MEDIA RELEASE

Reviews of recent Covid-19 cases in MIQ will continue to strengthen system

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Reports into the in-facility transmission of COVID-19 at the Grand Millennium and Grand Mercure managed isolation facilities in Auckland earlier this year have been released today. Joint Head of Managed Isolation and Quarantine, Brigadier Jim Bliss, says a number of recommendations have been made, which he welcomes, and action in response is well underway.

While it has not been possible to conclude with absolute certainty where and how transmission occurred, the reports conclude aerosol transmission is regarded as the most plausible pathway.

“MIQ has served New Zealand well, helping to bring more than 140,000 people here safely, while protecting freedoms that we all now enjoy,” said Brigadier Bliss.

“The MIQ system is something that continually evolves and changes – which reflects the changing nature of the COVID-19 virus. As part of our commitment to continuous improvement, we review incidents to ensure we capture any learnings and make any necessary changes. We also work proactively with other external agencies, like the Ombudsman, who regularly review MIQ.

“We, along with the Ministry of Health, have taken a really close look at what went on with these cases in March and April, not least to see how we can strengthen the wider MIQ system. Each of the reports includes a number of recommendations for improvements, which are either complete or underway,” he said.

“This includes emptying out both the Grand Mercure and Grand Millennium and completing full, on-site assessments of the ventilation at these sites. The two facilities will remain unoccupied until such time as the necessary work has been completed.

“A programme of extensive reviews and remediation of ventilation systems across all managed isolation facilities is underway. Remediation work at the Grand Mercure is almost complete. An extensive assessment of the Grand Millennium’s ventilation system has been done and a remediation plan is being developed,” Brigadier Bliss said.

The Director-General of Health, Dr Ashley Bloomfield, said returnees to New Zealand and the wider community could feel confident in the MIQ system.

“I want to reassure the New Zealand public that the overall risks to returnees of contracting COVID-19 within one of our managed isolation or quarantine facilities and taking it into the community has been, and continues to be, assessed by public health experts as very low.

“It’s important to understand that we don’t rely on a single layer of protection to prevent the spread of COVID-19. We have multiple layers of defence at our border and inside MIQ that work together to create barriers and safeguards that protect returnees, border workers and the wider community. That’s why so many people have been able to go through MIQ, with only a very small number of incidents such as these. Where ever they occur, we investigate and make any required changes. As part of this process, the Ministry of Health undertakes regular infection prevention and control audits of the MIQ facilities, and any recommendations are actioned.

“The reviewers themselves noted that, whilst the reviews focused on outlining necessary improvements as a result of the incidents, it is in fact the success of the wider MIQ system that has been integral to the nation’s success in keeping COVID-19 largely out of our communities,” he said

The report’s authors noted that it’s important to place the recommendations within the context of the hard work and sacrifice of New Zealand’s border workers.

“The Review Team said they observed teams of people who are committed to keeping COVID-19 out of our communities, and that it’s important that their resilience and dedication is recognised. I wholeheartedly agree with their comment,” said Brigadier Bliss.

“MIQ workers have been at the absolute frontline of keeping COVID-19 out of New Zealand, and they have made considerable personal sacrifices to make sure the wider community is safe. They do a fantastic job and I want to personally thank every worker who’s contributed to what has undeniably been a world-leading effort”.

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Notes for editors

The Grand Millennium case involved three workers testing positive, among them a security worker who was subsequently found not to have been tested for a number of months.

The Grand Mercure case consisted of two separate incidents. In the first incident two positive returnee cases were genomically linked, strongly indicating in-MIF transmission. The second incident involved a positive returnee who was permitted onto a bus ride to a Managed Isolation Walk. This resulted in 14 other returnees on the bus being considered close contacts and having to stay another 14 days in managed isolation. No community transmission occurred as part of this breach.

