations, Workforce.
Email: Michele.Evans@sa.gov.au | **Tel:** (08) 8282 0727 / Mobile: 0466 833 806
Workforce Directorate | Lyell McEwin Hospital | Northern Adelaide Local Health Network
Address: Haydown Road, ELIZABETH VALE SA 5112

From: Evans, Michele (Health)
Sent: Wednesday, 22 April 2020 5:13 PM
To: 'info@hsusant.org.au'; 'Anne Ashwood'; 'Ed Grue'; 'krowney@professionalsaustralia.org.au'; 'Louise Graham'; 'Rosie Ratcliff'; 'cody.hastings@unitedworkers.org.au'; 'Bernadette Mulholland (bernm@sasmoa.com)'
Subject: RE: NALHN Updates

FYI – I Have followed up directly with our COMMS department today after the COVID Update meeting and they have advised that it is possible after all for you to be placed on the automatic mailing list ☺

I am arranging for you all to receive these automatically via your generic inbox email addresses direct from NALHN.

I will confirm once COMMS has advised this has been finalised.

Regards

Michele Evans

Michele Evans | Manager Workforce Relations, Workforce.
Email: Michele.Evans@sa.gov.au | **Tel:** (08) 8282 0727 / Mobile: 0466 833 806
Workforce Directorate | Lyell McEwin Hospital | Northern Adelaide Local Health Network
Address: Haydown Road, ELIZABETH VALE SA 5112

From: Evans, Michele (Health)
Sent: Wednesday, 22 April 2020 11:56 AM
To: 'info@hsusant.org.au'; 'Anne Ashwood'; 'Ed Grue'; 'krowney@professionalsaustralia.org.au'; 'Louise Graham'; 'Rosie Ratcliff'
Subject: RE: NALHN Updates

FYI

Regards

Michele Evans

Michele Evans | Manager Workforce Relations, Workforce.
Email: Michele.Evans@sa.gov.au | **Tel:** (08) 8282 0727 / Mobile: 0466 833 806
Workforce Directorate | Lyell McEwin Hospital | Northern Adelaide Local Health Network
Address: Haydown Road, ELIZABETH VALE SA 5112

From: Evans, Michele (Health)
Sent: Monday, 20 April 2020 9:28 AM
To: 'info@hsusant.org.au'; 'Anne Ashwood'; 'Ed Grue'; 'krowney@professionalsaustralia.org.au'; 'Louise Graham'; 'barry.mcbride@cpsu.asn.au'
Subject: NALHN Updates

FYI

Regards

Michele Evans

Michele Evans | Manager Workforce Relations, Workforce.
Email: Michele.Evans@sa.gov.au | **Tel:** (08) 8282 0727 / Mobile: 0466 833 806
Workforce Directorate | Lyell McEwin Hospital | Northern Adelaide Local Health Network
Address: Haydown Road, ELIZABETH VALE SA 5112

Bernadette Mulholland

From: Bernadette Mulholland
Sent: Tuesday, 3 March 2020 2:06 PM
To: TePohe, Julienne (Health)
Cc: McGowan, Chris (Health); Kaharevic, Melisa (Health); Katharine Webster; Ed Grue
Subject: RE: Overseas Travel

Thanks Julienne

I spoke with Melisa.

But as expected this is fast becoming an issue in particular I just received an email asking what the escalation process is.

I understand some cases are arriving at the Eds and they are referred to the PCCs and are swabbed in the car is this correct or is there another process.

Bernadette

From: TePohe, Julienne (Health) <Julienne.TePohe@sa.gov.au>
Sent: Tuesday, 3 March 2020 12:50 PM
To: Bernadette Mulholland <bernm@sasmoa.com>
Cc: McGowan, Chris (Health) <Chris.McGowan2@sa.gov.au>; Kaharevic, Melisa (Health) <Melisa.Kaharevic2@sa.gov.au>; Katharine Webster <katharine@sasmoa.com>; Ed Grue <edgrue@sasmoa.com>
Subject: Re: Overseas Travel

Hi Bernadette

We are working through this at the moment. Melisa will be in touch shortly.

Julienne TePohe

Sent from my iPhone

> On 3 Mar 2020, at 12:40 pm, Bernadette Mulholland <bernm@sasmoa.com> wrote:
>
> HI Chris and Julienne
>
> I know there is a lot going on but am just wondering what I need to let the doctors know regarding travel arrangements.
>
> I am also aware of a employee in health who has just returned from Bali who will be going back to work on Thursday any rules around this.

Bernadette

<image001.png>

From: McGowan, Chris (Health) <Chris.McGowan2@sa.gov.au>
Sent: Thursday, 27 February 2020 4:03 PM
To: Bernadette Mulholland <bernm@sasmoa.com>
Cc: TePohe, Julienne (Health) <Julienne.TePohe@sa.gov.au>; Kaharevic, Melisa (Health) <Melisa.Kaharevic2@sa.gov.au>; Katharine Webster <katharine@sasmoa.com>; Ed Grue <edgrue@sasmoa.com>
Subject: Re: Overseas Travel

julienne, please involves CPHO as Health and Safety my prohibit travel to unsafe destinations.

Sent from my iPhone

> On 27 Feb 2020, at 4:31 pm, Bernadette Mulholland <bernm@sasmoa.com> wrote:
>
> Dear Julienne
>
> We have medical officers travelling to Europe for Professional Development, including Italy and Spain.
>
> The query has been raised, will the employer be looking at a quarantine period for these medical officers on their return from overseas travel and if so how will that be paid or is it business as usual.
>
> SASMOA is happy to discuss with the employer.
>
> Bernadette
>
> <image001.jpg>

Bernadette Mulholland

From:	Bernadette Mulholland
Sent:	Wednesday, 4 March 2020 10:20 AM
To:	McGowan, Chris (Health)
Cc:	TePohe, Julienne (Health); Kaharevic, Melisa (Health); Dwyer, Lesley (Health); O'Neill, Sue (Health); Gough, Lindsey (Health); Geraghty, Maree (Health); Tea Boromisa; Ed Grue; Katharine Webster; Rob Bonner; sAndrews@professionalsaustralia.org.au; Sue Cummins (sc@cpsu.asn.au); Murphy, James (Health); Nicola.Spurrier@sa.gov.au
Subject:	Updated Advice- CoronaVirus COVID-19 Workplace Relations Advice to Directors of Workforce NSW
Attachments:	Final Consolidated MoH Novel CoronaVirus COVID-19 Advice to Health Agencies 03.03.20.pdf; Staffing Arrangements Communication - WR update 5 Feb.pdf

Dear Chris

I have included everyone in the email simply to determine how to coordinate this issue. I have also touched base with Melisa and this was appreciated. There are Health and Safety aspects and industrial aspects being raised with SASMOA.

Please see the documents and correspondence from NSW provided to all States by our Federal ASMOF Office. I do not know if the information has been updated. However, members are looking for similar guidance. Some members have asked if this can be distributed given there is a view there is no alternative.

Some medical staff are increasingly becoming distressed due to concerns that, in their view some LHNs are unprepared for the multiple possible coronavirus patients presenting.

Issues are being raised about medical waste and cleaning and impacts on staffing numbers in the ED and other Divisions..

Can I get some written guidance on this one, I know it is very busy but I can only see these inquiries increasing. Happy to meet and discuss if this is useful. Have some time early in the morning at 7.30 am to 9.00 or after hours Thursday and Friday but can see if I can bump some meetings.

Regards

Bernadette Mulholland
SASMOA, Senior Industrial Officer

Bernadette Mulholland

From: Bernadette Mulholland
Sent: Thursday, 19 March 2020 3:31 PM
To: Kaharevic, Melisa (Health)
Cc: Cusack, Michael (Health); John.Maddison@sa.gov.au; Nicholls, Jonathan (Health); Ed Grue; Katharine Webster
Subject: NALHN Considerations

Hi Melisa

In endeavouring to be constructive can I just provide SASMOA's observations on NALHN. Accept that I am not attempting to offend no doubt I will.

- There is a level of leadership maturity in NALHN less developed and sophisticated than we find in CALHN and SALHN, the other two spine hospitals. The LHN does not have the same resources or skill level to keep pace with the other two sites and this is worrying and concerning for frontline doctors. To accommodate this shortfall it is opportune to put to one side the view by clinicians generally that they have to be controlled and their ideas ignored. The frontline clinicians in NALHN are the only defence and will provide good ideas which need careful consideration this includes putting to one side rejection based on personality, position and profession.
- Additional resourcing is required in NALHN to assist in this emergency. As a priority NALHN needs communication officers commensurate with CALHN and SALHN. There should be no reason why senior communications officers cannot be seconded to assist NALHN as there is a lack of daily information that is received in other LHNs.
- The frontline doctors in the ED have requested scrubs. They are concerned about contamination and bring home to their families the COVID-19 virus, is there the ability for the Department to source the scrubs if not why not and how else would you address this anxiety.
- NALHN frontline doctors are purchasing their own eye protection from Bunnings and they have concerns regarding PPE access. Can we help them to understand how this can be addressed.
- I also get the sense that NALHN is waiting the leadership from the Department before they implement a process whilst SALHN and CALHN have progressed at the local level. Perhaps ling NALHN to SALHN to understand what they are doing will assist and SALHN could help mentor NALHN on day to day matters. I accept this may be an extra burden on SALHN but it would make a big difference. Having some visibility over CALHN through the doctors I don't believe they would be the preferred mentor given various responsibilities and capacity.
- Our frontline doctors at NALHN talk to their colleagues in CALHN and SALHN and therefore are aware of the additional protection their colleagues in these LHNs have access to that they don't. We need to provide consistency in PPE that is being provided at these other two spine hospitals to NALHN.

We are keen to work with the Department and NALHN to support the frontline clinicians on COVID-19 at LMH and Modbury Hospital

Bernadette

SASMOA

From: Bernadette Mulholland
Sent: Friday, 27 March 2020 5:12 PM
To: SASMOA
Subject: Lyell McEwin Emergency Department Building Upgrade

From: Bernadette Mulholland <bernm@sasmoa.com>
Date: 26 March 2020 at 8:57:47 pm ACDT
To: "Health.NALHN-OCEO@sa.gov.au" <Health.NALHN-OCEO@sa.gov.au>, "Maree Geraghty (Health)" <Maree.Geraghty@sa.gov.au>
Cc: Ed Grue <edgrue@sasmoa.com>, "Sandra Wilkinson (Health)" <Sandra.Wilkinson@sa.gov.au>, Melisa Kaharevic <Melisa.Kaharevic2@sa.gov.au>
Subject: Lyell McEwin Emergency Department Building Upgrade

Dear Ms Geraghty

SASMOA has been advised this evening that NALHN and SA Health have determined to commence building works for the new Emergency Department at the Lyell McEwin Hospital during a Pandemic which threatens the lives of the whole community.

In the view of SASMOA members, this decision directly impacts and places at significant risk both the frontline health workers, patients and the community

Although SASMOA has requested from NALHN administration the NALHN workforce planning for COVID-19, given the incredible dangers faced by frontline health workers, NALHN's engagement has been significantly lacking. There has been limited advice on how NALHN will limit the risks that are known from the disease and having been involved with planning in other LHNs COVID-19 workforce response, NALHN appear behind by some weeks.

The writer has raised these concerns at various levels of the health bureaucracy which has given limited recognition to these concerns.

It is the writer's and SASMOA members view that proceeding with the planned build in such an environment demonstrates the lack of concern the administration appears to have for the health, safety and welfare of staff and patients in a COVID-19 environment. It would be sensible of any employer, but expected of the model employer, to demonstrate leadership in these situations. Unfortunately it is the view of SASMOA, given this recent decision and resistance to engagement, that such leadership appears lacking, placing staff and patients at peril and undermining the confidence of health workers and the community in the bureaucracy's ability to protect them in this pandemic.

The writer further understands in recognition of the life and death situation faced by NALHN staff and the community, resulting from the COVID-19 threat, a Level 1, Code Brown was also issued today by NALHN.

Given that the employer appears unwilling to adhere to its duty of care to protect staff and the community SASMOA will meet with members to determine an appropriate response to ensure members safety and the community. Further information regarding the meeting, which is to be held tomorrow, will be provided to the employer in due course.

SASMOA would request that the employer not proceed with the LMH ED building works until the

threat of the Coronavirus to the community and frontline health staff has finalised. Could you please provide your written response no later than 10.30 am tomorrow to allow SASMOA to respond accordingly.

Regards

Bernadette Mulholland
SASMOA, Senior Industrial Officer

Sent from my iPhone

To the Executive Director, SafeWork SA

I provide the following report in accordance with the provisions of section 117 (6) of the Work Health and Safety Act 2012 (SA) and regulation 28(2) of the Work Health and Safety Regulations 2012 (SA).

I am aware that this report, either in part or in full, may be published on the SafeWork SA website.

ENTRY PERMIT HOLDER (EPH) DETAILS

Name:	**Bernadette Mulholland**
Contact number:	**08 8267 5151**
Permit No:	**ET-19-00307**
Name of union represented:	**South Australian Salaried Medical Officers Association (SASMOA)**

WORKPLACE ENTERED

Workplace Name:	**The Royal Adelaide Hospital**
Street Address:	**Port Road, Adelaide**
Date:	**Monday, 06 April 2020**

DETAILS OF ALLEGED CONTRAVENTION: in my opinion the following provision/of the Work Health and Safety Act 2012 (SA) has or have been contravened:

The Royal Adelaide Hospital ("RAH") forms part of the Central Adelaide Local Health Network (CALHN/PCBU) and is South Australia's largest accredited teaching hospital.

The RAH is the designated COVID-19 Hospital for the State of South Australia. Patients who have COVID-19 requiring hospitalisation will be required to be taken and admitted to this hospital for treatment.

Since the commencement of the COVID-19 pandemic there has been repeated requests to the Department of Health and Wellbeing and Local Health Networks by the EPH to determine the sufficiency of personal protective equipment (PPE) to ensure the health and safety of frontline doctors who are at potential risk from contracting the disease should PPE not be available. This is more important in RAH as the dedicated COVID-19 hospital.

There is a shortage across the world of PPE, particularly masks, and Australia is no different. The EPH was receiving repeated contact from frontline doctors that they are unable to access appropriate PPE and in a timely manner, this includes frontline doctors situated at the Royal Adelaide Hospital. Last week the EPH was further advised by frontline doctors situated at the RAH, that clinicians were being asked by PCBU delegates to reuse, single use masks due to anticipated shortages. The advice from the makers of some of the particular masks (attached) confirmed that the masks would not have the same protection should these masks be reused.

In addition, doctors were also concerned that due to supply shortages of certain types of masks that the frontline doctors had been fit tested for had now run out and further fit testing was required for new types of masks. This shortage was not relayed to doctors creating anxiety and concern for their health and safety and the process for fit testing had been delayed. Frontline doctors were of the view that this left them vulnerable particularly in the RAH Intensive Care Unit were the sickest COVID-19 patients currently reside.

There had been discrepancies between the advice provided by the PCBU and the doctors to the EPH regarding the sufficiency of mask stocks, in particular N95 masks, which provide the most protection for doctors when dealing with COVID-19 positive patients.

For information, "*fit testing*" is a validated method that determines the brand and size of respirator most suited to the doctor's face. A machine is used at the RAH to fit test the frontline doctor to ensure the mask fits appropriately thus providing safety protection from COVID-19. (*SA Health, Clinical Guideline, Respiratory Protection Against Airborne Infectious Diseases Clinical Guideline*)

Fit testing, as the EPH understands from the discussion with PCBU representatives at the RAH on Monday, and advice provided by frontline doctors, that in the event that a particular mask supply, for which the clinician is fit tested is exhausted, a replacement mask of similar requirement but perhaps different brand and/or type, would require the doctor to be fit tested again. This is the appropriate and ensures the health and safety of the doctor.

On Thursday, 2 April 2020, the EPH received emails and text messages from SASMOA members working in the RAH advising that in the ICU, where COVID-19 patients had been admitted, the N95 masks were about to run out. There were no alternate masks and even if there were an alternate product the PCBU delegates had yet to organise fit testing for the frontline doctors to ensure the new masks were appropriate and safe. The doctors who contacted the EPH were of the view that the shortage of masks in the ICU was an immediate risk to their health and safety.

