LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON THE COVID-19 PANDEMIC RESPONSE

(Reference: COVID-19 pandemic response)

Members:

MR A COE (Chair)
MS T CHEYNE (Deputy Chair)
MRS V DUNNE
MS C LE COUTEUR
MR M PETTERSSON

TRANSCRIPT OF EVIDENCE

CANBERRA

FRIDAY, 1 MAY 2020 (morning session)

Secretary to the committee:
Mr H Finlay (Ph: 620 50129)

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

Privilege statement

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Amended 20 May 2013

The committee met at 11.10 am.

STEPHEN-SMITH, MS RACHEL, Minister for Aboriginal and Torres Strait Islander Affairs, Minister for Children, Youth and Families and Minister for Health
COLEMAN, DR KERRYN, Chief Health Officer, ACT Health
JONASSON, MS KYLIE, Acting Director-General, ACT Health
McDONALD, MS BERNADETTE, Chief Executive Officer, Canberra Health Services
PEFFER, MR DAVE, Deputy Chief Executive Officer, Canberra Health Services
EDGHILL, MR DUNCAN, Chief Projects Officer, Major Projects Canberra

THE CHAIR: Good morning and welcome to the sixth public hearing of the Select Committee on the COVID-19 pandemic response. On behalf of the committee, I would like to thank you, minister, and your officials for returning today. Once again, I understand that you have been forwarded a copy of the privilege statement. I ask you to please confirm for the record that you each understand the privilege implications of that statement.

Ms Stephen-Smith: I have read it; I understand and acknowledge the privilege statement.

Dr Coleman: I have read and understood the privilege statement.

Ms Jonasson: I have read and acknowledge the privilege statement.

Ms McDonald: I have read and acknowledge the privilege statement.

Mr Peffer: I have read and acknowledge the privilege statement.

Mr Edghill: I have read and acknowledge the privilege statement.

THE CHAIR: The hearing today is being recorded by Hansard and we are being broadcast live via the Assembly's website. I would like to remind you that we would very much appreciate succinct answers, as the time allotted is brief and we want to get through as many questions as possible. Before we go to questions, do you have a brief opening statement?

Ms Stephen-Smith: No, we do not have an opening statement.

THE CHAIR: Minister, could you please provide an update on what advice has been given to you about community transmission and what risks still exist in the community?

Ms Stephen-Smith: At this point in time, the advice from the Chief Health Officer, who I will ask to speak to this very briefly as well, is that we do not have any evidence of community transmission here in the ACT. Members of the committee would be aware that, as of yesterday, we have no active cases of ACT residents. We are in a good position, but one of the things that we have done from last Friday is to start to request everyone who has symptoms, even if they are mild—a sore throat, dry cough, shortness of breath or a fever—to get tested at one of the testing facilities so

that we can identify if we have undetected cases of COVID-19 in the community that might indicate community transmission that we are otherwise unaware of. So far, we have had, on average, a couple of hundred people tested each day since that started. I will ask Dr Coleman to give some more precise figures, but none of those tests that have come back so far have come back positive. I think that is a good sign that we do not have community transmission.

We discussed last time that if we were seeing widespread community transmission we would start to see some very unwell people appearing at hospital. Of course, we have been testing for some time those who come to hospital with respiratory symptoms or otherwise unexplained fever. Again, we are not seeing positive results there, which would be another indication of community transmission. I will hand over to Dr Coleman to talk about the number of tests that have been conducted over the last week.

Dr Coleman: Since the announcement of the opening up of testing to all people with respiratory symptoms, we have had between 170 and 280 people being tested every day and no positives have come out of that. I think that adds to the evidence that we are confident about no serious underlying community transmission. Additionally, we have been testing all illness in aged-care facilities. At the moment, we still do not have any influenza-like illness outbreaks in aged-care facilities.

The cautious note is to say that we still have an open border with New South Wales and there are still cases appearing in New South Wales. I think the protections and the testing that we continue to do are really important, moving forward.

THE CHAIR: What about the risk of community transmission in schools? What is the risk there?

Dr Coleman: The evidence currently shows that children are not a major vector of transmission of coronavirus, as they are with influenza. However, we do know that adults are at the same risk as other adults when it comes to transmission of coronavirus.

THE CHAIR: What advice do you have for the education minister and for the government regarding whether schools could operate or not?

Dr Coleman: My advice is the AHPPC statement, which states that schools are safe environments for children and encourages us to work with our individual jurisdictions on addressing community concerns regarding how we move forward with schools.

