Appendix A: Jurisdiction specific issues NSW

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This document is a NSW specific appendix to the Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units. This appendix is to be used in conjunction with the national guidelines and provides additional jurisdiction specific guidance for NSW and will be regularly reviewed.

The NSW Government is working towards no community transmission within NSW. Accordingly, this appendix takes a precautionary approach to the control of COVID-19. NSW public health units (PHU) should err on the side of caution when making decisions about testing and quarantining of COVID-19 contacts, recommending closure of venues or workplaces or schools, and other disease control interventions which place restrictions on individuals. This is in order to minimise the risk of a large outbreak requiring widespread community restrictions with consequent economic costs.

This appendix will be reviewed regularly.

Appendix A: Jurisdiction specific issues NSW

Cases

1. Assigning cases for investigation and public health management

During an outbreak, once discussed with HPLT:

- Cases will be notified centrally to PHRB Surveillance team.
- PHRB Operations Team (PHRB OT) will allocate case interviews to PHUs with capacity across the network.
- Upon case interview the PHU undertaking the case interview will identify, make initial call and record in NCIMS close contacts that are identified by each case.
- After discussion with HPLT, exposure venues in the outbreak area (as defined by HPLT) may be referred to PHRB OT for central coordination of risk assessment and contact tracing across the public health network. In these circumstances, a consistent approach to risk assessments will need to be agreed.
- All exposure venues outside the outbreak area will be handed over to the PHU of jurisdiction (please cc Operations for visibility as per usual).

a. Cases residing at usual address

PHU staff are responsible for the case investigation and ongoing follow up of cases residing in their Local Health District (LHD).

b. Cases temporarily residing outside their usual jurisdiction (including returned travellers)

Where a case is residing at a different residential address from usual, the PHU of their home address will undertake the initial public health follow up. The ongoing clinical care of these cases will be the responsibility of the LHD of their current location.

Except for below, public health management will continue to be the responsibility of the PHU in the LHD of residence. Ongoing follow up of contacts will be managed by the NSW Ministry of Health’s COVID-19 Public Health Response Branch (PHRB) Close Contact Tracing Team (PHRB CCTT).

c. Cases in quarantine in police-managed hotels

All returned travellers with a positive or indeterminate COVID-19 test result are transferred from police-managed hotels to Special Health Accommodation (SHA) for clinical management.

The PHU for the LHD in which the case resides will undertake the case interview and, in collaboration with the Royal Prince Alfred Virtual (RPAV) team, contact management of the case’s travel companion/s. Where a positive case is identified in a police-managed hotel, Health Care Australia (HCA) will notify the patient of their positive result prior to the PHU undertaking the interview. Where a positive case is identified and is already located in SHA, the Royal Prince Alfred Virtual (RPAV) team will inform the patient of their result. The SHA will advise PHRB Surveillance when the case has been notified and this will be updated in NCIMS as a note, prior to the PHU of usual residence or PHRB (for
people who normally reside interstate) conducting the interview. Flight crew in quarantine hotels will be notified of their positive result and have the interview undertaken by PHRB OT.

During the case interview, advise the returned traveller that their clinical care will be managed by the RPAV clinical team when they are transferred to SHA. All returned travellers are to be asked the Indigenous Status question during case interview. Once the case interview is complete and the case is transferred to the SHA ongoing PHU contact is generally not required. The clinical management, including discharge processes and communication of results, are managed by RPAV and the SHA.

The date of release is a decision made by a multidisciplinary team which meets on a regular basis and consists of RPAV clinicians, ID physicians and public health physicians. On discharge the discharge date will be noted on NCIMS within a business day of discharge in most circumstances by SLHD.

Where the returned traveller has been transferred to the SHA prior to the case interview, the PHU can contact the SHA Bed Manager to obtain the room phone number.

Where there are concerns about a management or isolation issue in the SHA, the PHU Director can email the SLHD PHU Director.

**Note that the SHA has processes for the following:**

- All positive cases will have serology taken, and family members who are PCR negative may also have serology taken to assist with cohorting/close contact decisions.

- Where the returned traveller states they have had a previous COVID-19 infection they are requested to provide all documentary evidence (e.g. PCR, serology, clinical notes, discharge certificates etc.) to the RPAV team to assist with classification of their illness. All positive cases, even when it may be a historical infection, need to transfer to the SHA while this is being assessed.

- SHA staff will have a discussion with returned travellers that have been in quarantine with other people regarding the best living arrangements to minimise transmission and reduce time in quarantine for all members of the travelling party.

- The SHA has established protocols and processes in place for:
  - Management of clinical conditions, including non COVID-19 related medical issues;
  - Determining historical cases;
  - Determining variants of concern that may require additional clearance tests; and
  - Determining the appropriate length of stay in quarantine.
  - Management of social, emotional, mental and cultural wellbeing.

**d. Cases not assigned a jurisdiction**

Cases in hotel quarantine who do not have a residential address in NSW (e.g. interstate residents in hotel quarantine) will have their initial interview conducted by the PHRB CCTT.

**e. Cross-jurisdictional cases and clusters**

When a case has contacts across more than one LHD (e.g. workplace settings, border communities) the PHU managing the case is responsible for transferring follow up of contacts/exposure sites to the relevant PHU. This can be negotiated between PHU Directors, ensuring that the PHRB OT is informed of the arrangements so that any PHRB OT follow up is directed to the correct PHU. In complex situations a teleconference should be organised by PHRB OT. The teleconference should include all affected PHUs and the PHRB OT and should determine which PHU will manage each of the exposure sites and contacts, or any necessary source investigations. If support is required, the PHRB OT can facilitate sharing of information between the PHUs. The PHRB OT will help coordinate responses to clusters involving multiple LHDs.

**2. Specific settings**

PHUs and the PHRB must follow the relevant NSW specific Incident Action Plan for investigation and management of cases in the following settings:

- **Aged care facilities**
- **Schools and early childhood education centres**
• Universities and TAFE
• Disability Group homes
• Abattoirs and meatworks
• Hospitals (healthcare workers) – in development
• Commercial vessels

Management Plans are in place to guide response in Aboriginal communities and health services (contact Centre for Aboriginal Health).

Cases and contacts in correctional facilities are managed by Justice Health and Forensic Mental Health.