On Friday, 3 April 2020, the EPH was also advised by doctors that the PCBU intended to repurpose single use masks and that in the view of the doctors and the provider of the masks (see attached) would not provide the same safety protection. On that day the EPH submitted the attached form, pursuant to s120, to determine whether the PPE required, including masks and more specifically N95 masks, to allow medical officers to perform their roles safely in the dedicated COVID-19 hospital was sufficient. The EPH was advised by doctors that the masks supply would be exhausted by Sunday.

On Monday, 6 April 2020, the EPH met with PCBU delegates at 9.00 am to discuss sufficiency of PPE. The N95 mask is the most commonly used mask and the delegates confirmed there was a shortage. The delegates advised 35 masks per day, per patient, were currently being used. This is known as the "burn rate" and determines how many masks the RAH will need.

The PCBU delegates did state that the internal process for securing the masks is relatively easy however there needed to be masks available. The PCBU delegates stated the process to obtain masks will again be advised to staff this day.

The PCBU delegates confirmed that N95 Aura masks were now depleted. On, Thursday, 2 April 2020, 16,000 Halyard ProShield masks had been secured and delivered and on Saturday, 5 April 2020 14,000 3M cups masks had been delivered. A picture of the supplied masks is attached. The PCBU delegates felt that there were now enough masks for one month. There was currently an order submitted by the PCBU to procure a further 285,000

masks. The PCBU had commenced fit testing clinicians in the high-risk areas including the RAH Intensive Care Unit, the Emergency Department, the MER team, Tech Suites and Flu clinics with these newly acquired masks. In particular the ICU clinicians had been fit tested on Saturday, 5 April 2020 and the Emergency Department on Sunday, 6 April 2020. The PCBU delegates advised that the RAH was using five fit testing machines to minimise delays and, two of the machines were being operated 24/7 to ensure the fit testing of masks for the high-risk areas was achieved.

The PCBU delegates advised only particular services needed access to N95 masks or equivalent, and those doctors requiring these masks were determined by national guidelines and infection controls guidelines.

The PCBU delegates at the time of meeting with the EPH stated 300 RAH clinicians had now been fit-tested for the new masks however some of those tested had failed the test and these clinicians were being re-tested today by experienced fit testers.

The PCBU delegates confirmed that the safest and best process to protect clinicians was to ensure fit testing. The PCBU delegates advised that they were aware that interstate that some hospitals were only performing "*fit checking*" which is a procedure that must be performed every time a P2/N95 respirator is used to ensure it is properly applied. The PCBU delegates confirmed the "fit check" was useful for donning and doffing PPE and that "fit testing" must be implemented and complied with when new masks are being provided to clinicians to ensure their safety and protection.

It was confirmed by the PCBU delegates that once a doctor had been fit tested for a mask then this is documented by a sticker on the identification badge of the particular doctor confirming the fit testing of a particular mask. Once the doctor had been fit tested for a particular mask they would not be required to be fit tested again for that brand of mask.

The PCBU delegates did advise that once Detmold commenced providing masks then further fit testing would need to occur for doctors at the RAH. There may be some issues with the Detmold masks for clinicians as the design of the mask will only fit most common face shapes and alternatives for clinicians who are unable to wear the Detmold masks would need to be sourced.

The PCBU delegates advised that in the future the PCBU will always ensure that at the site there will be at least a seven-day supply of masks at the RAH determined on patient volume. The example given was as COVID-19 patient presentations increased then a greater supply of masks will need to be held at the RAH site over a 7 day period.

In regards to other PPE other than masks, additional scrubs for RAH were being procured. Given that other hospital service clinicians within RAH, who did not normally wear scrubs were seeking to utilize scrubs then additional scrubs were being purchased. The PCBU delegates advised there is easy access to showers at the RAH for doctors to enable them to shower and to leave the hospital in fresh clothes minimizing external contamination

The PCBU delegates advised there are well stocked numbers of goggles, gowns and shield masks and doctors are expected to wipe down their shoes with sanitizer regularly and before the doctor leaves the hospital site.

The PCBU delegates advised that the PCBU representatives had touched base with the doctors in the RAH Intensive Care Unit and advised the clinicians of the new masks and they were comfortable with this advice.

The EPH questioned the role of OH&S Officers and was advised by the PCBU delegates that any health and safety concerns are escalated to the clinical leads, who then escalate these health and safety concerns to the RAH Command Centre.

The EPH questioned the repeated use of masks and was advised by the PCBU delegates that there was some evidence to suggest that the masks can be repurposed however it was also acknowledged that this may not provide the same protection. The EPH advised she would provide to the PCBU a copy of the 3M sheet which states that the masks were only appropriate for single use. The PCBU delegates confirmed the masks were only going to be used for single purpose and not repurposed.

The EPH continues to hold concern regarding PPE access and sufficiency at the RAH and will continue to monitor the situation with the SASMOA members.

The EPH would ask the PCBU to make available to SASMOA members accurate advice regarding the available PPE and provide at least 7 days-notice if there is a shortage of masks or other PPE necessary for the protection and safety of doctors at the RAH.

The EPH requests that SafeWork SA implement the following with the PCBU at the RAH given the site is the designated COVID-19 hospital;

- Regular SafeWork SA independent checks to determine the adequacy, appropriateness and availability of PPE including the availability of masks at the RAH.
- That regular fit and timely testing for masks occur at the RAH for doctors so their health and safety is not at risk.
- The PCBU, where there is compromised ability to adhere to social-distancing requirements, provide access to surgical masks minimising risks to doctors' health and safety.
- The PCBU provide clear written advice that masks used by doctors are for single usage and are not intended for repurposing and/or reusing.
- The PCBU provide a formal written direction that, in the event that required PPE is not available, frontline doctors are not required to undertake tasks requiring PPE.

The EPH has requested further and better particulars regarding the quantity and size and type of PPE health by the PCBU and will forward this information to SafeWork SA on provision by the PCBU.

4	Signature of EPH:	Date 8 - 4 - 2020

5	SAFEWORK SA USE ONLY:	InfoNET File No.:	Report triaged by:	Names redacted: ☐
				Report saved on Q:/: ☐
		Report saved on InfoNET: ☐	*Further action required Yes / No*	Report sent to Comms Unit: ☐
			Date / /20	EPH s/sheet updated: ☐


3M 8210
Particulate Respirator
3M recommended for sanding, grinding, sawing, sweeping and insulating
Adjustable noseclip
Soft nosefoam
Patented filter media
WARNING
N95 Approved
20
BSN medical
Medium
ProShield® N95 Medium

NOTICE OF ENTRY

Full Name of entry permit holder: Bernadette Mulholland

Name of union represented: South Australian Salaried Medical Officers Association

Name and address of workplace being entered:	Date of entry or proposed * entry:
Royal Adelaide Hospital Port Road Adelaide 5000 SA	06 April 2020 at 9.00 am *(*For entry under section 120 or 121: 24 hours – 14 days' notice must be given)*

Purpose of Entry

☐	**Section 117 –**	To enquire into a suspected contravention of the WHS Act.
X	**Section 120 -**	To **inspect** employee records or information held by another person, in relation to a suspected contravention of the WHS Act.
☐	**Section 121 -**	To consult and advise relevant workers on health and safety matters.

Permit number. ET-19-00307

Details of the suspected contravention to which this **notice** relates:

Members advise the EPH has not got the required personal protective equipment, including masks and more specifically N95 masks, to allow medical officers to perform their roles safely in a COVID-19 hospital.

The EPH will be seeking to ascertain for each service the number of masks and the types of masks provided by the PCBU to each service within the Royal Adelaide Hospital to ensure there are sufficient masks for medical officers and the right masks to protect their health and safety and minimise risk of infection.

Additional – for entry under section 120 to inspect employee records held by the relevant PCBU and documents held by another person.

Declaration

X The above union is entitled to represent the industrial interests of worker/s at this workplace.

X The provision in the union's rules that entitles the union to represent the industrial interests of these worker/s is: Rule 3

Sections 117 and 120 only:

X The suspected contravention relates to worker/s that the union is entitled to represent.

Section 120 only:

X The employee records or other documents proposed to be inspected relate to worker/s the union is entitled to represent.

WHS entry permit holder signature: [signature]

Date: 3/4/2020

The legislation provides for civil penalties of up to $10,000 **for individuals and $50,000 for a body corporate relating to breaches of right of entry laws.**

3M Science. Applied to Life.™

Technical Bulletin

March, 2020
Release 2

Disinfection of Filtering Facepiece Respirators

Considerations for healthcare organizations and occupational health professionals

Description

We at 3M have been studying ways to sterilize or disinfect filtering facepiece respirators for years. There are at least four key aspects of successful disinfection of respirators, and most studies do not take all four into consideration. The disinfection method must:

- be effective against the target organism, such as the virus that causes COVID-19;
- not damage the respirator's filtration;
- not affect the respirator's fit; and
- be safe for the person wearing the respirator (e.g. no off-gassing of chemicals into the breathing zone).

If the filtration is damaged or the respirator does not fit, it will not help reduce exposure to airborne particles at the level indicated, such as N95, FFP2, etc.

As of March 27,2020, no disinfection method has met all four of these key criteria, and without all four, the method is not acceptable. 3M is now working with several major sterilization and disinfection companies and consulting with external experts to develop an effective disinfection method. We are working as quickly as possible and are hopeful that we will find an effective method soon.

Background

Filtering facepiece respirators (FFRs), such as those that meet the filtration efficiency requirements for classification as such as N95, FFP2, KN95, and similar, are commonly used to help provide respiratory protection in a variety of workplaces, including healthcare settings. A common infection prevention practice employed by healthcare organizations is to utilize FFRs as one-time-use items when worn in the presence of infected patients.[1] In the face of a global pandemic and associated FFR shortage, 3M has received numerous questions concerning potential methods to disinfect FFRs, including questions relating to studies that have evaluated the effectiveness of various disinfection methods on FFRs. In an attempt to respond to urgent requests we are receiving from customers and organizations around the world, we have prepared this bulletin to provide information concerning a few methods that have been suggested to potentially help disinfect FFRs.

Based on currently available data, 3M does not recommend or support attempts to sanitize, disinfect, or sterilize 3M FFRs.

We note, however, that the U.S. Centers for Disease Control and Prevention (CDC) has published guidance on managing respirators during pandemics including the reuse and extended use of respirators at:
https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html

Disinfection Methods Often Considered for FFR

IONIZING RADIATION

Ionizing radiation has the potential to significantly impact the performance and/or integrity of 3M filtering facepiece respirators. The effect of ionizing radiation on the filtration performance will not be apparent by visible inspection or noticeable when wearing the respirator. Therefore, as with any research regarding sterilization, disinfection and reprocessing, it is especially important to have the filtering facepiece respirators evaluated in a test laboratory using equipment designed to evaluate filtration of particulate respirators. In past research, 3M has found that attempts to sterilize respirators with ionizing radiation (e.g. e-beam, x-ray) have significantly damaged the filter media and are, therefore, not acceptable methods.

ETHYLENE OXIDE

3M does not support the use of ethylene oxide to sterilize, disinfect or reprocess filtering facepiece respirators. Ethylene oxide (EtO) has been determined to be carcinogenic to humans by the inhalation route of exposure, and the U.S. National Institute for Occupational Safety and Health (NIOSH) and the CDC recommend that worker's exposures be kept as low as possible.[2] Since filtering facepiece respirators are designed to fit over a worker's breathing zone and workers breathe through them for hours every day, as well as the particulate filter media not being intended or effective to reduce exposure to EtO, we cannot rule out the possibility that filtering facepiece respirators sterilized with EtO will continue to off-gas into the worker's breathing zone, exposing the worker to EtO. To the best of our knowledge there has not been sufficient research done, at this time, to demonstrate that sterilization of filtering facepiece respirators with EtO is safe for the wearer.

According to the U.S. Environmental Protection Agency (EPA) Integrated Risk Information System and the Agency for Toxic Substances and Disease Registry (ATSDR) Toxicological Profile for Ethylene Oxide[3], the acute (short-term) effects of ethylene oxide in humans include mainly central nervous system depression and irritation of the eyes and mucous membranes. Chronic (long-term) exposure to ethylene oxide in humans can cause irritation of the eyes, skin, nose, throat, and lungs, and damage to the brain and nervous system. There also is some evidence linking ethylene oxide exposure to reproductive effects. EPA has concluded that ethylene oxide is carcinogenic to humans by the inhalation route of exposure. Evidence in humans indicates that exposure to ethylene oxide increases the risk of lymphoid cancer and, for females, breast cancer.

MGS, UBGI, and MOIST HEAT

A study from the University of Nebraska Medical Center[4] evaluated the effectiveness of three disinfection methods on two 3M FFR models: the 3M™ Health Care Particulate Respirator and Surgical Mask 1860 and the 3M™ Aura™ Health Care Particulate Respirator and Surgical Mask 1870 (the latter of which has since been discontinued and replaced in the 3M FFR product line by the 3M™ Aura™ Health Care Particulate Respirator and Surgical Mask 1870+). Each of these FFRs was subjected to only 1-cycle (1X) of one of three disinfection methods tested: ultraviolet germicidal irradiation (UVGI), microwave-generated stream (MGS), and moist heat. The study found that UVGI, MGS, and moist heat effectively reduced viral load of H5N1 virus by > 4 log median tissue culture infective dose. It also found <5% filter penetration on each FFR following subjection to one of the three disinfection methods.[2] However, this study did not investigate the effect of these disinfection treatments on respirator fit.

3M has conducted a similar study to better understand how these disinfection methods might affect fit and filtration of the 3M™ Healthcare Particulate Respirator and Surgical Mask 1860 and 3M™ Aura™ Health Care Particulate Respirator and Surgical Mask 1870. In the 3M study, one of the three disinfection methods (UVGI, MGS, and moist heat) was performed between 5-10 cycles (5X-10X) on a small sample of FFRs (N = 3 of each model). The 3M study found the filtration performance was not affected, in that the respirators continued to provide at least the minimum filtration efficiency required for the N95 designation. However, all three disinfection methods caused damage to at least one respirator in each sample. Observed damage included: delamination or compression of the respirator's nosefoam, a strong burnt odor, the respirator straps on the 1870 lost elasticity, and the MGS and moist heat methods melted the respirator material surrounding the metal noseclip and staples. This damage compromised the fit of these respirators and made them not suitable for use. Table 1 summarizes the

results found in the 3M study. **Sanitization, disinfection, or sterilization of FFRs utilizing these specific methods is, therefore, not recommended or supported by 3M at this time.**

Decontamination Methods and Impact on Facepiece Materials

Table 1: 3M Study of Damage Due to Attempted Disinfection of Models 1860 and 1870

Disinfection Method Tested by 3M (repeated 5X-10X per FFR)	Results on 3M 1860 and 1870
Microwave Generated Steam 2-min @ full power, 50ml H_2O	Metal nose clip and staples melted surrounding plastic; nosefoams delaminted; straps on 1870 lost elasticity
Ultraviolet germicidal irradiation (UVGI) 30-min @ 254nm (15-min per side)	Straps on 1870 lost elasticity; strong burnt odor; nosefoam compressed on 1860
Moist Heat 30 mins, 60°C, 80%RH oven	Metal nose clip and staples melted surrounding plastic; nosefoam delaminted; straps on 1870 lost elasticity

MGS, BLEACH, LHP, MOIST HEAT, and HPGP

A study published in the Journal of Engineered Fibers and Fabrics (JEFF)[5] evaluated 3-cycle (3X) processing of eight disinfection methods: UVGI, ethylene oxide (EtO), hydrogen peroxide gas plasma (HPGP), hydrogen peroxide vapor (HPV), MGS, bleach, liquid hydrogen peroxide (LHP), and moist heat. This study did not assess the efficiency of the disinfection method to inactivate microorganisms. Appearance, odor, and filtration performance were evaluated. The specific FFR models evaluated in the study were not disclosed so it is unclear if 3M FFRs were included. The study found that four methods caused visible damage/changes to the FFRs: MGS, bleach, LHP, and moist heat. Hydrogen peroxide gas plasma treatment was the only disinfection method resulting in high penetration levels (> 5%). EtO, HPV, and UVGI disinfection did not cause any observable physical changes to the FFRs and did not negatively affect filter penetration.[3] This study did not evaluate respirator fit. Table 2 summarizes the results found in the JEFF study.

