



Special Commission of Inquiry into the Ruby Princess

# EXHIBIT 93

Second statement of Dr Sean Tobin dated 19 June 2020 (including annexures)

# **SPECIAL COMMISSION OF INQUIRY INTO THE RUBY PRINCESS**

## **Second Statement of Sean Tobin, 19 June 2020**

### **Response to Questions from the Special Commission of Inquiry**

- 1 My full name is Sean Nicholas Tobin.
- 2 I have previously signed a statement dated 29 May 2020, and given oral evidence on 9 and 10 June 2020. Set out below are questions from the Commissioner, and my response to those questions.

**Question 1: In relation to the asymptomatic case in Germany he referred to in his evidence on 9 June 2020, could Dr Tobin please provide details as to when he thinks that case occurred.**

- 3 I believe I first became aware of the asymptomatic case in Germany through an email sent to me from the Center for Infectious Disease Research and Policy (CIDRAP) Academic Health Center, University of Minnesota on 1 February 2020 which included a link to their website's summary report of the publication. A copy of the email I received from CIDRAP, and the summary report linked in the email, appear as **Annexure SNT-1**.

**Question 2: Could Dr Tobin advise, as definitively as he can (and with references to contemporaneous documents if available), when he personally regarded it as important to stipulate that there be two swabs taken from people who were swabbed for flu on board cruise ships?**

- 4 I believe this was on 19 February 2020, following an email from Professor Ferson. A copy of Professor Ferson's email appears as **Annexure SNT-2**.

**Question 3: Could Dr Tobin please provide an exhaustive list of the documents and data to which he personally had regard when devising the**

**draft protocol of 19 February 2020 at Tab 18 of the NSW Health Statements Annexure bundle? (T13 on 10 June 2020).**

- 5      **Annexure SNT-3** contains a list of publications in January and February 2020 that I was reading and conscious of when contributing to the drafting of the 19 February 2020 procedure.

**Question 4: Please provide any information that was available to Dr Tobin from cruise ship companies regarding the difficulties experienced in obtaining sufficient swabs for Covid- 19 testing. If nothing was done to address the deficiencies that were canvassed in evidence re the number of stipulated swabs, please provide an explanation and consideration of why that was the case. Additionally, the Commissioner seeks an explanation as to why swabbing passengers onboard prior to disembarkation did not follow as a result of any deficiency in relation to the availability of swabs (T39 on 10 June 2020).**

- 6      I do not recall receiving any direct communications from cruise ship companies about difficulties in obtaining respiratory swabs.
- 7      Concerning communications from the Ruby Princess regarding the availability of swabs, I refer to **Exhibit 55** tendered on 17 June 2020, which is an email chain ending in an email from Ruby Senior Doctor on 7 March 2020 at 9:30pm.
- 8      On 13 March 2020 at 9.58pm I was copied into an email from Dr Selvey where she reported on a meeting of the Communicable Diseases Network Australia (**CDNA**) and the Public Health Laboratory Network (**PHLN**) to discuss reducing COVID-19 laboratory testing due to a national and international shortage of consumables, including respiratory swabs. The email from Dr Selvey outlined a strategy to reduce unnecessary testing and reduce swab usage. A copy of Dr Selvey's email, which was also copied to Roy Byun (who was the PHEOC Laboratory Liason Officer), appears as **Annexure SNT-4**.

- 9 The Ruby Princess was considered low risk at the time of the risk assessment being undertaken on 18 March, and I didn't turn my attention to the number of swabs in relation to the 19 February Procedure.

**Question 5: All information available to Dr Tobin as to who it was that granted pratique to the Ruby Princess on 18/19 March 2020, in what terms, and why? (T47 on 10 June 2020)**

- 10 As at 18-19 March, I did not know who granted pratique for the Ruby Princess.
- 11 From the documents available to me, I understand that Ms Ressler emailed Ruby Senior Doctor and others on 18 March 2020, advising that an on board health assessment was not required (see Annexure 19 to Ms Ressler's statement), and Ms Ressler sent text messages to Mr Odermatt on 19 March 2020 that it was ok to disembark (see the document referred to in footnote 123 of the voluntary statement from the Commonwealth of Australia (**Commonwealth Statement**)).
- 12 I am not aware of any other documents from NSW Health in relation to the grant of pratique on 18-19 March 2020.

**Question 6: Dr Tobin is asked to provide copies of any written procedure as to the granting of the medical component of pratique, (T79 on 10 June 2020)**

- 13 The following procedures were developed prior to the on-set of the COVID-19 pandemic, and provide guidance on the granting of the medical component of pratique:
- (1) NSW Health Human Biosecurity Officer Guideline dated 3 March 2017, a copy of which appears at **Annexure SNT-5**
  - (2) Standard Operating Procedures for CDONCALL Officers dated 19 August 2019. The relevant pages from the Standard Operating Procedure appears at **Annexure SNT-6**; and

- (3) Document 25 of the documents accompanying the Commonwealth's Statement. While I had not seen that guideline before, the guidance to the Biosecurity Officer in relation to attending to ill travellers and communicating with HBOs and CHBOs is consistent with my understanding.
- 14 In relation to COVID-19 communications, document 31 of the documents accompanying the Commonwealth's Statement is an email exchange between Ms Ressler and Franz Odermatt which sets out a process for communications as to whether public health assessments would be required.
- 15 Tab 28 of the Annexures to NSW Health Witness Statements, which is the CoVID-19 Response – Cruise Ship Screening Procedure, at:
- (1) page NBM.100.001.0279 refers to the communication with, among others, the Sea ports biosecurity officer that NSW Health will not be conducting a public health assessment.
  - (2) page NBM.100.001.0285 includes contact details of Mr Odermatt and Border Force; and
  - (3) page NBM.100.001.0289 is the cruise ship assessment summary form, which provides a checklist for whether the information has been reported to the PHUD/HBO and whether the PHUD/HBO has confirmed if pratique granted.

**as well as an explanation of:**

- (i) any lines of communication as systematically set up and explained to him re communication to and from biosecurity officers who ultimately granted pratique for a ship; and**
- 16 In addition to the relevant portions of the documents referred to in paragraphs 13 to 15, I understand from Public Health Units that Biosecurity Officers working in NSW have been provided with information on how to contact a Human

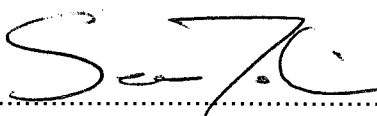
Biosecurity Officer in NSW relevant to their area of work and have included these details in the standard operating procedures used by the Biosecurity Officers. For Biosecurity Officers working at seaports, I understand that this is generally through the public health unit in which the seaport is located. For example, the Overseas Passenger Terminal is located within the SESPHEU's district.

- (ii) **who it was that provided the medical input necessary before a biosecurity officer would feel able to grant pratique in the face of a COVID-19 risk? (T100 on 10 June 2020).**

17 An HBO or a CHBO.

**Question 7: Please provide detail of any other ships of which Dr Tobin had experience that made a material change to the state of art, as opposed to simply providing further instances of the potential for cruise ship passengers to be asymptomatic and transmit infection in the community? (T68 on 10 June 2020)**

18 I have no further details to provide.

Signed:  .....

