TRANSCRIPT

PANDEMIC DECLARATION ACCOUNTABILITY AND OVERSIGHT COMMITTEE

Review of Pandemic Orders

Melbourne—Monday, 31 January 2022

MEMBERS

Ms Suzanna Sheed (Chair)
Mr Jeff Bourman (Deputy Chair)
Mr Anthony Carbines
Ms Georgie Crozier
Mr Enver Erdogan
Ms Emma Kealy
Ms Harriet Shing
Ms Vicki Ward
Mr Kim Wells

WITNESSES *(via videoconference)*

Professor Brett Sutton, Chief Health Officer,

Ms Nicole Brady, Deputy Secretary, Public Health Policy and Strategy, and

Ms Jacinda de Witts, Deputy Secretary and General Counsel, Regulatory, Risk, Integrity and Legal, Department of Health.

The CHAIR: I would like to first of all declare open the public hearing of the Pandemic Declaration Accountability and Oversight Committee. This is the committee's first hearing following its establishment late last year under the new public health and wellbeing legislation.

I would like to also begin by acknowledging the traditional owners of the various lands on which we are meeting today. We pay our respects to them, their culture, their elders past, present and future and elders from other communities who may be here today.

Before I welcome our witnesses for today can I remind everyone that phones should now be turned to silent, and if you are on Zoom, leave your camera on at all times and microphone off unless speaking. Members may remove their masks when speaking but must put them back on when finished speaking.

Firstly, I would like to introduce our witnesses for today. I welcome Professor Brett Sutton, the Chief Health Officer; Ms Nicole Brady, Deputy Secretary, Public Health Policy and Strategy; and Ms Jacinda de Witts, Deputy Secretary and General Counsel, Regulatory, Risk, Integrity and Legal. Welcome, everyone.

Next I would like to introduce the witnesses to our committee—perhaps people could indicate by raising their hands. I am the Chair, Suzanna Sheed; Deputy Chair, Mr Jeff Bourman; the Honourable Anthony Carbines; Ms Georgie Crozier; Mr Enver Erdogan; Ms Emma Kealy; Ms Harriet Shing; Ms Vicki Ward; and the Honourable Kim Wells.

All evidence taken by this committee is protected by parliamentary privilege. Therefore you are protected against any action for what you say here today, but if you go outside and repeat the same comments, including on social media, those comments may not be protected by this privilege. The same applies to committee members. All questions must be answered fully, accurately and truthfully. Witnesses found to be giving false or misleading evidence may be in contempt of Parliament.

All evidence given today is being recorded by Hansard and the hearing is being broadcast on Parliament's website. You will be provided with a proof version of the transcript for you to check as soon as it becomes available. Verified transcripts, PowerPoint presentations and handouts will be placed on the committee's website as soon as possible. Broadcasting or recording of this hearing by anyone other than Parliament and accredited media is not permitted.

Professor Sutton, I invite you first of all to proceed with a 5-minute opening statement to the committee, which will be followed by questions from the committee. The committee will be looking to have 10 minutes each for questions given that we have a 2-hour time frame. We have just received the PowerPoint that was distributed on your behalf for your presentation, some of which I can say we are well aware of. But obviously your role and your tasks are the ones that we are probably most keen to focus on, so thank you.

Mr WELLS: Chair, can I call a point of order. It is just a procedural matter. From where Professor Sutton sits, can he see that this hearing is being held in a COVID-safe way—that is, that we are socially distanced and we have our masks? Can we just get confirmation that he can see that this is a COVID-safe way of holding a hearing?

Prof. SUTTON: Thank you. Apologies, but I cannot see anyone on the screen—oh, I can now. Yes, it looks pretty COVID-safe to me. Thank you.

Mr WELLS: Okay. So, then, the reason I am asking this procedural matter is: why aren't you in the room with us and why are you doing it by Zoom if we are following all the COVID-safe plans? I do not understand.

You are very keen to stand next to the Premier giving press conferences, but when it comes to a public hearing you are not here.

Ms SHING: Just further to the point of order, if I may, I am not sure, Mr Wells, as ambitious as that point of order might be, that it is actually a point of order. I suspect that it might well be a question that you want to put to Professor Sutton in the course of the hearing—

Mr WELLS: No, it was a procedural matter, and I asked it through the Chair. It was a procedural matter. The question is very simple: why isn't—

Ms SHING: You are going to the substance of Professor Sutton's advice.

Mr WELLS: No, you are not the Chair. I am asking the Chair. It is a procedural matter: why isn't Professor Sutton in the room with us? Because there is no reason why he cannot be with us if we are having a COVID-safe plan and this is following his orders.

Ms SHING: I would like to raise a point of order then in relation to that procedural matter, if I may, Chair.

The CHAIR: Do I need to rule on that one first?

Ms SHING: No, I get to raise it before you then knock it out of the room. The procedural matter as it relates to the way in which this hearing is set up is one thing. To ask Professor Sutton or indeed anybody else about why it is that they are here or appearing virtually or remotely is another. So I would actually seek to get a ruling from the Chair about the basis upon which, firstly, the procedural matter has been acquitted by reference to Professor Sutton's comments on the set-up of the room, and perhaps if Mr Wells has a question about Professor Sutton's attendance or otherwise—

Mr WELLS: It is a procedural matter.

Ms SHING: that it be dealt with in the course of questions after—

Mr WELLS: No, it is a procedural matter—

Ms SHING: I maintain through a point of order that it is not.

Mr WELLS: and we have asked very clearly and Professor Sutton has confirmed that this is COVID safe. So the question is, through the Chair: why isn't he here when everyone else is here? There are no exceptions; nobody else is doing it by Zoom. So the question is, quite clearly: why isn't Professor Sutton here in the room with us?

The CHAIR: On the point of order, there is no requirement for the Chief Health Officer to be present. We have a letter from the minister in response to our invitation to Professor Sutton and others that he attend, and it was noted then that he would be attending by Zoom. I think it is also relevant to note that the fewer the numbers in the one room the better, and I am content to rule the point of order out of order.

Mr WELLS: A further point of order. We still have not heard the reason why Professor Sutton is not here. I understand what you are saying, but we have not heard from Professor Sutton why he is not here.

Ms SHING: Just further to that point of order, the current recommendation is to work from home if you can. There is therefore scope for an individual to take the decision that works best for them in the circumstances that apply to them. It is not in fact a mandate. You would know that, Mr Wells, if you had read the advice.

Mr WELLS: Professor Sutton is at every press conference with the Premier, so why is this different?

Ms SHING: Sorry, Mr Wells. In addition to that, the parliamentary committee structure has allowed for witnesses and for members to attend virtually as a consequence of COVID-safe arrangements that have been in place for an extremely long period of time now. Mr Wells, you would be well aware of that, and indeed you have attended numerous hearings and indeed meetings virtually as well.

Mr WELLS: But Professor Sutton—

Ms WARD: Is this really how you want to spend your time?

Mr WELLS: No. Professor Sutton confirmed that we are in a COVID-safe area, and there are three chairs there, socially distanced, and he and his two advisers could have been part of this hearing.

Ms SHING: Parliamentary committee hearings allow it, Mr Wells.

The CHAIR: Can I have some order, please. I have ruled on this. We are wasting time now. We have Professor Sutton here and we have a limited period to discuss the issues we want to with him. I would ask that he proceed with his presentation.

Prof. SUTTON: Thank you, Chair, and good afternoon, members. If I could have my slides up, please, I will be very happy to speak to them.

Visual presentation.

Prof. SUTTON: Thank you for the invitation to this hearing. I am here to talk about my advice since the new pandemic legislative framework has been in place. As you know, it took effect on 15 December. My understanding, as you have said, of the committee's role—I am very happy to talk to you about my advice for the orders that have followed since the first pandemic declaration made on 15 December, and I would like to commence by providing a short 5-minute presentation about my role as Chief Health Officer with respect to the pandemic declaration process and the making of orders.

Next slide, please. As you know, a pandemic declaration by the Premier provides legal authority for the Minister for Health to issue pandemic orders. The Premier must seek advice from me as Chief Health Officer and the minister before making, varying, extending or revoking a declaration. In accordance with the accountability and transparency mechanisms in the new model, my advice is then made public and then the declaration can be made by the Premier before coming into force, and that allows for the minister to consider settings and seek advice from me and others before making pandemic orders.

Next slide. The minister is required to seek and consider my advice before making, varying, extending or indeed revoking a pandemic order. The minister may also seek advice from other stakeholders that he considers appropriate. In the short time that the new legislation has been in effect a number of orders have already been made and I or my colleague Professor Ben Cowie as acting CHO have provided advice to the minister for each order. This advice is contemporaneous to address the public health risk at that point in time. While some settings or factors may remain relatively stable, others can change quickly, and that requires updated advice to ensure the orders are relevant to the existing circumstances.

The public health control measures I propose must be reasonably necessary and proportionate to the public health risk at the time. When formulating the measures, I recommend to the minister I have to have regard to the compatibility of those measures with Victoria's Charter of Human Rights and Responsibilities. In deciding any proposed pandemic order the minister also gives proper consideration to human rights under the charter. The detailed consideration of those matters is set out in the human rights statement and the minister's reasons for decision.

Next slide, please. These are just some key dates on which I or Professor Cowie have given written or verbal advice to the minister and some dates of the pandemic declaration and orders having been made.

Next slide. This slide summarises the policy changes that have been made to the orders since the first declaration was made in December. For each change the minister considered CHO advice as well as feedback from stakeholders and other experts. The minister's statement of reasons outlines his considerations and reasons for accepting my advice in full or in part at that particular time as part of his broader decision-making responsibilities under the Act.

Next slide. My role in pandemic orders—this flowchart provides an overview of how orders are made and how my advice as CHO facilitates the minister's acquittal of his legislative responsibilities. The process is followed regardless of the urgency, complexity or nature of changes to orders being proposed. Even when changes are urgent the minister must still formally request and consider my advice and undertake a charter assessment to ensure the measures are proportionate to the public health risk. The Act does allow for advice to be given

verbally to ensure orders can be made urgently as required, and a written record of my advice still needs to be made public and published.

Next slide, please. This slide summarises the outline of the most recent advice of 10 January 2022, which was provided by the acting chief health officer. It summarises key topics included in the advice to the minister. I wish to draw your attention to the section of that advice titled 'This advice is based on the information that is available'.