UVGI, EtO, and HPV

Although the JEFF study found three disinfection methods (EtO, HPV, and UVGI) caused no visible changes to the FFRs, it is unclear what specific FFR models were evaluated or what effect was achieved with regard to microorganism deactivation. **At this time sanitization, disinfection, or sterilization of 3M FFRs utilizing these specific methods is, therefore, not recommended or supported by 3M.**

Table 2: Results of various disinfection methods on FFRs found in JEFF study (Sheet 1 of 2)

Disinfection Method Utilized in JEFF Study (repeated 3X per FFR)	Results on Various Unknown FFR Makes and Models
Ultraviolet germicidal irradiation (UVGI) 15-min @ 254nm (only one side of FFR faced lamp, not straps)	No observable physical change
Ethylene oxide 1-hr 100% EtO Sterilizer	No observable physical changes
Hydrogen Peroxide Gas Plasma ~55-min , 59% H2O2, 45°C-50°C	Filter penetration exceeded 5% on multiple samples
Hydrogen Peroxide vapor 15-min dwell, 125-min total cycle time, 8 g/m3 concentration	No observable physical changes

Table 2: Results of various disinfection methods on FFRs found in JEFF study (Continued) (Sheet 2 of 2)

Disinfection Method Utilized in JEFF Study (repeated 3X per FFR)	Results on Various Unknown FFR Makes and Models
MGS 2-min @ 1,100 W full power, 50 mL H2O	Separation of nosefoam from FFR; melting of head straps
Bleach 30-min @ 0.6% sodium hypochlorite solution	Nosefoam slightly tarnished; staples oxidized to varying degrees; discolored or dissolved inner nose pad
Liquid hydrogen peroxide30-min @ 6% hydrogen **peroxide** solution	Staples oxidized to varying degrees
Moist heat 30-min @ 60°C, 80% RH	Seperation of nose foam from FFR; melting of head straps

Summary

If organizations choose to attempt to disinfect filtering facepiece respirators, using any of the methods described above or any other methods, then such organization should carefully consider the findings described in this document and understand that doing so may impact the filtration performance and/or the respirator materials in such a way that may reduce the respirator's ability to seal to the wearer's face and provide the expected protection for this type of respirator.

References

1) U.S. Centers for Disease Control and Prevention, "Pandemic Planning: Recommended Guidance for Extended Use and Limited Reuse of N95 Filtering Facepiece Respirators in Healthcare Settings," March 2018, https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html.
2) U.S. National Institute for Occupational Health and Safety (NIOSH), Worker Health Study Summaries - Sterilization of Medical Instruments and Treatment of Spices (Ethylene Oxide). https://www.cdc.gov/niosh/pgms/worknotify/ethyleneoxide.html, April 2017.
3) U.S. Environmental Protection Agency, Hazard Summary, Ethylene Oxide. https://www.epa.gov/sites/production/files/2016-09/documents/ethylene-oxide.pdf, December 2018.
4) Lore, M.B., Heimbuch, B.K., Brown, T.L., Wander, J.D. and Hinrichs, S.H. Effectiveness of Three Decontamination Treatments against Influenza Virus Applied to Filtering Facepiece Respirators. Ann. Occup. Hygiene 2011;1-10.
5) Bergman, M.S., Viscusi, D.J., Heimbuch B.K., Wander, J.D., Sambol, A.RI, Shaffer, R.E. Evaluation of Multiple (3-cycle) Decontamination Processing for Filtering Facepiece Respirators. J Engineered Fibers Fabrics 2010;5:33-41.

Personal Safety Division
3M Center, Building 235-2W-70
St. Paul, MN 55144-1000

3M PSD products are occupational use only.

In United States of America
Technical Service: 1-800-243-4630
Customer Service: 1-800-328-1667
3M.com/worksersafety
In Canada
Technical Service: 1-800-267-4414
Customer Service: 1-800-364-3577
3M.ca/Safety

2 April 2020

Dr Christopher McGowan
SA Health, Chief Executive
Office of the Chief Executive
Citi Centre Building
11 Hindmarsh Square
ADELAIDE SA 5000

Attention: **Ms Melisa Kaharevic**
SA Health, Director Workforce Services

SA Salaried Medical Officers Association
ABN: 60 932 342 397

Australian Salaried Medical Officers Federation (SA Branch)
ABN: 23 172 174 608

Dear Dr McGowan

COVID – 19 - Personal Protective Equipment (PPE) Interim Guide ("the Guide")

SASMOA welcomes the opportunity to respond to the above document given PPE is a current priority for frontline doctors in the COVID-19 crisis.

The employer has a duty of care and must, so far as is reasonably practicable, ensure the health and safety of its employees. Employees also have a duty to protect themselves and their colleagues.

SASMOA submits that in some Local Health Networks (LHN), frontline doctors feel at risk and unsafe because of the actions or inaction, by employer delegates, arising from various requests by doctors to provide PPE and this being refused and/or consistent punishment and intimidation by the employer's delegate when a doctor using their professional judgement, given the clinical situation, dons a mask for both their own and patient safety only to be challenged and instructed to remove the mask.

Many frontline doctors who have spoken with SASMOA, are of the view that some LHN delegates, have adopted a *laissez-faire* attitude or "*business as usual*" approach in response to the COVID-19 crisis "*serving frontline staff up as cannon fodder*" by failing to provide the clinicians with the correct PPE commensurate with the clinical situation as determined by the frontline doctors.

This is exacerbated further when frontline clinicians witness in their daily lives, implemented safety equipment and strategies by other

1st Floor, 161 Ward Street
(PO Box 64)
North Adelaide
South Australia 5006

Telephone: (08) 8267 5151
Fax: (08) 8267 1891
Email: sasmoa@sasmoa.com
Website: sasmoa.com

employers, such as supermarkets, who are installing screens to protect their frontline staff in response to COVID-19. No doubt in the coming years and, with hindsight, the clinical evidence of this pandemic will demonstrate what we should and should not have done. However, given that the frontline doctors, in SASMOA's view have the ability to gather the most current evidence-based knowledge on COVID-19 through national and international health connections, (see attached some recent documents provided to SASMOA on PPE) SASMOA intends to be guided by their professional needs and advice in terms of PPE to ensure our members health, safety and welfare is prioritised.

Members have requested that SASMOA cautions the employer, in failure to recognise, address and provide PPE for doctors as it may result in paralysis of some services and implement barriers to frontline doctors to focus on their clinical tasks. Many frontline doctors now speak of low morale and wellbeing given the failure by the hospital executives to make them feel safe.

SASMOA wishes to emphasise that the continued bullying by various levels of management of frontline doctors, when in the doctor's professional view, they should be wearing a mask given their medical expertise and knowledge in their service, will no longer be tolerated. SASMOA intends to immediately respond with a safety inspection should such behaviour continue, utilising the powers provided pursuant to the *Work, Health and Safety Act (SA) 2012* and industrial laws and provide these concerns publicly amongst its membership.

SASMOA confirms that on consideration of all information available relating to COVID-19, that the underlying principle for donning particular PPE must be based on a judgement by the medical officer. The Guide should be considered as simply the minimum standard expected. If the administration disagrees with this medical decision, the administrator should provide the instruction in writing to the frontline doctor. Remembering the provision of care by a doctor to a patient cannot be overridden by the employing authority.

SASMOA notes the employer has not covered within the document the most common scenario between the frontline doctor and patient, the adherence to the maintenance of spatial distancing of 1.5 metres. This distancing is not possible in all health environments and this situation in a health/hospital setting is foreseeable by the reasonable person. The ongoing issues of hospital crowding has not disappeared as a result of this pandemic. Frontline clinicians continue to be forced to work in confined service areas, in large numbers. HCWs are high risk epidemiologically. It is absurd to suggest that outside the hospital environment clinicians must maintain a distance of 1.5 metres but within

the confines of the health environment, that performing their role and function in this setting provides permission to work closely together.

SASMOA members further submit that there is no accounting within the document for asymptomatic spreaders who disperse droplets broadly if not wearing a mask. The evidence so far gained is that these droplets may remain for days on surfaces. (See attached)

SASMOA therefore insists on an additional section within the Guide titled "*Health Care environments where social distancing is not practical*".

> *"In lieu of not being able to maintain a social distance of >1.5 metres at all times, a surgical mask must be worn in these areas. Long term continual use of masks for this purpose is acceptable but must be changed if the mask becomes wet or soiled"*

Further, issues for consideration within the document (provided by one of the doctors the writer shared this Guide) are set out below.

- Page 1 - Healthcare facilities – HCW - Setting, patient room – Type of PPE or procedure. This depends on the type of procedure and not one size fits all. This should state as a minimum, surgical masks for routine care but medical judgement may be required in considering whether the type of procedure may require a P2/N95 mask.
- Page 1 - Healthcare facilities – Cleaner - Setting, patient room – Type of PPE or procedure. This depends on the type of procedure and not one size fits all. This should state as a minimum, surgical masks for routine care but medical judgement may be required in considering whether the type of procedure may require a P2/N95 mask. SASMOA is aware some cleaners who have exceptional personal circumstances that would require a P2/N95 mask
- Page 2 – "Triage" HCW- what is the definition of a "barrier screen". It is confusing and repeated throughout the document.
- Page 3 – "Physical examination of patient with respiratory symptoms" current response is that this is confusing and needs clarity of definition of "aerosol generating procedures".
- Throughout the document is states "No PPE" and then follows "PPE according to standard precautions and risk assessment". Advice from some is that this is confusing

There are other matters that the writer notes are not included in the document regarding PPE, in particular scrubs. No clinician should be expected to provide their own clothing or, work in a clinical environment in the current setting, without at least access to clean scrubs. SASMOA requests that scrubs be offered to frontline doctors together with

agreement, by the employer, to wash the scrubs at the end of the shift. This will assist minimising contamination to the HCW's family and community which is both foreseeable and reasonable based on the evidence. The inclusion of access to scrubs can occur either at the beginning of the document or towards the end. If reference to scrubs is not included for frontline doctors then the matter will be escalated.

Individual circumstances need also to be accommodated when assessing the need for PPE. For example, a frontline doctor may have an underlining condition that makes them vulnerable in the event that they are exposed and contract COVID-19. The writer is aware, of two separate matters, where doctors have been medically advised that the continuous wearing of a N95 mask would allow their continued presence in their particular frontline service. However, the service has refused to accommodate this reasonable request.

It must be remembered that "*one size fits all*" approach is not appropriate in a health setting. Provision within the document for local adjustment depending upon setting, individual characteristics, patient characteristics etc. must be included in the document. Perhaps in such circumstances risk assessments should be undertaken by the treating medical officer and decisions made regarding duty to protect self and others will need to be respected.

Finally, SASMOA has been requested to raise the issue of regular cleaning of work areas and the provision of principles regarding the frequency of this process.

Please note SASMOA intends to rely on this and any other correspondence provided by the Association in the event that the employer fails to implement health and safety requests raised by SASMOA and its membership.

Yours sincerely

Bernadette Mulholland
SASMOA, Senior Industrial Officer

C.C SASMOA Members

Minister for Health and Wellbeing

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Universal Masking in Hospitals in the Covid-19 Era

Michael Klompas, M.D., M.P.H., Charles A. Morris, M.D., M.P.H., Julia Sinclair, M.B.A., Madelyn Pearson, D.N.P., R.N., and Erica S. Shenoy, M.D., Ph.D.

As the SARS-CoV-2 pandemic continues to explode, hospital systems are scrambling to intensify their measures for protecting patients and health care workers from the virus. An increasing number of frontline providers are wondering whether this effort should include universal use of masks by all health care workers. Universal masking is already standard practice in Hong Kong, Singapore, and other parts of Asia and has recently been adopted by a handful of U.S. hospitals.

We know that wearing a mask outside health care facilities offers little, if any, protection from infection. Public health authorities define a significant exposure to Covid-19 as face-to-face contact within 6 feet with a patient with symptomatic Covid-19 that is sustained for at least a few minutes (and some say more than 10 minutes or even 30 minutes). The chance of catching Covid-19 from a passing interaction in a public space is therefore minimal. In many cases, the desire for widespread masking is a reflexive reaction to anxiety over the pandemic.

The calculus may be different, however, in health care settings. First and foremost, a mask is a core component of the personal protective equipment (PPE) clinicians need when caring for symptomatic patients with respiratory viral infections, in conjunction with gown, gloves, and eye protection. Masking in this context is already part of routine operations for most hospitals. What is less clear is whether a mask offers any further protection in health care settings in which the wearer has no direct interactions with symptomatic patients. There are two scenarios in which there may be possible benefits.

The first is during the care of a patient with unrecognized Covid-19. A mask alone in this setting will reduce risk only slightly, however, since it does not provide protection from droplets that may enter the eyes or from fomites on the patient or in the environment that providers may pick up on their hands and carry to their mucous membranes (particularly given the concern that mask wearers may have an increased tendency to touch their faces).

More compelling is the possibility that wearing a mask may reduce the likelihood of transmission from asymptomatic and minimally symptomatic health care workers with Covid-19 to other providers and patients. This concern increases as Covid-19 becomes more widespread in the community. We face a constant risk that a health care worker with

early infection may bring the virus into our facilities and transmit it to others. Transmission from people with asymptomatic infection has been well documented, although it is unclear to what extent such transmission contributes to the overall spread of infection.[1-3]

More insidious may be the health care worker who comes to work with mild and ambiguous symptoms, such as fatigue or muscle aches, or a scratchy throat and mild nasal congestion, that they attribute to working long hours or stress or seasonal allergies, rather than recognizing that they may have early or mild Covid-19. In our hospitals, we have already seen a number of instances in which staff members either came to work well but developed symptoms of Covid-19 partway through their shifts or worked with mild and ambiguous symptoms that were subsequently diagnosed as Covid-19. These cases have led to large numbers of our patients and staff members being exposed to the virus and a handful of potentially linked infections in health care workers. Masking all providers might limit transmission from these sources by stopping asymptomatic and minimally symptomatic health care workers from spreading virus-laden oral and nasal droplets.

What is clear, however, is that universal masking alone is not a panacea. A mask will not protect providers caring for a patient with active Covid-19 if it's not accompanied by meticulous hand hygiene, eye protection, gloves, and a gown. A mask alone will not prevent health care workers with early Covid-19 from contaminating their hands and spreading the virus to patients and colleagues. Focusing on universal masking alone may, paradoxically, lead to more transmission of Covid-19 if it diverts attention from implementing more fundamental infection-control measures.

Such measures include vigorous screening of all patients coming to a facility for symptoms of Covid-19 and immediately getting them masked and into a room; early implementation of contact and droplet precautions, including eye protection, for all symptomatic patients and erring on the side of caution when in doubt; rescreening all admitted patients daily for signs and symptoms of Covid-19 in case an infection was incubating on admission or they were exposed to the virus in the hospital; having a low threshold for testing patients with even mild symptoms potentially attributable to a viral respiratory infection (this includes patients with pneumonia, given that a third or more of pneumonias are caused by viruses rather than bacteria); requiring employees to attest that they have no symptoms before starting work each day; being attentive to physical distancing between staff members in all settings (including potentially neglected settings such as elevators, hospital shuttle buses, clinical rounds, and work rooms); restricting and screening visitors; and increasing the frequency and reliability of hand hygiene.