Name: Sean Nicholas Tobin

Date: 19 June 2020

-----Original Message-----

**From:** CIDRAP [redacted@umn.edu]

**Sent:** 1 February 2020 10:15 AM

**To:** Sean TOBIN [mailto:redacted]

**Subject:** Daily News Headlines



## Daily News HEADLINES

UNIVERSITY OF MINNESOTA

Jan 31, 2020



### nCoV expands in Europe; antiviral drug study to launch in China

[Lisa Schnirring | News Editor | CIDRAP News | Jan 31, 2020](#)

The outbreak is now approaching 10,000 cases, including 213 deaths.

[More »](#)



### German nCoV probe notes likely spread before symptoms

[Lisa Schnirring | News Editor | CIDRAP News | Jan 31, 2020](#)

"We are learning more about the biology of this virus, its transmission dynamics, and clinical spectrum every day."

[More »](#)



## CDC quarantines 195 passengers; US declares nCoV public health emergency

Stephanie Soucheray | News Reporter | CIDRAP News | Jan 31, 2020

The 2019-nCoV-related move is the first federal quarantine in more than 50 years.

[More »](#)



## Mutated Strep strains found with lower antibiotic susceptibility

Chris Dall | News Reporter | CIDRAP News | Jan 31, 2020

Group A *Streptococcus* has been deemed universally susceptible to beta-lactams, but the armor might be cracking.

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## News Scan for Jan 31, 2020

- US flu rebound, kids' deaths
- Recent DRC Ebola cases
- Pathogen-spewing hospital toilets
- MERS in the UAE
- Polio in 4 countries

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Center for Infectious Disease Research and Policy  
Academic Health Center, University of Minnesota, Minneapolis, MN

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# German nCoV probe notes likely spread before symptoms

Filed Under: [COVID-19 \(/infectious-disease-topics/covid-19\)](#)

[Lisa Schnirring | News Editor | CIDRAP News \(/ongoing-programs/news-publishing/news-publishing-staff\)](#) | Jan 31, 2020

One of the key questions in the fast-growing novel coronavirus (2019-nCoV) outbreak has been the possibility that asymptomatic people transmit the virus to others, and German researchers yesterday who described a workplace illness cluster suggest that it probably played a role in virus spread.

The report involves Germany's first patient, whose illness was announced on Jan 28. German researchers detailed their investigation findings in a letter to the *New England Journal of Medicine*.

Earlier this month, Chinese health officials said they suspected a role for transmission in the outbreak when a patient has no obvious symptoms, but experts have said they are waiting for more evidence. Asymptomatic transmission is known to occur with other respiratory viruses, but it isn't thought to be a major driver of disease spread.

## Reassessment of transmission dynamics?

The man had attended work meetings with a Chinese colleague who became ill on the plane as she returned home to Shanghai, where she was diagnosed as having 2019-nCoV.

On the day after she tested positive, she reached out to the German company, and contact tracing began. The man—who had been sick a few days before with fever and cough—was now fever-free and well, yet he tested positive for the virus. He had not been out of Germany in the 14 days before his symptoms began.

Two days later, three company employees tested positive for 2019-nCoV, but only one had contact with the Chinese woman, who is considered the index patient. The other two had contact only with their German coworker, the first to get sick.

All of them are hospitalized in isolation, and none have severe infections. Germany reported three more cases linked to the workplace cluster today, involving two employees who had contact with the earlier patients and a child of one of the employees.



alphaspirii

The authors wrote that the first patient's clinical course is notable, not only because it signifies local transmission, but also because the Chinese woman apparently transmitted the virus during the incubation period.

"The fact that asymptomatic persons are potential sources of 2019-nCoV infection may warrant a reassessment of transmission dynamics of the current outbreak," they wrote.

Also, the German man who was infected first had a high sputum viral load, even though he was recovering, which they said raises concerns about prolonged 2019-nCoV shedding after recovery.

### **Asymptomatic...or subclinical?**

Isaac Bogoch, MD, an infectious disease physician and researcher at the University of Toronto, said on Twitter today that the clinical spectrum can range from asymptomatic to subclinical to clinical, and the question is who is more likely to spread the virus to a greater number of people? People with subclinical infections may be shedding the virus and passing it to others, but might not be sick enough to seek medical care, he said.

He noted that the index patient reported to be asymptomatic later went on to become ill, a pattern seen with other respiratory infections.

He said typically it's symptomatic people who spread respiratory viruses by coughing, but it appears that asymptomatic people can transmit disease, as well. "But in general, when it comes to respiratory infections, those with symptoms transmit more," Bogoch said.

Quickly identifying symptomatic people can help prevent transmission to others, but the process depends on public education, public health, and healthcare capacity, he added.

Learning about 2019-nCoV requires being humble and open-minded, Bogoch said. "We do not have all the answers. We are learning more about the biology of this virus, its transmission dynamics, and clinical spectrum every day."

### **See also:**

Jan 30 *N Engl J Med* [letter \(https://www.nejm.org/doi/full/10.1056/NEJMc2001468\)](https://www.nejm.org/doi/full/10.1056/NEJMc2001468)

Jan 28 CIDRAP News story "[WHO seeks to answer nCoV unknowns as more local spread noted outside of China \(http://www.cidrap.umn.edu/news-perspective/2020/01/who-seeks-answer-ncov-unknowns-more-local-spread-noted-outside-china\)](http://www.cidrap.umn.edu/news-perspective/2020/01/who-seeks-answer-ncov-unknowns-more-local-spread-noted-outside-china)"

Jan 31 Isaac Bogoch Twitter [thread \(https://twitter.com/BogochIsaac?ref\\_src=twsrc%5Egoogle%7Ctwcamp%5Eserp%7Ctwgr%5Eauthor\)](https://twitter.com/BogochIsaac?ref_src=twsrc%5Egoogle%7Ctwcamp%5Eserp%7Ctwgr%5Eauthor)

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**CDC director thanks Americans, but warns COVID-19 pandemic is far from over**

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**Regeneron to begin trials for COVID-19 antibody cocktail**

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Office of the Vice President for Research, University of Minnesota, Minneapolis, MN

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## Annexure SNT-2

-----Original Message-----

**From:** Mark Ferson (South Eastern Sydney LHD) [mailto: [REDACTED]]  
**Sent:** 19 February 2020 5:06 PM  
**To:** Jeremy MCANULTY [mailto: [REDACTED]], Sean TOBIN [mailto: [REDACTED]]  
**Subject:** FW: COVID-19 Cruise Ship samples

[Comment from Kelly about swabs](#)

[If it's not too late maybe it could be incorporated into Kerry's letter to CLIA members](#)

**The following procedures should be used to collect nasopharyngeal swabs:**

- Collect two viral swabs using droplet precautions. One swab can be used for rapid influenza testing on board immediately but the other swab must be **placed in transport medium and** stored in a refrigerator in preparation for disembarkation and COVID-19 testing.