For cases and contacts associated with patient transport, the PHU will conduct the case investigation. Where issues extend beyond the PHU’s jurisdiction, this should be referred to the PHRB who will coordinate the response through teleconference with relevant parties.

3. Case interview

Initial call immediately after notification

Where the notification of a new case has not come via NCIMS or PHRB, the PHU should immediately notify PHRB Operations (available 24 hours per day, 7 days per week).

The PHU should conduct an initial phone call to the case or their carer ASAP and within 2 hours of notification (within extended operating hours, 8am to 10pm). The purpose of the initial call to the case or their carer is to:

• Inform the case of their result if they have not already been notified of this (note that this can take time and cause distress, impacting on the timing of the case interview).

• Ensure the case is linked to an appropriate clinical service for care.

• Explain the need to isolate and how to do so
  • Assess capacity to isolate the case from other members of their household.
  • Identify householders at risk of illness (elderly, comorbidity) and facilitate provision of alternative accommodation for the case or contacts as necessary.

• Collect epidemiological information using the case investigation questionnaire
  • Identify close contacts.
  • Identify likely source of infection.

For locally acquired cases arising in people not already in quarantine, information regarding the probable source of infection, exposure risk to others and intended source investigation should be conveyed by the PHU Director or delegate to PHRB Operations within 30 minutes of completion of the interview.

The PHU should expedite laboratory testing e.g. GeneXpert if urgent results are required to guide public health action.

The PHU should make multiple attempts to interview the case as required. All communication methods available should be utilised including phone, text message and email. Multiple attempts should be made throughout the first few hours after notification.

If the case is unable to be contacted after 6 hours since notification, and a minimum of 3 messages (by phone, text and/or email) have been sent, or there is a genuine concern that the case is not in isolation, the PHU should escalate the matter urgently via the PHRB. Refer to the NSW Health requests to NSW Police protocol for non-compliant and non-responsive close contacts, for details of the agreed process and reporting time frames and ensure that all relevant information is provided in the referral.

Data management

• On completion of the initial case interview, the following data should be entered into NCIMS as soon as possible (and within 2 hours in extended hours):
  • Indigenous status.
- Country of acquisition if known.
- Likely source of infection (local, overseas, interstate).
- Source of local acquisition – for local cases (household or epi-linked to known case or cluster/ investigation ongoing/no links to known case or cluster).

- **On the same day** as the initial interview, the PHU should complete the remaining core fields as per the case data entry guide and attach the full questionnaire in NCIMS.

- On request from the PHU Director, the PHRB may assist with data entry into NCIMS from the scanned questionnaire attached to the record.

- The PHU should review the minimum dataset for all cases at least weekly to ensure core fields are complete.

**Laboratory results that appear inconsistent with the epidemiological and/or clinical picture**

When laboratory test results are indeterminate, or there are concerns about a potential false positive result, or an estimation of the time of acquisition of the infection is required to inform the public health investigation:

- If an indeterminate or inconclusive PCR result is reported, the sample (both extract and original material) should be transported to either ICPMR or SEALS for supplementary testing. The result should be considered in the context of the clinical and epidemiological circumstances to inform any further public health action.

- If practical, direct the case and relevant close contacts to a public COVID-19 clinic or hospital and request re-collection of a respiratory swab and collection of a blood sample for SARS-CoV-2 serology. Note, blood samples for serology testing cannot be collected at drive through collection centres or pop-up clinics. Where urgent results are required (i.e. within 2 hours) the PHU should arrange for specimen collection at a suitable clinic or a home visit.

- Inform PHRB OT of cases and contacts who will be sampled and estimated time of collection. Case and contact details to include:
  - Name
  - Date of birth
  - Indigenous status
  - Specimen details (specimen type, collection date)
  - Test(s) requested and reason for the test
  - Testing laboratory (where specimen will be initially received or located)
  - PHU contact details and requesting officer’s name and role.

This information is required to enable follow-up with NSW Health Pathology and to organise transport of specimens to other laboratories.

- PHRB OT will immediately inform NSW Health Pathology liaison officer to coordinate urgent transfer and testing of samples.

- Respiratory swabs can be tested at the receiving laboratory.
  - If rapid testing is required, contact the Clinical Microbiologist to request testing using GeneXpert or liaise with NSW Health Pathology for alternative options.
  - If after-hours testing is required or the receiving laboratory is unable to test, organise for the respiratory swab(s) and blood sample(s) to be sent to ICPMR. The PHRB and NSW Health Pathology are able to assist with transportation.

- Blood samples should be sent directly to ICPMR for quantitative serology testing.
  - Notify PHRB OT of case and contacts (as above)
  - If urgent or after-hours serology testing is required, notify PHRB OT to coordinate testing with NSW Health Pathology and ICPMR
• Discrepant results can be reviewed by an urgent out-of-session meeting of the Expert Panel on the Review of COVID-19 Diagnoses:
  o Complete the case summary proforma and submit to PHRB
  o The case should be managed as a confirmed case while awaiting the conclusion of the Expert Panel

4. Source investigation

If a case’s source of infection is unknown, investigate the possible source of infection (unless otherwise specified in the Incident Action Plan relevant to the specific setting), as per Identification of potential source contacts in the SoNG.

Investigation usually involves taking respiratory swabs and blood samples for serologic testing of people in close contact with the case in the 14 days before the onset of symptoms in the case. If there are a large number of upstream contacts, discuss prioritisation with PHRB Deputy Controller. Sources include:

• Household contacts
• Settings with potential for rapid transmission (e.g. residential settings and closed community settings)
• Potential source contacts who report a history of illness
• Potential source contacts who had possible exposures themselves (e.g. visited an exposure location/airport or hotel quarantine employee)
• Workplace close contacts
• Settings visited during days 5-7 before symptom onset (the median incubation period for COVID-19)
• Settings outside the home where transmission is known to have occurred, such as pubs, clubs, gyms, family gatherings, religious services

5. Management of the case

The PHU must confirm that the case is able to completely self-isolate within their own home or other suitable facility. If there is any concern about this, the case should be accommodated at Special Health Accommodation (SHA). SHA accommodation can be arranged by emailing and providing the case’s name, DOB, address of residence, contact number(s), NCIMS number. Ensure appropriate handover of relevant case details and that the case is aware you are arranging with SHA.