Next slide. The section includes key considerations that inform the Chief Health Officer advice. The subheadings are advice based on what is achievable practically. This includes assessment of system capacity constraints and how community behaviours, such as constraining mobility, are impacting the current pandemic situation. Importantly it notes wherever possible that these measures should be readily understood by the community and be the least restrictive that are reasonably available in the context of the current epidemiology. There is also: overview of current epidemiology—case numbers, deaths, ICU numbers and other metrics; emerging evidence about omicron—that included data from global sources that was rapidly evolving at the time; emerging evidence about vaccine effectiveness—that really includes the effectiveness of two doses of the vaccine, the effect of waning immunity and the significant benefits gained from a third dose; and omicron's effects on the health system—the advice noted that Victoria was experiencing significant pressures in the pathology and testing system. It also considered hospitalisations and ICU admissions and the strain on our hospital system, exacerbated by many healthcare workers who were having to isolate or furlough. Modelling the impact of omicron drew on modelling and forecasts locally from the Burnet Institute and the Doherty Institute's modelling, which was nationally focused; and an overview of the refined approach, which sought to synthesise all the above-mentioned information and summarise the key issues that this advice to the minister addressed.

Next slide. And the CHO advice appropriately cites all literature, or most literature, that informs the advice. The bibliography for the 10 January 2022 advice is provided in this screenshot. Most of the studies referenced were from late last year or early this year, and it included hyperlinks where there is online access to the literature.

In summary, I hope this has provided the committee with an overview of my role in the pandemic declaration and the orders that are made and the significant work that goes into the drafting of the Chief Health Officer advice to the Premier and the minister. I would be very happy to take your questions on any aspect of my role.

The CHAIR: Thank you, Professor Sutton. Following on from that, I thought I would ask the first question—in fact have the first 10 minutes or as much of it as I need. When you are going through the process of formulating your views, do you use consistent groups of people to advise you or do you canvass opinions from multiple experts as to their opinion based on the evidence available, and do you share evidence among the people that you rely on when you are taking that advice from others?

Prof. SUTTON: Yes, I do. I certainly have core advice that is formulated, assessed, synthesised from Ms Brady's team in fact—the strategy and policy team—which has a number of senior medical advisers, public health experts and policymaking experts. They are a real fundamental pillar in advice to me in terms of bringing the epidemiological information to bear on the policy decision-making, but also reaching out to stakeholders. Beyond that core group that informs my recommendations to the minister, I do reach out to other individuals, including those that have provided advice about modelling and about some scenario modelling around the predictions of newly emergent risks such as the omicron wave. So it is a combination of that core team—the strategy and policy team and any other relevant experts at the time, really depending on the kind of threats or emergent risks that are current when I am considering my recommendations.

The CHAIR: Thank you. I think from the general public's point of view we often hear from people like Catherine Bennett, Mary-Louise McLaws, Tony Blakely. I am just wondering what role they play in discussions with you and also whether you take into account advice such as that from overseas experts.

Prof. SUTTON: Yes, thank you. Certainly I follow that commentary made by those individuals. They are the public face of epidemiology and public health in many respects, but there are many, many others that we do not hear from necessarily. All of them are really on my radar in terms of looking for advice that is relevant at the time. Sometimes I reach out to them formally, sometimes I follow their own references and their own reflections on modelling international experience.

With respect to the international literature and international data, the data intelligence team in the COVID-19 division certainly scan internationally for all of the relevant evidence. With respect to the omicron wave, they were obviously looking very carefully at the National Institute for Communicable Diseases in South Africa and the early experience as that wave took off in Europe through the UK's national health security group and the European centre for disease control. So there is a really broad scan, but it obviously changes its focus and priorities depending on where the emergent epidemiology might be most focused.

The CHAIR: Thank you, Professor Sutton. Just a further question. You mentioned that you speak to other stakeholders, and I am just wondering: in coming to a decision as to what your advice will be, to what extent do you engage with stakeholders about the orders and how they might be grounded in reality once they become orders and play out? For example, the hospital and care facilities order provides that aged-care facilities can have up to five visitors a day, but I am hearing constantly that they are getting no visitors, that even when there is not an outbreak they are shut down. So I am interested to know the reality. You make the orders, but are you able to drill down and understand how that will function in an institution that might have to apply those rules?

Prof. SUTTON: Look, it is certainly a challenge. I think there are two separate issues. One is: what are the proportionate measures that need to be made in order to manage the risk of transmission, the risk of further impacts on the health system, the number of cases, the number of hospitalisations and deaths that might occur? The particular challenge that you are talking about in the aged-care sector does intersect in a way in terms of the implementation, but largely for my team in discussions with peak bodies and with consumer representatives and our aged-care experts within the department and beyond it seems to be not so much an issue of the difficulty in applying those measures but somewhat a cultural reluctance or a risk aversion to the appropriate application of those measures.

The pandemic orders with respect to aged-care visiting provide a ceiling, so you cannot go beyond those numbers. The fact that there are so many settings that are much more risk averse and are actually going to a much more restrictive setting is not determined by the pandemic orders; they are absolutely free to allow visitors up to that ceiling that we provide in the pandemic orders. But we do make absolute best efforts to say, 'Not only are these the pandemic orders, but our general guidance would be that you have to appropriately balance the wellbeing—psychological and social wellbeing—of residents in aged care against the risk of transmission'. We are providing detailed guidance. There has always been guidance for the aged-care sector. But it is being updated to be really more explicit about that issue, because we know that lockdown has occurred for protracted periods of time and that visitor restrictions have been really much less than we think is reasonable in the circumstances.

The CHAIR: Thank you, Professor Sutton. What I hear out in the community from people is that aged care simply do not have the resources. They do not have the staff to man the door, they do not have the RATs. So there are a whole lot of things that are occurring out there that make it almost impossible for them to facilitate the five visitors a day, let alone one, and many of them are in lockdown. So I am just wondering, I suppose, within the department and from your point of view: how do you manage the reality of it?

Prof. SUTTON: I think it obviously has to be an ongoing, iterative process in terms of the review, what those challenges are and to try and support the sector as best we can. The rapid antigen test supplies from the commonwealth for private sector aged care—the constraints in RAT availability have been substantial, but they are really much improved in recent weeks, especially in Victoria, with the very substantial order and the rollout of millions of rapid antigen tests. But we do need to understand what the practical effect of some of those constraints are. I would emphasise that there are circumstances where it is not a resourcing question—human resourcing or other resourcing question. It really is a concern about what the accountabilities are should transmission occur. I think we need to just have ongoing conversations about the balancing of those health and human rights concerns within those settings and to be as clear as we can that there is an easier pathway that balances those risks where, for example, lockdown of entire facilities does not need to occur, that positive residents need to be kept to their rooms, that there might need to be restricted movement for people in the same wing or one area of an aged-care facility but not the entire facility, and that for those who are fully vaccinated, especially those who have received a booster dose, the risk is much, much less for them even though it is not zero.

The CHAIR: Thank you. That is all the questions I have at this stage. Mr Bourman.

Mr BOURMAN: Thank you, Chair. Thank you, Professor Sutton. I just want to delve in quickly. One of the things towards the back of the presentation you gave us was about:

MY RECOMMENDATIONS ARE BASED ON WHAT IS ACHIEVABLE PRACTICALLY

I want to understand who decides what is practical. How is it decided what is practical? Obviously locking up the entire state is not practical so you have got to move on from there. Is it a subjective? How is that actual action arrived at to be achievable or otherwise?

Prof. SUTTON: Yes. Thank you. Look, I think it has got subjective and objective elements. Clearly we need to be engaged in those conversations about the supports that are required in order to enable those orders to have their best effect. We do look at an evidence base that is compiled from credible international and local literature—where people have done this internationally and in other settings. And so it is reviewed by experts within the strategy and policy team and others. We look at the advice of the Australian Technical Advisory Group on Immunisation and the comments that they have made about vaccination in particular, the Therapeutic Goods Administration, the World Health Organization, our own leading public health research organisations such as the Doherty and the Burnet Institute. In lots of circumstances there is a real body of international public health literature, including large systematic reviews on some of these interventions, and sometimes meta-analyses are used where all of the data is compiled together from different studies on a given topic that can tell us what the most robust advice coming out of those interventions is. So a range of public health and social measures are often assessed through that frame from a number of large studies—quarantine and what its effect is for those individuals who are close contacts, what the effect of a mask mandate is and the difference between a mask mandate versus a strong recommendation for masks. The effect of physical distancing, for example, shows an over 40 per cent reduction in risk of COVID-19 transmission when compared with settings in which some of those non-pharmaceutical interventions are not implemented. They are from study authors internationally through 2020 right up to late 2021.

There have been systematic reviews and meta-analyses on other non-pharmaceutical interventions and their contribution to reducing transmission. Others look at exactly what kind of physical distancing is required to make the greatest impact. They are also supported by the datasets in other countries in terms of the particular vaccination coverage—one dose, two doses, three doses, the period of time between doses. All impact on the transmission that is occurring. So we look at that, but we also have those conversations locally around what the industry reflections are on being able to implement some of those measures, what some of the challenges are that they face, both behavioural challenges and compliance challenges but also the practical implementation challenges—for example, ensuring that for those who are granted a furlough from quarantine as a close contact, who need to return to critical care workforces, they have got the appropriate logistical support to be able to make sure that those individuals are getting their RATs and are doing the daily testing for five days in order to return to work in those critical industries. And what some of the challenges are around the very specific orders that we make to make sure that those furloughed workers who return to critical industries are maintaining safety within workplaces—for example, to have a staggered time to eat and not to be mixing, especially without a mask, during break times with other staff, how they are supported to report on their vaccination status and to ensure that they are doing the RAT testing as required. They are some examples of that interplay between international and local evidence gathering and then the practical implementation in specific settings.

Mr BOURMAN: Thanks for that answer, Professor Sutton. I notice the word 'policy' comes up from time to time. In the context of this situation, how does policy affect the advice you give? And whose policy? Is it a departmental policy, government policy?

Prof. SUTTON: Look, it is a term used pretty broadly. The strategy and policy team may well provide policy that ends up as guidance in particular settings. For example, some of the recommendations that we have made around the return to school and the school reopening plan are absolutely informed by that policy. But that policy is also a foundation for me in turning those policy settings or considering those policy settings in terms of making a recommendation to the minister for pandemic orders. Some of those policy settings in fact become recommendations for me or considerations that I provide to the minister in the making of pandemic orders.

Mr BOURMAN: Thanks, Professor Sutton. I have got to think about the policy thing; I might get back to that later. When it comes to the recommendations that you give to the government, when they are formulated, are they formulated regardless of the—how should I put it—overall end effect in a purely policy and

epidemiological context, or is it the minimum to get the job done type approach, the minimum impact on people's lives to get the job done?