THE CHAIR: What specific advice has been required regarding the hub schools and how is it that they can be safe, yet all the other schools remain closed?

Dr Coleman: I think that is a health and safety issue.

Ms Stephen-Smith: With the hub schools, the creation of the safe and supervised school facilities is in response to the decision that the primary learning for term 2 would be remote learning, with a recognition that there needed to be a capacity for essential workers to send their children to school and for children who may otherwise be vulnerable to still attend a school setting. Because it looked like there were going

to be a relatively small number of those children, the practical issue was about how to ensure that there was an appropriate supervised site. It was about either opening every single school for a dozen children per school or opening a smaller number of schools and hubbing those children who need supervision into those spaces. There was a practical consideration as to how these safe and supervised sites could be staffed—I am not the education minister; I am speaking from a practical perspective—and still enable the vast majority of students to access quality remote learning, which, of course, teachers are working on. It is not that teachers are not working; they are delivering quality remote learning to students.

THE CHAIR: You are confident that the hub schools are safe?

Ms Stephen-Smith: I do not know what you are suggesting, Mr Coe. I do not understand why they would not be safe.

THE CHAIR: Okay; happy with that response.

MRS DUNNE: Minister and Dr Coleman, what protocols should schools, hub schools or schools that are returning, like some of the independent schools, be putting in place in terms of cleaning and the like which are probably above and beyond what would normally happen in the routine of schools?

Dr Coleman: We are currently working with the schools around what those additional measures could be, noting that there are not currently any active cases that we are aware of in the community, so the risk is very low. The major issues are around protecting adults and adult transmission. There will need to be thinking around school drop-offs, staffrooms and those kinds of places where adults intermingle, and implementing the appropriate protection around their 1.5-metre distances. We are also looking at additional cleaning mechanisms for the more frequently touched surfaces.

MS LE COUTEUR: We keep talking about children. For these purposes, at what age do you stop being a child? We have high schools and colleges. Are college students children or adults, from a health point of view?

Dr Coleman: These are very difficult cut-off questions and I would not be able to give you a hard cut-off. However, we have not seen any evidence, in primary or secondary schools, or colleges, of major outbreaks in any of them. We also have very small numbers in all of our categories, under 20. I think that the evidence at this stage applies across all of those school settings.

MS CHEYNE: I have questions for Dr Coleman about cases and testing. I have two broad questions and two specific ones. Dr Coleman, have there been any cases where the person was both confirmed at one time as having COVID-19 and having already cleared the virus in the ACT? To put it another way, the virus was confirmed and added to our numbers but immediately was classified as a recovered case.

Dr Coleman: There has been at least one case. I am not sure whether it was immediately classified but it was reclassified within a couple of days. The case in particular was where we contact traced back to find the source of the case. Let us say case No 1 was the case. We contact traced back to the source of case No 1 and case

No 0 turned out to be somebody that we diagnosed at that point in time from serology. That person had already finished their illness at the time of investigation; therefore, they were not a current active case. But we were confident that that case had been the source of infection of case 1 because it was a household contact. We contact traced around that and they had put no further people at risk during that period of time.

MS CHEYNE: I appreciate that we have been requiring people who are symptomatic to be tested when the criteria were stricter; now, of course, it is broader. Of our 106 confirmed cases, have there been any confirmed cases where the person was asymptomatic, perhaps, again, such as through contact tracing or serological tests?

Dr Coleman: That case was one example. If we have any examples, it would be a very, very low number. Sometimes it is very difficult to determine if someone is asymptomatic or has mild symptoms. The reassuring thing from this particular case is that this person did not transmit to anybody else apart from the immediate household contact, which we know are the actual major risks from indoor family household contacts.

The evidence still supports that if there are asymptomatic cases and any transmission from asymptomatic cases, it is not a large number and it is not resulting in the pandemic increasing in cases. It would be a very, very small contribution to the overall picture. It may be that with numbers maintaining so low and all jurisdictions getting down to almost zero, this is when we might start to see the asymptomatic or the very small symptomatic cases appear. The implication, given that we are not seeing lots of cases, is that it is not actually causing more cases in the community.

MS CHEYNE: That is very useful; thank you. The two most recent confirmed cases in the ACT were related to overseas travel and a cruise ship. Are you able to expand on those two cases, given that there has not been a great deal of overseas travel recently; nor have there been too many people disembarking from cruise ships? Are these people who returned from overseas quite a long time ago and it took them a while to develop symptoms or to be confirmed, or are they quite recent returnees?