Where cases self-isolate within their home, the PHU/LHD must:

• Ensure the case is aware of isolation requirements
• Arrange ongoing clinical management within the LHD using Hospital in the Home or equivalent (e.g. GP care) and welfare support for the case
• Ensure that the case’s GP is aware of the diagnosis and has the opportunity to be involved in the patient’s care

Clinical management is the responsibility of the clinical service managing the case.

The LHD or clinical service managing the case should contact the case or their carer at least every 2 days to:

• Monitor clinical progress and detect deterioration
• Assess compliance and barriers to effective isolation
• Identify emerging welfare needs such as food or psychological support

Cases who are not able to be contacted while in self-isolation should be followed up using all communication methods available (phone, text message, email, etc.) at different times throughout the day. If the PHU is persistently unable to contact the case (after a minimum of 3 attempts over a 6 hour period (including attempts made by the clinical service), the PHU should escalate the matter urgently to the PHRB. Refer to the NSW Health requests to NSW Police protocol for non-compliant and non-responsive close contacts for details of the agreed process and reporting time frames and ensure that all relevant information is provided in the referral.
Where a case is found or suspected of being non-compliant with isolation, the LHD should apply their local escalation pathway to ensure effective self-isolation. Actions to assist in compliance may include urgent counselling from their GP, an LHD clinician or the PHU/PHRB, or assistance with practical matters such as supply of food or medication. Where counselling fails, a Public Health Order and referral to the police for compliance and penalties may be appropriate (as per protocol). Where possible, PHUs should establish an Aboriginal Cultural Support model to provide additional support and care for Aboriginal cases and contacts.

Compliance with isolation requirements for infectious patients is a very high priority. Where a case has not been able to maintain safe home isolation, the LHD must provide a report to the Chief Health Officer (CHO) and PHRB, via email, including the steps taken to ensure compliance, as soon as possible after the issue has been identified.

For cases who live in an apartment complex, the PHU must assess whether there has been a risk to other people in the apartment complex. This assessment should consider the layout of shared areas such as communal laundries, lifts and entry points. Where there may be a risk to other residents then the PHU should determine whether they may be close or casual contacts and arrange for a rapid communication to those residents and facilitate urgent testing. Masks must be encouraged when residents of an apartment block are in common areas.

If the case lives alone or is otherwise vulnerable, the LHD should actively follow-up non-responders to ensure the case has not clinically deteriorated. PHUs should negotiate with local services managing the case how best to communicate information on follow up and clinical management.

Data management
- PHUs should clarify with all local clinical services involved in managing the case how best to ensure NCIMS and clinical progress notes are updated, and that all important information on clinical management is communicated between services.
- NCIMS Workflows for clinical management:
  - Welfare check required today for nCoV2019 cases.
  - Welfare check OVERDUE for nCoV2019 cases.

6. Release from isolation

In general, the clinical service conducting the case follow up should manage release of the case from isolation (as per SoNG criteria and provide any relevant documentation as required). PHUs are to negotiate with local clinical services how best to communicate information on release from isolation.

LHDs are responsible for providing the “release from isolation” date for all cases managed in the community within a business day of release from isolation. This isolation information is used to provide public reports on the number of active cases in NSW. Locally acquired cases transferred to the SHA will have their release from isolation date recorded in NCIMS by SLHD.

7. Recovery – telephone call

Recovery interviews are not currently routinely undertaken, but may be conducted at times to collect important outcome data. The purpose of recovery calls is to determine the duration of illness and obtain complete data on underlying illnesses and collect any missing data. PHRB CCTT is responsible for completing recovery interview calls using a standardised questionnaire. Alternatively, PHUs can elect to collect this information for their cases. When they are undertaken, recovery calls are conducted 3 weeks from onset of symptoms. Cases who continue to report symptoms are contacted again at 2-3 weekly intervals until symptom resolution.

Any matters identified relating to clinical and/or welfare needs or release from isolation will be referred to the PHU or a local service nominated by the PHU.

Data management
- The person responsible for collecting the recovery information (PHRB CCTT or PHU) is responsible for completing the relevant recovery fields in NCIMS. The completed questionnaire is to be scanned and attached to the NCIMS record.
• The recovery date and final symptom profile should be updated at the time of uploading the recovery questionnaire.

• The PHRB Data Entry Team (Surveillance) will update remaining information on the case questionnaire into NCIMS

• Information on recovery for residents of residential care facilities (RCFs) will be managed separately in consultation with PHUs and the COVID-19 Public Health Response Branch.

• NCIMS Workflows for recovery data
  o PHRB CCTT - All cases ≥ 21 days after calculated onset date not yet interviewed
  o PHRB CCTT- All cases at 14 days past last interview date and not yet recovered

Contacts

1. Close contacts overview

A close contact is to be identified as outlined in the CDNA SoNG unless more stringent criteria are applied by the PHU or specified in the NSW Incident Action Plan relevant to the specific setting. In addition, where the confirmed case is asymptomatic and a likely source of infection has been identified, consider the case’s infectious period to begin 24 hours after exposure to their source of infection. Assessment and management of contacts is the same regardless of vaccination status. Close contacts who identify as Aboriginal should be offered Aboriginal Cultural Support by their LHD of residence.

See below for guidance on assessing and managing contacts where cases have attended public venues and situations with large numbers of contacts.

Close contacts should be interviewed to identify if they work in a high risk setting, or live with other people who work in health care or other high risk settings defined in the SoNG. If either of these apply, testing of the close contact should be expedited.

All close contacts of cases should be advised to:

• Quarantine for 14 days after their last exposure to the case (day 0 being the last day of exposure)

• Seek immediate testing regardless of symptoms (quarantine entry screening) and identify themselves as a close contact when attending the clinic so that the testing can be prioritised and sample labelled as “Urgent – Public health outbreak control”, see https://www.pathology.health.nsw.gov.au/covid-19-info/process-to-expedite-testing

• Continue to isolate regardless of the test result

• Test again if symptoms occur

• Test on day 7 if they are able to access a drive through testing clinic

• Test on day 12, or later (quarantine exit testing)

In addition, named close contacts of cases should be advised to:

• Inform their secondary close contacts (see below) to get tested and isolate until they and the primary close contact return negative results

Where the identified COVID-19 close contact is not able to self-isolate from household members they should be provided alternative accommodation. Where household members cannot isolate from the close contact, they will need to isolate with the close contact for the entire quarantine period and have a test at the end of that period. Should the close contact test positive at any time, the household members will be considered close contacts of that case.