Prof. SUTTON: It certainly takes into consideration what might be considered the least restrictive interventions amongst the available measures. The changing epidemiology changes what that threshold might be, but we are always looking to have the most reasonable impact on people's lives against the consideration of what it means with respect to health and wellbeing and the direct effects of COVID-19 as an illness. We know that we have now got to very close to 95 per cent two-dose coverage of vaccines for the 12 and above population in Victoria, so that has changed the equation in terms of what the recommendations are as least restrictive measures and there is a great deal more scope to be lighter touch in those measures. But we do understand some of the fundamental things that still impact very significantly on transmission, and isolation and quarantine are a couple of those measures. They are ones that need to remain as absolute pillars of the public health response, and that is why they have mandates in terms of the isolation period and mandates in terms of the quarantine that is required for household and household-like contacts. Other measures may be less impactful, but they tend to be those with a lesser impost on the individual. And some of them are very easy recommendations to make, such as mandated mask wearing in indoor settings outside of private homes, because they are a relatively light impost for a very substantial public health benefit.

Mr BOURMAN: Thank you. I am done.

The CHAIR: Thank you, Professor Sutton. We will move now to Mr Carbines.

Mr CARBINES: Thanks very much, Chair, and thanks, Professor Sutton. I thought, just off the back of the procedural matters on which you ruled, it would be good to go to a question that relates to the new pandemic orders and in particular just picking up firstly around the Minister for Health's advice, in line with current strong recommendations, that where you can you should work from home and that attendance by Department of Health representatives would be online. There will be a concern, I think, Professor Sutton, that we do not want people—particularly workers, for example—to be prejudiced or disadvantaged because they follow the recommendations. So my question to you would be—

Mr WELLS: Is he going to a press conference now?

Mr CARBINES: Well, can I ask my question? I am sure you will get your chance.

Mr WELLS: No. You can do your press conference from home.

Mr CARBINES: Professor, the recent advice to the Minister for Health has been to require people to work from home. Can you explain to the committee why you have recommended this and the reasons for that recommendation? Thanks very much.

Prof. SUTTON: Certainly. Thanks, Mr Carbines. So the recommendation to work from home was again one of those balances. It was a recommendation rather than a mandate, recognising the really significant volume of people who come together in workplace settings all of the time, and despite the COVID-safe settings that we also recommend and have some requirements for in workplaces across Victoria, that does not reduce the risk of transmission within those workplace settings as fully as working from home and reducing the number of people that need to come together in those settings does. So the work-from-home recommendation really does provide an additional downward pressure on transmission because it limits the number of people who come together with other individuals, in indoor settings in particular.

I recognise that we have got very high vaccination coverage. The challenge of the omicron wave and the omicron variant is that it had some immune-escape capabilities. You are still very highly protected from death, from hospitalisation and from being in ICU; you are less protected from being infected and passing it on to other individuals. That has meant that we have seen, across Australia and across the world, unprecedented numbers of cases. And that in turn, even with the direct protective effect of the vaccine, has meant that we have got the most pressure on our health and hospital system that we have ever had over the last two years. And so the work-from-home recommendation was really to put that additional downward pressure on, recognising that vaccines are not the perfect protection across the board for people gathering indoors and that masks, although worn in indoor settings, are also removed for various reasons and some people have legitimate exemptions from wearing masks, and so transmission can occur in workplaces and does occur in workplaces. So working

from home if you are able to, and with the understanding of your workplace, is an important additional measure.

Mr CARBINES: Thanks. I will just remove my mask now and ask a further question, which is about—this is for people who are tuned in, in particular, watching our hearings this afternoon—the difference between a recommendation and a requirement, particularly around working from home and the strong recommendation at this time in the pandemic orders. I think it is helpful for people to have a good understanding of this when they are making these decisions themselves and how they apply that given the recommendations and the requirements. Perhaps you could take the committee through a bit of that. Thanks, Professor Sutton.

Prof. SUTTON: Yes, of course. Thank you. A requirement is mandatory; it requires a pandemic order; for example, a person must work from home if they are able to, unless they are exempt. That is one example of something that could be mandated; for example, if they are an essential worker such as a schoolteacher. A strong recommendation does not require a pandemic order, but it is still a very significant message from government, and we hope it is understood in that vein, where compliance with that recommendation does make a really significant difference. So it does not mean that it is any less necessary for an individual to protect themselves from becoming infected or infecting others, and at a population level the more people, for example, who work from home if they can, the less public health risk there is overall. But it does not have the pandemic order and it does not therefore have some of the penalties or compliance and enforcement regimen that sits over the top.

Mr CARBINES: Further to that, Professor Sutton, probably just around the CBD in particular, we have noticed with the recommendations and requirements—while they have a different meaning and a different assessment—people in Victoria and their willingness to take that into account in the way in which their behaviours and actions have been displayed or noticed in recent times. What is your assessment or opinion around the removal of working from home recommendations and the public health risk?

Prof. SUTTON: Certainly it is not a recommendation that I would change at this point in time. Under section 165AL(1)(a) and (b) of the Act I have to assess several factors before I make a recommendation to the Minister for Health. I need to consider the epidemiological situation at the time. My advice from the 4th and 10th of January says, for example, that as people return to work at a time where the more transmissible omicron variant comprises the majority of cases—and it is almost 100 per cent now—the risk of community transmission is higher if there are more people working on site. Children are returning to school today obviously as well, and we do expect transmission to occur as a result. The recommendation to work from home will help counteract that because kids going back to school are going to slow the decrease in case numbers that we might otherwise see. And there is still a significant pressure on the health system caused by omicron either directly with the numbers in hospital ICU and on ventilators or indirectly with the still many health workers needing to furlough as close contacts or isolate as COVID-positive individuals.

The Australian Health Protection Principal Committee is still recommending that people work from home if they are able to. New South Wales, I believe, extended its work from home recommendation through February. People are familiar with working from home after this very long two years, where it has been a requirement for quite some time, and it is part of a suite of public health and social measures, like social distancing and wearing a mask, that are known to slow community spread, even if it is no longer possible to eliminate it altogether. So despite widespread transmission and really rising case numbers in recent weeks, even with a highly vaccinated society, they do remain as pretty fundamental measures to further limit the spread of COVID-19 and the impact on the health system. They are less disruptive to the economy and people's wellbeing and mental health than lockdowns, that is for sure, and indeed business closures. But some of the limitations in people in the CBD, for example, relate to just how many people have been infected and how many people are close contacts and needing to quarantine. This shadow lockdown, as it has been termed, is also an effect of very substantial transmission. So reducing that transmission also helps support the workers who can keep businesses running and the willingness of people to visit them.

Mr CARBINES: Probably just lastly, on that matter, Professor Sutton, there is probably a great empathy from Victorians who know someone who has been unwell or has had an impact or effect in relation to the pandemic. While you have to balance up a range of professional advice and medical advice, perhaps just those other observations of community behaviour and, as you say, in terms of a shadow sort of winding back of

people's interactions in the community—does that have any place in the considerations you make in relation to your advice?

Prof. SUTTON: Yes, of course it does. I mean, I have been hugely gratified by Victorians' understanding of the public health measures that have been recommended or required, and I think we are so well placed because of that depth of understanding and the level of willingness to really follow those recommendations or requirements. We have been very successful in managing the pandemic over a long period of time. The advice that I and my Department of Health colleagues provide to government does weigh up each of the proposed health measures to identify that least restrictive reasonably available measure, and we have to make recommendations that are proportionate to risk. So to the extent that a community are doing it themselves, understand and are willing and are engaging with that conversation that we are having with them, are understanding the reasons and the argument that we are making and looking to protect themselves and those around them, then the less there needs to be in terms of pandemic orders or in mandates, because there is such a terrific understanding from the community in terms of those really important measures that make a difference to transmission and do the job of protecting our health system.

You know, I have to consider the evidence base in those recommendations but also the precautionary principle. With the omicron wave coming, acting early when we did not have all of the information that we wanted was still a really important one. The primacy of prevention in the Act is really important. It is much more difficult if you are just going to act on the many, many thousands of people who are already unwell if those illnesses can actually be prevented by reasonable measures taken early and then the principle of proportionality that I have discussed.

Mr CARBINES: Thanks very much, Professor Sutton. Thanks, Chair.

The CHAIR: Thank you, Mr Carbines. We will now go to Ms Crozier for her questions.

Ms CROZIER: Thank you very much, Chair. Thank you all for being with us today.

Mr WELLS: They're not.

Ms CROZIER: Well, no, they are not in person, Mr Wells, but on screen. Could I just ask a couple of questions. We have only got 10 minutes, and I have got a number of questions—and I hopefully will be submitting some questions on notice that Professor Sutton or the department will also help the committee answer. So you mentioned that you were giving advice on 4 and 10 January, I think. The key dates for the CHO advice talk about the acting chief health officer, but I want to understand: was it your advice to stop IVF?

Prof. SUTTON: No, it was not.

Ms CROZIER: Okay. So whose decision was that, Professor Sutton?

Prof. SUTTON: So it is really on the advice of the acute health team. The state controller is the Secretary of the Department of Health, Professor Euan Wallace. He has to consider the advice that he is getting from the commissioning and service improvement team within the health department. He clearly—

Ms CROZIER: Okay. So you did not have any input into that, or the acting chief health officer?

Prof. SUTTON: No, I have to have input because I have to make the consideration about whether it would have really substantial public health implications. With respect to elective surgery, it is largely a matter—and this is what I confirmed with the state controller—of the available workforce, the available theatre beds, the available ward beds. So it was really about hospital system capacity, and it did not have a really material impact on public health implications.

Ms CROZIER: Okay. I will come back to the elective surgery. On 19 January there was verbal advice made to a minister, which has not yet been published. That was the same day as the government backflipped on the IVF ban. Was that your advice or was it again Professor Wallace's?

Prof. SUTTON: So the decision to resume IVF was again based on that advice given to Professor Wallace. I was involved, again being asked by the then acting Minister for Health, James Merlino, as to whether there

would be public health implications in the resumption of IVF, and again I said, 'It's not a material issue from a public health—

Ms CROZIER: Okay. So that was an error of judgement clearly then made because of the decision that was done in the first place, and it was after that massive campaign.