Dr Coleman: There has been a small number of returning travellers coming back, in particular, from South America—some of those cruise ship travellers have only just started to come back in to Melbourne—and from India and other places. We will continue to see a small number of travellers coming, and the majority of them will do hotel quarantining in other states and territories, given that we are not receiving international flights at the moment. These two cases came in through different ports. With both of the cases we diagnosed them much later, at the end of their illness. I think that goes to the point now that we are picking up the cases who are much less of a threat both to individual health and to community health.

MS CHEYNE: Thank you; that is very useful. My final question is about that particular case. I think the dates were 18 April, 19 April and 20 April. It is about the classification of someone who was in hospital—it was the same person but they never actually left hospital. Was the patient classified as having cleared the virus and that is why they were recorded as not being in hospital, but they were actually in hospital for complications that had arisen from the virus? Is that correct? How has that changed or affected how the classification criteria and tally are being used, going forward?

Dr Coleman: You are absolutely correct; that is exactly what happened. At a certain period of time we can clear someone from being an active case or an infectious risk. In this individual circumstance, they were still in hospital because of complications from the infection, so there was some confusion about whether that person should still be on our numbers or not. This often happens when we are trying to work through how we present the data, depending on the purpose of presenting the data. In this case, we felt it was important that we still reflect that this was a COVID case in hospital, even though they were not currently required to be under infection control precautions. These are things that we take nationally and we make a decision about how we report that consistently across the jurisdictions, moving forward. It is about what you want the data to tell you.

MS CHEYNE: Will all jurisdictions be taking a similar approach—if someone is still in hospital from COVID-related complications, even if they have cleared the virus, they will be tallied as being in hospital?

Dr Coleman: They will be presented as at one time having been in hospital. You will notice that some of the jurisdictions' tallies are changing quite a bit, and we are having to now present our data as currently in hospital and at some time having been in hospital. That is how we are moving forward now.

MS CHEYNE: Okay; understood.

MR PETTERSSON: In regard to testing, I note that the testing criteria have changed recently, to cover people with mild symptoms. How long do we expect this phase of testing to be in place until we move, maybe, to wider community sampling for the testing?

Dr Coleman: The current testing criteria have been expanded for two weeks. The current ones will be finishing next Friday—another week to go. We encourage anyone who has any mild symptoms to get out and get tested, to give us the best possible information. During this week we will be reviewing this information, as well as looking at the national plan. Nationally, we are looking at a really strong surveillance and monitoring plan, moving forward, which covers off who we should be testing and how we should be testing them.

While we do not encourage or recommend testing people who are asymptomatic, just general people from the community, because the result does not mean anything to us, there is thinking around how we might do some cohort studies—of some individual groups of people—and do various tests to see what the degree of current or previous exposure may have been. That may be a combination of a PCR test as well as a serology test.

Once that national conversation has bedded down how we will be moving forward, we will be aligning the ACT testing. I am reasonably confident that across Australia we will be maintaining and promoting testing to anyone who has symptoms, moving forward.

MR PETTERSSON: Do you think that national dialogue will be concluded in time

for that Friday end point of this phase of testing and you will roll straight into the new phase?

Dr Coleman: I am confident that the conversation around all people being symptomatic needing testing, moving forward, will be finalised, yes. The rest of the conversation about which cohort groups will be proposed as cohort studies is likely to continue as well. I believe they will be having that conversation over the next week in national cabinet.

MRS DUNNE: Dr Coleman, can I get some reinforcement on this? Generally speaking, asymptomatic patients have very low virus load; is that essentially what you are saying, and that they tend to be less potent spreaders?

Dr Coleman: Yes. If asymptomatic people exist—and we think that the asymptomatic people may actually be pre-symptomatic or post-symptomatic; there is still some question around that itself, about whether it is before or after the symptoms have appeared—we are confident that there is very low viral load if they are infected and that they are a very low transmission risk.

MRS DUNNE: I have another question, and for the most part it is probably to be taken on notice. There seem to be a range of complications because, essentially, it seems to be an inflammatory disease. Could you point the committee to what the current thinking is about complications and what the long-term impact might be for people at the severe end? There has been lots of discussion, and I would like the committee to be informed about, medically, what the concerns are about the long-term complications associated with COVID-19.

Ms Stephen-Smith: We should probably take that on notice and provide the committee with some references that the AHPPC and health experts think are the best ones.

MRS DUNNE: That would be great; thank you.