For close contacts who identify as Aboriginal, decisions about alternative accommodation should be made in collaboration with the individual and their family. PHUs can organise locally through their LHD services, or the CCTT will arrange hotel accommodation through FCM. Refer to COVID-19 Accommodation referral processes: for people who need support to safely self-isolate.
2. Secondary close contacts

Named close contacts must be asked to notify any secondary close contacts of their contact status. This includes the following people:

- Everyone they share their home with
- Everyone who has been in their home since they were exposed to COVID-19
- Everyone in a home that they visited since they were exposed to COVID-19
- Friends who they have shared a confined space with, such as a car, since they were exposed to COVID-19.

Where health care facility managers become aware of a primary close contact among their staff, they should arrange a rapid PCR test (e.g. GeneXpert) for the primary close contact. If the primary close contact rapid PCR test is negative there is no need for isolation or testing of asymptomatic secondary close contact/s.

Secondary close contacts are advised (via the Secondary Close Contact factsheet):

- To get a COVID-19 test (even if they don't have symptoms) and isolate at least until they and the primary close contact receive negative results
- If they are a healthcare worker, that they will need to speak with their manager and be risk assessed if there is a need for the healthcare worker to return to work before receipt of the primary close contact's test result
- To test immediately if any symptoms develop
- If they have effectively isolated from the close contact and can continue to isolate from the close contact, and both they and the primary close contact have received negative test results, they are able to stop self-isolating
- If they are not able to effectively isolate from the close contact, the secondary contact:
  - Must stay in isolation for the full 14-day quarantine period since the date of the primary close contact’s exposure (day 0 being the last day of exposure)
  - Test again if symptoms develop or the close contact tests positive.

In families with multiple children where a child is a close contact, the affected child should maintain strict isolation from the other children for the duration of quarantine and in particular, they should not play together or share toys. Refer to NSW Health COVID-19 self-isolation guideline.

In situations where household close contacts with a shared exposure are to isolate at the same home but not effectively isolate from each other, they must understand that if one becomes a case:

- the other(s) will have an increased risk of infection, and
- the other(s) will need to quarantine for a further 14 days after last exposure to the case while the case was infectious

Refer to NSW Health COVID-19 self-isolation guideline.

3. Interstate close contacts

Close contacts identified by the case at interview who are known to be interstate should be entered into NCIMS immediately by the PHU (refer to data entry guide) and flagged as requiring interstate notification. These contacts will be transferred to the relevant jurisdiction within 4 hours by PHRB for initial contact and follow up.

4. Initial call

Initial calls to close contacts identified during the case interview are to be undertaken by the PHU. Where the
PHU does not have capacity to follow up close contacts within 4 hours (within extended operating hours), request and refer for CCTT follow up to PHRB, refer to Protocol - Request for contact Tracing from Public Health Units, The Contact Tracing Template outlines the information to be provided (where possible) for these requests. Where the CCTT does not have capacity, they will coordinate the list and allocate work to other PHUs with additional contact tracing capacity. Contact tracing and follow up of close contacts in high-risk settings, such as clinical settings and household contacts, should be undertaken by the PHU where possible.

The initial call should be made within 4 hours of identification of the close contact (within extended operating hours). If there a significant numbers of close contacts, those at highest risk (such as household contacts) should be contacted first. The purpose of the initial call to the contact or their carer is to advise them of quarantine requirements and to advise testing.

The PHU/CCTT should make multiple attempts to speak to the close contact. All communication methods available should be utilized including phone, text message and email. Multiple attempts should be made throughout the first few hours after identification.

If the contact is unable to be contacted after 6 hours since notification, and a minimum of 3 messages (by phone, text and/or email) have been sent, or there is a genuine concern that the contact is not in isolation, the PHU should escalate the matter urgently to the PHRB. Refer to the NSW Health requests to NSW Police protocol for non-compliant and non-responsive close contacts for details of the agreed process and reporting time frames and ensure that all relevant information is provided in the referral.

Some contacts will require evidence (e.g. for their employer) that they are required to quarantine. The service making the initial call will need to confirm if this is required and provide a quarantine certificate (COVID-19 Requirement for isolation/quarantine letter template is available).

Data management
The service (PHU or PHRB CCTT) making the initial call is responsible for registering the individual as a close contact in NCIMS and completing the core fields (as per close contact data entry guide).

5. Ongoing contact follow up

After an initial phone call, follow up involves at a minimum a daily text message (using Whispir) or a call every 2-3 days.

Close contacts are to be followed up regularly to:

- Assess for the presence of symptoms and prompt testing if symptomatic.
- Reinforce the need for quarantine (irrespective of a negative test result)
- Identify barriers for effective quarantine
- Identify quarantine assistance needs and provide referrals where appropriate

In addition to the above, and where possible, ongoing cultural support will be provided to close contacts who identify as Aboriginal.

Quarantine assistance issues identified during follow up will be escalated and managed within the LHD.

Data management
The service making the call (PHU or PHRB CCTT) is responsible for updating NCIMS.

6. Day 7 testing of travellers in hotel quarantine

All travellers in hotel quarantine require a nose and throat swab at day 7. This is to:

1. Identify asymptomatic infections which may transmit to a person who is co-quarantining with the infected contact (as the asymptomatic close contact may already be PCR negative by the time of the quarantine-exit swab); and
2. Facilitate the implementation of additional public health measures required for VoC cases such as further investigation of potential infection control breaches during the airport/hotel transfer and prevention of flight crew members return to their home country; and
3. Allow earlier transfer to the SHA and potentially earlier release from isolation should no symptoms develop.

7. Exit screening of contacts

Exit screening at 12 days after last exposure is required to identify potentially unrecognised infections among close contacts. All close contacts are required to have an exit test on day 12 after last exposure. On day 11, CCTT text or call close contacts reminding them of the need to have a D12 test.

CCTT reviews exit screening status during the day 14 finalisation call. Any close contact who indicates at any time during isolation that they refuse exit screening or are identified as missing exit screening results at day 14 will be referred by CCTT to the PHU for assessment.

Close contacts refusing exit screening should be counselled by the PHU. If after counselling the person still refuses testing then the PHU should issue an urgent public health direction to extend the isolation period for the person, unless the PHU director is satisfied, following a risk assessment and counselling, that, on the balance of probabilities, it is safe to release the person from isolation.