If I can move on to the resumption of elective surgery, you were talking about the lack of theatre beds. As of today we have got 33 people on a ventilator, 873 in hospital and 10 000 cases. Why can Victoria's health system not cope with this? Why is elective surgery not resuming? And what is your advice to the minister about a gradual plan to resume elective surgery based on these figures? And you spoke about modelling. Could the committee have all of that modelling so that we can understand thoroughly what advice you are providing to the minister and the government on these matters?

Prof. SUTTON: So as I have said, I do not provide advice on the cessation or the resumption of elective surgery. They are matters for the state controller. Where it intersects with public—

Ms CROZIER: Sorry to interrupt you. You are providing advice on the epidemiological modelling—the modelling that has been done. You have referred to that time and time again. You said that this modelling has been done. We had a briefing from Professor Wallace. He would not give us the modelling last week about some of the impacts to hospitalisations. So surely you have a view on why elective surgery, which is having a massive impact within the Victorian community and those people who cannot get their surgery, is not taken into consideration, Professor Sutton? Why is it being handballed to the controller that you have just referred to?

Prof. SUTTON: Well, the role of the Chief Health Officer in the *Public Health and Wellbeing Act* is pretty clear. It relates to matters of public health, it does not relate to matters of the operational management of the hospital system or the health system more broadly. So it is entirely appropriate that Professor Wallace is the decision-maker in that but also that he interacts with me about the potential public health implications.

Ms CROZIER: Okay. Well, they are big public health implications, because we have got a backlog of people in pain and becoming more debilitated.

Prof. SUTTON: Well, that is not a public health issue per se. Public health refers to the transmission risk with COVID-19 and the best measures to manage that.

Ms CROZIER: Okay. As I said, we have got some good figures coming out, and you recognise the Victorian community's efforts in that. If I could go to, then, the advice that was provided on Friday regarding the tennis crowd, which would increase to an 80 per cent ability to attend the tennis, which coincided with the tennis finals, magnificent as they were. At that time there were 101 000 active cases, 39 deaths, 114 in ICU and nearly 13 000 new cases on Friday when that decision was made. So what other restrictions will be relaxed if that tennis crowd could go from 65 per cent capacity to 80 per cent based on what you are saying in terms of the risk to the Victorian public? I mean, on Friday those numbers were higher than the numbers for the previous Monday.

Prof. SUTTON: So the decision about the increased cap for the tennis was a decision made by the Minister for Health. Again, I did not make a recommendation—

Ms CROZIER: So he did not get advice? Sorry, Dr Sutton, did he not get advice from you about the risk of spread when the crowd increased?

Prof. SUTTON: So I had a request for a public health view, and I provided no recommendation for or against. I said that it was primarily a matter really of social licence and social considerations as a really significant public event.

Ms CROZIER: This was a very significant public event which we all agree was fabulous. But the social considerations override the public health risk—is that what you are saying?

Prof. SUTTON: Well, the pandemic Bill, as I understand it, passed through Parliament, explicitly gave the minister the opportunity and indeed the obligation to have broader considerations about what pandemic orders should be imposed.

Mr WELLS: Without health advice.

Ms CROZIER: Without health advice. So if I could just move on to another question—thank you, that is very helpful, Professor Sutton. You provided, or the Chief Health Officer's office provided, advice to the minister on 7 January that 'one size fits all' for mandates for boosters should not apply. Why did the advice change?

Prof. SUTTON: I do not believe the advice has changed. What do you mean with respect to 'one size fits all'?

Ms CROZIER: Well, in terms of the orders it is there, that a 'one size fits all' for mandates for boosters should not apply, and yet the Premier yesterday or last Thursday was pushing at national cabinet that he wants a third vaccination to be mandatory—he did not rule out a fourth and a fifth vaccination to be mandatory also—and yesterday that he wants that third dose to be mandated within weeks. So was that your advice to government?

Prof. SUTTON: I have not been requested to provide advice on broader vaccine mandates at this stage—

Ms CROZIER: So that is the Premier's own decision then?

Prof. SUTTON: When and if I get a request from the minister for advice on those potential measures, I will be very happy to assess the epidemiological situation at that time and to provide my recommendations on how that might change, if at all.

Ms CROZIER: Thank you. So it sounds like the Premier is making these decisions without your input as yet.

Prof. SUTTON: I do not believe there have been any decisions made. When I get a request—

Ms CROZIER: No, he said yesterday he wants third doses mandated within weeks. He went to national cabinet pushing for this. In this advice on 10 January:

> I have considered a consistent one-size-fits-all approach to vaccination mandates for all workforces and even for the general community but, at this time, I do not consider this to be a proportionate response for reasons …

Now, that is the acting chief health officer's advice to the Minister for Health, so I am really perplexed that you are saying that you are not giving that advice, yet it is in the written advice and the Premier is coming out and saying this. So what on earth is going on regarding the mandate of boosters and who is giving the advice to the health minister and the Premier when he is going out there publicly stating this? Where is the advice coming from? Is it not from you? He has told us, you have told us, for two years that it is proportionate, it is reasonable, it is keeping Victorians safe, and yet it sounds like the Premier is making these decisions up. Is that—

Ms WARD: That is your reading.

Ms CROZIER: Professor Sutton just said, Ms Ward.

Prof. SUTTON: When additional pandemic orders are made that alter the mandates around vaccines to be broader or less broad and I get a request from the Minister for Health for recommendations around that, I will look at the evidence at the time, I will look at the epidemiology at the time and I will provide my recommendations.

Ms CROZIER: So that advice has not been requested as yet.

Prof. SUTTON: No, it has not.

Ms CROZIER: Thank you. With the changed rules, why is mandatory QR coding still necessary?

Prof. SUTTON: QR codes are really part of our way of life across many parts of Australia—

Ms CROZIER: But they are not working.

Prof. SUTTON: They do play a role. They are not a huge impost; most of us do it automatically. We do it—

Ms CROZIER: But can we contact trace? Sorry to interrupt you. I am just curious because no-one seems to be QR coding, and clearly contact tracing cannot be undertaken because there are too many cases—100 000 PCR tests got ditched. You do not know the true numbers. You cannot contact trace properly, so why are we still QR coding?

Prof. SUTTON: The role of QR codes is really twofold. One is that check-in so that if you later become a positive case and it is known, those other individuals who were in those settings as casual contacts can be notified and prompted to get tested. It is true that not all settings have the same risk. There are some settings with QR codes where the risk of transmission to others is not as great. They are under review at the moment, and we will look at the—

Ms CROZIER: When will that review be finalised so the public will have that understanding of what is high risk and what is not?

Prof. SUTTON: I have asked the team to complete it by mid-February—

Ms CROZIER: Thank you.

Prof. SUTTON: It is already informing those settings that appear to be higher risk, where QR codes really should continue. The QR code system has also supported the vaccine certification process, so that is another element that we need to consider with the use of QR codes and the Service Victoria app.

Ms CROZIER: Thank you very much. That is good to know. Professor Sutton, did you provide advice as to how the exemption panel would operate for the tennis exemption?

Prof. SUTTON: No. The panel works independent of me.

Ms CROZIER: Okay. So there was no input from you as Chief Health Officer as to how the exemption panel would operate. The two-tiered process that was undertaken—there was absolutely no input from you?

Prof. SUTTON: No, there was not.

Ms CROZIER: Okay. Thank you very much. How much time have I got left, Chair?

The CHAIR: Very little.

Ms CROZIER: Okay. I have got so many questions. Could I ask: what is the actual number of hospitalisations and ICU admissions that the department considers to be at a peak? Because there was modelling done last year and I am just wondering what the new figures are that you seem to think would be at a peak.

Prof. SUTTON: I think we are likely to be at a peak now. I think it is unlikely to go above 1500 hospitalisations and I think it has probably already peaked. I think that peak will look bumpy—it will be a plateau and it will have up-and-down days—but it will not significantly increase from the position we are in right now. That is, at least, my view today.

Ms CROZIER: Okay, well, that is also very encouraging. Hopefully you will be reviewing some new restrictions. I think the Chair has given me the wind-up. Thank you very much for your time.

Prof. SUTTON: Thanks, Ms Crozier.

The CHAIR: Thank you. Moving now to Ms Shing.

Ms SHING: Thanks, Professor Sutton and witnesses, for attending this hearing today. I would like to pick up on the substance of the QR code discussion, which Ms Crozier has begun in the last round of questions, and to talk about what you have said is the relatively modest impost, to quote you back at yourself, of checking in but also what that looks like around social licence on the one hand and habit-forming and habit-maintaining behaviour on the other. In some circumstances where contact tracing is not the primary purpose of QR check-in there in fact becomes an element of, to paraphrase a certain member of elected Parliament in Canberra, personal responsibility around being able to track where you have been and what you have been doing but also what that

looks like around the need to contact trace and the need to use QR codes for check-in should omicron merge into something else or should we have further development in variants along the lines of delta or anything else that we have seen before. What are the consequences of changing requirements in pandemic orders and removing QR codes and check-ins—so those relatively modest imposts—if they then need to later be reinstated from your experience in epidemiological challenge and the social components of that?

Prof. SUTTON: Yes. Thanks, Ms Shing. Certainly it has become part of our day-to-day lives, but it has also been part of our genuine contact-tracing system that is telling you about where someone who later tests positive has been. Like the pandemic, like our response to it, it has changed over time, but fundamentally it is still doing the job that it was created for as a safe and secure way of sharing that contact information to people who are at greater risk of getting COVID-19 and then getting that prompt to test and to quarantine until you get that test result. Given the really significant spread of COVID in the community and the contact-tracing changes that were agreed by national cabinet late last year, we do not use the QR details of people who check in at every single site—too many people, too much transmission with omicron for it to be the most worthwhile intervention across all sites. So it is getting focused, but we do need it in reserve for potential superspreader events. We have seen QR codes work, for example, in some of those high-risk indoor settings—weddings, for example—where the attack rate, where the proportion of people who are close contacts who end up turning positive, is extremely high, almost like a household setting. So we should keep it in reserve for that. To your point, there is a benefit in maintaining it rather than stopping it and then trying to build the social licence to use it again. So if it were to be dropped completely and we turn off a restriction with frequency, I have to consider that in my advice and what that whiplash effect of lots of changes would mean in terms of understanding and compliance and people questioning the utility and the benefit of a system that they have actually come to trust.
So I have often tried to avoid that rapid toing and froing in particular settings in my advice, but I think, as I have said, it is appropriate to review, to provide focus and to make sure that it is giving best bang for buck in terms of those settings that are the highest risk for onward transmission.