MS LE COUTEUR: I would like to talk about the pop-up ED unit. What criteria do you have for its use? Given that, presumably, it will not have a lot of clients when it starts, what protocols do you have for its actual use?

Ms Stephen-Smith: I will hand over to Dave and Duncan to talk a bit more about this shortly. When we announced the construction starting, one of the things that I said was that the best-case scenario would be that we would not use the facility. It was clearly intended to be an emergency department surge facility. That is what the design has been towards. You are right; at this point in time, with no active cases, it is looking like we may not need that emergency department surge capacity. But this situation may change. It is really important to recognise that, while we are in a really good position, there is still a virus out there in the world and there is still a virus out there in Australia. We have seen in other places how quickly cases can multiply once you start getting a few clusters in a community.

We have been clear that this is a COVID facility and that it will be used only for COVID purposes. Construction is progressing well and it is on track to be completed

in mid-May. We are now working through whether we use that facility for some simulation work, whether we use that facility for some other COVID-related activity, or whether we essentially keep it there and available as an emergency department surge facility, should it be required at some point during winter for COVID patients. That is the work that we are doing at the moment. I will hand over to the CHS and MPC teams to talk about what the step thinking around that is and how much we have co-spent on the facility to date.

Mr Peffer: The surge centre was always designed and envisaged to provide that surge capability as part of our territory-wide plan. The surge centre fits neatly within the trigger thresholds that we have as we progress through that plan. We have, essentially, a baseline; as we move through baseline capacity, we flex up, which is where we bring online additional capacity either within or adjacent to ICUs, EDs and patient wards across the territory. From flex, we then move in to surge. It is at that point in time that the surge centre is activated.

The contracting arrangements for the surge centre provide plenty of flexibility for the territory to activate capacity and bring it online with a three-week runway or notification to Aspen Medical when we anticipate that demand will require us to have that capacity online.

The surge centre is currently a part of that territory-wide plan. It has clear triggers for when we would bring it online as either an emergency department or potential ward capacity, depending on what is required. It does have capacity in it for resuscitation, and that is how it has been factored into the plan at this time.

MS LE COUTEUR: Is there any plan for when it will be transiting out of COVID-19 if we continue to have a lack of demand—which we would be grateful for—or will it just be empty?

Mr Peffer: No, the centre was always envisaged as a temporary facility. The planning exemption that provided for construction of the surge centre is tied to the declaration of the health emergency at the moment. If that declaration no longer exists then the planning exemption requires that the surge centre is demobilised and deconstructed.

It has been designed in such a way that the majority of the facility can be demobilised and stored in 20-foot shipping containers; so it is mobile and it can be moved and reconstructed at a different site if it were to be needed there. But at this stage there is absolutely and unequivocally no question about it being a temporary surge centre associated with the current pandemic.

MS LE COUTEUR: You said it was a three-week—I think you used the word "runway"—or notification period for people to start working in that area. That seems like an awfully long time if we do get a second wave. Is that going to work? What happens if we do get a rapid increase in cases and it has not been stood up?

Mr Peffer: No. We have agreed with Aspen Medical to provide us with the flexibility to scale up or scale down as required. There were two ways that we could have done it. We could have locked in everything up front and we would have been potentially paying for capacity that was not required to come online in the surge centre; or we

could provide ourselves with the flexibility which gives us discretion in notifying Aspen Medical to stand up that capacity in the surge centre when it is required.

We went with the latter, recognising that the environment we are operating in, week to week, is changing significantly. We felt that the flexibility in being able to switch on or activate capacity in the surge centre outweighed the potential risks around that three-week runway.

Having said that, Aspen Medical has commenced its recruitment activities to identify the workforce that would be located within a surge centre if it were to be activated. They have their register of clinicians that they would be able to call on. Three weeks has been the best endeavours target set in the overarching contract, but it is possible that it may come online sooner, if Aspen is able to do that. That is how we have structured the workforce arrangements within the surge centre in the contract.

MRS DUNNE: In relation to the Aspen facility, there is a contract on the contracts register which covers what seems to be, essentially, the build, and that is a $14 million-and-change contract. Is there a service contract and, if so, where is it and can the committee see it?

Mr Edghill: As Mr Peffer just mentioned, the way that the contract has been structured is that there is a head contract with what we call work orders underneath. It is the work orders underneath that trigger the provision of the services.

MRS DUNNE: Currently, the work order is for building the facility. What you are saying is that there will be other work orders under that. How do I reconcile that this is a $14 million contract with the announcement that, overall, it would be a $23 million contract until the end of June if it was used as a surge facility? I am just trying to reconcile the figures.