[Mark](#)

---

**From:** Kelly-Anne Ressler (South Eastern Sydney LHD)  
**Sent:** Wednesday, 19 February 2020 1:53 PM  
**To:** Mark Ferson (South Eastern Sydney LHD)  
**Cc:** Toni Cains (South Eastern Sydney LHD) ; Vicky Sheppeard (South Eastern Sydney LHD)  
**Subject:** Fw: COVID-19 Cruise Ship samples

Hi Mark

The guidance for taking swabs needs to come from the commonwealth through CLIA, we need to get the companies to stock the green tubes and train their medical staff, urgently. The advice to test flu swabs was only interim. We could then confirm with the ships during risk assessment that they have collected the correct swabs.

K

---

**From:** Leena Gupta (Sydney LHD)  
**Sent:** Wednesday, 19 February 2020 13:32  
**To:** Mark Ferson (South Eastern Sydney LHD)  
**Cc:** Vicky Sheppeard (South Eastern Sydney LHD); MOH-PHEOOperations; Toni Cains (South Eastern Sydney LHD); Kelly-Anne Ressler (South Eastern Sydney LHD)  
**Subject:** RE: COVID-19 Cruise Ship samples

Thanks- we will put in our procedure, but that would mean we should not be handling them either.

We are keen for timing reasons for the swabs to be done beforehand. So I guess will this information be communicated to the ships beforehand too and ask them to retake the swabs if done incorrectly. We don't want to be doing that as it will simply delay things and it can be done in advance with proper written guidance. Perhaps the guidance for taking swabs- could be sent with the pre-arrival information?

Thank you  
Leena

**Dr Leena Gupta**

Clinical Director | **Public Health**

L [REDACTED]

<http://www.slhd.nsw.gov.au/populationHealth/PHU.html>



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---

**From:** Mark Ferson (South Eastern Sydney LHD)

**Sent:** Wednesday, 19 February 2020 1:21 PM

**To:** Leena Gupta (Sydney LHD) [REDACTED] >

**Cc:** Vicky Sheppard (South Eastern Sydney LHD) [REDACTED] >; MOH-PHEOOperations

[REDACTED] >; @SESLHD-PublicHealthUnit-IDTeam [REDACTED]

[REDACTED]; Toni Cains (South Eastern Sydney LHD) [REDACTED]

[REDACTED]

Dear Leena

For some reason the medical centre staff on the Voyager of the Seas this morning improperly packed the swabs by placing two in each plastic bag 'head to tail' thus making it very difficult for the lab staff to handle the swabs safely. These swabs had already been collected by the medical centre and are from the rapid flu test kit. I didn't look closely at them when we were handed them this morning by the ship's doctor.

See the email below and attached photos from Anna Condylis, the scientist who runs Virology at Randwick.

Bill Rawlinson has asked that someone in each team check that – if the ship's medical centre has already taken swabs – that the swabs are not placed in this dangerous way. If they have for some reason the lab will not accept them and it is better to ask them to recollect a swab properly. And if your team is going to ask the medical centre to collect a swab from one or more patients, it is of course better to use the green labelled swabs containing transport medium.

Regards

Mark

**From:** Anna Condylis (NSW Health Pathology)  
**Sent:** Wednesday, 19 February 2020 1:03 PM  
**To:** Mark Ferson (South Eastern Sydney LHD) [REDACTED]; Vicky Sheppard (South Eastern Sydney LHD) [REDACTED]; MOH-PHEOOperations [REDACTED]  
**Cc:** William Rawlinson [REDACTED]; Susan McLennan (NSW Health Pathology) [REDACTED]; Robert Lindeman (NSW Health Pathology) [REDACTED]  
**Subject:** COVID-19 Cruise Ship samples

Dear Mark,

The samples we received today from Royal Caribbean Voyager of the Seas arrived in an unacceptable state. They were bloodied swabs without a sheath or cover placed directly into plastic bags (see photos). We processed them today due to the urgency but our staff were quite concerned. This is a WHS issue and considering the documented transmission of COVID-19, we will not be able to process samples that arrive in this manner in the future.

If required, we are more than happy to supply you with green viral swabs.

Regards,



**Anna Condylis**  
 Senior Hospital Scientist  
 Virology Laboratory, Microbiology Dept.

E [REDACTED] | W [www.pathology.health.nsw.gov.au](http://www.pathology.health.nsw.gov.au)

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NSW Health Pathology acknowledge the traditional custodians of the lands on which we work and pay our respects to ancestors and Elders, past and present. We are committed to honouring Australian Aboriginal and Torres Strait Islander peoples' unique cultural and spiritual relationships to the land, waters and seas and their rich contribution to society.

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## Annexure SNT-3

### Publications - February 2020

Backer J, Klinkenberg D, Wallinga J. Incubation period of 2019 novel coronavirus (2019-nCoV) infections among travellers from Wuhan, China, 20-28 January 2020. *Euro Surveill*;25(5)2020 (published online 6 Feb).

Chen J. Pathogenicity and transmissibility of 2019-nCoV—a quick overview and comparison with other emerging viruses. *Microbes Infect* 2020 (published online 4 Feb).

Gu X, Cao B, Wang J. Full spectrum of COVID-19 severity still being depicted – authors’ reply. *Lancet* 2020 (published online 14 Feb).

Guan W, Xian J. The progress of 2019 novel coronavirus (2019-nCoV) event in China. *J Med Virol* 2020 (published online 12 Feb).

Heymann DL, Shindo N. COVID-19: what is next for public health? *Lancet* 2020 (published online 13 Feb).

Horton R. Offline: 2019-nCoV outbreak—early lessons. *Lancet* 2020 Feb;395(10221):322 (published online 1 Feb).

Kampf G, Todt D, Pfaender S, et al. Persistence of coronaviruses on inanimate surfaces and its inactivation with biocidal agents. *J Hosp Infect* 2020 (published online 6 Feb).

Lee PI, Hsueh PR. Emerging threats from zoonotic coronaviruses—from SARS and MERS to 2019-nCoV. *J Microbiol Immunol Infect* 2020 (published online 4 Feb).

Patel A, Jernigan DB. Initial public health response and interim clinical guidance for the 2019 novel coronavirus outbreak—United States, December 31, 2019-February 4, 2020. *MMWR* 2020 Feb 7;69(5):140-6 322 (published online 5 Feb).

Thompson R. Pandemic potential of 2019-nCoV. *Lancet Infect Dis* 2020 (published online 7 Feb)

Wang FS, Zhang C. What to do next to control the 2019-nCoV epidemic? *Lancet* 2020 Feb 8;395(10222):391-3 (published online 6 Feb).

Wang LF, Anderson DE, Mackenzie JS, et al. From Hendra to Wuhan: what has been learned in responding to emerging zoonotic viruses. *Lancet* 2020 (published online 11 Feb).

Wilder-Smith A, Freedman DO. Isolation, quarantine, social distancing and community containment: pivotal role for old-style public health measures in the novel coronavirus (2019-nCoV) outbreak. *J Travel Med* 2020 (published online 13 Feb).

Xu Z, Li S, Tian S, et al. Full spectrum of COVID-19 severity still being depicted. *Lancet* 2020 (published online 14 Feb).

Zhang H. Early lessons from the frontline of the 2019-nCoV outbreak. *Lancet* 2020 (published online 11 Feb).