The extent of marginal benefit of universal masking over and above these foundational measures is debatable. It depends on the prevalence of health care workers with asymptomatic and minimally symptomatic infections as well as the relative contribution of this population to the spread of infection. It is informative, in this regard, that the prevalence of Covid-19 among asymptomatic evacuees from Wuhan during the height of the epidemic there was only 1 to 3%.[4,5] Modelers assessing the spread of infection in Wuhan have noted the importance of undiagnosed infections in fueling the spread of Covid-19 while also acknowledging that the transmission risk from this population is likely to be lower than the risk of spread from symptomatic patients.[3] And then the potential benefits of universal masking need to be balanced against the future risk of running out of masks and thereby exposing clinicians to the much greater risk of caring for symptomatic patients without a mask. Providing each health care worker with one mask per day for extended use, however, may paradoxically improve inventory control by reducing one-time uses and facilitating centralized workflows for allocating masks without risk assessments at the individual-employee level.

There may be additional benefits to broad masking policies that extend beyond their technical contribution to reducing pathogen transmission. Masks are visible reminders of an otherwise invisible yet widely prevalent pathogen and may remind people of the importance of social distancing and other infection-control measures.

It is also clear that masks serve symbolic roles. Masks are not only tools, they are also talismans that may help increase health care workers' perceived sense of safety, well-being, and trust in their hospitals. Although such reactions may not be strictly logical, we are all subject to fear and anxiety, especially during times of crisis. One might argue that fear and anxiety are better countered with data and education than with a marginally beneficial mask, par-

ticularly in light of the worldwide mask shortage, but it is difficult to get clinicians to hear this message in the heat of the current crisis. Expanded masking protocols' greatest contribution may be to reduce the transmission of anxiety, over and above whatever role they may play in reducing transmission of Covid-19. The potential value of universal masking in giving health care workers the confidence to absorb and implement the more foundational infection-prevention practices described above may be its greatest contribution.

Disclosure forms provided by the authors are available at NEJM.org.

From the Department of Population Medicine, Harvard Medical School and Harvard Pilgrim Health Care Institute (M.K.), Brigham and Women's Hospital (M.K., C.A.M., J.S., M.P.), Harvard Medical School (M.K., C.A.M., E.S.S.), and the Infection Control Unit and Division of Infectious Diseases, Massachusetts General Hospital (E.S.S.) — all in Boston.

This article was published on April 1, 2020, at NEJM.org.

1. Rothe C, Schunk M, Sothmann P, et al. Transmission of 2019-nCoV infection from an asymptomatic contact in Germany. N Engl J Med 2020;382:970-1.
2. Bai Y, Yao L, Wei T, et al. Presumed asymptomatic carrier transmission of COVID-19. JAMA 2020 February 21 (Epub ahead of print).
3. Li R, Pei S, Chen B, et al. Substantial undocumented infection facilitates the rapid dissemination of novel coronavirus (SARS-CoV2). Science 2020 March 16 (Epub ahead of print).
4. Hoehl S, Rabenau H, Berger A, et al. Evidence of SARS-CoV-2 infection in returning travelers from Wuhan, China. N Engl J Med 2020;382:1278-80.
5. Ng O-T, Marimuthu K, Chia P-Y, et al. SARS-CoV-2 infection among travelers returning from Wuhan, China. N Engl J Med. DOI: 10.1056/NEJMc2003100.

DOI: 10.1056/NEJMp2006372

Search
No Results

Search
No Results

Medscape

Thursday, April 2, 2020
News & Perspective Drugs & Diseases CME & Education Academy Video

Perspective > Medscape Infectious Diseases

COMMENTARY

'Stealth Transmission' of COVID-19 Demands Widespread Mask Usage

Eldad Einav, MD

DISCLOSURES | March 29, 2020

1€

ADD TO EMAIL ALERTS

ews and guidance in Medscape's Coronavirus Resource Center.

Last Saturday, my local hospital reached a sad milestone: We had our first COVID-19 death.

I am a staff cardiologist at the hospital in Binghamton, New York, and like hospitals everywhere, we have been anticipating a surge in patients. Personal protective equipment (PPE) is in short supply and is being rationed. We are encouraged to reuse disposable equipment multiple times, and access to surgical masks is limited.

The epidemic is overwhelming the healthcare system, and clinicians are essential regardless of specialty. As I considered my own high risk for exposure, I reviewed existing protective measures that could keep me from contracting the virus and further transmitting it to my coworkers, family, and especially to my elderly father who resides with me.

I was concerned to see that most healthcare workers (HCWs) and patients are still roaming the hospital floors and the emergency department without wearing masks. Hospitals are citing guidelines from the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) restricting mask use mostly to close encounters with symptomatic individuals or confirmed cases with COVID-19.

I decided to research the evidence and justification behind official prevention guidelines. My findings were rather striking.

It is widely agreed that face masks (even surgical masks and non-fit-tested respirators) are an effective barrier against COVID-19, as its primary mode of transmission is through respiratory droplets. Contrary to common belief, however, respiratory droplets are released not only when sneezing or coughing, but also when talking.

Still, the CDC strongly discourages mask use in the community or by healthcare workers when not directly exposed to a symptomatic individual. The message from authorities is clear: Among asymptomatic individuals, masks are *not* effective against the spread of COVID-19. In fact, facing a nationwide shortage of masks, the surgeon general tweeted, "STOP BUYING MASKS!"

To be clear, mask use is one of the most effective physical interventions to prevent the spread of respiratory viruses. A comprehensive Cochrane review examined multiple physical preventive measures (eg, screening at entry ports, isolation, quarantine, social distancing, barriers, personal protection, hand hygiene) and found that masks were the most consistent and comprehensive measure.

So why not recommend universal usage, for HCWs and the community alike?

The main reason given by authorities is that there is no evidence showing that it is effective in the community. However, "there is an essential distinction between absence of evidence and evidence of absence," write Hong Kong scholars in a comment in *The Lancet* . The paucity of data regarding widespread mask use does not mean that masks are not effective.

169 Read Comments

Next

Cite this: Eldad Einav. 'Stealth Transmission' of COVID-19 Demands Widespread Mask Usage - Medscape - Mar 29, 2020.

What to Read Next on Medscape

BUSINESS OF MEDICINE

Coronavirus Social: Patient Questions, Daily Dispatch, Infographics

WITNESSES:

ANDREWS, SARAH, Director, Professionals Australia (SA Branch)

ROWNEY, KIMBERLEY, Senior Organiser, Professionals Australia (SA Branch)

473 The CHAIRPERSON: Welcome to the meeting. The Legislative Council has given the authority for this committee to hold public meetings. However, due to the current situation concerning the COVID-19 pandemic, the committee has resolved to exclude strangers from the gallery. A transcript of your evidence today will be forwarded to you for your examination for any clerical corrections. The uncorrected transcript of your evidence today will be published immediately upon receipt from Hansard, but the corrected transcript, once received from you, will replace the uncorrected transcript.

I advise that your evidence today is being broadcast via the Parliament of South Australia website. Should you wish at any time to present confidential evidence to the committee, please indicate and the committee will consider your request. Parliamentary privilege is accorded to all evidence presented to a select committee; however, witnesses should be aware that privilege does not extend to statements made outside this meeting. All persons, including members of the media, are reminded that the same rules apply as in the reporting of parliament.

We would like to acknowledge that the land we meet on today is the traditional lands for the Kaurna people and that we respect their spiritual relationship with their country. We also acknowledge the Kaurna people as the traditional custodians of the Adelaide region and that their cultural and heritage beliefs are still as important to the living Kaurna people today.

My name is Tammy Franks, and I am the Chair of this COVID-19 Response Committee, a select committee of the upper house. To my right are the Hon. Nicola Centofanti and the Hon. Connie Bonaros. To my left are the Hon. Kyam Maher and the Hon. Emily Bourke. If you have an opening statement and you would like to deliver that now, please introduce yourselves and present that opening statement and then we will launch into questions.

Ms ANDREWS: I am Sarah Andrews, Director, Professionals Australia.

Ms ROWNEY: I am Kimberley Rowney, Senior Organiser, Professionals Australia.

Ms ANDREWS: Thanks for the opportunity to present today. I do have just some short opening remarks which go to some of the work that medical scientists and technical officers have done in SA Pathology through the pandemic.

When the outbreak of coronavirus first occurred, it was difficult to get testing kits because of the high demand globally. The virology division in SA Pathology was able to design and get a validated method up and running within two weeks, while kits were sold out worldwide and unavailable. This in-house testing was available one week before the British National Health System, with their large pool of laboratory experts, were able to have their own in-house test up and running.

The alternative to developing our own testing regime would have been to physically send people's respiratory samples interstate for testing, which obviously significantly delays results and places the patient and community at risk in the interim. The skills and knowledge base to do this in-house work can't be undervalued. Yet, it is precisely this capability and capacity that will be undermined if staff cuts go ahead in SA Pathology, which are forecast to begin any day now.

It's also worth noting that if an outbreak had occurred during the flu season it would have been potentially a very different picture because of the strain on the resources within the organisation. It's likely we would have been stretched beyond breaking point and the community would have had a very different experience during this pandemic, because it is not just about being resourced to scrape by and business as usual, it is about having surge capacity.

It's not just coronavirus, there are other less publicised examples of outbreaks that have been tested at Flinders Medical Centre, and significant salmonella outbreaks in the past. But coronavirus is in fact a perfect example of how critically important medical scientists and technical officers are for detecting disease and defending the community.

I think it's worth noting, too, that whilst it looks like we took it all in our stride in SA Pathology and just increased our workloads, it is true that the scientists, in conjunction with clinicians, also had to make decisions about what work was a priority and what wasn't. Obviously, testing for COVID-19 was, but that meant that testing for things like salmonella was put further down the list and that's really because it is a lower priority. It can't be transmitted person to person and often will resolve itself. But it does mean that there were testing delays in other areas of the organisation.

I think we would have heard through the media that one of the real success stories of SA Pathology has been the high amount of testing that has been occurring and that has absolutely been critical to flattening the curve. It is true, though, that there is increased complexity in handling the specimens: more time, more care, more PPEs required. We are now going to see, though, that there will be an increase in workload coming into the flu season and people are now feeling more confident to visit their GPs again.

Whilst in some areas of SA Pathology the workload was down at the height of the pandemic so far, they came in and helped backup in the virology division, so they were sent elsewhere to help support those teams. With people returning to their GPs to have other tests, that may not be possible in the future. We also did have very good information early on about what was happening in the community and were able to identify hotspots.

SA Pathology did have a good opportunity to track and trace and isolate people to prevent the virus from spreading widely. I think it's well known, too, the initiative of the drive-through testing clinics. That made it very accessible for members of the community to have tests. It's also true that early on SA Pathology tested more broadly than many other jurisdictions. People who presented with a respiratory illness were automatically tested for COVID-19. This wasn't something that happened elsewhere.

It is the high number of testing that really made a significant difference and we were able to do that because we had a very cost-effective testing regime. We know, for instance, in the United States that tests are hard to come by and they are very expensive and so people are making choices about who gets tested. I don't know how you make those choices. We don't have those difficult decisions to make because the testing kits were created in-house and so that's saved the government a lot of money.

474 The CHAIRPERSON: In terms of the accuracy of the tests, have we got some understanding of what level of accuracy the tests that we have been using to date have?

Ms ROWNEY: We have had no reports to the union from workers that the tests are inaccurate. One of the reasons is because the testing has been designed and led by very experienced scientists and clinicians. I want to note that one of the criticisms that has come out of the UK with the NHS is that, because they got rid of senior scientists and they centralised, it has really impacted the accuracy and the amount of testing they can undertake.

Because here in South Australia workers have fought to keep scientists, particularly senior scientists, in their positions, we have been able to develop accurate tests and respond to the demands of the community.

475 The CHAIRPERSON: In terms of the serology tests—from my understanding, looking for antibodies—currently that is, under a direction I think it is, banned for everyone else bar SA Pathology. Is there work being done in SA Pathology, to your understanding, to develop testing for antibodies?

Ms ROWNEY: That's not a question I can answer, I am afraid.

Ms ANDREWS: I don't know.

Ms ROWNEY: I should say, just on that, we have not had many meetings with SA Pathology willing to engage with the union, so information from the employer has been very difficult. That is certainly a question that we would plan to put to the employer, if indeed we could meet with them.

476 The CHAIRPERSON: In terms of your ability to represent your members to advocate where there are concerns and issues, you have noted the lack of meetings with the direct

management, how has the access been to members of both government and also, given we are in a public health emergency, to those who are the State Controller and the State Coordinator?

Ms ANDREWS: I can speak with regard to the Executive Director of SA Pathology and other directors within SA Health that have responsibility for SA Pathology. We would normally meet regularly with them and they cancelled all of those meetings because life was too urgent. We thought that that was a very good reason to maintain the meetings. So we were left with scrambling, requesting meetings that took weeks and weeks to organise when normally they would be automatically in our diaries.

We were emailing the executive director asking a whole range of questions on behalf of members, really critical issues with regard to access to PPE, for instance, or what their planning was for staffing if they suddenly had a reduction in workload because people had to self-isolate. They were reluctant to respond to us. We had to send correspondence multiple times and eventually an HR officer would get back to us with a response of sorts.

Ms ROWNEY: We still have questions outstanding from I believe three weeks ago, though it could be four, regarding PPE, working from home arrangements, social distancing, availability of car parking and whatnot for scientists and technical officers. They have not responded to those questions. We have followed up those questions. They have, however, scheduled for the end of next week the next meeting to deal with the government's cuts to pathology. So whether or not we will get the answers to those questions then I don't know, but they're certainly prepared to talk to us about the next phase of cuts.

477 The Hon. K.J. MAHER: Have Professionals Australia heard anything about recommencement of voluntary separation packages in SA Health?

Ms ANDREWS: We haven't formally heard. We do know, with regard to the budget cuts, that it is the intention of the executive director to meet those by cutting staff.

478 The Hon. K.J. MAHER: If the plan that the government embarked on to privatise SA Pathology had have happened, how do you think that would have left us in terms of our response to the current pandemic?

Ms ANDREWS: I think it would have been a quite different scenario. We know that privatisation means that organisations are seeking for a profit first and foremost, so they run with a business as usual premise. They don't staff with any capacity for surge work that comes through, which we have seen with the pandemic. But also it comes to having the right equipment and testing kits available. In South Australia, the private pathology providers don't have the skills and experience that the state does with regard to the medical scientist workforce. So they don't have the kind of capacity that SA Pathology has. It would have been a very different picture.

479 The Hon. K.J. MAHER: A much weaker response, given what you've said?

Ms ANDREWS: We wouldn't have had the testing regime. It would have been really devastating for our community.

Ms ROWNEY: We know, in relation to VSPs, whilst the government has not been open and honest about their plans, if we were to look to places like the UK, where they have had the NHS and austerity measures for the last few years, where senior scientists have left and not been replaced, that's what happens with VSPs—because it is the senior scientists who have worked for a long time who will most likely be prepared to retire. There has been strong feedback coming back from the UK under the NHS that, because of the loss of senior scientists and the reduction in staff and the centralisation of laboratories, it has had a dramatic and detrimental impact on the NHS's response to COVID-19.

480 The Hon. K.J. MAHER: I think it is just over $50 million over the next two years that the budget says SA Pathology is required to meet its savings targets. Could that be done without damaging our ability to respond to a crisis like this?

Ms ANDREWS: No.

481 The Hon. K.J. MAHER: What sorts of services might be cut if a savings target in the order of $50 million over two years was budgeted?

Ms ROWNEY: I think the question is: what wouldn't be cut? The government has remained committed to its $35 million saving for 2021-22 and $45 million the year after. We can't see how you can run a service and gut it. SA Pathology is a public health provider. You can't cut one section and not think it's going to affect the health care overall. The reality is, to make those kinds of budgetary savings, it's slash and burn across the entire service.

482 The Hon. K.J. MAHER: In terms of the SA Pathology staff in general, how manageable has the workload been on the staff, particularly the scientists in the system, at the moment?

Ms ANDREWS: Certainly, the scientists in the virology lab had massive workloads, particularly early on, so they have been incredibly busy. It is also such a highly specialised workforce that you can't really call in others to just come in and help. They can come in and do some work around the edges, but they actually can't do the main work, so you've got a group of people that just can't be replaced. They had to be incredibly careful to make sure that those workers remained safe during the crises because if we lost them that would have been highly problematic for the organisation and obviously for the community.