Mr Edghill: The structure of the contract has been done, as Mr Peffer said, so that it is part of the mechanism to be able to ramp up and ramp down the clinical services as needs be. There are two work orders which have been signed at present and which are on the contracts register underneath the master terms and conditions. The first one is for the design and construction of the facility, and that is well underway.

There is another that has been incorporated as a work order under the contract for equipment purchases which are necessary to go into the facility. And then, as and when those operating services are needed, there will be potentially multiple work orders which are signed and which trigger the provision of those services. That is part of that flexible arrangement.

MRS DUNNE: How much of that $14 million that is currently attached to that contract is build and how much is equipment?

Mr Edghill: There are the two components. The exact numbers are commercial-in-confidence but, in broad terms, the design and the construction of the facility is in the vicinity of $10 million and then the purchase order for equipment has been put in, which is up to the value of $3.5 million. Those two numbers together get to the $14 million.

MRS DUNNE: Why are these figures commercial-in-confidence?

Mr Edghill: Sorry?

MRS DUNNE: Why is the build contract commercial-in-confidence?

Mr Edghill: The contract itself is up there but, as with most of our contracts that we enter into across the entirety of our infrastructure program, the exact dollar amounts are often redacted because there is some commercial sensitivity to those from the private sector in terms of—

MRS DUNNE: I am asking what are the commercial sensitivities.

Mr Edghill: That is primarily a question for Aspen Medical, given it is Aspen that requested that certain information be kept confidential, which is regular. That normally happens in our infrastructure program with our delivery partners. But, in broadbrush terms, the $14 million is the work orders which have been signed to date, which are approximately in that sort of $10 million range for the design and construction component and $4 million for equipment, or up to.

MRS DUNNE: Is my reading of the contract correct that the territory owns both the building and the equipment at the end of the process?

Mr Edghill: Correct, absolutely. There is retained value in what is being built at the moment for the territory. As Mr Peffer noted, it is being constructed in a way where it can be dismantled. Around 90 per cent of the materials can be re-used. There will be future options for the ACT government either to use the facility for other purposes or to think of other methods for disposal. There is inherent value in what is being delivered.

MRS DUNNE: The contract itself was executed on 24 April; is that correct?

Mr Edghill: That was the signing date, correct.

MRS DUNNE: From answers to questions on notice we can see, minister, that there was agreement in principle between you and the Chief Minister back on 22 March, from memory, to go down this path with Aspen. Then cabinet signed off on it on 16 April, which was the day before the Chief Minister last gave evidence to this committee. What was the long delay, and how does this pass the pub test that, maybe at the time the decision was made to go to Aspen, it looked like we would need surge capacity? Clearly, we do not currently need surge capacity. Has there been any thinking between 22-ish March and 24 April, when the contract was signed, on whether or not we needed to go ahead with this?

Ms Stephen-Smith: I will hand over to Dave and Duncan to talk about the detail of why it takes some time to negotiate an agreement like this. But, essentially, when the decision was taken, we were entering into good-faith negotiations with Aspen Medical. They were certainly ramping up design, having a lot of conversations with Canberra Health Services about the model of care, what we were potentially going to

need from an infrastructure perspective and what we were potentially going to need from a staffing perspective. They had clearly put resources into this effort. Even when we held the press conference at the beginning of construction, we did not know that we would be where we are today. There was still a high level of uncertainty about what the course of this pandemic was going to look like in Australia. And there still is, to be frank.

I think there is an element that we did need to move fast and that we needed to move in good faith with our partners at Aspen Medical. But I hand over to Dave and Duncan to talk about the process of what happened between 22 March and 24 April.

MRS DUNNE: Can I also ask: the Chief Minister's answer to a question on notice says that you, minister, and he, the Chief Minister, had an in-principle agreement back on 22 March. When did we first come up with the idea of building (a) surge capacity and (b) having a discussion with Aspen about that surge capacity?

Ms Stephen-Smith: That was quite a quick process, so probably in the week or two before that initial in-principle discussion and conversation. But again, I hand over to Dave to talk about it.

MRS DUNNE: Could we tie down that date, that timing, on notice, please?

Ms Stephen-Smith: Yes.

Mr Peffer: That is correct. The thinking around designing a surge centre to provide that additional capacity that could come online rapidly did really occur in the week before the in-principle agreement, during a meeting between the minister and the Chief Minister. Following that, there was an exchange of letters in which the Chief Minister, as Treasurer, was settling with agencies, on treasury advice, the funding to be outlined in the supplementary appropriation that would be provided for a range of COVID-19 response activities. As part of that, endorsement was given to proceed and enter the contract with Aspen up to the given value that we have discussed.