The public health direction must be in writing and from an authorised medical practitioner (see Template-Direction under clause 5 of the Public Health Self-Isolation Order). If the close contact fails to get tested, they should be sent a letter reminding them that they will need to quarantine until the new date specified in the letter. If the close contact subsequently gets tested, and returns a negative result, then a revocation letter should be sent to release them from quarantine.

Close contacts on day 14 who agree to exit screening after further discussion with PHUs should be informed to isolate pending results and referred back to CCTT for follow up.

8. Contact follow up day 14 – telephone call

PHRB CCTT is responsible for follow up of all non-household contacts (except where the PHU has indicated they will conduct follow-up).

Release from quarantine can be considered at least 14 days from the date of last exposure to the case, or for people in the same household, the date of effective case isolation. The following criteria must be met:

- The contact is symptom free.
- The case has been adequately isolated from the close contact throughout the contact’s 14-day quarantine period.
- Exit screening results from day 12 or later are available.

Symptomatic contacts should be advised to seek testing and remain in isolation beyond day 14, at least until test results are available. Symptomatic close contacts who previously tested negative should be re-swabbed.

Data management

The service making the call (PHRB CCTT or PHU) is responsible for updating NCIMS.

9. Casual contacts

Casual contacts who are identified between 0-3 days after exposure

The contacts should be advised to:

- Get tested for COVID-19 and self-isolate until they receive a negative result
- Get another COVID-19 test 5 days after exposure
- Wear a mask when in the presence of others, avoid gatherings and minimise movements until they receive a negative day 5 test result; they can still attend work where the staff member has an essential role
- Monitor for COVID-19 symptoms and get tested again at any time if they develop any symptoms.
Casual contacts who are identified 4 or more days after exposure

These contacts should be advised to:

- Get tested for COVID-19 immediately
- Self-isolate until they receive a negative test result
- Monitor for COVID-19 symptoms and get tested again at any time if they develop any symptoms.

Where electronic contact lists are available this advice can be provided as a Prodocom email/SMS sent by the PHRB.

For large stores such as supermarkets or hardware stores the PHU director can apply discretion if applying the above criteria will have significant impact on the operation of the business.

Consult with the PHU Director and PHRB controller/deputy controllers if an alternative approach is sought.

10. Testing of travellers released from quarantine

Travellers, who have not been cases (acute or historical cases), are required to have a COVID-19 test 2 days after leaving quarantine. This applies to travellers and their carers in hotel quarantine and people exempt from hotel quarantine (but not declared flight crew). PHRB CCTT will call all travellers who have been discharged from a police-managed quarantine hotel on day 16 after the traveller arrived in NSW and remind the person to have a COVID-19 swab that day, even if they do not have any symptoms. PHRB CCTT will call or text all travellers on day 21 to check for symptoms and request that the person has another COVID-19 swab if they have symptoms and self-isolate until a negative result is received. Negative travellers discharged from SHA will be advised by the SHA Discharge team of the requirement to test on day 16 and if they have symptoms any time.

The traveller is not required to isolate while waiting for their day 16 swab result, so long as they have no symptoms. However, they should be advised to not work in or visit any high risk settings until a negative result is received. This includes healthcare and aged care facilities; residential disability care facilities; remote Aboriginal communities; hotel quarantine facilities and transportation; homeless shelters; prisons; boarding schools; and school camps.

CCTT will escalate to the relevant PHU, if during the call/text from CCTT:

- A person who has symptoms refuses to have a day 16 or day 21 COVID-19 swab, or has not sought testing in a reasonable timeframe.
- Refuses to comply with the direction to not to attend a high risk setting until they have had a negative day 16 (or later) test.

CCTT will also inform the PHU if a person reports symptoms during follow up call or text.

Such people who refuse testing should be counselled by the PHU. If after counselling the person still refuses testing then the PHU should issue an urgent public health direction to comply, unless the PHU director is satisfied, following a risk assessment and counselling, that it is safe not to have a further swab.

Response to a positive test in a person released from quarantine

When a person returns a positive swab result then the PHU should:

1. Urgently contact the person to isolate until further assessment is made.
2. Ask the person if they have had previous COVID-19 symptoms or documented infection and if so, seek evidence of this.
3. Ask the household contacts to isolate away from the case until further assessment.
4. Arrange for urgent nose and throat re-swab and test on 2 platforms (including GeneXpert where available), urgent serology, and a full respiratory pathogen multiplex panel. Where re-testing results are consistent with the historical case definition in the SoNG, no further public health action is required.
5. Where re-testing results do not meet the historical case definition, seek advice from PHRB.
6. Ascertain the individual’s Indigenous status. If individual identifies as Aboriginal, where possible, refer to Aboriginal cultural support.
On completion of quarantine, a person may have a further COVID-19 swab for a variety of reasons, such as due to developing symptoms or to meet requirements for further travel. If a positive result is returned, management is the same as above.

11. Management of contacts of flight crew or passengers identified as having a Variant of Concern (VoC) and who were infectious on the flight or while moving through the airport

The PHRB Operations team monitors all confirmed cases of COVID-19 who are international flight crew and passengers who have been identified as having a VoC and who were infectious on the flight or while moving through the airport. Risk assessment of contacts is undertaken through case interview and review of CCTV from the airport to identify any potential transmission risks (e.g. not wearing a mask). PHRB will share the risk assessment with the relevant PHU.

When contacts have been identified and risk assessment completed, the contacts are provided with appropriate isolation and testing advice. If the contact is a close contact requiring isolation, their local PHU will be informed. The PHU is responsible for assessing the contact’s ability to self-isolate appropriately at home or whether they need to self-isolate in the Special Health Accommodation.

In addition to routine close contact testing (immediate and exit testing), close contacts of a VoC case who are in quarantine with someone else or in hotel quarantine are asked to have an additional test on day 7 of their isolation period.

Please see the Protocol for Management of SARS-COV-2 Variants of Concern (VOC) Strains in NSW Hotel Quarantine.

NSW Health surveillance and testing program

NSW Health introduced a program of routine screening of quarantine and border workers, to identify any transmission of COVID-19 to quarantine workers, in mid-December 2020. The program is overseen by the State Health Emergency Operations Centre and Sydney Local Health District. Workers are tested for COVID-19 using a saliva specimen.