Ms SHING: Thank you very much for that explanation. I note also that you have referred to settings changing very, very quickly, that we are often in a very volatile situation as far as development, spread and transmission of variants in particular—those individual cases, which I think, as you referred to in the course of delta last year, can go from one case to a hundred in a week, I think you said, and then another week after that can go up to a thousand. When we are talking about different circumstances that apply at different times, I assume that your advice is refined and in fact is targeted at circumstances as they are evolving and as the modelling suggests that they will continue to evolve. How do you make sure that you are staying on top of the research, the guidance, the modelling and the evidence that Ms Brady's team and indeed others provide to you in the course of providing that material and then providing that to the minister as part of a range of other considerations, with a particular focus, if I may, on proportionality and your role in that space?

Prof. SUTTON: Thanks, Ms Shing. Certainly there have been times when the evidence changes very rapidly or risks emerge with no notice, and the omicron wave was an example. Even though we saw it with some notice emerge in South Africa, we did not know enough about it and we needed to invigilate the evidence that was out there very substantially. So Nicole's team has been really fundamental as a linchpin in working with our DIME team, the team that works on evidence and analysis for the Victorian setting but also compiles international evidence for me and collates it on a weekly basis and goes out and looks at specific questions that might inform changes to pandemic orders or recommendations from me regarding pandemic orders. So we do need to be on our toes and continue to scan internationally. And we go to the usual trusted sources—so the US Centers for Disease Control and Prevention, the United Kingdom Health Protection Agency and the European Centre for Disease Prevention and Control as well as the World Health Organization and many others. And there are a number of academics who are focused on some of the very critical questions that we try and look into—for example, what it means to have a particular proportion of cases who end up in hospital, the proportion who end up in ICU or the proportion who die, so that we know that that question of proportionality also takes account of the changing severity of this illness. Omicron is less severe at an individual level, but as we have seen, the huge numbers because of its immune-escape potential have meant that it has challenged our health system more than ever before.

Ms SHING: Thank you for that. One of the things that arises directly from that is the COVID-safe orders as they relate to changes to allow exemptions to isolation requirements for specified critical workers. I would like to get from you today an explanation as to why these exemptions have been made by reference to your role and the impact of these decisions on maintaining Victoria's healthcare system to the extent that that interfaces with

the immune-escape potential and with other considerations and the proportionality that you have just referred to.

Prof. SUTTON: Sure. So it has really been in recent weeks, and it changed very substantially over a short period of time, not just for Victoria, for New South Wales, ACT, Queensland in particular—really substantial numbers per capita of community transmission with the omicron variant. That very large number of cases led to an even larger number of close contacts that subsequently affected workforce availability. We have seen how isolation of cases and quarantine of close contacts have disrupted the distribution of food to supermarkets, the logistic chains and essential networks. They have impacted staffing in health care, aged care and disability services, where the pressures are greater than ever before, so that was a double whammy. I am particularly aware of the strain it places on nurses, carers, support workers, paramedics and doctors in these settings, and that can compromise the service delivery in those settings. So the recently introduced changes that allow for exemptions of close contacts who are asymptomatic—so no symptoms and well—have been needed to preserve the capacity of those essential workforces and those services while maintaining public health measures to protect the community. So they apply only to a critical subsection of the workforce—emergency services, education, health, aged care, disability, custodial, transport and freight, food production, the kind of critical supply chain areas—and they will only be granted where it is necessary for the worker to return to their place of work, for the continuity of operations and where all other options have been exhausted. So it is not a free-for- all. It is not, 'Oh, I can do five days of RATs and go back to work and it doesn't matter'; it is only when there is no other option available for those workers to be performing that critical role. So the worker must notify their employer as a close contact, and both parties have to consent to the worker returning to their place of work. And of course those workers, because they are essential workers, must be fully vaccinated in addition. So all mitigations are in place but with that exemption to allow for those critical services to continue.

Ms SHING: So would you say, then, that it is fair to conclude that this is an example in the context of exemptions to isolation requirements for specified critical workers of the way in which you are performing your role under 165AL as it relates to necessary or appropriate public health measures and that balancing act of competing considerations and proportionality that you have referred to earlier in your presentation?

Prof. SUTTON: Yes, I think that is exactly right. The risk of transmission remains for someone who is in quarantine and could develop illness, but having an N95 mask in a healthcare setting that is fit checked and fit tested and making sure that they are doing a RAT every day as they return to work during that quarantine period is a balancing act, and it does relate to the fact that we do not want to compromise the care that is being given in those really critical settings. They are constrained in other ways. They have to do quarantine for the rest of their time, so they go direct to work and then they come direct home. They minimise their contact with other people. Where possible, they avoid public transport. They have to wear a face covering at all times and then the N95 respirator for healthcare workers. They do not go to shared break areas, and their employer has to have those break times staggered in order to protect everyone. Of course if they develop symptoms or if they test positive on a rapid antigen test, then that exemption no longer applies. They are a case; they have to isolate for their seven-day period, and they have to notify others, including their employer, that they have turned positive.

Ms SHING: Thanks very much, Professor Sutton. I have had the wind-up, so I will hand back to you, Chair.

The CHAIR: Thank you, Professor. We will go now to Ms Emma Kealy.

Ms KEALY: Thank you very much, Chair. Thank you for joining us today, Professor Sutton. Professor Sutton, in your briefing today there are three notes here of advice that was provided to the minister but has not yet been published. Can you advise when that will be published or at least made available to this committee?

Prof. SUTTON: Look, I am not directly involved in the publication. Obviously it has to meet the legislative requirements for publication. So if that advice has been recorded, it will meet those legislative requirements for being made public.

Ms KEALY: Thank you. Professor Sutton, obviously we can only refer back to the most recently published advice from the Chief Health Officer's office, so we have to refer to that. Now, I am just concerned that in the last series of advice there is only one mention of mental health in there. That is despite the World Health Organization stating that mental health:

> … must be front and centre of every country's response to and recovery from the COVID-19 pandemic.

Now, given we have seen our mental health system at absolute capacity, if not over capacity, why does mental health only rate one single mention in the advice to the minister?

Prof. SUTTON: It is not to say that mental health is not a consideration through all of the crafting of the recommendations to the minister on pandemic orders. Clearly—

Ms KEALY: Well, shouldn't that advice be published, then, in accordance with the legislation?

Prof. SUTTON: No, my point is about the specific mention of mental health. All of the recommendations for the orders are taking account of the least restrictive measure, and there is absolutely a recognition that more restrictive measures can be more impactful on mental health. When you do not have other measures such as the wonderfully high vaccination coverage that Victoria now has, then those much more restrictive measures do have profound impacts. But wherever possible those least restrictive measures are recommended to address public health risks, and that is infused through all of those recommendations to the minister. The physical distancing—

Ms KEALY: Thank you. I will just move on, Professor Sutton, if I can, because we have got limited time. You might be familiar with a research paper which was published last week by the Murdoch Children's Research Institute, which highlights, and I quote:

> School closures during the pandemic have had large impact on children's health, future productivity and earnings, with serious consequences such as learning delays and disruption of social and emotional development are more likely in children already affected by adversity.

In paragraph 53 of the advice provided on 9 January it states that the pandemic declaration provides an ongoing mechanism to introduce further restrictive measures. Could this mean a return to statewide school closures?

Prof. SUTTON: I have no expectation that there will be statewide school closures. As I say, at any point in time where I get a request to review recommendations to the minister for pandemic orders applying to school or any other setting, I will look at the epidemiology at the time and I will make those recommendations accordingly. But I see nothing in the current epidemiology or indeed in the emergent risks, including with the BA.2 sublineage of the omicron variant, that should threaten the reopening of schools from my perspective.

Ms KEALY: Thank you, Professor Sutton. Mandatory vaccination for school students—is that something that you are considering at present?

Prof. SUTTON: The question, again, has not been asked of me. The mandates will come up for consideration, and I will put my mind to the advice available to me—again the epidemiology and the recommendations—bearing in mind that children are a special case where it comes to the exercise of their sovereignty. They need to be considered separately and specially, I think, with regard to mandates.

Ms KEALY: Thank you, Professor Sutton. Ms Crozier raised before paragraph 93 of the most recent written advice to the Premier from the Chief Health Officer's office around the one-size-fits-all approach for a vaccine mandate. This is in specific relation to boosters; however, it does state that a vaccine mandate is not a proportionate response. Given we have got a vaccination rate of over 94 per cent now and there is an expectation that about 5 per cent of the population cannot or will not get vaccinated, when will the vaccine mandate be withdrawn?

Prof. SUTTON: Look, like any pandemic orders and my recommendations that underpin them but do not determine them, it will have to depend on how the emergent risks and the ongoing epidemiology of this pandemic go. I think we are in a terrific position with our second dose coverage. The fact that our third dose coverage is approaching 39 per cent is another great positive, and the fact that we have got a childhood vaccination program for COVID-19—well, five to 11s—that has now hit the 40 per cent mark as kids return to school is another additional mitigation. They are all positively weighted to being able to have lesser measures in place, but we have to consider what the immune evasion potential of any new variant may be and what that means in terms of what vaccines can provide as direct protection for the individual who is vaccinated but also that indirect protection or herd immunity protection.

Ms KEALY: I do not disagree with you, Professor Sutton. You can see the bruise on my arm from my third vaccination.

Prof. SUTTON: Good on you.

Ms KEALY: I am a strong supporter of vaccination. However, we know that a number of the workforce are workers who are not vaccinated. Have you done any modelling? Do you know how many workers have been stood down and are not able to attend work because they cannot work from home across Victoria?

Prof. SUTTON: As I say, when the request for a review of vaccine mandates comes to me, I will look at all of the available evidence, including that—the impact on those who—

Ms KEALY: Professor Sutton, vaccine mandates have been in place for a long time. When was the last time you were asked by the minister or the Premier for updated advice on vaccine mandates?

Prof. SUTTON: Look, Professor Cowie was the last one to provide advice on that. I would have to take it on notice as to when I—

Ms KEALY: Can we get a copy of that, please?

Prof. SUTTON: Well, it is in the pandemic orders and is available as published advice as well.

Ms KEALY: Thank you very much, Professor Sutton. In regard to the advice that has been provided to the minister, it does refer to the issue around staff furloughing. But we know in specific instances it has targeted areas, particularly when we refer to that one-size-fits-all approach, that work alone. For example, during harvest we had people who would be on a header or in a truck all day and they were not able to work because they could not get vaccinated. I am worried that the proportionate response is not always in place, and if the government is not seeking a review of those orders, perhaps we are not correctly meeting the requirements of supporting our Victorian community to get food from the paddock to the plate.