At that point in time when the decision was announced, we had been working with Aspen for the week, sort of designing what that facility could look like. It was very much a fluid process, and I think we benefited from the willingness of Aspen to be flexible through that design period and also in looking at the model of care within the surge centre.

Had we agreed to all the terms up-front, I do not think we would have ended up with a contract that provides us with the flexibility to issue the work orders that Mr Edghill has talked about and bring capacity online for the surge centre to meet the demand as it arises. But in terms of the actual contract negotiations and the process that we went through for the surge centre, I will pass to Mr Edghill.

Mr Edghill: Between 9 April, which is when physical activities began on site, and 24 April a few things happened. One was a commitment to purchase equipment which was being made in that period and was subsequently incorporated under the master terms and conditions. But then, secondly, there was a process that we needed to work through in terms of structuring the contract in a way that would make it good for the

ACT government and for Aspen too. Whereas originally we could have gone with a contract that had everything in it, holus bolus, it did take us a little while to restructure the contracts to have a master set of terms and conditions and then the work orders underneath.

But certainly, one of the key learnings that we have had from the project so far is that there are complexities in building a facility such as this, and I think we are very grateful that we are now starting in circumstances where we are not at peak surge and peak issues with the pandemic because in that sort of situation you are getting into further restrictions on being able to build on site, supply chain issues and so forth. It obviously does take a while to build a facility like this. It started on 9 April, the phase when we have had it delivered. I think, in retrospect, one of our key learnings is that now has been the right time to actually deliver it, rather than waiting until the pandemic becomes appreciably worse.

MRS DUNNE: I have a couple of very brief supplementaries, and if you have to take them on notice I am happy. What is the floor space of the facility on Garran oval?

Mr Edghill: I will take that on notice, but it is in the order of 2,000 square metres.

MRS DUNNE: And is that in any way comparable to the vacant floor space in Calvary Private Hospital that has not been fitted out?

Ms Stephen-Smith: We have discussed before whether vacant space in private hospitals or, indeed, in public hospitals would be an appropriate alternative to emergency department surge capacity, and I think it is really important that we remember we are talking about emergency department surge capacity.

Ms McDonald can talk a bit more about this if you would like, noting the time, but this element of the health services response is part of a very broad-ranging consideration of every single square foot of space in every public and private hospital across our city and thinking about how that would be most appropriately used in a response. Any suggestion that no consideration was given to all those other things is completely inaccurate.

MRS DUNNE: I did not make the suggestion; I asked the question. Do not—

Ms Stephen-Smith: And I am making the comment that there is an implication and that implication should not be read into how—

MRS DUNNE: I was asking for information; I was not making implications. Minister, this is not that sort of group.

Ms Stephen-Smith: I apologise. Others have. I hand over to Ms McDonald to talk about how that process has worked.

Ms McDonald: In looking at all capacity across the system, in particular with emergency department capacity, one of the principles of the model of care from a clinical perspective that our clinicians were very keen for us to understand and to implement was that we would keep our expansion of our services as close to the

existing services as possible. For emergency department expansion in our flex plan and then into our surge plan, we have some capacity which is located within the emergency department footprint, both at Calvary and CHS, and then expanding out from those footprints as close as possible.

What we have found, though, is that in both our facilities our emergency departments are reasonably locked in in terms of expansion space close to the emergency department. You are looking at then expanding out into ward areas, which are really not the best facilities for emergency department access. The option was then discussed with Aspen in terms of a standalone facility, whilst not as close as possible to emergency departments but reasonably close so that it could be self-sufficient as an emergency department.

Other space that is vacant or would require some sort of refurbishment has been included and looked at as part of our inpatient ward capacity and then also for expansion of intensive care, because intensive care, whilst you can do it close to the current ICU, you can also expand out into ward areas in a much more custom design, in terms of expansion. Emergency departments are much harder to do and run within a current ward environment or even more to refurbish into an emergency department. That is why we chose this particular option.

THE CHAIR: Minister, as of the date of the contract being signed—that is, about a week ago—how many people with COVID were in the emergency department?

Ms Stephen-Smith: I do not think that is probably the most useful metric because—

THE CHAIR: I would still like to know. As of 23 April, how many people with COVID were in the emergency department?