COVID-19 testing of saliva is undertaken daily for designated quarantine facility workers, transportation providers and airport workers. If the worker is away from work for more than three days (e.g. on leave or a break between shifts) they are asked to have a COVID-19 nose/throat swab on the fourth day after the last saliva test. If the worker is still away from work on the tenth day after the last saliva test, they are strongly recommended to have another nose/throat swab on that day. This is a screening test targeted at asymptomatic workers who may be exposed to SARS-CoV-2 in their workplace.

Symptomatic workers must isolate immediately on symptom onset and have a nose/throat swab as soon as possible and notify their employer as soon as practicable.

Management of a non-negative saliva COVID-19 PCR test:

Communication of results and initiation of response

NSW Health Pathology to notify Public Health Response Branch (PHRB) Surveillance via telephone and line listing. If after hours (between 10:00pm to 8:00am), NSW Health Pathology to email PHRB Surveillance at the time of result and follow-up with a phone call at 8:00am. PHRB Surveillance to notify PHRB Deputy Controller, Operations, relevant (residing location of worker) PHU, SLHD and SHEOC duty officer. If the worker’s personal contact details are not available, PHRB Operations to liaise with the SHEOC to obtain details (for notification process and NCIMS) 1.

1 Note: For staff who work in SHA, RPA lab should notify SLHD PHU and CE SLHD. SLHD PHU will then notify PHRB and the GM SHA.
Immediate Public Health actions

Urgent isolation and testing

- Relevant PHU to notify worker of their results and direct the worker and household members to isolate. PHU to notify household that they should remain in isolation pending further investigation of the case.

- PHU to facilitate confirmatory collection and testing of an urgent nose and throat swab from the worker. This is the primary objective at this point. PHU to liaise with NSW Health Pathology Liaison Officer. The test must be conducted as soon as possible on a rapid platform and a second platform.

- PHU to undertake urgent assessment of capacity of case to self-isolate, including from household members. If the PHU has concerns about the ability of the case to isolate effectively at home, the PHU may discuss transfer to the SHA with SLHD but this must not delay testing. The PHU must notify SLHD PHU if the case is transferred to the SHA.

- PHU to interview the person to determine their household and other close contacts.

Confirmatory testing

- If the worker is asymptomatic, the PHU to request for the confirmatory nose/throat swab to be tested on two different platforms (recommended by NSW Health Pathology). If “not detected” for SARS-CoV-2 on both platforms, stand down the public health response.

  - If the worker becomes symptomatic at any time, the worker must have a repeat nose/throat swab for testing, and the worker and household contacts must remain in isolation until the result of the symptomatic swab is known.

- If the worker is **symptomatic** and the nose/throat swab result is “not detected” for SARS-CoV-2 on two different platforms:

  - Collect a second nose/throat swab from the worker for urgent COVID-19 PCR testing (on two platforms) at least 24 hours after the first saliva specimen was taken (24 hours will give time for the viral load to increase if the worker has an acute infection).

  - Request a full respiratory pathogen multiplex panel; note that even if the multiplex done on the first nose/throat swab has identified a pathogen contender for the illness, a second nose/throat swab must still be collected and tested for SARS-CoV-2 on two different platforms.

  - Maintain the worker and household contacts in isolation until the result of the second swab is known.

- In the rare event that there is clear discordance between the saliva specimen result and the nose/throat swab result (i.e. the saliva specimen test is strongly positive with low Cts on multiple gene targets and the nose/throat specimen result is “not detected”):

  - Collect a second nose/throat swab from the worker for urgent COVID-19 PCR testing.

  - Maintain the worker and household contacts in isolation until the result of the second swab is known.

If any nose/throat swab result is “detected” for SARS-CoV, no further PCR diagnostic swab testing is required on the case and a thorough public health response is undertaken (case interview, isolation, assessment of contacts, quarantine of close contacts, source investigation) by the relevant PHU/PHRB as per CDNA SoNG and NSW SoNG Appendix. Workplace investigation to be undertaken in line with protocols related to the workplace.

The managing PHU should contact the relevant NSW Health Pathology lab to provide contact details for reporting of confirmatory nose/throat swab results. The managing PHU is usually the place of residence of the staff member, unless they are a staff member of SHA, or are transferred to the SHA because they cannot isolate at home, in which case the managing PHU will be SLHD. The relevant NSW Health Pathology lab to report confirmatory nose/throat swab on both platforms to the managing PHU by phone. The managing PHU is

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2 A second confirmatory swab is not required because PCR testing of a nose and throat swab is highly sensitive and significantly more sensitive than PCR testing of saliva. Additionally, if the worker has an acute infection, the time period between collection of the saliva and nose/throat swab specimens means that the nose/throat swab will likely be collected when the worker has a higher viral load than when the saliva specimen was collected making a false negative nose/throat swab even less likely. A negative confirmatory test provides a definitive position on infection status, regardless of the result of the initial saliva sample result.
responsible for reporting results to PHRB Surveillance and Operations by email. If the result is positive, the PHU to call PHRB Surveillance.

**High Risk Settings**

1. **Police-managed quarantine hotels**

**Returned travellers identifying as Aboriginal or Torres Strait Islander**

When a returned traveller identifies as Aboriginal or Torres Strait Islander, cultural support will be offered. Where cultural support is requested the PHU in the LHD of residence will be contacted to organise this support from the local Aboriginal Liaison Officer.

**When there has been an infection control breach involving a worker in a police-managed hotel that requires public health management.**

In these circumstances, where the worker is a close contact, the PHU in the LHD of residence will be asked to undertake management of the worker including follow-up of self-isolation and testing. This process will also be undertaken for infection control breaches at airports and seaports.

**Confirmed case of staff or visitor who has been to a police-managed hotel**

Where a confirmed case of COVID-19 is notified in someone who has been to a police-managed quarantine hotel (staff or visitor), the PHRB will determine the best approach to liaise with the hotel management. A plan for a risk assessment will be developed in consultation with PHRB and SHEOC as soon as possible and within 6 hours.

2. **Early childhood education centres (ECEC)**

Where a confirmed case of COVID-19 is notified in someone who has attended an early childhood education centre (e.g. childcare educator or child attending ECEC) close contacts should be identified as:

- All staff and children who attended the ECEC on the date(s) of exposure irrespective of classroom, groupings or cohorting arrangements.
- All visitors who attended the centre on the date(s) of exposure should be risk assessed as close or casual contact depending on time spent with the case or in the centre (>1 hour would be considered a close contact).