Zhou P, Yang XL, Wang XG, et al. A pneumonia outbreak associated with a new coronavirus of probable bat origin. *Nature* 2020 (published online 3 Feb).

## Publications - January 2020

Hui DS, I Azhar E, Madani TA, et al. The continuing 2019-nCoV epidemic threat of novel coronaviruses to global health—the latest 2019 novel coronavirus outbreak in Wuhan, China. *Int J Infect Dis* 2020 Feb; 91:264-6 (published online 14 Jan).

Lancet Editorial. Emerging understandings of 2019-nCoV. *Lancet* 2020 Feb;395(10221):311 (published online 24 Jan).

Li Q, Guan X, Wu P, et al. Early transmission dynamics in Wuhan, China, of novel coronavirus-infected pneumonia. *N Engl J Med* 2020 (published online 29 Jan).

Liu SL, Saif L. Emerging viruses without borders: the Wuhan coronavirus. *Viruses* 2020 Jan 22;12(2) (published online 22 Jan).

Nature. Stop the Wuhan virus. (Editorial) *Nature* 2020;577(7791):450 (published online 21 Jan).

Paules CI, Marston HD, Fauci AS. Coronavirus infections—more than just the common cold. *JAMA* 2020 (published online 23 Jan).

Rothe C, Schunk M, Sothmann P, et al. Transmission of 2019-nCoV infection from an asymptomatic contact in Germany (letter). *N Engl J Med* 2020 (published online 29 Jan).

Wang C, Horby PW, Hayden FG, et al. A novel coronavirus outbreak of global health concern. *Lancet* 2020 (published online 24 Jan).

## International situation reports

WHO Disease Outbreak News - Novel coronavirus

([https://www.who.int/csr/don/archive/disease/novel\\_coronavirus/en/](https://www.who.int/csr/don/archive/disease/novel_coronavirus/en/) ).

WHO COVID-19 Situation Reports (<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports>) – Situation reports 1-29.

ECDC COVID-19 Situation updates (<https://www.ecdc.europa.eu/en/covid-19/situation-updates> ).

## Australian Health Protection Principal Committee statements

(<https://www.health.gov.au/committees-and-groups/australian-health-protection-principal-committee-ahppc#statements> ).

13 February 2020 — travel restrictions and potential exemptions

1 February 2020 — expanded case definition, travel advisory, self-isolation for travellers from China, border measures

29 January 2020 — self-isolation for close contacts of confirmed cases, and travellers from Hubei

## Communicable Diseases Network Australia (CDNA) COVID-19 Guidelines

(<https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm> ).

Version 1.8 - 17 February 2020 - Inclusion of statement reflecting that passengers of the Diamond Princess cruise meet the criteria for close contact.

## Program for Monitoring Emerging Diseases (ProMED) COVID-19 information reports

(<https://promedmail.org/coronavirus/> ).

**Annexure SNT-4**

-----Original Message-----

**From:** Christine SELVEY [mail to: [REDACTED]]

**Sent:** 13 March 2020 9:58 PM

**To:** Jeremy MCANULTY [mail to: [REDACTED]], Kerry Chant (Ministry of Health) [mail to: [REDACTED]]

**CC:** Sean TOBIN [mail to: [REDACTED]], Roy Byun [mail to: [REDACTED]]

**Subject:** Testing strategy

Hi Jeremy and Kerry

As you are well aware, CDNA and PHLN met today to talk about reducing COVID-19 lab testing due to a national and international shortage of consumables, including reagents.

There are some things we can do to reduce unnecessary testing:

- inform clinicians not to test asymptomatic people
- ask that managing clinicians do not do repeat swabs on cases until the case is completely asymptomatic
- reduce swab usage by promoting the use of a combined nose/throat swab (where single swab kits have been provided)
- inform hospital clinicians **not** to do a resp viral screen with every COVID-19 test, unless the resp viral screen is clinically indicated, as the resp multiplex uses the same extraction and other reagents as the SARSCoV2 tests. However, for private labs, until there is an MBS item for COVID-19 testing, the private labs will only get paid for the resp viral screen.

Additionally Bill R is doing some work over the weekend to get data on the sensitivity and specificity of testing:

- by pooling specimens – he has some initial data from today showing good results from pools of 4 (which would quadruple capacity with the same amount of reagent)
- by using heat to denature the viral proteins thereby removing the need to extract the RNA – the extraction step uses the Roche kit which is in such short supply.

Nationally the Commonwealth is centralising procurement of a variety of COVID-19 supplies, including lab stuff; investigation local production, etc.

Today the CMO has written to all GPs to ask them to test according to the case definition only.

Cheers

Christine

**Dr Christine Selvey**

Acting Director | **Communicable Diseases Branch, Health Protection NSW**  
NSW Health, LMB 961, NORTH SYDNEY NSW 2059

[REDACTED]

[REDACTED]



# Human Biosecurity Officer Guideline

How to assess and manage a suspected case of a listed human disease.

Version	Date	Approved
1.0	3 March 2017	Dr Vicky Sheppeard Chief Human Biosecurity Officer (NSW)

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## Introduction

This guideline is intended for NSW Health medical officers designated as Human Biosecurity Officers (HBO) under the Commonwealth Biosecurity Act 2015 (the Act).

Most powers of HBOs under the Act are directly linked to the listed human diseases (LiHD), and the most significant is the imposition of a human biosecurity control order (HBCO). A HBCO can only be imposed if a person has symptoms or signs of a LiHD, was exposed to a LiHD or did not comply with entry requirements relating to a LiHD.

Most calls from a Department of Agriculture biosecurity officer (BO, previously AQIS quarantine officers) from Sydney Airport or other first ports of entry are likely to be requests to assess and manage illness in an ill traveller, or manage contacts of an ill traveller. In these situations, the main task of the HBO is to assess the probability of a LiHD and, if required, institute case and contact management, advise staff about personal protection measures, and provide advice on precautionary environmental cleaning and disinfection.

This guide focuses on how to assess for the likelihood of a LiHD, and subsequent case management options.

## Listed human diseases (LiHD)

At commencement of the Act on 16 June 2016 there are seven listed human diseases (LiHD):

- Human influenza with pandemic potential
- Severe acute respiratory syndrome (SARS-CoV)
- Middle East respiratory syndrome coronavirus (MERS-CoV)
- Viral haemorrhagic fevers (VHFs - various)
- Smallpox (*variola virus*)
- Yellow fever (YFV)
- Plague (*Yersinia pestis*).

These are also Category 4 notifiable conditions in NSW under the Public Health Act 2010, except Yellow fever, plague and smallpox which are Category 3 conditions. Note that the *Human influenza with pandemic potential* LiHD is equivalent to the category 4 condition *Avian influenza in humans* in the Public Health Act.

This is important to note as the Public Health Act also has provisions for making a public health order for Category 4 and 5 conditions under certain circumstances.

A public health order based on a Category 4 condition, being an order that requires the person to undergo specified treatment at a specified place, may authorise the person subject to the order to be detained at that place while undergoing the treatment.

A public health order based on a Category 5 condition may authorise the person subject to the order to be detained at a specified place for the duration of the order.