We did see a 30 per cent reduction in testing in other areas of the organisation, so workload did drop for a period of time, and that's purely, as we understand it, because people stopped going to their GPs for testing. Probably, quite frankly, they should have still been going for testing if they were worried that they might have cancer because obviously you need to bring treatment in really quickly. I think there is an education piece that needs to go on there to encourage the community to keep up with their health visits.

Ms ROWNEY: Certainly, we know that work is ramping up in SA Pathology now that things, like in the public health care system, outpatient clinics, are starting to resume. You are seeing the resumption of elective surgery. That has an increase across pathology services, particularly for elective surgery going in for pretesting and then following the surgery, the testing that comes out of that. There's certainly been a ramp-up in the service despite us doing heavy loads of testing for COVID.

483 The Hon. K.J. MAHER: What supports have been put in place to support staff during this time?

Ms ROWNEY: In terms of wellbeing?

484 The Hon. K.J. MAHER: SA Pathology specifically but for your members in general. The Hon. Connie Bonaros asked a question last time about SASMOA members, their mental health. What has the government done to support and help?

Ms ANDREWS: I'm not aware of any additional support that has been provided. There has certainly been no communication to our members with regard to anything more that they might be able to do. What is highly concerning is that currently we are in negotiations for the next enterprise agreement with the government.

One of the things the government is seeking to cut—and we discussed this in negotiations only yesterday—is workers' access to mental health training. It was an initiative that was brought in with the current enterprise agreement, so it's only been running for a few years, so it still doesn't have the reach that it really needs to get across the public sector. There are still a lot of people who are seeking to access this training. One of the cuts the government is currently wishing to make is mental health training for public sector workers.

485 The CHAIRPERSON: Is that mental health first aid?

Ms ANDREWS: Yes.

Ms ROWNEY: The reason for that is they say that all those who want to have the training have already had it, which is an interesting thing to say because when we surveyed our members no member can tell us anything about the training. I said to large groups of them, 'Have you done your mental health first aid training?' They said, 'What's mental health first aid training?' So how can you be aware of training and apparently have had it if you don't even know what it is.

We know our members are extremely stressed. They are extremely concerned about their wellbeing. They are very concerned about their colleagues' wellbeing, particularly doctors and

nurses with the reports coming out from overseas. Our members are under an enormous amount of pressure, and for a very long period of time they have felt the need to deliver and not ask questions because of the threat of privatisation and the threat of job cuts.

We hear from senior scientists now, 'Yes, privatisation is off the table, but if I speak up am I going to be one of the people who is tapped on the shoulder and my job is going to go? What sort of consequence is that not just for me but for the colleagues I am responsible for training, teaching and leading?' That is what is having a detrimental impact. There are also things like access to PPE. Basic questions that have not been answered are having a detrimental impact on their wellbeing.

486 The CHAIRPERSON: Did you get a vending machine?

Ms ROWNEY: Sadly not.

487 The Hon. K.J. MAHER: Are your members reporting shortages of PPE or have they been reporting shortages?

Ms ANDREWS: Yes, they have, and they have been asked to do fairly controversial things. They have been specifically requested to re-use single-use masks. That is a scary example of the kinds of things that happen when there is a lack of access to the PPE you need to do your job. It's worth noting, too, that labs are not designed with much space, so they can't social distance in many labs and so they need the PPE—they can't stay clear of each other. We do hope that, in the event that the women's and kids' hospital does get built, these kinds of scenarios are contemplated in the future so that there is enough space for people in lunchrooms and there are enough lockers, just the really basic things that we take for granted.

488 The Hon. K.J. MAHER: Do you have any other examples of the difficulties with the shortage of PPE, like being asked to re-use single-use masks? Are there any other things you can point to?

Mr ROWNEY: There is an email from Dr Tom Dodd, the Clinical Services Director, to all staff advising that, if you cannot socially distance, you are required to wear a mask. In a laboratory, you can't socially distance. We have images of masks in paper bags on lab coat hooks with two or three other lab coats because there aren't enough hooks for staff to re-use.

For those who aren't aware, every time you touch your mask the integrity of the protection breaks down, so when you are told to not just re-use it for that shift but that you have to take it off every time you take a sip of water or leave the laboratory—and in these laboratories you can't have access to water, food or drink for obvious reasons—these people are taking it off three, four or five times. They are having to remove it, put it in a paper bag, which then becomes soiled, go off and have their break and then return, put that mask back on and then, in some instances, do that the next day.

When staff were asking questions about that, they weren't getting answers and were workshopping things to do: 'If I microwave it, will that make it safe? If I spray it with hand sanitiser or put some hand sanitiser on a tissue and blot it, does that make it safe?' This is a question we put to Julie Hartley-Jones, the Executive Director of Statewide Services. It's worth nothing that Julie Hartley-Jones was a nurse in ICU. She's an extremely experienced nurse in ICU who knows about PPE but cannot answer simple questions about access to PPE and re-using it.

Sarah is right: the hospitals are not set up for social distancing. They are set up for communal working. Our members don't have individual lockers. It's simple things, like if you wear your shoes in a laboratory you have to take them home because you cannot leave them in your locker. It's really basic things that don't happen that affect our members' health care and make them very stressed and their families.

489 The Hon. K.J. MAHER: This is my final question. As we know, we saw dramatic cuts to elective surgery that are starting to be eased. Was there any government requirement to limit any SA Pathology testing for anything else while there was so much work to be done with COVID-19?

Ms ANDREWS: Not that I am aware of.

Ms ROWNEY: Not that we are aware of, no.

490 The Hon. C. BONAROS: I have a couple of questions, thank you. The Premier has come out on absolutely every occasion made available to him and praised SA Pathology in terms of the world-class response that we have had here. It has been the envy of other jurisdictions. It has been the envy of the world. We have heard a lot about the pandemic planning, the stockpiling, the reagent.

My first question is: is it possible, for the purposes of this committee, to provide us with an overview of that pandemic planning, one that we are not getting from the media but one that is coming from you, in terms of precisely what that entailed? How much work went into that pandemic planning over the last 10 years to ensure that we were in a position to be able to deal with a crisis like this? We can take that on notice if there is something we can provide to the committee. I think that would be useful for us.

Ms ROWNEY: We have asked for that plan. It has not been shared with us. What we can come to you with, though, is we can explain how scientists and technical officers stockpiled equipment of their own initiative.

491 The Hon. C. BONAROS: That would be very useful.

Ms ROWNEY: We can come back to you with that.

492 The Hon. C. BONAROS: Secondly, again, in relation to the praise that we have heard from the Premier and the Minister for Health and Wellbeing in relation to the role that SA Pathology has played, and the subsequent announcement that there was not going to be any privatisation, do you think that in fact the reality is that we have relied on SA Pathology, we have relied on doctors, we have relied on nurses, we have relied on clinicians, rather than relying on any sort of strategic plan of the government to carry us through this crisis? Do you think there was any overall planning for a pandemic in terms of government policy or have we just been relying on all those experts and their expertise in effectively getting us to where we are today?

Ms ANDREWS: My discussions with members is that it's the work of senior medical scientists in conjunction with clinicians and technical officers that has really guided us through. It's their understanding of what will happen if a pandemic occurs and what steps they need to put in place. I am not aware of any plan or directive by government which kicks in if something is about to occur.

493 The Hon. C. BONAROS: Other than, 'We are going to declare an emergency and then we are going to look at you guys for how that is going to be handled effectively.' My final question is this: SASMOA has just presented evidence, and one of the questions I put to them was about the level of disparity and disrespect towards their own members and clinicians and doctors in terms of having them involved in our SA Health planning.

They talked about a very bad record of successive governments in keeping their doctors at the front foot of the decision-making process. Their concern is that, despite everything we have learned from COVID, we are slipping back into old habits. Is that a fair analysis? Are you concerned about the same, especially in light of the fact that we still have cuts on the table? Are you concerned that—and we are not out of the woods yet—we are saying it's going back to business as usual, effectively?

Ms ANDREWS: I have no reason to think otherwise, unfortunately. Certainly, in the middle of March, we knew that SA Pathology were making plans for workarounds in the event that they did have significant drops in their workforce. They have blatantly refused to share those with us, which is effectively our members, which is effectively the workforce. They have not shared any of their plans with the workforce about how things are going to play out. It is also concerning that the government is currently trying to weaken consultation clauses in the negotiations for our enterprise bargaining at the moment, so we see a future that is going to play out very poorly for workers, if things like that go ahead, given the difficult state we are currently in already.

494 The Hon. C. BONAROS: And not just for workers, though, in terms of their negotiations, but the risk to the public in terms of the outstanding service that we have received.

Ms ROWNEY: I can think of countless times when, because workers have spoken up, there have been positive outcomes for patients or disastrous outcomes have been prevented. One of the great challenges for the membership that Professionals Australia represents, whether it's

medical scientists and technical officers in SA Pathology or whether it's diagnostic medical physicists in SAMI who are responsible for radiation safety, is we are constantly having to say, 'Have you spoken to SA Pathology? Have you spoken to SAMI? What does this mean for those workers?', because they are forgotten.

They are forgotten, for example, in LHNs when something happens at a hospital and they don't tell the SA Pathology workers who were there, like an incident with the staff. They forget when they are planning to expand an ED that, maybe if we are expanding the ED because we are going to have more patients, we need to ensure we have diagnostic services like SA Pathology staffed appropriately to meet the demands of that service. Lyell McEwin is a really good example of where that challenge remains.

495 The Hon. C. BONAROS: What about the easing of restrictions? Are those discussions taking place?

Ms ROWNEY: I am not aware of any discussions.

496 The Hon. C. BONAROS: So in terms of planning and knowing that we are at this phase now but we need to be vigilant and so forth but we are also working on easing restrictions, do you think it's suitable that those discussions be taking place with SA Pathology and doctors and clinicians so that we are all on the same page?

Ms ROWNEY: Absolutely. Surely you want medical experts in the decision-making process when we are talking about a pandemic.

497 The CHAIRPERSON: I understand that SASMOA raised quite early on their concerns about their members and workers compensation and presumptive COVID recognition under the workers compensation act. Have you raised similar issues on behalf of your members?

Ms ANDREWS: No, we were happy for them to take the lead on that.

498 The CHAIRPERSON: On that note, unless there are any further questions—

499 The Hon. C. BONAROS: Just in terms of the evidence that you gave about social distancing and so forth for vulnerable, high-risk workers in SA Pathology, do you think the response to their needs in terms of leave or not being able to work were appropriately addressed?

Ms ANDREWS: It has been particularly difficult. It's been like right down to the wire when we have been asking if people can work different shifts. It has been very difficult to get answers and to get acceptance that workarounds need to occur. Even when we present solutions, to get human resources to come on board without a fight has been difficult.

Ms ROWNEY: On that, when we have raised concerns, and I can think of some instances, and I won't speak to the specifics because it identifies the workers, where they have wanted to work in a certain way because there is a risk to others. We have gone to HR and executive with questions, and HR and executive said, 'We're not going to talk to the union about it, but we're dealing with the worker individually. We're not going to engage the union because it's not really your business. We will deal with the worker individually.'

It's worth noting, though, that the workforce in SA Pathology is fairly thin. If you have large groups of workers who can no longer work because they are vulnerable, maybe because, for example, they are aged over 60, all of a sudden you lose a really large section of your workforce. Also, SA Pathology is 73 per cent women. It is 86 per cent women in the laboratory. That means there are high numbers of pregnancies. How do you account for pregnant workers not being able to go to work?

500 The CHAIRPERSON: Thank you. I had just one question on notice. You mentioned Dr Tom Dodd's email with regard to the use of PPE, but you also noted that you had some photos of masks placed into paper bags. Any correspondence or documented evidence of workers being asked to reuse their PPE, if I could put that on notice to you as a question to bring back for the committee.

Thank you again for your evidence today and your ongoing work with your membership. As you know, the transcript will be forwarded to you for clerical corrections, but it will also go up uncorrected today.

Ms ROWNEY: Thank you.

Ms ANDREWS: Thank you.

THE WITNESSES WITHDREW

Archived: Tuesday, 23 June 2020 11:10:04 AM
From:
Sent: Friday, 12 June 2020 11:42:01 AM
To: COVID-19 Response Committee
Subject: Response to QON - COVID-19 committee
Sensitivity: Normal
Attachments:
IMG_2424.jpeg ;COVID-19 Guidelines (002).pdf ;

Good morning Leslie and Antony,

Please find attached the photograph and communication that Professionals Australia committed to providing when we have evidence. I was referring to the bottom of page 2 in my evidence.

Regards,

Kimberley Rowney
Senior Organiser, South Australia

Professionals Australia

1/69-79 Gilbert St Adelaide 5000
W: www.professionalsaustralia.org.au


KATHARINE

COVID-19 GUIDELINES

Laboratory Safety Precautions for COVID-19 Pandemic

SA Pathology's primary responsibility is the safety of our staff. Secondly, SA Pathology must maintain a workforce to perform the critical diagnostic testing, including detection of SARS-CoV-2, that our patients and the SA population require during the COVID-19 pandemic.

The aims of the precautions listed below are to minimise the risk of SARS-CoV-2 infection in staff at SA Pathology while allowing the organisation to maintain diagnostic capacity. Additional advice is provided for at-risk workers (e.g. chronic respiratory conditions; immunocompromised or > 70 yo).

The initiatives are categorised under: general workplace precautions: PC2 laboratory-specific interventions, and special measures for high-risk/mission-critical areas. These initiatives have been discussed with infectious diseases physicians, public health authorities and the Public Health Laboratory Network (PHLN). The initiatives are based on expert opinion from PHLN, and on local, national and international guidelines referenced at the end of the document.

General guidelines for a workplace

SA Pathology is firstly a workplace. All areas including laboratories must follow Commonwealth and WHO guidelines for being "workplace-ready" for COVID-19.[1-3] These guidelines include:

- working from home where feasible
- when working from home is not feasible
- promoting hand hygiene and cough/sneezing etiquette
- implementation of social distancing (>1.5 m between people with > 4 m^2 per person)
- minimising face-to-face meetings
- frequent cleaning and disinfection of high-touch surfaces
- avoidance of public transport to and from work

PC2 laboratory guidelines

The COVID-19 guidelines from PHLN that are now embedded in the COVID-19 SoNG (series of national guidelines) published by the Communicable Diseases Network Australia (CDNA),[4] continue to recommend standard PC2 procedures for non-microbial pathology testing (such as routine biochemistry and haematology). Auto-analysers should be used according to standard practices. The guidelines suggest that capping and uncapping of samples is not a high-risk aerosol generating procedure. Use of standard personal protective equipment (PPE) and PC2 practices are as important as always, with particular importance attached to hand hygiene and the cleaning and disinfection of high-touch surfaces.

Personal protection measures and equipment

- hand hygiene
- surface disinfection
- gowns
- gloves
- eye protection
- masks

Additional precautions (e.g. processing specimens in class II biosafety cabinets-BSCs) are in place for certain higher-risk samples and procedures.

Standard protocols should be used for sample packaging. Diagnostic samples for testing should continue to be shipped as standard "Category B".

Staff are again reminded of the increased importance of routine vaccinations this season:

- influenza vaccination
- pneumococcal vaccination if indicated[5]

Prevention and Management of Spills

Each laboratory area must:

- check the contents of their spill kit and the procedures for managing a spill;
- review their work processes to minimise the risk of spills (e.g. transport specimens between locations in secondary containers); and
- refresh staff on the procedures for management of a spill.

SARS-CoV-2 is an enveloped virus and is therefore susceptible to most disinfectants. For the routine cleaning of benches, 70% ethanol or 1.25% w/v bleach with a contact time of 10 minutes are suitable disinfectants. For cleaning proteinaceous spills (e.g. sputum), a stronger concentration of bleach (3% w/v) is required. Bleach/sodium hypochlorite solutions must be prepared daily.

Detailed information on disinfectants and on the management of spills is provided in PRC-EXE-157, PRC-EXE-169 and TRD-0617 on Q-Pulse, and in the attached references 6-9.