This is due to the nature of childcare arrangements that involve mixing between age groups and class groupings due to variable supervision quotas as well as the nature of the close contact in these settings due to physical contact required in caring for small children and personal hygiene considerations for small children.

3. **Public venues and situations with large numbers of contacts**

When a case has been in a public venue (e.g. restaurant, pub, gym, sporting venue, place of worship etc.), a site-specific assessment should be conducted as soon as possible and within 6 hours.

Recent experience in NSW includes multiple instances where transmission has occurred between people in public venues who do not meet the threshold for a close contact, according to the SoNG definition. These include transmission in places of worship, gyms, pubs and restaurants to a person who was not identified to be in close proximity to the case and/or had spent less than one hour in the same room as the case. Therefore, in some public venue settings the close contact definition is more conservative than in the SoNG.

Unless there is a clear documented reason to differ, this includes:

- People who have had any face to face contact with the case.
- People who have spent an hour or more in the same room with the case.
A thorough risk assessment should be undertaken by the PHU to assess any public venue or large gathering attended by a case during their infectious period. Consult with the PHU Director and/or PHRB controller/deputy controllers when there is any doubt about the level of risk.

Factors for consideration include:

- Whether more than one case has been associated with the venue.
- Number of people and spacing within the venue. If there is crowding, then this would increase the risk of transmission and decrease the threshold to determine close contacts.
- Ventilation in the venue (e.g. indoor or outdoor seating areas)
- Type of activity in the venue. Higher risk activities include mixing and socialising such as pubs and clubs; or physical exertion such as sporting venues especially gyms. Singing, playing woodwind instruments or other activities that involve the production of droplets would also be of higher risk.
- Movements of the case within the venue. A case that moved around the venue, particularly where a staff member is the infectious case, or sat at a bar, may create a greater risk.

These definitions of a close contact are general guidance and assessment should be guided by expert judgement based on experience of transmission in similar settings, characteristics of the site, and characteristics and behaviour of the case. It may not be necessary for a close contact to be defined by a period of time. If the case had undertaken a high-risk activity such as singing, loud talking or exercise in the venue, this could lower the time threshold for the definition of a close contact.

**Managing contacts from public venues**

For public venues and where there are a large number of close or casual contacts to be traced:

- The PHU will alert the PHRB OT of the situation.
- The PHU will alert the venue and advise the venue to clean thoroughly and obtain information to enable risk assessment and contact tracing.
- The PHU will obtain a list of patrons from the venue. For venues using COVID Safe Check-in with the Service NSW app, the PHRB OT will obtain a list of patrons or venues visited by a case directly from Service NSW and share these lists with the relevant PHU.
- All persons present at the time of the case should be classified as either no contact ‘monitor for symptoms’, casual contact, or close contact, and managed accordingly:
  - Close contacts must be advised to isolate and test as per above guidelines for close contact management. If there are large numbers a holding SMS may be sent out advising isolation until someone from NSW Health contacts them by phone.
  - All casual contacts at the venue during the relevant date/time should be advised to get tested regardless of symptoms and self-isolate until a negative result is received as per above guidelines for management of casual contacts. This information may be provided by SMS or email for large numbers of contacts.
  - If the venue includes separate areas and it can be determined which of the separate areas the case was in, it may be appropriate to treat people from other areas as casual contacts, no contact or ‘monitor for symptoms’.
- Shopping centre, large supermarket and hardware store visits and short visits to stores and other venues should be assessed in consultation with the PHU Director. If the visit is brief and no significant interaction with staff or patrons is reported (e.g. purchasing a takeaway coffee) it may be reasonable to classify the visit as ‘monitor for symptoms’ or no contact. Longer visits (e.g. over an hour in a shopping centre) or visits with brief close interactions with staff/patrons (e.g. a 5 minute physically distanced conversation with a sales assistant) may be considered casual contact. PHU or PHRB will use mass SMS service to contact close and casual contacts using a list of patrons obtained by the PHU.
- PHU will liaise with PHRB and CCTT to:
  - Phone all close contacts
- Place close contacts on Whispir after the phone call (those who consent) for daily SMS follow-up
- Undertake routine contact follow-up

- PHRB will include large venues with close or casual contacts in the media update to promote increased awareness for getting tested if symptoms develop. In general, small venues where all contacts can be identified and contacted individually in a timely manner may not need to be included in the media or on the web.

- PHU must alert the venue that it will appear in the media release and on the website.

- PHRB will arrange for the venue to be listed on the on NSW Government website [https://www.nsw.gov.au/covid-19/latest-news-and-updates](https://www.nsw.gov.au/covid-19/latest-news-and-updates) of latest COVID-19 case locations in NSW. Listing venues in the media and on the website provides earlier notification of contacts and enables people who are contacted by the contact tracers to verify the call by checking the website. When listing casual contact venues on the website the PHU Director should consult with PHRB whether the venue can be exempted from aged care facility visiting restrictions.

### Management of contacts from public transport

When a case has used public transport during their infectious period, PHUs should obtain the case’s Opal card number during case interview and provide this to PHRB. PHRB will work with Transport for NSW to obtain accurate journey details and details of contacts.

- **For public transport journeys of cases during their infectious period ≥ 60 minutes in the same bus, ferry or train/tram carriage:**
  - Anyone who was on the public transport journey with the confirmed case for 60 minutes or more in the same bus, ferry or train/tram carriage is considered a close contact (verified based on Opal card data if available). They should get tested immediately and self-isolate for 14 days, regardless of the result. Known Opal card holders will be sent an SMS alert and will be called by the CCTT and the journey will be notified in media as a close contact exposure.

- **For public transport journeys of cases during their infectious period < 60 minutes, or in a different train/tram carriage for any time:**
  - Anyone who was on the public transport journey with the confirmed case for less than 60 minutes in the same bus, ferry or train/tram carriage is considered a casual contact (verified based on Opal card data if available). They should get tested immediately and self-isolate until they receive a negative test result as per the guidelines for management of casual contacts above.
  - Anyone who was on the public transport journey with the confirmed case in a different train/tram carriage should monitor for symptoms. If symptoms occur, they must get tested immediately and self-isolate until they receive a negative result.
  - Known Opal card holders will be sent an SMS alert and the journey will be notified in media as an exposure site.
  - Note: Where the train/tram carriage is unknown, assume the contact to be in the same carriage as the case.