Detailed information on each of the listed human diseases can be found in the NSW Health control guidelines for that notifiable condition. See:

<http://www.health.nsw.gov.au/Infectious/controlguideline/Pages/default.aspx>

[Table 1](#) provides a guide to the major signs and symptoms, geographic distribution, and source exposure periods of interest for the LiHDs.

[Table 2](#) provides an overview of transmission modes and potential infectious periods for LiHDs.

## Traveller with illness checklist

When a BO is called to review an ill traveller they administer the traveller with illness checklist (TIC) in order to determine the management pathway, especially when escalation to a HBO is required. The TIC form is available for reference at [Appendix 1](#).

It is important to remember that BOs do not have any medical training and will usually only contact a human biosecurity officer if certain symptoms are reported as per the TIC algorithm.

The TIC identifies travellers with **fever in the past 24 hours** plus one or more of **cough, bleeding/bruising, rash, or jaundice**. A report of fever (fever, chills or sweats) in the last 24 hours is a requirement for any further assessment by the BO as part of the TIC.

The TIC will be administered in one of four settings:

1. On-board an aircraft or other vessel, prior to the disembarkation of passengers.
2. When an ill traveller is identified outside the vessel but prior to completion of all immigration and biosecurity procedures.
3. When an international traveller presents themselves to an immigration or biosecurity officer on arrival and indicates that they are unwell.
4. Following notification from the National Incident Room that an ill traveller is on a particular vessel.

## Responding to a call from a Biosecurity Officer (BO)

### 1. Take the call / call the biosecurity officer back immediately

Any call from a BO is potentially a call about the possibility of a LiHD in a traveller on a vessel prior to disembarkation of passengers.

It is essential that calls from a BO are actioned immediately as they may be coming from on board a plane with many hundreds of passengers waiting to disembark, who cannot disembark until the HBO has advised the BO on the action required.

### 2. Establish initial information before discussing symptoms in detail

Establish and document the following information in writing:

- the location of the person
- the full name and contact number of the BO
- the airline / vessel number and when it departed its origin (date and time)
- the ill traveller's full name, gender, date of birth and nationality
- which listed human disease the BO is concerned may be present
- the symptoms/signs that have been reported.

Use the NSW Health Biosecurity Officer Response Form ([Appendix 2 – NSW Health Human Biosecurity Response Form](#)) to record the incident details.

### 3. Assess the probability of a listed human disease

Ask the BO, and if necessary the ill traveller or family members directly or 'on speakerphone', about symptoms, date of onset, precise timing of travel in countries with the LiHD, and all potential LiHD exposures (e.g. camels for MERS- CoV).

In general, the pre-test probability of LiHDs in returning travellers is very low as the LiHDs are uncommon (YF, MERS) or exceptionally rare (others).

For there to be a reasonable possibility of a LiHD in a traveller entering Australia, there should usually be:

- a plausible exposure during the typical incubation period before the onset of symptoms AND
- symptoms compatible with the listed human disease AND
- a history of travel to an area with current epidemiological evidence of the LiHD.

The assessment of probability of a LiHD is based on best judgement. There may be situations where the above criteria are not met but the clinical suspicion of a LiHD remains high. For example, a traveller presenting with clinical features of a viral haemorrhagic fever without a known epidemiological link to an endemic or outbreak area.

### Assessment resources

Detailed information on each of the listed human diseases can be found in the NSW Health control guidelines for that notifiable condition. See:

<http://www.health.nsw.gov.au/Infectious/controlguideline/Pages/default.aspx>

[Table 1](#) provides a guide to the major signs and symptoms, geographic distribution, and source exposure periods of interest for the LiHDs.

[Table 2](#) provides an overview of transmission modes and potential infectious periods for LiHDs.



**Table 1. Key signs and symptoms, geographical distribution and likely exposure risks for each LIHD**

Listed human disease	Signs and symptoms	Geography	Exposures
<b>Human influenza with pandemic potential</b>	Some or all of: Fever, cough, sore throat, runny nose, muscle ache, headaches, fatigue.	No current pandemic identified. See advice at time of pandemic. Suspected avian influenza should be considered also because of pandemic influenza potential.	See advice at time of pandemic. Likely to be exposure to a case 2-7 days prior to onset. Ask about contact with birds or poultry in an affected country.
<b>SARS-CoV</b>	Symptoms consistent with severe pneumonia requiring hospitalisation, which includes: Fever, cough and other respiratory symptoms.	No known person-person transmission of SARS since 2003. Mainland China, Hong Kong or Taiwan might raise concern as previous places with circulation. See advice at time of re-emergence.	Currently, requires an exposure in 10 days prior to onset, either to country, case, healthcare setting or unexplained pneumonia cluster.
<b>MERS-CoV</b>	From most consistent to least: Fever and pneumonia, fever and respiratory illness, fever and upper respiratory symptoms.	Probability highly dependent on where travelled. See: country list in latest ECDC MERS Risk Assessment / Country list on CDC webpage / Recent ProMED reports.	Exposure in 14 days prior to onset to one of: confirmed case, camels / raw camel products in affected country, healthcare facilities in affected country, or affected country only.
<b>VHF (including Ebola virus disease)</b>	Fever +/- headache, muscle pain, weakness, fatigue, diarrhea and vomiting, abdominal pain, unexplained bleeding or bruising.	Previously West Africa and other African countries. See CDC outbreak distribution table for current places. Consider checking on ProMED.	Requires exposure in 2-21 days prior to onset to an area with a current outbreak, or contact with a known case.
<b>Smallpox</b>	Classically, an illness with acute onset of fever >38.3°C followed by a rash characterized by firm, deep seated vesicles or pustules all in the same stage of development without other apparent cause. Often with severe fever and headache and abdominal pain 1-4 days prior to rash illness. Rash is concentrated on face and limbs (centrifugal distribution)	Eradicated. Classify risk of smallpox as low, moderate or high according to CDC algorithm. See advice if re-emergence detected. Also consider Monkeypox. See CDC guide on assessment, including comparison with chickenpox (centripetal rash distribution) <a href="https://emergency.cdc.gov/agent/smallpox/clinicians.asp">https://emergency.cdc.gov/agent/smallpox/clinicians.asp</a>	Onset of symptoms 7- 17 days after exposure. See advice at time of re-emergence.
<b>Yellow fever</b>	None to mild or more severe. Initially fever, headache, muscle pain, vomiting and fatigue. Then sometimes a toxic phase of fever, jaundice, bleeding and multi-organ failure.	Endemic in Africa and 13 countries in Central and South America. Refer to WHO area map on CDC site. Also see Australian Government list.	Onset of symptoms if present at 3-6 days after exposure to mosquito bites in an affected area.
<b>Plague</b>	<b>Bubonic</b> - fever, headache, weakness and swollen lymph nodes. <b>Septicaemic</b> – fever, weakness, abdominal pain, shock. <b>Pneumonic</b> – fever, weakness, severe pneumonia, shock.	Endemic in many African countries (most cases), with epidemics occurring in Asia and South America. Madagascar, Democratic Republic of Congo and Peru are the 3 most endemic countries. See CDC map including WHO references.	Contact with infected animal tissue/fluid, flea bite. Takes 2-6 days to develop symptoms of bubonic plague, or 1-3 days for airborne exposure leading to pneumonic plague (prompt treatment vital).