Prof. SUTTON: I would absolutely take into consideration the criticality of particular workforces and how they might be impacted by not being available to provide work.

Ms KEALY: With due respect, Professor Sutton, that has not occurred to date.

Prof. SUTTON: No, it has. All of the pandemic orders are made on recommendations that take into consideration the proportionality for those specific areas.

Ms KEALY: But we have just had harvest. There were people who were not vaccinated who could not assist and the landholders could not find any backup workers. They are simply not there. It was the same situation with the CFA. CFA volunteers are not able to go onto a truck if they cannot get vaccinated. I am wondering what the advice is to provide information and medical evidence to the Premier. You are saying it is being balanced and you are balancing it, but we are not seeing that through the advice, so I am wondering: is there other advice that you have provided to the Premier or to the minister?

Prof. SUTTON: All of the advice that is provided to the minister with respect to pandemic orders is published, including verbal advice that is provided. That would be the case for me at any point that I am reviewing vaccine mandates.

Ms KEALY: And that includes boosters, which may be the booster shot or the fourth or the fifth vaccine, which was referred to by the Premier yesterday?

Prof. SUTTON: If that is the request of me. Clearly, I cannot provide advice around fifth shots that are not even under consideration in Australia.

Ms KEALY: Well, I think it is, because the Premier mentioned it yesterday in his press conference.

Prof. SUTTON: There is no fifth shot that is available anywhere in Australia at the moment.

Ms KEALY: So the Premier is making it up?

Prof. SUTTON: A fourth shot is available for immunocompromised individuals, and at the moment they are not under consideration for mandates.

Ms KEALY: I want to ask some questions about rapid antigen tests. Paragraph 47 of the most recent advice from the Chief Health Officer's office refers to greater reliance on rapid antigen testing. Last August our side of politics asked for the introduction of RATs in Victoria's testing capabilities. What was the advice of the department to the government at that time? Did you support RATs or did the government reject that proposal?

Ms SHING: Can I just raise a point of order, Chair? I am just wondering how we are going to address matters that come up relating to the period prior to the pandemic legislation amending the Act. I note that the first declaration of the 7th, coming into effect on the 15th, of December is the starting point for the work of this committee, so I would just seek some guidance from the Chair as to how we deal with matters, whether they go back to the start of December or indeed to two years ago. I think it is a slippery slope that I would welcome some guidance and a ruling from you on, Chair.

Ms KEALY: On the point of order, Chair, I specifically referred to paragraph 47 of advice provided by the acting chief health officer to the Premier at the time. It is a direct quote from that. I am referring specifically to that advice that has been provided to the Premier, and that is absolutely within the scope of this committee—in fact it is our job to do that.

The CHAIR: On the point of order, my view is that the legislation is not retrospective—that we do not examine previous orders in detail. We will be looking at the orders that have been made since this legislation came into operation, but that does not necessarily rule out the possibility of making some comparison between a decision made and based on an order made then as opposed to an order made now. So there is capacity to use that, Professor Sutton, in some sort of comparative sense, should you wish to.

Ms SHING: Thank you, Chair.

Mr WELLS: On a further point of order, I would ask that if Labor are going to use the tactic of calling points of order, then the clock should be stopped so—

Ms SHING: You spent 10 minutes on a procedural matter at the start of the hearing.

Mr WELLS: It did not eat into anyone's time. I would ask you, Chair, to make sure that the clock is stopped, because it is a typical Labor MP tactic to wind down the clock. So I ask you to stop the clock if there is a point of order called from either side. I think that is only fair.

Ms SHING: Such as your point of order just now?

The CHAIR: Let us hear from Professor Sutton. I think that is who we want to hear from. There is always a little bit of leeway. Ms Kealy still has a few minutes left.

Prof. SUTTON: Thank you, Chair. On RATs, I have been a supporter of them. I think they have a place, and now a very substantial place. That has changed significantly over the course of this pandemic. We are at a point now where 10 000 cases per day would create a demand for testing that could not conceivably be met by PCR testing, especially given the high positivity rate for those who are presenting for testing, which is around one in five individuals. That means that those tests need to be processed individually. Previously they had undergone batch testing, where you can do a number at a time. So the PCR system could not hold up with the omicron wave and it was very clear that RATs needed to be a very substantial part of our testing system. Indeed I was strongly supportive of the procurement of millions of RATs for Victoria. The—

Ms KEALY: Do you know when the order went in, Professor Sutton?

Prof. SUTTON: No, it is not part of my pandemic declaration and orders-making advice.

Ms KEALY: Perhaps the department could provide that information about when the order went in, who supplied it, what volume and what was paid.

Members interjecting.

Mr WELLS: Okay, we have got how many people answering on his behalf?

The CHAIR: Can we move on?

Ms CROZIER: We will get the correct dates, not just from the Labor Party MPs.

Ms KEALY: From the department, please, specifically.

Prof. SUTTON: With respect to how it has changed over the course of time, in early August there was no home test approved in Australia. In fact there was no home testing approval for rapid antigen tests until November, and our situation in Victoria was that we had limited and for a period no transmission at all. They are not circumstances where you would use RATs in the community, and indeed how would you do it if people could not test at home? But we were using at that time RATs in circumstances where we knew that they could provide an additional level of assurance for people who needed a result early on.

Ms KEALY: Thanks, Professor Sutton. When did that start, using RAT testing in Victoria?

Prof. SUTTON: It has been in some settings for several months, including back to August, as I believe.

Ms KEALY: August—going back to August? Okay. Thank you. So the same time that we called for it. Thank you for confirming that.

Prof. SUTTON: No. The place—

Members interjecting.

Ms KEALY: Professor Sutton, I would like to go back to the PCR testing—

The CHAIR: Can we let Professor Sutton answer the question.

Members interjecting.

Ms KEALY: I have a question for Professor Sutton and I would ask Ms Ward if she would not rudely interrupt and take up my time. We provided very good—

The CHAIR: Order! This is the last question, and Ms Kealy can ask it before her time is well and truly over the 10 minutes.

Ms KEALY: Professor Sutton, in respect to RATs, you referred to the need to roll out RATs at home because the pathology testing system could not keep up with the demand for PCRs. Can I ask: what information was provided to you from pathology companies as to the maximum capacity of their testing system and what modelling was done in regard to when you would hit peak testing? Given that coincided with a large number of recommendations to ease restrictions coming into the Christmas period, which was when we saw a peak of omicron cases coming through, did you take into consideration or what advice did you provide to the minister and to the Premier in regard to when Victoria's pathology testing system would meet its maximum capacity and therefore try and minimise a situation where people were getting their results 12 days after they were tested or 100 000 tests were actually thrown out?

Prof. SUTTON: The rapid antigen testing, indeed the entire testing program, is overseen by a deputy secretary within the department, Phuong Pham, and he can provide that information in terms of the conversations that he had with pathology—

Ms KEALY: I appreciate that, Professor Sutton. Thanks for your cooperation. We would love to know the numbers of tests that were discarded also, please.

The CHAIR: Okay. Thank you, Professor Sutton. We will move now to Ms Ward.

Ms WARD: Thank you, Chair, and thank you, Professor Sutton. Thank you for your time today and that of your team and for all the work that you have been doing. I would just like to go back to a number of the comments that you have made around vaccinations—firstly, how happy you are with the great result that we have had from Victorians who have come forward to get themselves vaccinated. You also referred in bits and

pieces around how your advice and your understanding of how we respond to this pandemic has changed as those vaccination numbers have gone up. Bearing in mind, Chair, what you were saying around a little bit of overlap around that conversation to understand the journey we have been on, if you like. Could you talk to us just in general terms, because I know we have only got the 10 minutes, around how your advice has changed and how our response is changing based on the fact that we have such a high vaccination rate for those over 12?

Prof. SUTTON: I would be happy to, thank you. It is very clear: vaccination is the absolute backbone, if you like, of the public health response. It remains the best way to develop immunity and prevent COVID-19 disease, especially severe disease, resulting in hospitalisation or ICU admission, being on a ventilator or dying. It has been reflected in all of our data for a period through December to January with the omicron wave in particular, which demonstrates a significantly greater rate of cases, hospitalisations, ICU and deaths in those who have not been fully vaccinated—you know, zero or one dose—compared to those who have been fully vaccinated who have received two or three doses. Some of it obviously applies to people who had the delta variant infection as well as with omicron, but for both variants the vaccine plays a really significant role in providing that direct protection. Our high vaccination rate in Victoria really gives greater confidence in mitigating those severe health outcomes and therefore the strain on the health system and those other downstream effects on productivity and wellbeing. It is also a reflection, I think, of the high acceptance in Victorian society of vaccination, and the community engagement has played a really significant role in building that high acceptance and maintaining it. I think it will apply to the impacted booster doses, again because the booster dose adds another really significant protection on top of two doses with the omicron variant, and with any potentially emerging variants there is likely to be some cross protection. Even if there is some ability to get around the immune system with new variants, that direct protection from severe illness, from being hospitalised or dying, is really one of the key considerations in coming to a view that there can be less restrictive measures
in addition to that very high vaccination coverage.

Ms WARD: Thank you. I was also really happy to hear you say that we are up to about 39 per cent when it comes to that booster, that third dose, particularly in response to omicron. I have got my own circumstance, where I drove a friend to Fed Square to see one of the great free music gigs that were on. We drove home again and the next day she tested positive. It was about 2½ weeks since I had had my booster. I did not get it, which I think is incredible—it is amazing actually. I know that there is a bit of luck along with vaccination, but can you talk to us around why a third dose could be so incredibly important?

Prof. SUTTON: Certainly. So compared to those who are completely unvaccinated, having three doses reduces about 70-fold your risk of hospitalisation. Compared to getting two doses it reduces your risk six or seven or eightfold—you know, different studies in different countries. But it is an order of magnitude again. I am not talking about 10 per cent or 20 per cent reduction; I am talking about a sevenfold reduction compared to two doses. And so for the individual who is receiving that vaccine, getting that third dose and having the one to two weeks for its full effect to build in your immune system is a really important additional protection. It is particularly important for those individuals who have pre-existing conditions that make them more at risk of hospitalisation or dying. But in general terms it is important for everyone, because anyone can be hospitalised with omicron, and with the huge numbers that we have seen across the state we are all getting exposed from time to time as close contacts or casual contacts.

In addition to that direct protective effect of the third dose, it does also reduce your risk of getting infected with symptomatic illness at all, and so it does also play a role in reducing those overall numbers that we are seeing with the omicron wave. That is why my recommendations to the minister on measures to be put in place were about flattening that curve to give as many people as possible the opportunity to get that third dose to help reduce the overall numbers of omicron, because it does also protect against transmission and infecting others to a degree. Even though it is not as strongly protective against infection as we would like, it is certainly very protective against severe illness.