Formation of Teams

Where practicable, all laboratory areas are strongly encouraged to form teams separated in time or place, either at different locations or on different shifts. These teams must not intermingle at breaks or between shifts.

By forming teams that do not intermingle, the human exposure of each staff member is reduced, thereby reducing each individual's risk of SARS-CoV-2 infection. This intervention is also a business continuity strategy ensuring that a single SARS-CoV-2 positive staff member does not place an entire laboratory section into quarantine.

Minimising the risk of & responding to a SARS-CoV-2 positive worker in higher-risk critical areas

The following additional risk-based precautions are recommended for areas:

- that are "mission critical", or
- where laboratory layout does not permit effective social distancing (i.e. staff members (<1.5 m apart with < 4 m^2 per person spend > 2 hours together cumulatively within a 24-hour period/shift)
- Senior Directorate staff must determine the above areas in their sections. Specimen reception areas, automated laboratories and the Virology section are examples of mission-critical areas in a COVID-19 pandemic.
- All areas in SA Pathology will introduce these additional precautions when the local community transmission of SARS-CoV-2 accounts for >10% of cases (i.e. there is no known contact or international/ overseas travel for >10% of COVID-19 cases)[10]

In higher-risk & mission-critical areas, the following additional measures (figure 1) will be employed:

- all laboratory staff in these areas will have symptom and temperature checks recorded using a tympanic thermometer at the start and end of their shifts; a staff member with a temperature > 38.0ºC will be referred immediately for medical assessment and SARS-CoV-2 testing.
- all laboratory staff in these areas will pre-emptively wear a surgical mask while at work to reduce transmission from an unrecognised (pre/early)-symptomatic case in the laboratory
- a single surgical facemask will be worn throughout a shift, removed & stored in a paper bag during breaks, to be re-donned prior to re-commencing work
- staff will practice social distancing during breaks
- facemasks must be worn correctly, removed properly, disposed of safely and used in combination with good universal hygiene behaviour in order for them to be effective (figure 2)[11]

- facemasks should be donned and doffed according to the Biosafety Manual procedure (PRC-EXE-369), with particular attention to hand hygiene before applying and after removing the mask.
- See additional PPE measures and donning and doffing sequence for various pathology laboratory situations (figure 3)
- Masks should be worn in non-laboratory areas (e.g. blue space) where recommended physical distancing recommendations cannot feasibly be met.

Management of SARS-CoV-2 positive workers and contacts

- all laboratory contacts of a SARS-CoV-2 positive co-worker will be classified as "casual" contacts not requiring home quarantine if they have been:
  - following the surgical mask protocol, or
  - have been > 1.5 m from the index case with > 4 m2 per person & have spent < 2 hours cumulatively within a room with the case within a 24 hour period while the case was symptomatic.
- if necessary, a Medical Officer from the MID Directorate will assist the Communicable Diseases Control Branch (CDCB) with the classification of the fellow workers of the SARS-CoV-2positive case as "casual" or "close". This decision will be based on various factors including the work environment, duration of exposure and the case's symptoms.
- the laboratory area where the SARS-CoV-2 positive worker predominantly worked while symptomatic (or in the previous 24 hours) would undergo terminal cleaning as described in reference 9. Spotless and other hospital cleaners are familiar with these routine procedures used for the rooms or theatres of patients under infection control precautions.
- if the SARS-CoV-2 positive worker's colleagues had not been following the above surgical mask-protocol, they will commence wearing surgical masks at work for 14 days according to the above regime
- immediate urgent SARS-CoV-2 testing should be performed at the earliest symptom onset on any laboratory contact of the index case

Rationale for surgical masks

Wearing of a surgical mask is not primarily intended to protect the wearer. Rather, the mask reduces the spread of the wearer's respiratory secretions and hence their infectiousness to co-workers. The wearing of a surgical mask therefore aims to reduce "close contacts" of a newly-diagnosed SARS-CoV-2 positive co-worker into "casual contacts".[12] The routine wearing of surgical masks is gaining increasing support in the medical literature as an intervention during the COVID-19 pandemic.[13] These casual contacts do not need to be quarantined for 14 days and can continue working. They must however seek medical attention and SARS-CoV-2 testing at the earliest onset of any symptoms (as described below).

Symptomatic laboratory staff must immediately seek medical attention and testing

Laboratory personnel are critical contributors to the state's healthcare system. As such, they must comply with state and national guidelines for healthcare workers (HCWs).[12] They must follow quarantine requirements after interstate and overseas travel unless an exemption is obtained.

As the pandemic evolves, acquisition of SARS-CoV-2 infection will become more likely outside the laboratory. Staff members exposed to a SARS-CoV-2 positive case outside of the laboratory will be managed according to community protocols as "casual" or "close" contacts as advised by the Communicable Diseases Control Branch (CDCB).

Laboratory staff should not attend work if they have been in close contact with a confirmed, probable or suspect case of COVID-19 (either in the community or at work) within the past 14 days when not protected with appropriate personal protective equipment (PPE).

Staff with any signs of respiratory tract infection must seek prompt medical attention and SARS-Cov-2/ respiratory viral PCR (RVP) testing. Early recognition and quarantining of infected staff will be an important infection control measure in maintaining a workforce and diagnostic testing capacity during the COVID-19 pandemic.[12]

A standardised request form for SARS-Cov-2 testing of laboratory workers has been prepared and is available through SA Pathology Clinical Directors and Genevieve Sturman (for the Automated Laboratories).

Staff may present to a COVID clinic or a drive-through service where HCWs are being prioritised for specimen collection. Details about specimen collection alternatives are available on the SA Pathology intranet.

The staff member is to remain in self-isolation pending the SARS-CoV-2 test result.

If SARS-CoV-2 positive, the laboratory worker must inform their supervisor and self-isolate. Ongoing medical supervision of a positive worker will be arranged by CDCB and State Command, and may involve the worker's general practitioner or a Hospital-in-the Home team.

The SARS-CoV-2positive worker can return to work when the following criteria are met:

- the person has been afebrile for the previous 48 hours
- resolution of the acute illness for the previous 24 hours
- be at least 7 days after the onset of the acute illness
- PCR negative on at least two consecutive respiratory specimens collected 24 hours apart after the acute illness has resolved – this will be reviewed as the pandemic evolves in Australia (see reference 6 as of 2/4/20)

Interventions at SA Pathology for at-risk staff members

SA Pathology will follow state and national guidelines, and will recognise staff members at increased risk during the COVID-19 pandemic as:[14]

- those with chronic respiratory conditions
- immunosuppression
- > 70 yo
- > 65 yo with chronic medical conditions
- Aboriginal and Torres Strait Islander people > 50 yo

Where possible, these staff should work from home. If that is not possible, the following measures should be offered:

- paid car-parking to avoid public transport
- re-location to Frome Road or another lower-acuity work site
- work duties that have been risk-assessed and that are agreeable to the worker, their supervisor, their treating doctor and consistent with Human Resources principles. These duties and the above agreements must be documented
- if possible, at-risk staff should not work in higher-risk/mission-critical areas; if they do and are exposed to a SARS-CoV-2 positive co-worker, they are to remain at home for 14 days with regular medical supervision. Interval SARS-CoV-2 tests will be made available as recommended by the treating doctor.
- Any laboratory worker with concerns relating to their personal situation (e.g. health status) should discuss those concerns with their personal medical practitioner, line manager or Worker Health

There is no evidence currently that pregnant women suffer more severe COVID-19 disease nor is there evidence of miscarriage, teratogenicity or vertical transmission of SARS-CoOV-2 infection.[15] Nonetheless, for "an abundance of care", pregnant staff members should negotiate risk-assessed duties (with the appropriate PPE) agreeable to themselves, their supervisor and their obstetrician.

References

1. https://www.health.gov.au/sites/default/files/documents/2020/03/coronavirus-covid-19-information-on-social-distancing_2.pdf
2. https://www.health.gov.au/sites/default/files/documents/2020/03/coronavirus-covid-19-environmental-cleaning-and-disinfection-principles-for-health-and-residential-care-facilities.pdf
3. https://www.who.int/docs/default-source/coronaviruse/getting-workplace-ready-for-covid-19.pdf
4. https://www1.health.gov.au/internet/main/publishing.nsf/Content/7A8654A8CB144F5FCA2584F8001F91E2/$File/interim-COVID-19-SoNG-v2.4.pdf
5. https://immunisationhandbook.health.gov.au/vaccine-preventable-diseases/pneumococcal-disease
6. https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/resources/novel+coronavirus+environmental+management+fact+sheet
7. https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/resources/covid-19+information+on+waste+management
8. https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/resources/guide+to+dilution+for+chlorine+based+disinfectant+solutions?contentIDR=ecd1b900411006a68755cf8f6fad9ea1&useDefaultText=0&useDefaultDesc=1
9. https://www.health.gov.au/sites/default/files/documents/2020/03/environmental-cleaning-and-disinfection-principles-for-covid-19.pdf
10. https://www.covid19data.com.au/transmission-sources
11. https://www.health.gov.au/sites/default/files/documents/2020/02/coronavirus-covid-19-information-about-the-use-of-personal-protective-equipment-ppe-during-clinical-care.pdf
12. https://www.health.gov.au/sites/default/files/documents/2020/03/coronavirus-covid-19-information-on-work-attendance-and-testing-for-health-and-residential-aged-care-workers_0.pdf
13. Klompas M, et al. Universal masking in hospitals in the Covid-19 Era. N Engl J Med April 1, 2020 DOI: 10.1056/NEJMp2006372
14. https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/advice-for-people-at-risk-of-coronavirus-covid-19/coronavirus-covid-19-advice-for-older-people
15. https://ranzcog.edu.au/news/covid-19-and-pregnant-health-care-workers

Figure 1 - Mission-critical/higher-risk areas

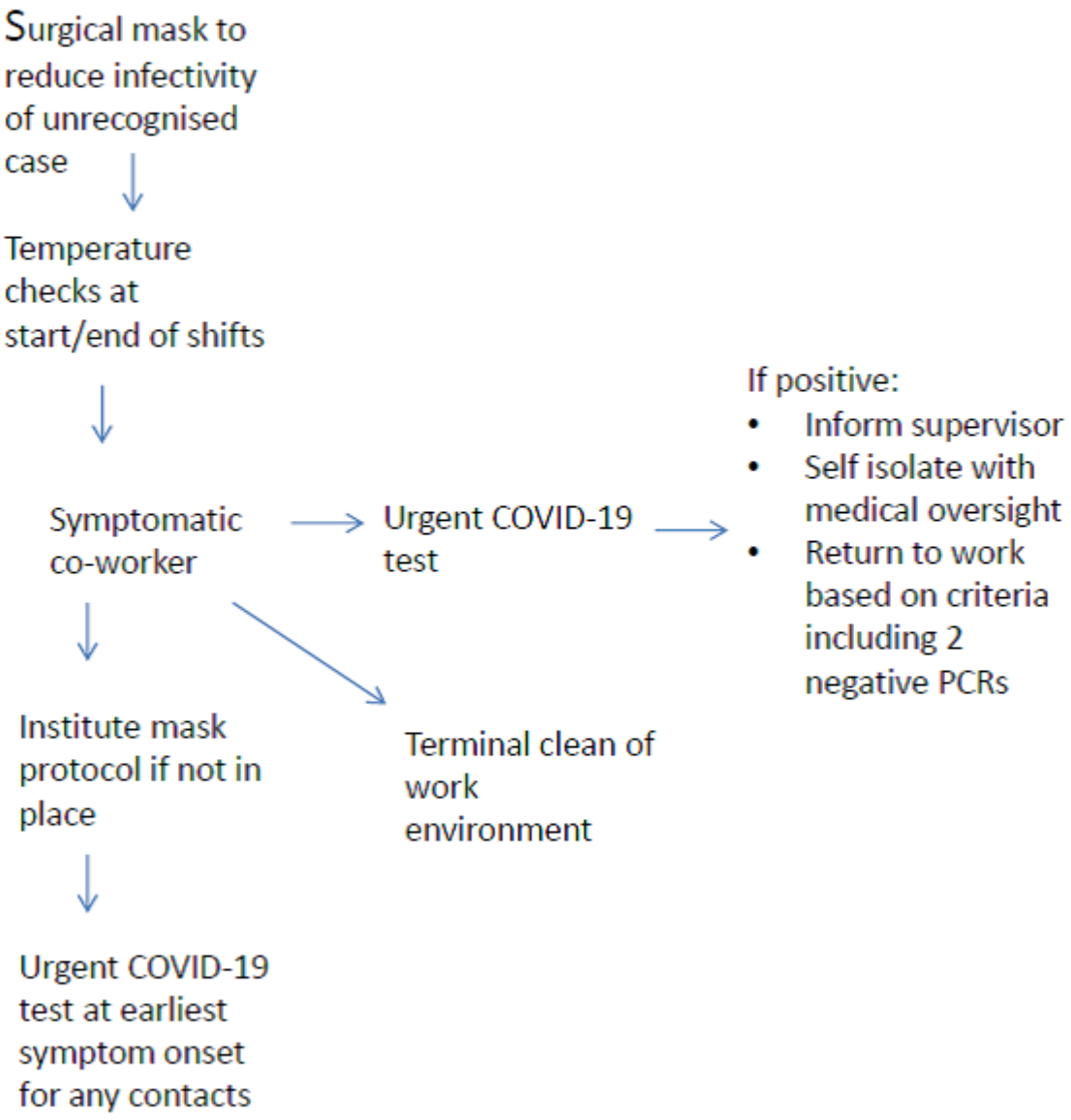
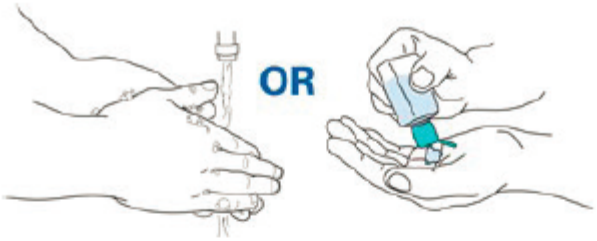


Figure 2. Donning and doffing.

SEQUENCE FOR PUTTING ON PPE

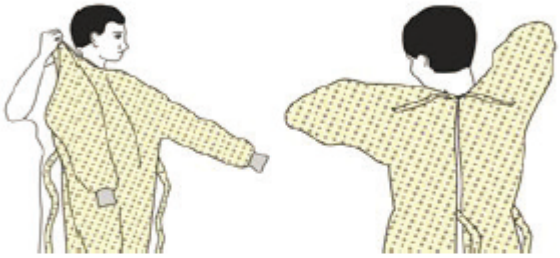
HAND HYGIENE

- Wash hands or use an alcohol based hand rub.
  Hands must be washed when visibly soiled



GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back.
- Fasten at the back of neck and waist.



MASK

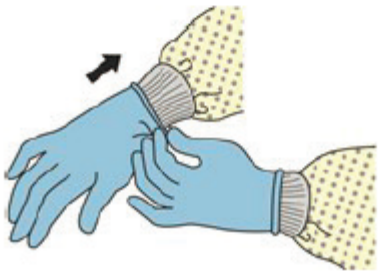
- Secure ties or elastic bands at middle of head and neck.

PROTECTIVE EYEWEAR OR FACE SHIELD

- Place over face and eyes and adjust to fit.

GLOVES

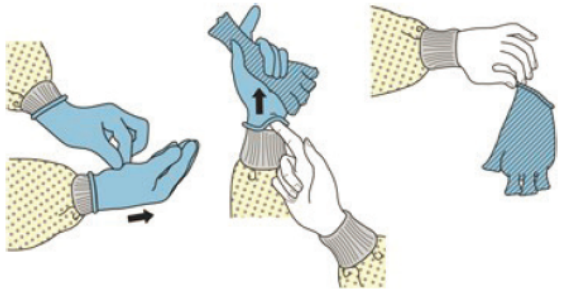
- Extend to cover wrist of isolation gown.