**Table 2. Transmission mode and potential infectious periods for Listed Human Diseases (LiHD)**

Human influenza	Transmission via droplet transmission, airborne transmission or surface contamination (for 1-2 days, on hands for 5 minutes), from 1 day before symptom onset up to 7 days after (adults) or longer (children up to 21 days after onset)
SARS	Transmission via droplet transmission or surface contamination and possibly airborne transmission, from an unknown period before, during and after symptom onset
MERS	Transmission through close contact, probably droplet transmission but unknown, for an unknown period before symptom onset to at least 24 hours after symptoms end, but unknown
VHFs	Transmission by direct contact of mucous membranes with blood or body fluids of case, not air/water/food, from onset of symptoms in the case until after death (highest risk), and for prolonged periods in protected fluids like ocular fluids
Smallpox	Transmission through close contact, usually direct contact, but rarely airborne, from onset of fever until last smallpox scab falls off
Yellow fever	Cases are not infectious to other people – only to certain exotic mosquito species from shortly before onset to five days after onset of symptoms
Plague	Only pneumonic plague is infectious via direct close contact when droplets can be inhaled after the case coughs, from any point when coughing occurs.

#### 4. Review the options available

##### a. Patient management options:

1. No further action - the traveller is free to go;
2. Independent medical assessment - the traveller is free to go, but should be told to seek medical advice;
3. Further monitoring required – the traveller is free to go but must take further actions to monitor their condition and report to CDB or their local public health unit;
4. Hospital transfer - an ambulance should be arranged to take them immediately to hospital;

##### b. Options for non-compliant travellers:

1. Human biosecurity control order – a LiHD is suspected and a HBCO is imposed
2. Other actions under the Public Health Act 2010 – a LiHD is not suspected but there are other public health concerns, or a decision is made to use state powers to manage.

##### c. Grant or withhold pratique

#### 5. Determine the required case management and implement it

Subject to judgment, **a given listed human disease is suspected** if symptoms are compatible AND there is exposure to an affected geography AND the exposure is of appropriate timing and plausibility in relation to the incubation period.

- **Independent medical assessment should generally be recommended** if hospital transfer is not contemplated AND a HBCO is not contemplated (and a LiHD is not suspected) AND the person is unwell with any symptoms.
- **Hospital transfer direct from the port of entry should generally be arranged** if a LiHD is suspected AND the person is potentially infectious (Table 2) or is unwell even if not potentially infectious. Hospital transfers will also be required for people not suspected to have a LiHD but who are too unwell to go home.
- **A human biosecurity control order should generally be imposed** if a LiHD is suspected AND the person is potentially infectious (Table 2) and the person is non-compliant with public health recommendations. This would include the person intending to travel on to another destination despite identification of a potential LiHD that requires medical assessment in hospital.

**Pratique should generally be granted** once the assessment is complete, unless there is a compelling reason why it is unsafe to let passengers disembark. Such a reason might be a genuine belief other passengers were exposed to a LiHD and themselves need to be identified

and assessed before the mass of passengers is allowed to disembark.

In addition to the principles for management above:

- **For possible human influenza with pandemic potential**, no clear advice is possible at present on threshold for hospitalisation / HBCO, as there is no declared pandemic.
- **For possible SARS**, there should be a presumption of transfer of a suspected case to hospital in airborne, contact and droplet transmission-based precautions. In the absence of confirmed SARS cases in the world at present, a HBCO is not likely to be justifiable.
- **For possible MERS**, the threshold for transfer to hospital is probably presence of pneumonia and travel to countries with active cases, but to impose a HBCO probably requires pneumonia AND at least one of either confirmed case contact / camel exposure / healthcare exposure in a country with active cases
- **For possible VHF**s, the threshold for transfer to hospital when there is contact with an active outbreak area plus suspicion of LiHD and potentially infectious, regardless of how unwell the person is. A HBCO should be considered if the person will not agree to be hospitalised.
- **For possible smallpox**, no clear advice is possible at present, as there are no declared cases. A HBCO is unlikely to be required as patients are typically gravely ill.
- **For possible yellow fever**, hospitalisation should be considered for any suspected case who is unwell. A HBCO is unlikely to be justifiable even if non-compliant given lack of infectiousness to humans, unless the traveller is indicating an intention for onward travel to an area where there are mosquito vectors competent to transmit yellow fever (e.g. dengue-receptive areas of North Queensland).
- **For possible plague**, hospitalisation is highly recommended given poor prognosis without rapid antibiotics. A HBCO should be considered if non-compliant with any form of plague, especially pneumonic, however patients are usually so unwell it would not be necessary.

### What to do if you decide no further action is required

Undertake the following actions:

- Check you have recorded the full name, date of birth, gender of the ill traveller;
- Check you have recorded the contact phone number and intended residential address;
- Request that the BO scan and email a copy of the TIC form to [dooh.health.nsw.gov.au](mailto:dooh.health.nsw.gov.au) for record-keeping purposes;
- Enter details of the call on NCIMS as a new Human Biosecurity Report using the data entry wizard;
- Scan any paper notes as a PDF document and attach to the NCIMS file, and
- Inform the CHBO on the next business day.

### What to do if you decide an independent medical assessment is required

Undertake the actions above (under 'no further action') but also take down details of the intended general practice or general practitioner the person intends to seek care from.

### What to do next if you decide a hospital transfer is required

Undertake the following actions:

- Call the CHBO to discuss the case or, if unavailable within 15 minutes or known to be on leave, the Director, HPNSW;
- Obtain the BO Team leader's mobile number and advise the BO that Ambulance NSW will liaise with their Team Leader by mobile phone to arrange pickup location and timing;
- Contact the HSFAC for Ambulance NSW to organise urgent transfer in an appropriate vehicle to the Children's Hospital - Westmead (CHW) (if aged  $\leq 16$  years) or Westmead Hospital (WMH) (if aged  $\geq 17$  years), providing the BO Team leader's details for liaison;
- Call the on-call ID consultant for CHW or WMH to advise of the case and the details and timeframes for likely arrival.
- Provide advice to the BO on contacts and environmental management below;
- Send an email summary of the situation to the CHBO, CHO, Director Health Protection and CD On-Call;
- Liaise with all parties until the patient is admitted to hospital and determine next steps for confirming or otherwise the LiHD.

See [Appendix 3 – Contact details](#).

## **What to do if you decide that a Human Biosecurity Control Order (HBCO) is needed**

Consult [Appendix 4 – Decision algorithm for Human Biosecurity Control Orders](#).

An HBCO is only applicable for someone who is non-compliant with public health recommendations, i.e. refusing to follow any actions necessary, as determined by a HBO. This includes refusing transfer to hospital if directed, not complying with a request from a biosecurity official to provide information or to remain within an area at a port.