Ms Stephen-Smith: I think it is the number of people who present to the emergency department potential or suspect COVID that is probably a more useful metric than the number of people who are in the emergency department at any one time who are COVID positive because, obviously, people present to emergency. They may or may not have COVID but they need to be treated as if they may potentially be a COVID patient.

The advice I had this morning was that on any one day there are probably—and I checked that this is right—between 30 and 50 people presenting with symptoms that mean that they have to be treated as if they may potentially be a COVID patient. Obviously, as we go into the winter season more people are presenting with respiratory symptoms, and that is a normal part of winter. I am not sure if that helps in terms of your—

THE CHAIR: Minister, you keep stats of people who are suspected COVID or potentially COVID cases?

Ms Stephen-Smith: Yes, in the sense that those people who are presenting to emergency with those symptoms would be treated in that way and would be tested. I hand over to Bernadette.

THE CHAIR: What might be easier would be if you take on notice each day, just as a time series for the committee, how many people presented, how many people were admitted with COVID and then how many people were discharged from COVID. That would be a very useful time series for the committee. Is that okay?

Ms Stephen-Smith: I think we need to recognise that those numbers of people with COVID admitted and discharged are going to be quite low because, obviously, we do not have very many people actually with COVID in our community.

THE CHAIR: I understand that. What was the date that the sod was turned at Garran oval to commence construction of this temporary facility?

Mr Edghill: 9 April.

THE CHAIR: What was the actual authority for the contractors to commence work on 9 April if there was no contract in place? What was the authority? How did they have the confidence to go ahead?

Mr Edghill: I think one of the things that we are actually quite grateful for during the process is that in Aspen Medical we have a partner who has been willing to work very cooperatively with the ACT government. Of course, there was an element for Aspen Medical of proceeding at their own risk, but I think it points to the collaborative and open nature that we have been working together that they felt confident moving forward.

Of course, on 9 April we did have the benefit of discussions and proposals from Aspen Medical. Before that work commenced we had ensured that, from a development approval perspective, all exemptions had been appropriately obtained. And it was also clear from the outset of those works, from a work health safety perspective, which party had possession of the site.

THE CHAIR: As of the sod being turned, had the final cost for the construction of the facility been agreed to?

Mr Edghill: For the design and construction component, yes; the pricing has not moved between what we discussed on 9 April and what went to the contract final.

THE CHAIR: Had the cost of the equipment been finalised or was that still up in the air then as well?

Mr Edghill: Subsequent to 9 April, there was a purchase order that was put in for equipment—and, just to put it into context, 11 April was Good Friday. We were actually working on this over the Easter weekend. And that is because what was being seen in the market at that point in time was that the availability of the equipment was drying up—not on a week-by-week or a day-by-day basis but there were changes hour by hour, both with respect to the supplier of the equipment and the price of the equipment too.

What we resolved with Aspen Medical—and it is reflected in the contracts, which are online—was that we agreed with Aspen Medical on the equipment list that would be

needed. One of the most tricky parts was the ventilators at that particular point in time. We agreed with Aspen Medical on the equipment list and the price up to which we would be comfortable with them negotiating for us. The reason why we did that is so we could move quickly to secure the equipment as needs be. The contract contains a mechanism whereby what we actually pay for the equipment will be up to or below that cap and we will pay on an open-book basis, where we actually have the invoices for the equipment from the original equipment manufacturer supplied to us.

THE CHAIR: I understand that the cost may be sensitive but can you please provide to the committee the equipment list, the date received or the fact it is pending, if so, and the brand, the manufacturer of that equipment and also who will own it?

Ms Stephen-Smith: I think we will take that question on notice because we will have to consider what elements of that are in confidence in terms of—

THE CHAIR: I would be very disappointed if the list of equipment was regarded as commercial-in-confidence, and whether it has been received and the manufacturer is commercial-in-confidence.

Ms Stephen-Smith: I understand that, and I am not saying it will be. I am just saying we will take that question on notice and provide as much detail as we can to the committee.

MS CHEYNE: Minister, there is quite a bit of national conversation in each state and territory about the relaxation of restrictions. Would the ACT even be able to think about relaxing any restrictions if we did not have the surge capacity that we now have with the Garran oval hospital?

Ms Stephen-Smith: Yes, I think we would be able to, but I do not think we would be in such a strong position in terms of the way the community has responded and the way our health protection services have worked to flatten the curve. I think the way we think about the ED surge facility is: when that decision was made and even when construction commenced, we did not know where we would be. The decisions about restrictions are also driven by where we are today and where we see the future of the pandemic in Australia. The Chief Minister has flagged that he will have more to say this afternoon in relation to the relaxation of restrictions, and he will probably have more to say next week as well.