SEQUENCE FOR REMOVING PPE

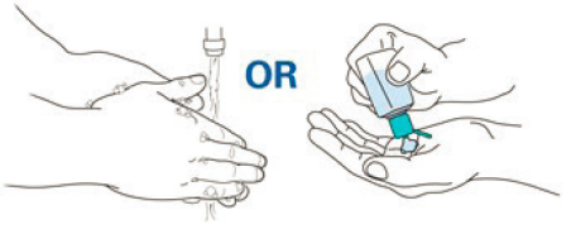
GLOVES

- Outside of gloves is contaminated!
- Grasp outside of glove with opposite gloved hand; peel off.
- Hold removed glove in gloved hand.
- Slide fingers of ungloved hand under remaining glove at wrist.
- Peel glove off over first glove.
- Discard gloves in waste container.



HAND HYGIENE

- Wash hands or use an alcohol based hand rub.



PROTECTIVE EYEWEAR OR FACE SHIELD

- Outside of eye protection or face shield is contaminated!
- To remove, handle by head band or ear pieces.
- Place in designated receptacle for reprocessing or in waste container.

MASK

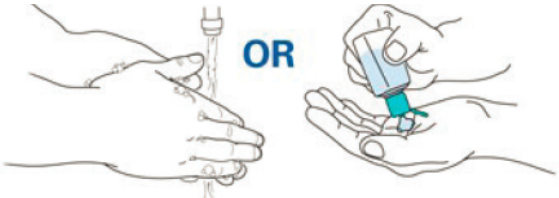
- Front of mask is contaminated—DO NOT TOUCH!
- Grasp bottom, then top ties or elastics and remove.
- Discard in waste container.

GOWN

- Contaminated gowns must be discarded in appropriate bin
- Unfasten ties.
- Pull away from neck and shoulders, touching inside of gown only.
- Turn gown inside out.
- Fold or roll into a bundle and discard.
- Store uncontaminated gown on hook, one per hook.

HAND HYGIENE

- Wash hands or use an alcohol based hand rub immediately after removing all PPE.



Adapted from CDC Guideline for Isolation Precautions[213].

Figure 3. Additional enhanced COVID PPE with donning and doffing sequences.

Note: COVID precautions for non-laboratory areas such as blue space apply when the physical distancing criteria cannot feasibly be met.

	Blue Space/non lab	Blue Space/non lab	Laboratory standard precautions	Laboratory standard precautions	Laboratory additional precautions	Laboratory additional precautions	Phlebotomy	Phlebotomy	Phlebotomy patients with respiratory symptoms
Risk	**Usual**	**COVID**	**Usual**	**COVID**	**Usual**	**COVID**	**Usual**	**COVID**	**COVID**
PPE	**nil**	**mask**	**gown**	**gown plus mask**	**gown plus eye protection plus mask plus gloves**	**gown plus eye protection plus mask plus gloves**	**gloves**	**gloves plus mask**	**gown plus mask plus eye protection plus gloves**
Donning PPE	wash or gel hands	wash or gel hands	wash or gel hands	wash or gel hands	wash or gel hands	wash or gel hands	wash or gel hands	wash or gel hands	wash or gel hands
		apply mask	don gown	don gown	don gown	don gown	apply gloves		don gown
		gel hands	gel hands	gel hands	gel hands	gel hands			gel hands
				apply mask	apply mask	apply mask			apply mask
				gel hands	gel hands	gel hands			gel hands
					apply eye protection	apply eye protection			apply eye protection
					gel hands	gel hands			gel hands
					apply gloves	apply gloves			apply gloves
Doffing PPE		gel hands	gel hands	gel hands	gel hands	gel hands	remove gloves	remove gloves	gel hands
		remove mask	remove gown	remove mask	remove gloves	remove gloves	gel hands	gel hands	remove gloves
		gel hands	gel hands	gel hands	gel hands	gel hands		remove mask	gel hands
				remove gown	remove eye protection	remove eye protection		gel hands	remove eye protection
				gel hands	remove mask	remove mask			remove mask
					gel hands	gel hands			gel hands
					remove gown	remove gown			remove gown
					gel hands	gel hands			gel hands

WITNESS:

GRIGGS, WILLIAM, Senior Medical Consultant COVID-19, SA Health

501 The CHAIRPERSON: Welcome to meeting. The Legislative Council has given the authority for this committee to hold public meetings; however, due to the current situation concerning the COVID-19 pandemic, the committee has resolved to exclude strangers from the gallery. A transcript of your evidence today will be forwarded to you for your examination for any clerical corrections. The uncorrected transcript of your evidence today will be published immediately upon receipt from Hansard, but the corrected transcript, once received from you, will replace the uncorrected transcript.

I advise that your evidence today is being broadcast by the Parliament of South Australia website. Should you wish at any time to present confidential evidence to the committee, please indicate and the committee will consider that request. Parliamentary privilege is accorded to all evidence presented to a select committee; however, witnesses should be aware that privilege does not extend to statements made outside this meeting. All persons, including members of the media, are reminded that the same rules apply as in the reporting of parliament.

We would like to acknowledge that the land we meet on today is the traditional lands for the Kaurna people and that we respect their spiritual relationship with their country. We also acknowledge the Kaurna people as the traditional custodians of the Adelaide region and that their cultural and heritage beliefs are still as important to the living Kaurna people today.

Good afternoon. My name is Tammy Franks and I am the Chair of this COVID response committee of the Legislative Council. To my right is the Hon. Nicola Centofanti and the Hon. Connie Bonaros. To my left is the Hon. Kyam Maher and the Hon. Emily Bourke. If you would like to introduce yourself, and if you have any opening remarks please make them and then we will move into questions.

Assoc. Prof. GRIGGS: Bill Griggs is my name. I was a retired doctor from the health service. I have recently been re-employed as a casual to assist with some of the COVID-19 stuff as of 30 April and I have also been doing some project work in the department. I have had a long career in health, which was focused on emergency response. I have been involved in a number of disaster responses, including both the Bali bombings, I was on the first plane into Banda Aceh after the tsunami, led a team to Samoa after a tsunami there, I have done a number of other military deployments as well and have been to plane crashes, train crashes, bus crashes, all sorts of things over the years here in Australia. I have also done some work overseas.

I also picked up a postgraduate diploma in aviation medicine, which included a year of occupational medicine and public health training, so while I don't have a full public health degree, I have some knowledge of that area. I did an MBA as well and got quite interested in non-medical board type work and I am currently a member of the boards of Funds SA, Super SA and ReturnToWorkSA, and I was previously the chair of the Motor Accident Commission.

502 The CHAIRPERSON: Thank you. Did you have any further opening remarks?

Assoc. Prof. GRIGGS: Not really. I am happy to answer questions.

503 The CHAIRPERSON: In terms of what this committee should be aware of—this is a COVID response committee of the upper house of the parliament. It was a motion of that upper house given the extraordinary times that we are in. We keep hearing that these are unprecedented times, although, in fact, there are some precedents that we can learn from. This is a committee that I think is designed to ensure that things don't fall through the cracks, so where should we be looking for things that are falling through the cracks?

Assoc. Prof. GRIGGS: The committee may be aware that I was vocal on Twitter towards the end of March in that I thought that we as a country were perhaps not moving as fast as we needed to. To be fair, what's happened is the events that subsequently happened were very much what I was feeling should happen and I was just one voice. The outcome that we have got in

terms of what's effectively eradication within South Australia and within large parts of Australia is a pretty good outcome when you look at other parts of the world.

There is an element of good management in that. There is an element of luck in it as well, because you can have bad luck and something can go wrong. If you go back to 2002 and the SARS outbreak, one of the problems that happened then was that a doctor from China went to a conference in Hong Kong and, working backwards, they worked out that he got into a lift in the hotel, went down to the ground floor in the lift and the seven other people in the lift all got the virus, all got on their planes and took it back to their countries.

That sort of thing is the sort of concern that I had when I go back to March, which you still worry about, that something might happen that will trigger an outbreak. Clearly, the measures of distancing have changed the behaviour of not just this virus but the normal seasonal influenza as well. We have much smaller numbers of cases of seasonal influenza because, I am sure, of the physical distancing that we are doing, the hand washing and the general attention to detail.

It is important to understand it's all about the reproductive rate of the virus and you don't have to get it perfect, you just have to get the reproductive rate down below one and as far below one as you can, then eventually the virus will die out. With SARS, there was no treatment and no cure for SARS but it disappeared. The same happened with MERS about 10 years later, the Middle East respiratory syndrome, another similar sort of disease. Again, it died out.

That opportunity was sort of missed with this episode. With international travel it is very easy for something to spread and get out of control, and if you haven't realised it's in your community and you're not testing for it, by the time you realise it's there it may have gone through a number of generations. The other problem is that when you are exposed to it and you become positive it takes a while to become sick.

It might take up to two weeks. That's one of the reasons for the two-week quarantine. But it might take say six days or seven days on average. Then for the day or so before you start to feel unwell you may start to spread it. So you can get one person who has it, they come into the state and go to a football match or whatever beforehand and spreads it to the people around them.

The people from the football match go off to their social events and by the time you have picked up the first one there are three or four generations of spread and it can get out of control. Early on we were looking at what is called the doubling rate, how frequently it doubled, and it was happening every three or four days in some of the places where it was out of control. That was obviously concerning.

I might just comment briefly on the concept of herd immunity, which people have talked about. The US currently has, if I remember the figures rightly, about 1.75 million positive cases, roughly, and about 100,000 deaths. To get to herd immunity you need about 60 to 70 per cent of the population. The US population is about 350 million. They would need to get to about 250 million and they are at 1¾ million.

Even if they have only recognised half the cases they have got, that might be three million. To get from three million to 250 million, that's a lot of time. That might be 70 times as long. It has taken them two months to get from 10,000 cases to 1¾ million and they've got the same amount of time with the same amount of deaths occurring every day for another 70 times that amount. You're getting up to 14 years to get to herd immunity using that methodology.

I have put a number of things on Twitter, and not just Twitter, on LinkedIn and on Facebook. I originally started using Facebook because people know that, although I am retired, I had some knowledge in this area and I had friends just asking me questions, 'What is this thing? What is it all about?' So I put a post there for the 100-odd people I knew on Facebook and it would get shared and it would get more shared, then I would get all these friend requests.

The last article I put on, which is 'Why I downloaded the COVID app', the last time I looked it had been shared 600 times primarily. I'm a storyteller. I try to make an effort to communicate to people clearly, if I can. There are a number of things that I've talked about. One of them I talked about back in the middle of April was how to get out of lockdown. Having said that we want to get us into lockdown, how do we get out of it? There's a concept that someone may have talked to you about: the hammer and the dance. The idea is that with the hammer you try to crush the virus, or

crush the problem, but then you've got to work out: how do I get on with life? There's no question—we can't just lock everything down.

Wearing my Funds SA hat or my ReturnToWorkSA hat, we've got large amounts of money that's invested. We have to work out how that's going to work. We have to make sure the economy works. What I wrote about, getting out of lockdown, was really that we need to look at the things that we've done that have been effective, and they include things like social distancing, they include things like travel barriers and they include things like keeping the number of people mixing together relatively low.

It seems that now we've got to the stage where we are at, a level where we have effectively eliminated the virus in South Australia—I will just talk about South Australia at the moment—we should be able to release some of those things. But the virus will come in; whether it's through an exempt worker, whether it's through whatever, the virus will come in, so we have to have the ability to identify when it comes in, so that's the testing, and then we have to have the ability to trace, to try to get it before it gets out of control. Singapore, who was early on listed as a country that was doing very, very well and touted as all sorts of things, suddenly had a big kick up and things got out of control. So, even though you're doing well, it can get out of control.

It is difficult for people who can't see someone dying next to them or they can't see that the hospitals are have all been full of sick people. With the issue of shutting down elective surgery, we did a number of things to try to make space because we were looking at what was happening in Italy and other places, and if that happened here we were going to need all that space. Fortunately, it didn't happen to that extent, but there's still this risk out there.

Someone asked me yesterday how did I think this was all going to finish up. There's a lot of talk about vaccines. I'm not an expert on vaccines. There is clearly a huge drive to get an effective and safe vaccine. If you consider how someone who works in the vaccine industry all the time behaves, a vaccine is something that is given to a million people who are perfectly well. You really don't want to damage too many of those million people by giving them a vaccine. You have to have it as something that is incredibly safe, so they have checks and checks and checks and checks and checks. So it does take a long while to make sure that there is not something that can be missed, and part of that is the time to wait and see.

Some bad drug effects may take a long time to turn up. The extreme examples are things like thalidomide, a German sleeping pill, and there were problems with babies that were born with phocomelia, with limb defects. There's another drug called stilboestrol, which was used as a drug to try to stop threatened miscarriage back in the fifties and sixties, I think, and it wasn't realised it was a problem until the female children started getting an unusual form of cancer in their early 20s. So sometimes it can be a long time. Clearly, you can't wait to test every drug for 20 years.

I think that, because of the consequences to the planet, to life, but also to society, there is a higher degree of risk that's acceptable in the vaccine development. My own feeling is there are a number that are already being tested on people. I would hope that within six to12 months or so there may be an effective vaccine. I might be wrong. I'm a bit of a glass half full person. If that's the case, we have to get to that point because, once there is an effective vaccine and it can be widely spread around, you can get herd immunity. In fact, it's a much more effective way than if you have had the disease and recover.

This is where we need to be able to keep some of the things in place. Some of the border barriers need to stay in place. The two weeks in a hotel is quite an effective barrier. It's not perfect, but it's quite an effective barrier. The two weeks coming into the state again I think is quite an effective barrier. It's not perfect, so the track and trace needs to come.

There was an outbreak in north-west Tasmania. What they did was send in a group of people to basically lock that area down and to try to track and trace. There's a challenge when there's an outbreak in having people who are really good at managing an outbreak, as opposed to just saying to the local people there, 'Make sure you use your PPE, make sure you do this and make sure you do that.' This is sending flying squads in and my understanding is that there is some planning for that as well.

I will comment on PPE, and I'm sorry I'm wandering over the place a bit. PPE is difficult, and I will give you an analogy. When you go to a shop and you want to buy a sandwich, the person behind the counter makes the sandwich, puts gloves on and they make the sandwich wearing the gloves. The idea is that they put a fresh pair of gloves on, they make the sandwich, they take their gloves off, they take your money and they throw the gloves away. They pay that. The next time they put another pair of gloves on. But I suspect you have all seen people who have a glove on the left hand and take the money with the right hand, or take the money with the glove, and nothing obvious seems to happen when they do that.

The challenge if you are in a nursing home and you are wearing PPE is that you have to check on half a dozen people. Theoretically, you have to change every time. You have to not touch the mask and contaminate it. You have accidentally touched a patient who may be positive and you have picked it up on you, but you don't realise that. You can't see anything and there is the ability to spread. I suspect that is one of the challenges that has happened in some of the nursing home environments. Sorry, I'm all over the place, so I might just pause for a moment and let you ask questions.

504 The CHAIRPERSON: Do you have a question?

505 The Hon. N.J. CENTOFANTI: No, I don't. I'm really sorry I have to leave, but I would love to hear more because you are very knowledgeable. Thank you for joining us, but I'm really sorry that I have to head off. I have a 1 o'clock meeting.

506 The CHAIRPERSON: In terms of where we get our information from, the AMA gave evidence that perhaps we should have a CDC. Certainly, the Centers for Disease Control and Prevention in the US provided guidelines quite early on. The AHPPC for Australia has provided some guidelines, and of course the World Health Organization comes to mind. Some of those guidelines have changed in this very short period because we are learning as we go. Do we need a CDC in Australia?

Assoc. Prof. GRIGGS: I don't know the answer to that. I would need to think about it. I probably didn't mention that I was involved with AHPPC for a number of years because I was the state controller for health and medical, particularly after the first Bali bombing, when we realised there was absolutely no plan at all for what to do if a bunch of Australians got injured offshore, so we had to make it all up at the time. A number of plans were written, and I wrote the draft of the first Australian trauma plan.