If there is a strong case for a HBCO:

- Call the CHBO to discuss the case, or if unavailable within 15 minutes, the Director - Health Protection or if unavailable, the Chief Health Officer.
- If there is agreement to impose a HBCO, follow the instructions in [Appendix 6 – How to implement a human biosecurity control order](#).
- Provide advice to the BO on contacts and environmental management below;
- Prepare to attend the port in person on the instruction of the CHBO. This is the only current scenario where in-person attendance at the port of entry is likely to be required.
- Notify the relevant PHU (usually South-East Sydney PHU) Director (or On-Call officer if director unavailable) to discuss possible staff attendance and assistance at the port.
- Maintain detailed notes and upload to a NCIMS Human Biosecurity Report.

## **What to do if you decide to grant pratique after a suspected LiHD**

If you assess that the ill traveller has suspected VHF, SARS, smallpox or possibly pandemic influenza and hospital transfer is planned or a HBCO contemplated and the vessel is an aircraft for which you plan to grant pratique following your assessment, take the following further steps:

- Discuss the matter immediately with the CHBO. If CHBO unavailable within five minutes, continue regardless with steps below.
- Grant pratique and instruct the BO to systematically record the following information about every passenger and crew member prior to permitting disembarkation:
  - full name; date of birth; contact phone number; seat number/role (for crew members) during flight
- Take further steps for the case as per hospitalisation / HBCO as determined.

Note that the collection of contact details from many passengers and crew may not be feasible for Biosecurity staff alone; this may require an escalated public health response to manage this exercise. See Point 8 below for instruction on escalating a public health response.

An option to speed up the process is for the BO to take the steward's copy of the passenger and airline staff manifest and record date of birth and contact phone number next to each person systematically. It must be possible to identify each and every disembarking person at the end of the process, including the pilots and all other crew members.

## **6. Advise on any required contact management and environmental management**

### **For possible human influenza with pandemic potential, for SARS and for MERS**

- Advise anyone with direct physical contact or who was within same room or section of the cabin for 15 minutes or more not wearing airborne protection to thoroughly wash hands and register as a contact.
- Advise cordoning off the health room / room the case was assessed in until cleaned using detergent and disinfected using a registered disinfectant by staff wearing PPE.
- Further action for contacts depends on whether the illness is confirmed in the suspect case(s) and/or discussion with CHBO/DHP/CHO.
- Note that for SARS, only routine cleaning of aircraft is recommended in the current setting with no SARS cases identified worldwide.

### For VHFs and smallpox

- Advise anyone with direct physical contact or who was within the same room as the case for 15 minutes or more without wearing airborne, droplet and contact precautions should wash hands and register as a contact.
- Advise that there should be no routine cleaning of aircraft and rooms occupied until specific advice is provided. A specialist environmental cleaning service may be required.
- Further action for contacts depends on whether VHF or smallpox potential is confirmed in the case.

### For Yellow fever

- Advise that there are no actions required by contacts and cleaning should be routine.

### For plague,

- Advise only those who had direct physical contact or who were within the same room as the case whilst the case was coughing with suspected pneumonic plague need to register as potential contacts. Standard cleaning and disinfection by staff wearing PPE, and further action depends on whether pneumonic plague is confirmed in the case.

## 7. Advise others of the situation and record your assessment and actions

When to escalate to CHBO by telephone (or Director HPNSW if CHBO unavailable):

- When you are not sure what to do, or
- If hospitalisation or HBCO is contemplated.

See the [Appendix 3 – Contact details](#).

Remember to record all actions as described above under *What to do if you decide no further action is required*.

## 8. Actions when an escalated public health response is required

The most likely (but still very rare) scenario where an escalated public health response is required is when a case of a suspected LiHD has been identified and it is determined that fellow passengers and crew are likely to be close contacts requiring registration for on-going public health monitoring.

This is likely to require a coordinated public health response, including:

- a public health field commander/team to attend the airport or seaport to collect the contact details of exposed passengers and crew and provide information and fact sheets
- establishment of a central and/or local public health incident response team to:
  - support the field command team
  - to commence contact symptom monitoring
  - liaise with the National Incident Room
  - coordinate public communications.

A decision to initiate an escalated public health response should be taken in discussion with the CHBO, Director – Health Protection, Chief Health Officer and PHU Director and HSFAC of the relevant local health district. The Office of the Chief Health Officer (OCHO) will also be key to supporting any centralised incident command structure (ICS).

See the [Appendix 3 – Contact details](#).

Also be aware that for incident involving Sydney International Airport or the international seaports in SES there will likely be implementation of the SES LHD Border Control Standard Operating Procedures (SOP).

## Appendix 1 – Traveller with Illness Checklist

Click on link:



Adobe Acrobat  
Document

Check for more recent versions on the H:/Drive. See under CDB/Human Biosecurity and Border.

## Appendix 2 – NSW Health Human Biosecurity Response Form

Click on link:



CDBOnCallAirportsRec  
ord-V2.pdf

Check for more recent versions on the H:/Drive. See under CDB/Human Biosecurity and Border.

## Appendix 3 – Contact details

### NSW Health

Chief Human Biosecurity Officer (CHBO)  
(and Director, Communicable Diseases)  
Director, Health Protection  
HPNSW CDOncall  
NSW public health units

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

### South-East Sydney Local Health District

SES PHU Director  
SES LHD HSFAC  
SES PHU After Hours contact

[REDACTED]  
[REDACTED]  
[REDACTED]

### Ambulance NSW

NSW HSFAC Emergency contact  
NSW Ambulance Controller

[REDACTED]  
Contact via NSW HSFAC

### Westmead Hospital (WH)

Direct Access number  
Ask for Infectious Diseases Physician on-call  
ICU shift co-ordinator  
Main switchboard

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

### The Children's Hospital at Westmead (CHW)

Main Switch  
Ask for the ID physician on call

[REDACTED]

### ICPMR (NSW Pathology – West)

CIDM Laboratory Service (CIDMLS)  
Normal hours  
After hours  
Ask for the Clinical Microbiologist on call

[REDACTED]  
[REDACTED]

### Australian Department of Health

National Incident Room (Canberra)

[REDACTED]



## Appendix 4 – Decision algorithm for Human Biosecurity Control Orders

Click on link:



Adobe Acrobat  
Document

Check for more recent versions on the H:/Drive. See under CDB/Human Biosecurity and Border.

## Appendix 5 – Human Biosecurity Control Order Form

Click on link:



Adobe Acrobat  
Document

Check for more recent versions on the H:/Drive. See under CDB\Human Biosecurity and Border.

## Appendix 6 - How to Implement a Human Biosecurity Control Order

Click on link:



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Document

Check for more recent versions on the H:/Drive. See under CDB\Human Biosecurity and Border.



Health

# STANDARD OPERATING PROCEDURES (SOP)

## FOR CDONCALL OFFICERS

INSTRUCTIONS AND ADVICE FOR CDB CDONCALL OFFICERS DEALING WITH  
COMMUNICABLE DISEASES INCIDENTS AND ENQUIRIES

COMMUNICABLE DISEASES BRANCH – HEALTH PROTECTION NSW

Revision Date:	19 August 2019
Version:	2.0
Status:	Current
Author:	CDB
HPERM	H17/46564

This revision: includes instructions for ordering Normal Human Immunoglobulin (NHlg) as post-exposure prophylaxis for susceptible contacts of specific infectious diseases (e.g. hepatitis A, measles, rubella), ordering Tetanus Ig IV for treatment, responding to calls about CPE cases/clusters, and Managing a Cold Chain Breach after hours.