Report summaries

Review: Grand Millennium Auckland - Joint MIQ/MoH incident review

An internal review was undertaken jointly by MoH and MIQ into the March border incident at the Grand Millennium in which three MIQ workers tested positive for COVID-19.

The review found that the overall response was strong. The three cases were quickly and effectively managed and there was no subsequent transmission into the community.

While it is not possible to conclude with absolute certainty where and how transmission occurred in any of the Grand Millennium transmission events, the report found the most likely mode of transmission to Case A from the Index Case was by aerosol transmission in a hallway, and between Case B and Case C by direct exposure from two workers on the same shift. While this is not confirmed, this is the most plausible hypothesis.

Following the revelation that Case B had not been tested for a number of months, the review recommended improving barriers to staff testing and vaccination and continuing to improve data management systems.

In total the review made six recommendations, with subsequent actions under each recommendation for implementation. All of these recommendations and subsequent actions are either underway or completed.

Report of First Security Incident at Grand Millennium by KPMG

KPMG was commissioned by MBIE to review what led to the incident at the Grand Millennium involving a security worker who was subsequently found not to have been tested for a number of months.

The objective of this review was to establish the facts of the incident, circumstances and actions leading up to the incident and assess the adequacy of First Security's internal processes to ensure that their workers at Managed Isolation and Quarantine Facilities completed their testing.

KPMG's assessment and analysis of the evidence found that the staff member (known as Case B) provided inaccurate information to their employer, First Security, stating that they had undergone each of their required tests. Case B had falsely stated they had undergone nine tests between 11 December 2020 and 24 March 2021. KPMG noted that First Security were made aware of Case B's non-compliance with testing on 8 April 2021.

KPMG noted that First Security developed systems and processes to keep and maintain records of border workforce testing and ensured resources were in place to operate the system. The system and processes were aligned to the relevant duties in the Required Testing Order and duties under Health and Safety at Work Act to protect workers from harm.

Eight (8) opportunities for improvement for MIQ were made and all are either underway or complete.

A number of changes have been implemented since this incident, including making the Border Worker Testing Register (BWTR) mandatory from 27 April 2021.

The BWTR and "WhosOnLocation" were being rolled out at the time of this incident, which meant the systems were not in a position to support active management of staff testing compliance. These systems are now working well, and employers are recording staff testing information into the BWTR, and we can cross reference this with the information in our "WhosOnLocation" system. MIQ has moved significantly from a high-trust model to a model where employee, employer and MIQ now share a greater responsibility for ensuring compliance with the Required Testing Order.

Review: Grand Mercure Auckland - Joint MIQ/MoH incident review

A joint review was undertaken by MoH and MIQ into the March incidents at the Grand Mercure to determine what, if any, further improvements could be made to the MIQ system to reduce the likelihood of cases occurring via the ventilation system. The review also considered if the necessary procedures were followed for managed isolation walks (MIW) and changes could be implemented to strengthen them further.

The review found that, while aerosol transmission via the fresh air supply cavity seems unlikely, it is nonetheless the most plausible transmission pathway between the index and secondary case. The risk of downward airflow between rooms via the mechanism outlined by the ventilation experts, appears to be unique to the Grand Mercure Auckland. However, considering the range of IPC measures and mitigations in place, the overall risk of transmission to the returnees that were accommodated at the Grand Mercure, was low.

The review also found that a breach in bus protocols and non-compliance with the Standard Operating Procedures for the managed isolation walks programme led to the 14 returnees, classified as close contacts of the secondary case, staying an additional 14-day period in managed isolation. A breach in normal procedure resulted in the secondary case's blue wrist band not being removed in error and this returnee attended a managed isolation walk when they should not have, later to return a positive COVID-19 test

A number of improvements to how MIW are managed have been recommended, many of which were immediately implemented when the situation arose.

In total the review made five recommendations and associated actions. All but one are either underway or completed. The remaining recommendation is being considered by the MOH Technical Advisory Group.