Ms WARD: That 70-fold number that you quoted around reduction in hospitalisation is pretty amazing. Assuming that we continue to see those third doses rise quite high I would imagine that there would be some significant changes to pandemic settings then because of that dramatic reduction in the likelihood of hospitalisation.

Prof. SUTTON: Yes. I think there is clearly opportunity for that to happen. We are seeing a reduction in cases day by day, week by week in Victoria. As I said, that might slow to a degree as school resumes. It will

slow to a degree as people start to move about and feel less anxious about being socially engaged and interacting. But we will continue to see a slow reduction in the case numbers, and I think part of the solution to getting to those low case numbers will be the further coverage of the third dose. But we have to bear in mind it will be an ongoing interplay with all of the sublineages, all of the other variants that might emerge and also escape some vaccine immunity.

Ms WARD: So you attribute some of the decline that we are seeing in positive cases to the fact that the third doses are increasing?

Prof. SUTTON: Yes, there is no question that beyond the direct protective effect there is also some effect on transmission with the third dose. And with such a significant proportion of the eligible population being vaccinated with the third dose, it must be playing a role.

Ms WARD: It goes a little bit to Ms Kealy's questions—are we seeing ourselves in a moving environment, if you like, where it is indeterminate how many vaccines or how the vaccines will need to roll out in the future because we are going to end up with different variants because the landscape will continue to shift?

Prof. SUTTON: Yes, I think that is the challenge, and it is quite a challenge to bring people along on that journey. Everyone wanted it to be over in 2020. We were hit again in 2021. We all wanted to put it behind us coming into this year, and we had the huge omicron wave. It is very hard to continue to come back and say, 'Look, we've got a really fantastic effect of vaccines that means that we're not in lockdown, but it is not enough to stop the huge numbers that we're seeing and it's not enough to stop the huge pressures on the health system and we need to look at further doses because we can see that the immunity wanes at the four-month mark in particular but even worse at six and nine and 10 months'. We just have to go into this with eyes wide open, accept the reality of those challenges and understand what we need to do in order to meet those challenges. I think the third dose will go a long way to that whole-of-community protection, but it may not be the whole story and if we see that there is waning again at a six-month mark or a nine- or 12-month mark, then it may well be the case of a booster at an annual interval or something akin to that, the same way that we are challenged with flu virus and the need for an annual booster for everyone.

Ms WARD: Yes, thank you. With that in mind—what you have just said—what factors would you bring into consideration when looking at mandating an ongoing vaccination, whether it is the third dose or any subsequent dose?

Prof. SUTTON: Clearly it is that overarching impact on health and wellbeing from a public health perspective. Death is the worst and most acute outcome to absolutely prevent. But hospitalisation and the long-term effects of COVID-19 are really substantial. People have effects of being hospitalised and being in ICU, and also if they have not ever gone to hospital still have the long-term effects of COVID-19. That is particularly true for adults, less concern it seems with children—their ability to bounce back from acute infection appears to be greater. But those overall direct health effects of COVID-19 and the numbers of people that are infected would be one of my most significant considerations, and then in discussions with the state controller and understanding the pressures on our hospital system to see what the threats to our health system are—the things that stop people being able to access timely care, the things that make them defer care with their primary carer, GP, practice nurse or pharmacist. There are lots and lots of impacts on people's behaviours from very high levels of transmission, so all of those I think would need to be part of my consideration around mandates.

Ms WARD: And just a quick one which I think you will not know off the top of your head: what is the average stay in hospital for an unvaccinated person versus a vaccinated person?

Prof. SUTTON: Oh, no, I am sorry. I do not know that.

Ms WARD: I did not expect you to. You can take it on notice. Thank you.

The CHAIR: Thank you, Professor Sutton. We will move now to Mr Kim Wells.

Mr WELLS: Thank you, Chair. I only have 10 minutes so we will do our best. Professor Sutton, is it going to be your recommendation to government that the Victorian population should receive an annual vaccination from here on in regarding COVID-19?

Prof. SUTTON: I cannot make any future predictions around what my recommendations can be. As I have said right through this hearing, I need to look at the circumstances at the time in order to make a proportionate response to the threats. If we are in a situation where there is longstanding immunity from a booster dose, whether it is called the third dose or whether it is a fourth dose, and it is not required every year, I certainly would not be making a recommendation or a mandate for it to occur every year. If we see—

Mr WELLS: Okay, thanks. Thanks for that. Did Victoria Police contact you regarding the I Cook Foods investigation?

Ms SHING: Can I just raise a point of order? I am really, really—

Mr WELLS: Can we stop the clock, please?

Ms SHING: struggling—well, you raised a point earlier—to see how this is relevant to the orders.

Mr WELLS: Okay. Sorry, let me rephrase the question. During the pandemic orders that have been in place, have you been contacted by Victoria Police in regard to I Cook Foods?

Ms SHING: A further point of order: this has got no—

Mr WELLS: I used the words 'pandemic orders'.

The CHAIR: Look, I think it is pretty clear what the role of this committee is, and it is to look at the pandemic orders and not to really try and pull in some red herring. We are here to talk about the pandemic orders and the section that we are tasked to look at.

Mr WELLS: I did use the term 'pandemic orders'. I just wanted to know—

The CHAIR: There is a level—

Mr WELLS: during the pandemic orders, have you been contacted by Victoria Police?

Ms SHING: You know that does not cut it, Mr Wells.

Mr WELLS: Okay, I will move on. Just following up from Emma Kealy's question, do you or do you not have the number of workers that have been stood down due to vaccine mandates?

Prof. SUTTON: I do not have them at hand. The relevant department—

Mr WELLS: Can we get them sent to the committee, please?

Prof. SUTTON: I can certainly inquire as to whether they are held with DJPR.

Mr WELLS: Okay. And then can we have a breakdown by workforce, because I think it is important for this committee to know—nurses, teachers, ambos, for example.

Prof. SUTTON: I believe for the healthcare workforce it is a tiny per cent. It is less than half of 1 per cent.

Mr WELLS: Yes, that is fine, but if we can get that information, that would be great.

Also, regarding the pandemic orders and the advice that you give the Premier and the Minister for Health, it is written or oral. Do you agree that when you give oral advice this advice is actually not freely available to the Victorian public—it is hidden or it is secret when you give oral advice?

Prof. SUTTON: I might ask Ms de Witts—

Mr WELLS: No, no, no. Well, I have only got 10 minutes, so we will have to keep going. But if you give your advice—your advice is what I am asking you—if it is written, we get to see it. If it is oral advice that you give, do we get to see that oral advice? Is it taped or written, or is there some way of doing it?

Prof. SUTTON: It is recorded. Ms Brady is here. She is often our transcriber, so I might get her to respond to that.

Mr WELLS: No, that is fine. If I could just ask, then, for the recordings to be provided to the committee. Can we have the recordings provided to the committee of that oral advice?

Prof. SUTTON: My understanding is that the legislation requires it.

Ms BRADY: I could confirm for you that it is published online in the pandemic order register, so whenever there has been oral advice provided as opposed to written Chief Health Officer advice, it is all there on the pandemic order register.

Ms SHING: Shown up for not doing your homework, Mr Wells.

Mr WELLS: Well, no. We can ask. We will go and double-check that; that is fine.

Ms SHING: Go and read some materials. Do your homework. Take it seriously.

Mr WELLS: I will move on. I just want to go back to a question that Georgie Crozier asked in regard to the tennis. Obviously it was a shambolic mess, the Djokovic situation. Are you saying that you had no role in the setting up of the medical exemption review panel?

Prof. SUTTON: Correct.

Mr WELLS: So you would have no idea who is on that committee?

Prof. SUTTON: No.

Mr WELLS: So when you came back from leave, you were not interested to find out—worldwide news—who was on the committee and who made the decision?

Prof. SUTTON: No.

Mr WELLS: Would Ms Brady know?

Prof. SUTTON: She may.

Ms BRADY: No, I do not.

Mr WELLS: So no-one knows. Is that—

Prof. SUTTON: It is of no relevance to me whatsoever in my role as Chief Health Officer or in the making of pandemic orders as to how that panel is constituted.

Mr WELLS: So you offered no advice whatsoever, or your acting CHO offered no advice whatsoever, in regard to that medical exemption for Novak Djokovic?

Prof. SUTTON: Correct.

Mr WELLS: Okay. It just seems very odd that when the Premier said on 27 October that Victoria would not seek exemptions for unvaccinated players the Victorian government would then approve a border permit for Novak Djokovic. You do not think that is odd?

Prof. SUTTON: That is not a question for me, Mr Wells.

Mr WELLS: Okay. Thank you. I will just go to some of the questions. In regard to mandates, on page 7 the acting CHO details the continuing increase in hospitalisation and ICU admissions with no indication that Victoria had peaked for either metric. What is the actual number of hospital and ICU admissions that the department would consider a peak if we are going to have another peak over the next couple of months?

Prof. SUTTON: Do you mean an acceptable or an unacceptable peak?

Mr WELLS: Well, a working peak. What would be the plan put in place that the hospital system could cope with in regard to another outbreak?

Prof. SUTTON: Look, I think that is probably for the state controller as well. This relates to the mobilisation of additional ventilators, ICU beds, ward bed capacity, workforce et cetera. They are not considerations for me specifically as to how we can meet them. I would obviously receive the state controller's advice on whether or not the trajectory of another wave or epidemic spike was going to challenge that and what we might need to do in order to stay under that number.

Mr WELLS: So would we be able to get that advice, or do we need to ask the state controller directly?

Prof. SUTTON: I guess you would have to ask the state controller directly, but I am not entirely sure what the question is. If it relates to what the absolute limit is that can be tolerated within the health system, perhaps that is answerable, but I am not sure that that would necessarily inform my advice as to where restrictions should be.

Mr WELLS: So in regard to what the hospital capacity would be if there was another outbreak over the next month, what would it be?

Prof. SUTTON: I would direct you to the state controller.

Mr WELLS: Okay. Ms Brady would not know that answer?

Prof. SUTTON: No.

Mr WELLS: I refer to modelling on the impact of omicron following the Australia-wide Doherty Institute modelling released in December. Did Victoria do any state-specific modelling as New South Wales and South Australia conducted?

Prof. SUTTON: Yes, we did. We did some modelling with the Burnet Institute.