### If a casual contact from a venue becomes a case (transmission occurs in the venue)

If a person who attended a venue who had been defined as a casual contact (and has no other known interaction with the case or close contact with any other case) subsequently becomes a case, then transmission has occurred in the venue which increases the risk level. In this situation:

- Other people who were at the venue at the same time as the case while infectious should be reclassified as close contacts and the same actions as for close contacts should be taken. The PHU should risk assess which of those casual contacts are reassigned as close contacts in conjunction with PHRB.
- The PHU should review the COVID-19 Safety Plan of venues where transmission may have occurred to identify and close gaps in their compliance.
4. Risk Assessment of Sporting Teams

When a case has played in a sporting team whilst infectious a risk assessment of all other players and associated people in attendance should be conducted by the PHU as soon as possible.

Assessment of the level of exposure between the case and other people in attendance and classification of these people as either close or casual contacts or ‘monitor for symptoms’ may require consideration of numerous factors including:

Sport factors

- Type of sport (e.g. contact or non-contact) and type of event (e.g. training or a match).
- Level of competition, as this may impact on the level of physical contact and intensity (respiratory effort).

Event factors

- Total duration of exposure, including both time in active play and time outside active play e.g. warm-ups, team huddles, post-game socialising, fights/melees, time in change rooms or other communal areas such as canteens.
- Transport to and from the venue e.g. carpooling and use of public transport.
- COVID-19 Safety Plan outlining actions to keep participants, volunteers and workers safe, including:
  - Physical distancing protocols, including: strategies to minimise co-mingling of participants from different games and timeslots; and staggered use of communal facilities.
  - Hygiene protocols, including: use of hand sanitizer; handshakes/ high fives; shared drink bottles, ice baths or towels; and cleaning of any shared equipment.

Venue factors

- Indoor or outdoor.
- Size of the field.
- Communal facilities such as showers and change rooms.

Player factors

- Age of the players (this may particularly impact on the nature of the game played, adherence to social distancing regulations and hygiene protocols and interactions with crowds/spectators).
- Position of the infectious player in the game including likely interactions with players in other positions, whether the case marked an opposition player, and whether the case rotated positions throughout the game.
- Interaction of the case with officials (e.g. coaches, referee/umpire, trainers) and with crowds/ spectators.
- Provision of first aid to anyone.

A general guide may be to consider the case’s teammates as close contacts given likely exposures both in play and when not in active play; and the opposition team as casual contacts. There should be consideration of classifying individual opposition players that the case played closely with throughout the game as close contacts. The final decision requires a thorough assessment of all factors mentioned above. Consult with the PHRB Controller/ Deputy Controllers and/or a PHU Director from another LHD when in doubt.
Management of people with an exemption to hotel quarantine

Management of travellers who have come from overseas, who have an exemption from hotel quarantine and who are in self-quarantine at home (or another venue in the community) is detailed in the NSW Protocol for the follow-up of returned travellers who have been granted an exemption from hotel quarantine and unaccompanied children.

PHRB Bunker will send details of returned travellers with an exemption to hotel quarantine and unaccompanied minors and diplomats to the PHU of their residential address for information only.

Special situations

At risk person
Where a person with no COVID-19 symptoms is tested for COVID-19:

• If the person tests negative then no action is required for any contacts (i.e. contacts do not need to isolate further).

• Further testing does not need to be performed for the purpose of determining infectiousness.

However, if the person subsequently tests positive (e.g. from routine testing or because they have developed COVID-19 symptoms):

• The usual guidelines for determining the infectious period should be used; however both swabs should be re-tested and further laboratory advice should be sought, in consultation with PHRB, to assist in interpreting the results and determining the infectious period.

Isolated positive SARS-CoV 2 IgM

Some countries, including China, have required potential travellers to have an IgM test for SARS CoV2 prior to travel, with evidence of a negative test presented to the consulate and/or travel provider. Testing for SARS CoV2 IgM has significant issues around detection and interpretation. An isolated IgM detection does not provide evidence of COVID-19 and the result is not notifiable by laboratories to public health. In the absence of other information to indicate that the person has symptoms or other positive tests for COVID, no public health action is indicated, and the result is not reported in isolation.

Expert Panels

The objectives of the panels are to:

• Guide and support the review of the diagnosis/investigation of COVID-19 cases.

• Provide expert advice.

• Inform appropriate public health action.


The purpose of the expert panel is to examine the evidence collected and review the diagnosis of COVID-19 for specific cases. Evidence to be considered includes clinical presentation, epidemiological information and laboratory test results.

The expert panel determines whether the initial diagnosis is consistent with the laboratory, clinical and epidemiological findings, and may also advise on the likely timing of infection.

PHUs and/or the PHRB will refer cases for review where the COVID-19 laboratory results are inconsistent with the epidemiological and/or clinical information, or where there is uncertainty as to whether the infection is recent or old.
2. Expert Panel on the Review of COVID-19 Diagnoses in Health Care Workers

The purpose of the expert panel is to review investigation reports on the likely source of infection for health care workers who have acquired COVID-19 in any setting. The expert panel findings will be shared with the relevant local health district or health service. Findings should be used to inform revision of internal infection control or other relevant guidelines and staff training modules.

A ‘health care worker’ refers to all paid and unpaid persons in health care settings who routinely enter or work in clinical areas or work with medical supplies, devices, equipment and clinical waste. It excludes those working only in the aged care and disability sector.

List of abbreviations:

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<tr>
<td>CHO</td>
<td>Chief Health Officer</td>
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<td>CCT</td>
<td>Close Contact Tracing</td>
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<td>CCTT</td>
<td>Close Contract Tracing Team</td>
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<td>ECEC</td>
<td>Early Childhood Education Centre</td>
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<td>FCM</td>
<td>FCM Travel</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>ICPMR</td>
<td>Institute of Clinical Pathology and Medical Research</td>
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<tr>
<td>LHD</td>
<td>Local Health District</td>
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<td>NCIMS</td>
<td>Notifiable Conditions Management System</td>
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<td>PHRB</td>
<td>Public Health Response Branch</td>
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