National cabinet is obviously considering this issue at a national level. But that is really driven by where we are in the pandemic. I think if we were in a position where we needed the ED surge facility, we would certainly not be in a position where we were looking at easing restrictions and, indeed, we would be at a stronger level of physical distancing and lockdown restrictions than we have been to date.

MR PETTERSSON: I note the recommencement of elective surgery. What are the factors that are considered in making a decision like that to recommence them, and what information or concerns underpinned the decision to cease elective surgery originally?

Ms Stephen-Smith: There are a couple of factors: the availability of personal

protective equipment, PPE, was a significant factor in the decision at the national level to cease both category 3 and most category 2 elective surgeries for a period. That really was about preserving that PPE and making sure that it was going to be available should we see an increase in COVID-19 cases. It was also about making sure that we had the capacity within our health system to respond to an increase in COVID-19 cases coming into our hospitals so that we did not have intensive care units and wards taken up with people who were recovering from elective surgery.

Those were the two driving factors, and I guess, that the factor then coming out of that and opening up some more capacity for elective surgery is a lot more confidence around PPE supply chains. We are now getting messages from Brendan Murphy, the commonwealth Chief Medical Officer, about the level of confidence. And Greg Hunt talks about this a lot. The commonwealth has done a lot of work to secure PPE supply chains. It probably helps that some of the international production has come back online, some of those supply chains have improved internationally, but there has also been a lot of work going on into securing supplies, which were pretty competitive for a period there. Those are the same factors that are going to drive any further decisions about opening up elective surgery further, making sure that we continue to have enough PPE, making sure that we continue to have enough hospital system capacity, should we see a spike in new cases.

MR PETTERSSON: My take from that is that this decision is more to do with easing concerns about PPE as opposed to changes in the expected future outbreak.

Ms Stephen-Smith: I think the two things are related. It is both. It is certainly about PPE availability in the event of a future outbreak, but the decision to return to more elective surgery is not based on a view that we will not get a second wave of COVID patients; it is based on the view that we are not seeing that wave at the moment and also that we are confident in that PPE supply line, should we see that into the future, whereas probably three or four weeks ago we did not have that level of confidence and we were really basing our decisions on how much PPE have we got now and what is our constrained supply line looking like and making sure that we are conserving as much PPE as possible.

MRS DUNNE: Can you tell me how many of the 106 cases of COVID-19 in the ACT have been in people 19 years or younger? I think I know the answer but I just want to have it clarified.

Dr Coleman: I can tell you. I can tell you that there have been fewer than five.

MRS DUNNE: You cannot tell us precisely how many?

Dr Coleman: We routinely do not release information in categories that are fewer than five because the risk of identifying somebody is too great, from our perspective.

MRS DUNNE: But on a daily basis you put out updates that give the age group, the age span, and there was one occasion when you put out an update where you specifically said that there was a student and what school that student came from. Can you answer the question: how many people of school age, 19 or under, have had COVID-19?

Dr Coleman: With respect to the student information, we would not go out first with that; that was out in the public and there was a clarification and a conversation with the family in question that that would be acceptable. At all times, when we release any information at that level, we seek permission from the family and the individual in question. I have not sought individual information or permission from the individuals in question, under 19 years of age. At this time, it is not—

MRS DUNNE: I actually thought this was a simple question but it seems it is not. Is the answer that the reason that you are not releasing that information in more detail is that they are minors, or is that a standard practice that you do not put out information in age categories?

Ms Stephen-Smith: It is standard practice that we do not put out that kind of information, and we see it every year in relation to flu data, as well, when we are asked how many people have died as a result of flu. If that number is fewer than five, we do not give a precise number; we just say it is fewer than five. That is standard practice in terms of releasing those numbers on those kinds of issues.

In relation to the student, there was also the compounding factor of, obviously, the school needing to close for cleaning. Those kinds of factors will also influence when further information is provided to the community because it is actually something that the community needs to act on or will see action being taken in relation to.

MRS DUNNE: That is clear, I think, but not satisfactory.

THE CHAIR: Thank you for your attendance, minister and officials. As per usual, you will be sent a draft copy of the transcript. Please check that that is accurate, particularly with regard to attributing the comments to the right person. Quite a few questions were taken on notice. The committee would very much appreciate those responses as quickly as possible. This committee hearing is adjourned.

The committee adjourned at 12.11 pm.