## BORDER HEALTH (QUARANTINE) CALLS

The CDB Director is also the designated Chief Human Biosecurity Officer (CHBO) for NSW under the Australian Biosecurity Act, and so has powers under this act. This also means we support Commonwealth Department of Agriculture Border Health biosecurity officers who do limited human health screening at the borders on behalf of the Commonwealth Department of Health under the Act.

For more information on human biosecurity functions and powers at the borders, see the Human Biosecurity Officer resources at the NSW HBO resource documents folder - [H:\Human Biosecurity and Border\Human Biosecurity Officers\NSW HBO resource documents](#)

Most health powers under the Act are directly linked to the listed human diseases (LiHD), and the most significant is the imposition of a human biosecurity control order (HBCO). A HBCO can only be imposed if a person has symptoms or signs of a LiHD, was exposed to a LiHD or did not comply with entry requirements relating to a LiHD.

Most calls from a Department of Agriculture biosecurity officer (BO, previously AQIS quarantine officers) from Sydney Airport or other first ports of entry are likely to be requests to assess and manage illness in an ill traveller, or manage contacts of an ill traveller. In these situations, the main task of the HBO is to assess the probability of a LiHD and, if required, institute case and contact management, advise staff about personal protection measures, and provide advice on precautionary environmental cleaning and disinfection.

#### LISTED HUMAN DISEASES (LIHD)

At commencement of the Act on 16 June 2016 there are seven listed human diseases (LiHD):

- Human influenza with pandemic potential
- Severe acute respiratory syndrome(SARS-CoV)
- Middle East respiratory syndrome coronavirus (MERS-CoV)
- Viral haemorrhagic fevers (VHFs - various)
- Smallpox (variola virus)
- Yellow fever (YFV)
- Plague (Yersinia pestis).

It is not reliable to clinically assess a patient by telephone, and telephone advice should not replace clinical assessment. There are a few steps to responding to enquiries regarding ill passengers:

- 1. Ask the BORDER HEALTH officer if they have applied the Traveller with Illness Checklist. If not, ask them to apply it first and call back if required.**
  - This is a structured questionnaire. For a copy go to the NSW HBO resources documents folder. Usually this has been done and they have reached a point in the Checklist which instructs them to seek advice from a state HBO.
- 2. Ask BORDER HEALTH for details that have prompted the call, and record passenger's name, age, place of residence, places travelled in last 2 weeks, symptoms, and degree of illness.**
- 3. Provide advice: the most common advice is that if the patient is sick he/she will need to see a doctor and the patient should tell the doctor that he/she has been overseas.**
  - If the patient is sick enough to need an ambulance then the airport will need to arrange an ambulance without delay. Otherwise the patient should be advised to see a GP as soon as possible. (Should that doctor diagnose a quarantinable disease, then the routine surveillance system should identify them in a reasonable time period.)
- 4. Take action if required:**
  - Listed Human Diseases are unlikely to be identified by airport screening but – very rarely – a passenger may present with symptoms and a travel history suggestive of a serious infectious disease which requires careful infection control and transfer to specialist hospital for assessment.

- If suspected, ask for the passenger to be isolated with a face mask and for an ambulance to be called, while you urgently seek advice from one of the Medical Epix or the CDB Director.
- The following are some short notes on Border Health infections to help with assessment. For more information you might like to consult the NSW HBO resource documents folder.
  - A possible human case of **avian influenza** would be made if the passenger has a fever and respiratory symptoms and reports contact with chicken or other birds (other than cooked ones) in a part of a country known to have recently had an avian influenza outbreak or had contact with a patient (or their specimens) diagnosed with avian influenza. **If suspected, ask for the passenger to be isolated with a face mask and for an ambulance to be called, while you urgently seek advice from one of the Medical Epidemiologists or the CDB Director.**
  - **Middle East respiratory syndrome coronavirus (MERS-CoV)** – sporadic cases continue to be reported from affected parts of the Arabian Peninsula, principally Saudi Arabia. Cases have been exported to other countries, including a case linked to a large outbreak in South Korea. Cases are unlikely to be identified at the Airport. PHREDSS do maintain a search for MERS symptoms in patients presenting to EDs where there is mention of travel in Middle East in the previous 14 days. For further information see the MERS-CoV alerts page: <http://www.health.nsw.gov.au/Infectious/alerts/Pages/MERS-Alerts.aspx>
  - The early stages of **viral haemorrhagic fevers** (VHFs – e.g. Ebola, Marburg) may resemble influenza and so is hard to diagnose definitively. However patients are likely to become ill quite quickly with bleeding, rash, gastrointestinal and other symptoms that would warrant hospitalisation. For example, a passenger identified with these symptoms who has a history of recent travel to a country where VHFs are prevalent (e.g. parts of sub-Saharan Africa - DR Congo, Sudan, Zaire, Uganda, Ivory Coast) and have been exposed to patients or communities in which outbreaks are occurring. **If suspected, ask for the passenger to be isolated with a face mask and for an ambulance to be called, while you urgently seek advice from one of the Medical Epidemiologists or the CDB Director/CHBO.**
  - **Smallpox and SARS** do not currently exist in the world as human diseases (as at April 2012) and so would not be routinely considered in the absence of cases identified abroad.
  - **Yellow fever** is also not a risk at ports and passengers with suggestive symptoms and travel history can be referred to a major hospital for assessment.
  - **Yellow Fever Quarantine Surveillance** - well travellers who have recently been to a YF endemic area and have not received a YF vaccine are routinely identified on arrival. These people are usually placed under Yellow Fever Quarantine Surveillance which means that the traveller will only be permitted to enter Australia if they agree in writing to notify health authorities if they develop any symptom of yellow fever infection in the six-day period following their departure from the declared yellow fever place. They should also be discouraged from travelling to Far North Queensland where there are competent mosquito vectors for YF.
- If a LIHD or other serious infectious disease is suspected in a traveller at a NSW seaport or the international airport, the SES PHU (or HNE PHU for Newcastle) will be contacted to assist in arrangements for transfer to, and assessment at, a designated specialist hospital (e.g. Prince of Wales Hospital, John Hunter Hospital). Staff caring for the patient should be advised to observe standard, contact, droplet and airborne infection control precautions, and to care for the patient in a single room until medically assessed.

- If AI or a VHF is suspected, BORDER HEALTH will be requested to take the details of passengers in surrounding seats to the patient, so that PHU staff can counsel them and place them under surveillance if necessary. If fellow passengers have already dispersed, their contact details may be obtained from the Incoming Passenger Cards either from the airport or through arrangements coordinated by the National Incident Room (DOHA) if the IPC's are already off-site.

#### BORDER HEALTH CONTACT DETAILS

BORDER HEALTH Central East HQ [REDACTED] Rosebery NSW

Phone: [REDACTED] Fax: [REDACTED]

BORDER HEALTH Sydney Airport: Phone: [REDACTED] Fax: [REDACTED]