Mr WELLS: Can that be released to the committee?

Prof. SUTTON: I believe it has been released.

Mr WELLS: Thanks. Page 8 details 591 cases in hospital—this is on page 8 of the table—representing an estimated 29.9 per cent of currently available ward beds statewide for COVID-19 patients. Does that mean there were only 1977 ward beds statewide for COVID-19 patients?

Prof. SUTTON: Again a question for the state controller. I presume that means those that are currently mobilised, not potentially mobilised.

Mr WELLS: Regarding paragraph 27 of the acting health chief's advice to the Premier, as of 5 January there were 53 patients with COVID-19 in intensive care units, representing an estimated 12.9 per cent of staffed private and public ICUs. Does that mean there were only 411 staffed private and public ICU beds in Victoria? Is that correct?

Prof. SUTTON: Again not a question for me, I am afraid, Mr Wells.

Mr WELLS: In regard to the tennis—I want to just loop this in—with the government medical panel that was established or constituted, under what legislation was that constituted?

Prof. SUTTON: I do not know that it was constituted under legislation. I do not know about the panel and its constitution.

Mr WELLS: Maybe Ms de Witts could answer that. We just want to know how it was constituted. Under what legislation or under what regulation was it set up?

Ms de WITTS: It was not set up under legislation. The panel was a review panel, and the exemption is actually granted by the doctor attending the individual. This was a supplementary panel that reviewed materials put through from Tennis Australia.

Mr WELLS: Okay. So who is on that panel?

Ms de WITTS: I do not know.

Mr WELLS: So you know how it was constituted but you are not sure who is on it?

Ms de WITTS: That is correct.

Mr WELLS: So who would have appointed those people? Is that the state controller?

Ms de WITTS: I do not know.

Mr WELLS: Thank you.

The CHAIR: Thank you. We will now move to our final 10 minutes. Mr Erdogan.

Mr ERDOGAN: Thank you, Professor Sutton, for your appearance today. I just want to clarify some confusion about your role that seems to have come out in the committee today, and in particular your role in rapid antigen testing, in the approval of tests and in their rollout. What is the Chief Health Officer's role with rapid tests?

Prof. SUTTON: My statutory role is to protect the public health and wellbeing of Victorians. That is largely done through communications and guidance, but in extraordinary circumstances—obviously, now—I have powers exercised in making recommendations to the minister on pandemic orders. There were no specific pandemic orders about the procurement of RATs, but I think the acting chief health officer, Ben Cowie, certainly provided advice to the minister that we would be facing a challenge through January of very significant numbers of people seeking testing and a reduced ability to get individual positive results back in a timely way, because the batch-testing availability was not there anymore. So Ben Cowie and I both provided verbal advice to the state controller and to the minister that we would face testing challenges and would need a significant uplift in our rapid antigen testing capability, the ability to capture those positive tests and the ability to use those positive tests to isolate and quarantine people in response to the omicron wave. He and I both provided that advice, and Phuong Pham, the deputy secretary for testing, instituted a really rapid and large-scale request, procurement and supply response.

Mr ERDOGAN: Thank you for clarifying that, Professor Sutton. Earlier today we talked about certain disadvantages faced by certain groups throughout the pandemic, and also you have clarified that there is a substantial place in our testing system for rapid antigen testing now. In light of that, what is your opinion about the free market determining the distribution and costs of these rapid antigen tests?

Prof. SUTTON: I think, you know, from the public health perspective, you want all feasible barriers to be minimised to the extent possible. They may relate to misinformation, so you want to provide accurate and timely information, especially in a confusing social media environment where misinformation and disinformation are really provided all too floridly. You want the financial barriers to be minimised for those people who most require access to testing, but there is a genuine public health benefit from reducing those barriers across populations, because the control of numbers has that pillar of isolation of cases and quarantine of their close contacts. You do not know that you have got a case that needs to isolate until they can get a test result, and those close contacts need the opportunity to be able to test during their quarantine period in case they become cases. So having a really free availability across the population of rapid antigen tests is really critical, and the extent to which you can minimise those barriers—whether they be geographic, barriers in understanding, barriers in cultural appropriateness of how you engage about the use of those tests and the instructions on how to use them—will provide several-fold benefits back to you by making sure that that availability and accessibility is really broad.

Mr ERDOGAN: Thank you. I did have a supplementary question to that, and part of it was answered. As we are all aware, the Victorian government is now providing free tests—well, millions of free tests have already been provided, in particular to a lot of schoolchildren, their parents and educators. Obviously it is the first day of school today. In light of that, how does that impact your decision-making and other health policy settings going forward if those free tests continue to be provided to other essential sectors?

Prof. SUTTON: Yes, look, they are a real bedrock. That advice to procure millions of tests was thinking about both those sensitive settings but also the broad population. It has been a useful tool for asymptomatic

surveillance—for example, before gatherings, in schools, in health care and other sensitive settings. And obviously we were the first to provide the free test kits, initially to school and workplace contacts back in November, but then the first to order en masse and to have a digital recording system up in place to be able to have those results in our database.

When the PCR system could not handle them, they were absolutely essential to be able to make sure that people could isolate and quarantine appropriately. And so we now have choice. We have got two viable and accessible options for symptomatic people to turn to: PCRs and RATs. Both systems still have some strain, but it is the second option that has cleared the way to get rid of the PCR backlog that really occurred across the country and restored our turnaround times, so the time to get your test result to 90 per cent by the next day. So that technology also means that we can use it in a surveillance program. That is what is happening in schools, and we are strongly recommending the RATs for every single school student in Victoria. You cannot do that with PCRs. It means that there is stronger community surveillance, more people getting tested and a more timely isolation for those cases that turn up. The close contacts that happen in households can now access those RATs. It means people can self-monitor their own infection status, do it quickly, easily and safely. If you are a household contact and you get symptoms and you test positive on a RAT, you are very, very likely to have the virus. So our settings reflect that: you need to isolate with that positive RAT result, you do not need the confirmatory PCR. So you can trust the result. You can then be linked in with our COVID-positive care pathway and get the certainty of help should you develop a significant illness.

Mr ERDOGAN: On that point, I guess Victoria was the first mainland state to create a system to record rapid antigen test results online. How has this new platform affected your COVID-19 response and your pandemic order recommendations?

Prof. SUTTON: It has certainly given a much clearer picture of the full burden of illness in the state, even though there are probably thousands of people who just have not tested. They have got no symptoms, they are not close contacts, so they are not getting tested through any approach. But we have moved to a point where half, a little more than half some days, of all positive results that come through are RAT-positive results. That means that we understand a truer and clearer idea of the burden of illness in the community—how many true cases there are out there—and it gives me greater certainty about those peaks that we think we are past. So we think we are past our case peak, and it makes me more confident, having seen that peak in cases close to two weeks ago, that we are now at a hospital plateau, if not peak, and therefore can make the appropriate adjustments to our settings to be proportionate, knowing that there is still significant strain on our hospital system—still over 2500 healthcare workers under furlough—but that we are over the real pinch point and that maybe we can make some proportionate changes as we drive cases down further.

Mr ERDOGAN: Just a final question, because you touched on an important point about the importance of people having trust in our public health orders and the risks of misinformation. That is why I guess we have these new pandemic orders and that is the reason for this committee. I guess this committee and the independent pandemic management advisory committee are also new aspects of the pandemic management process in Victoria. Can you tell us how you think these new committees could assist in improving transparency? Or do you agree that they do improve transparency?

Prof. SUTTON: Yes. Look, the proof is in the pudding. I think the structures are positive. Obviously it has been a matter for Parliament to design and agree on these elements. I do think the independent pandemic measures group has that broad church of inputs from those with public health expertise, infectious disease expertise, but also on human rights and charter considerations and the issues of social licence. So that breadth and diversity of voices that help inform the minister's choices around pandemic orders I think is a strength. Clearly if there is a view to question some of the pandemic orders that are in place and to make variations or to revoke some of those orders or to make a recommendation to revoke some of those orders, getting that broad representative view from that independent panel I think is also a strength. It provides for that variety of input and for those various disciplines to be able to provide perspectives that go beyond a purist public health perspective.

Mr ERDOGAN: Thank you very much for that, Professor Sutton.

The CHAIR: Thank you, Professor Sutton. That is all the questions. I would like to thank you and—

Ms KEALY: On a point of order, please. Sorry for interrupting. Chair, I would like to refer back to a comment that was made to Mr Wells during the presentation by Professor Sutton and Ms Brady regarding the recordings being published on the pandemic orders website. I have reviewed that now—fortunately I have got my iPad in front of me—and there are simply no audio recordings of discussions that have taken place between Professor Sutton and the minister or the Premier. Now, given that is available, I am asking that that be—

A member interjected.

Ms KEALY: I am being quite straight around this. We were told that there were verbal recordings and that they had been published. They have not been published. All I seek is that if the recordings are available—there are assumptions that they have already been published. They are not available. Can they please be published as soon as possible? Provided to the committee at the very least.

The CHAIR: Ms Kealy, any points of order now will be dealt with after the closing of this. We have got an opportunity to put questions on notice, and I am satisfied with that. So at this point—

Ms CROZIER: A point of order, please, Chair. I understand it is the end of the hearing and Professor Sutton, Ms Brady and Ms de Witts have been very helpful with the information they have provided, but it goes to the point that that is not what the committee has been told about the recordings being undertaken. That is not what has been actually published, and so what we are asking for is for those recordings to be provided to the committee so that they actually do match up with what is in the public domain. I think that is important for transparency.

Prof. SUTTON: Ms Crozier, they are transcribed, written—

Mr WELLS: No, you said recordings.

Prof. SUTTON: Publication—

Members interjecting.

Mr WELLS: Professor Sutton said recordings. I specifically asked. Now he is saying they are transcripts.

Prof. SUTTON: Verbal—

Mr WELLS: That is completely different to what he said. He said recordings and they were going to be up on the pandemic, and now all of a sudden it is transcripts.

Ms Shing interjected.

Mr WELLS: No, no. It is transcripts. It is a big difference to the recordings.

Members interjecting.

Mr WELLS: No, no. You are grandstanding now, I am sorry, Harriet.

Ms Shing interjected.

The CHAIR: On that note, Professor Sutton, the hearing is now over. I would like to thank you, Ms Brady and Ms de Witts, for your attendance today. The committee will follow up with some written questions, including perhaps some of those that have been raised, and they will be sent on to you. Again, I declare the meeting closed and thank you very much.

Prof. SUTTON: Thank you, Chair. Thank you, members.

Committee adjourned.