One of the challenges with AHPPC is that there are senior public health officers for each state. In fact, you could argue they are a good group for a coronavirus-type outbreak. Are they as good for a major disaster when it's not their speciality? Part of it is getting the right people in there. I know a number of people who are currently members. In fact, early on, I was talking to people saying, 'I know that you may not want to hear what I've got to say, but I'm going to tell you what I want to say.' There are at least two of them I know quite well who are also experienced responders and are very good. As far as a CDC, I would have to think about that and it's probably not entirely my area of expertise.

507 The CHAIRPERSON: Just on that, the AHPPC provided, for example, educational guidelines for schools. It particularly had different jurisdictions at different levels of children returning. Within a period of 24 hours, those guidelines went from including that children had to socially distance to deciding that children didn't have to socially distance. How much trust can the public have in the AHPPC when they change that sort of guideline in that way, with seemingly a response to political pressure rather than public health outcomes?

Assoc. Prof. GRIGGS: I think there are a couple of things in that. One is that theoretical guidelines, or guidelines that you think are good, may not be doable in practice. With the best will in the world, you will say something and then realise that actually, no, that's not going to work and we need to do something else. We also have this dilemma in our federation structure that disaster response is a state and territory responsibility, not a federal responsibility. While there has been an approach in this particular event to get some degree of centralisation, at the end of the day, each of the states makes their own call about how they do things.

The reality is that the states are all a little bit different for various different things. We have big geography. When we look at countries and we look at numbers, a lot of people have been

saying to me, 'We want to know what the rate is per hundred million of population or per million of population?' You look at China. There was a big outbreak in Wuhan, so if you said that was the population, you would get one rate but, if you said, 'Well, actually, China is this. It's huge.' But does it really matter that there are people who live 3,000 kilometres away who happen to be Chinese because that's the geography? Australia is the size of many of the European nations all put together, so it's not surprising that we have some different things happening in different jurisdictions.

The schools stuff was challenging. There is a concept here that is important to understand and that's the difference between the absence of evidence and the evidence of absence. I will use the *Ruby Princess* as an example. It was said by people that we had no evidence that there were no positive tests for people on board the *Ruby Princess* when it docked. The implication is that there was no evidence. In fact, if I understand things correctly, there were no test results at all. No COVID tests had been done. So to say that we have none, as opposed to, 'We have a bunch of tests that show we don't have it,' is not the same thing. Some of the wording early on was, 'We have no evidence that children are super spreaders or we have no evidence that it's a problem having children in schools.' That's not the same as saying, 'We have evidence that it's okay for children to be in schools.'

508 The CHAIRPERSON: But we do actually have evidence of Marist College in New Zealand as now their second biggest cluster.

Assoc. Prof. GRIGGS: Yes, so there are examples like that. There are also other studies that have been published. Part of this is learning as we go along. Things like how big our second wave is going to be, we don't know; we can speculate. There are studies that have been published that suggest that (a) children are less likely to get it—it doesn't mean they don't get it—(b) they are less likely to spread it, as far as we can tell, both to other children and to themselves. They are less likely to get sick. The logical but not proven argument might be, if they are not as likely to be sick, they are less likely to be coughing and spluttering and, therefore, less likely to be spraying the thing around.

Another argument is that you don't know they have it because you don't test them because they are not sick. But if they go home and give it to mum and dad, and mum and dad get sick, you would expect to find it in some way. I have a number of friends who are teachers who are saying, 'How do I escape? I am terrified.' I have a number of friends who are doctors and nurses who are terrified. I have friends overseas who have been emotionally destroyed by working in an intensive care unit where they say, 'We have 35 patients who have come in, all on ventilators, in this particular country, and we haven't written a protocol yet to get them off the ventilators because no-one comes off, they all just die.'

I wandered away from the question. If we go back to the question about trusting advice, I am a great believer, if I am going to give someone some advice, I try to explain what's behind it. There's some stuff that you have really good evidence for, and this is true in medicine. We might have really good evidence to do this in medicine. There's other stuff where there isn't very good evidence, but we have to make a decision, so we are going to do this and, if we need to, we might have to change that.

Certainly, with regard to the disaster response to stuff in the past, I went into Banda Aceh and had a few hours to try and assess a city of 400,000 people, which was still a third underwater and it was completely chaotic. We made a request for a whole stack of stuff, going, 'I hope we have not overdone this.' As it turned out, we hadn't, but it is difficult to make sure you get the messages right all the time. I do think it's important to let people understand the reasons behind the decisions as far as possible.

509 The CHAIRPERSON: Indeed, and that goes to the ANMF's evidence to us at the last hearing, that in fact they were pushing for references to be provided with the SA Health information and that wasn't at first forthcoming. Do other members have questions?

510 The Hon. C. BONAROS: Can I start by thanking you for being as vocal as you were on Twitter and Facebook and so forth, because a lot of us read those posts with a great deal of interest. I will admit I have always hyperventilated when there hasn't been hand sanitiser around, even without COVID, so for me the shortage was just next level. I read particularly the article that referenced you during the peak about what you should do to protect yourself and your family. It gave

a number of steps. I tried it. It was difficult, I have to admit. Without seeming alarmist, in a lot of places in the world that is critical even today.

My question really is: do you agree that there is no going back to old ways and that at some level—not at the levels that we have been exposed to during the peak of corona—there is some merit in us maintaining some of those practices that we have all now become accustomed to, whether it be the hand sanitiser or some level of social distancing or some level of avoiding handshaking, for instance—things that we have taken for granted previously but have become essential during the coronavirus?

Assoc. Prof. GRIGGS: There are very good public health reasons to do many of those things in an ongoing manner. I perhaps have a view that human beings tend to forget stuff and, over time, if a vaccine is developed and people have the vaccine and the coronavirus stops being a problem, then people will want to go back to normality that they know. But I agree—

511 The Hon. C. BONAROS: From a health perspective.

Assoc. Prof. GRIGGS: —from a health perspective, absolutely. Many of those things were things that would have been sensible before the coronavirus, just for the seasonal flu. There is always a balance between what's sort of socially acceptable. When I wore my chairman of Motor Accident Commission hat, I knew that if we changed the speed limit in the metropolitan areas to 20 km/h, we would save a lot of lives. It wasn't an appropriate thing to do because of the effects on the community.

I suspect people will want to go back, and there are a number of reasons. We see that even now. They want this to go away: 'I don't want it to be here anymore, and if I can go to the footy and I can go to pub and I can go to the beach, maybe that means it's gone and I don't have to be stressed about it anymore, because it's really stressful. Staying home and doing all this stuff is just really stressful, and I don't like it.' We are driven by habit—and one of my posts was about habit—and we want to go back to our old habits. I can understand that, but you make a valid point from a point of view of public health. Maybe there will be some things that do stick with us as time goes forward.

512 The Hon. C. BONAROS: In terms of our easing of restrictions, particularly in terms of border restrictions—we saw how easily a case re-entered South Australia, and there has been disagreement amongst state leaders about whether we ought to be easing our restrictions and so forth in South Australia more, particularly our border restrictions—are you confident with the approach that we are taking in terms of, particularly, our border restrictions? Do you think there is a need to maintain the level?

Assoc. Prof. GRIGGS: I am quite comfortable with the border restrictions as they are at the moment.

513 The CHAIRPERSON: I will just jump in at this point and note that we have just slapped an immediate ban on all international travel for compassion reasons; it's just been announced in the last five minutes. So there you go. Interstate is still apparently okay.

514 The Hon. C. BONAROS: So what's the ban?

515 The CHAIRPERSON: All international—no compassionate reasons. It looks a little knee jerk.

Assoc. Prof. GRIGGS: Like many things, there's a degree of reactivity. When something happens there is a response.

516 The Hon. C. BONAROS: Do you think that's based more on the fact that the first person who was allowed to come in on compassionate grounds had the virus, or the public response to that that we have probably slapped that ban now on those cases?

Assoc. Prof. GRIGGS: I am pretty sure that wasn't the first person who came in on compassionate grounds. I don't know, but I am pretty sure that there were other people who have come in on compassionate grounds, and there was, if you look at social media, a very strong public response to that. Again, I don't know how much. Many of the actual facts of the whole thing weren't clear to people but there was clearly a degree of stress. It is important to respond to the public in one

way or another, either explaining what and why we continue to do what we are doing or to potentially change things.

517 The Hon. C. BONAROS: Does that need to have a degree of alert but not necessarily alarmist responses? Is that a fair—

Assoc. Prof. GRIGGS: That's a fair thing. I am keen for things to be more locked down rather than less because I have got too good an imagination about what might happen if things go wrong. I think we have done extremely well in this country. We are sort of a bit of a victim of our own success because people go, 'Well, what happened? We did all this stuff, we cancelled the surgery, why did we do that? We didn't need to do that. We could have kept doing stuff. We could have kept doing these things. Why can't we have the pubs open with 50 people? Why can't we have a hundred people?' There will be continuing pushing.

Part of this is making sure the messaging is clear. Part of the reason for my activity on social media was to try to make the messaging clear. The thing about how to survive not to bring COVID home was based on a number of people asking me stuff and me thinking about it and looking at some other stuff and realising, 'Actually, there is a bunch of things I haven't necessarily thought of myself.' Then, when I put it all down I thought, 'Well, here's a 23-point thing. There will be some people who are really keen and are going to do each one of them right on time and there will be other people who just read it and go. "I hadn't thought of that." That's okay and it doesn't really matter.' It's just so that people think of things that they hadn't done. Actually, writing it myself changed my own behaviour.

518 The Hon. E.S. BOURKE: I might just continue on with what we were mentioning just before that. We have seen that there have been changes on compassionate grounds and a lot of that may have come from public pressure. Do you feel that we have sort of transitioned away from taking medical advice and are now sort of being persuaded by the headlines that we are seeing in the newspapers?

Assoc. Prof. GRIGGS: I will make a comment about medical advice. Medical advice is—a bit like I was talking about before—in some cases there is really good, solid evidence; in other cases it's, 'This is the best information that we have got at the time,' or, 'This is the interpretation of what we have got.' Maybe it changes. I remember when I started at medical school, the first day the professor, the head of the medical school, stood up and said, 'You are going to learn 40,000 new words, 300,000 new facts in the next six years. The problem is that about half of those facts are wrong—it's just we don't know which half.'

I have watched over my career, with the way I was told to treat something, suddenly a paper would come out and there would be a square way of change. The way we treated head injury underwent a complete square way of change two days before someone I knew very, very well came in as a patient with a head injury. I ended up treating him completely the opposite way to the way I would have treated someone a while back. It's a challenge not to hold onto those old things.

On the medical advice versus the political advice, one of the advantages that I thought I bring to Funds SA, ReturnToWorkSA and their investment teams is that I can provide some medical stuff for them to consider, what the patterns are likely to be and what might happen, because that's important in the total scheme of how they do their investments and what might happen and what may happen.

We need to think about the country as a whole and the state as a whole. It's not just about what the doctors say about health. That's not the only thing. It's a very important thing, but it needs to be taken in context. That's one of the challenges for this place: to work through the input from all the different parts of the community and try to work out what is the right solution. Subject matter experts and people with a narrow view will have a strong view about their own area but may not understand all the ramifications in other areas.

I am always willing to listen to other points of view, to listen to other things I haven't thought of and maybe change my point of view. There will clearly be decisions that are made as a result of political pressure, if you like, or community pressure. Sometimes they are decisions where you could do this or you could do that and you don't really know which it is, but there's pressure so we'll do this. Only time will tell; in fact, you may never know whether that was a good call or not.

There are a number of things. If they had had the international lockdown before *Ruby Princess* docked and all the people on board went for two weeks in a hotel the situation would have been quite different. The situation for many of the people onboard that ship was very sad, and for a number of other people, but it didn't end up with us getting out of control, which was a potential for something like that. I am not sure if that answers your question.

519 The Hon. E.S. BOURKE: You mentioned earlier that you are undertaking a number of projects with SA Health; is that right?

Assoc. Prof. GRIGGS: Yes.

520 The Hon. E.S. BOURKE: Are you able to expand on the nature of those projects, what you are undertaking?

Assoc. Prof. GRIGGS: I think so. One of the things I have been doing was doing some data analysis—this was independent before—for the boards, looking at what the effective R value is for different countries and what the progression is over time, and also within Australia. I did that to help those people. I shared that also with some of my medical colleagues, including some of the AHPPC members. Some of them said they would like to have the updates, so I kept having updates.

One of those was Nicola Spurrier. She rang me. She knew I was interested in data and analytics. One of the early things that we did in South Australia which was different with the testing was that, as well as targeted testing for people who had symptoms or who had travelled or whatever, anyone who had had a respiratory screen by their GP—so they had had a swab done because they might have the flu or whatever—the idea was to add COVID testing to that. So we did something that was different to everyone else. She wanted to know how many of those tests there were, how many were positive, etc.

The challenge is that many of the databases that are set up to record stuff are set up for individual patient reporting, for example, or they might be set up to facilitate billing or all sorts of things. Trying to pull that information, despite the fact that there were three or four databases, was challenging. She asked me if I would be willing to come and try to see if I could do that. I'm a puzzle solver. I like doing stuff. It went through a little process to get me officially signed up because I needed to be on board to access things which had the patient's names, etc., so I came in and was able to do that, get the information that was required. I gave that to her, and then got asked to look at some of the stuff around the databases as well.

521 The Hon. E.S. BOURKE: How many of those respiratory tests came back positive?

Assoc. Prof. GRIGGS: I'm just trying to work out whether I'm allowed to say the answer to that.

522 The Hon. C. BONAROS: Maybe take it on notice.

Assoc. Prof. GRIGGS: Can I take that one on notice?

523 The Hon. E.S. BOURKE: You can take that one on notice. I don't want you getting an angry email. Would you personally catch rush-hour public transport at the moment? I know you put on Facebook about travel barriers, but would you personally get on a tram or a train or bus at 5 o'clock?

Assoc. Prof. GRIGGS: I would be happy to do it if I thought physical distancing was being achieved.

524 The Hon. E.S. BOURKE: Is that achievable?

Assoc. Prof. GRIGGS: Everything is achievable if you police it enough or you have controls. If you had asked me the same question back in March/beginning of April, I would have said I am not keen because I wasn't sure what was in the community, so at the moment it's a little bit different. Assuming that there's still a risk of community spread, the whole idea of the document that I wrote about unlocking things was all about trying to maintain social distancing.

For example, if I looked at restaurants, the way I wrote that, you would say, 'Well, the number of people you can have in your restaurant is a function of how well you can maintain social differencing,' so it's the size of your restaurant and everything else. There might be one

restaurant that can have 10, and one that can have 20, or whatever. I know that there's been a bit of a change within the state to try to avoid having a specific number.

When you get close to other people there's an increased risk. I am 62 years old, so I am in a higher risk group. I have some health conditions which put me in a higher risk group as well, so I'm pretty keen not to get the virus if I can avoid it. It might be different for other people.

525 The CHAIRPERSON: Thank you for your evidence today. As I noted, it will be forwarded to you for any clerical corrections. If we could put on notice that question that the Hon. Emily Bourke raised and whether or not there are any restrictions on the sort of information you could share, if you can get back to us with that, that would be most appreciated. Thank you for your time.

Assoc. Prof. GRIGGS: Thank you very much.

THE WITNESS WITHDREW

Archived: Monday, 29 June 2020 4:35:21 PM
From: Griggs, William (Health)
Sent: Wednesday, 10 June 2020 7:42:32 PM
To: COVID-19 Response Committee
Subject: RE: Covid-19 Response Committee - Copy of the Transcript
Sensitivity: Normal
Attachments:

Dear Anthony,

Regarding the question under notice. Section 521. “How many of those respiratory tests came back positive?”, I am unable to provide a specific numerical answer to the question as the answer of itself, if it was in the public domain, may have potential to lead to identification of individual patient or patients. I do not have patient permission to release details which may lead to their identification.

Kind regards

Bill

A/Prof Bill Griggs AM ASM
MBBS MBA PGDipAvMed DUniv(hc) FANZCA FCICM FACAP FAICD

Senior Medical Consultant - COVID-19
Communicable Disease Control Branch
Department of Health and Welfare
Government of South Australia