

# **Briefing**

# Internal Review of the August Rio De Plata Tauranga Mariner Incident 2021

Date due:	24 September 2021	Action required by:	N/A
Security level:	IN CONFIDENCE	Health Report number	: 20211899
То:	Hon Chris Hipkins, Minister for COVID-19 Response		
Сору:	Hon Dr Ayesha Verrall, Associate Minister of Health		

# Contact for telephone discussion

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# Minister's office to complete:

□ Approved	Decline	□ Noted
□ Needs change	🗆 Seen	$\Box$ Overtaken by events
See Minister's Notes Comment:	□ Withdrawn	

# Internal Review of the August Rio De Plata Tauranga Mariner Incident 2021

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# **Purpose of report**

1. This purpose of this briefing is to provide an overview of the review on the response to the August Rio De La Plata Tauranga Mariner Incident undertaken by the Ministry of Health (the Ministry).

#### Summary

- 2. As part of the Ministry commitment to continuous improvement, an interval review was undertaken into the response of the August Rio De La Plata Tauranga Mariner Incident.
- 3. There have been lessons identified and this review makes five recommendations with specific actions to strengthen these areas. The relevant teams within the Ministry have been made aware of the actions necessary to implement these findings and the report outlines progress made against these. Consistent with our approach for continuous improvement, we have already enhanced and adjusted some crucial processes and systems from these learnings. These have been outlined in the review.
- 4. New Zealand Customs Service (NZ Customs) has also undertaken an operational review of the Rio De La Plata incident which has been presented alongside the Ministry's internal review to the Border Executive Board.
- 5. On 8 September 2021 the Ministry internal review of the August Rio De Plata Tauranga Mariner Incident alongside the NZ Customs operational review received endorsement from the Border Executive Border.



# Recommendations

We recommend you:

- a) **Note** that the Ministry has undertaken a review of the August Rio De La Plata Tauranga Mariner Incident 2021 which makes recommendations to further strengthen the ongoing COVID-19 response.
- b) **Indicate** whether you would like the Ministry to proactively release the report on its website. We will provide a communications pack to support this decision, if you decide to do so.

Yes/No

Yes/No

OAC

Dr Ashley Bloomfield **Director-General of Health** Date:  $\binom{6}{9}$  Hon Chris Hipkins Minister for COVID-19 Response Date:

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# Internal Review of August Rio De La Plata Tauranga Mariner Incident 2021

# Context

- 6. On 3 August 2021, the Ministry was advised that a ship pilot previously onboard Rio De La Plata (RDLP) from 21 July to 23 July 2021 had tested positive for COVID-19 in Queensland, Australia. Further investigations determined the case to have the Delta variant and the working hypothesis of Queensland health officials is that the Pilot was infected while onboard the RDLP.
- 7. The ship departed Botany Bay, New South Wales, Australia on 25 July 2021 and subsequently berthed in Tauranga on 4 August 2021. An initial assessment was undertaken on this date by the Ministry, which deemed the ship to be of low risk to New Zealand. Following this conclusion, crew members continued unloading cargo the next morning on 5 August 2021.
- 8. The ship was due to travel and arrive in Napier on 9 August 2021. Napier Port specified that the crew members were required to complete a COVID-19 test prior to arrival. As such, PCR and serology tests were completed for all 21 crew members at the Tauranga Port on 7 August 2021.
- 9. On 8 August 2021 results returned positive tests for 10 crew members and one indeterminate result which was treated as a positive case.
- 10. The ship had been anchored off the coast of Tauranga throughout the response. The shipping agent requested permission to dock in Napier Port on 10 August, however this request was declined. The shipping agent then confirmed that the ship would be heading to Malaysia to continue their journey to avoid disruption. On 10 August 2021, the RDLP left New Zealand shores.

# **Review Overview**

11. This internal review of the August Rio De Plata Tauranga Mariner Incident encompasses findings from a debrief held on 12 August 2021 which included various Ministry officials, chaired by the Manager, Planning and Programme Management within the Ministry's COVID-19 Health System Response Directorate. This debrief identified strengths as well as possible areas for improvement within the Incident Management Team (IMT) and wider Ministry's response to the August Rio De Plata Tauranga Mariner Incident. This review also outlines information derived from the *Daily COVID-19 situation update key facts and figures*.

# Recommendations

12. The Ministry August Rio De La Plata Tauranga Mariner Incident review makes five recommendations to strengthen areas identified for improvement. Consistent with our approach for continuous improvement, we have already enhanced and adjusted some crucial processes and systems derived from these learnings.

- 13. The recommendations that the review made are outlined below. Please refer to the review to see specific actions that sit within these recommendations, and progress against these.
  - a. Effective and timely information flow to stakeholders involved in the response
  - b. Strengthening internal decision-making process to ensure all relevant staff are aware or consulted in order to reach thorough and timely resolutions
  - c. Refinement of internal information related processes to allow for rigorous assessment and sound decision making
  - d. Clear allocation of responsibilities across agencies and sectors for when COVID-19 incidents occur at the maritime border
  - e. Engaging with port workers, regionally and nationally to ensure these groups are sufficiently informed and vaccinated.

# **Communications Approach**

- 14. The release of the report may generate moderate public and media interest.
- 15. If you choose to publicly release the report, we will provide you with a communications pack to support your decision.

# **Next Steps**

- 16. We will provide you with an update in the coming months regarding the progress of the review recommendations.
- 17. We will provide you with a communications pack if you wish to proactively release the report and work with your office on necessary steps for release.
- 18. A joint review will be undertaken between the Ministry, NZ Customs and Maritime New Zealand to explore the Mariner incidents that have required a response since July 2021. This review will provide a more comprehensive system wide perspective of the challenges and lessons identified, which will continue to inform our process of, and commitment to, continuous improvement. These include the Rio De La Plata Vessel, Fishing Vessel Playa Zahara, Fishing Vessel Viking Bay and the Container Ship MS Mattina incidents.

ENDS.

Appendix 1: August Rio De La Plata Tauranga Mariner Incident

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# August Rio De La Plata Tauranga Mariner Incident 2021

Internal Review of the August Rio De La Plata Tauranga Mariner Incident



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#### **INTRODUCTION**

A key strength of New Zealand's response to COVID-19 is the commitment to the continuous improvement of practices as we learn more about the nature of COVID-19.

The purpose of this internal review of the Ministry of Health's (the Ministry) public health response to the August Rio De La Plata Tauranga Mariner Incident is to uncover the challenges experienced and lessons identified, to inform our process of, and commitment to, continuous improvement. The review outlines specific actions and work streams addressing issues identified.

The New Zealand Customs Service (NZ Customs) has also undertaken an operational review of the August Rio De La Plata Tauranga Mariner Incident that highlights the challenges experienced in this event. This will report will be shared with stakeholders within the maritime industry.

#### WIDER REVIEW OF MARITIME INCIDENTS

The August Rio De Plata Tauranga Mariner Incident is one of four mariner incidents that New Zealand has experienced since July 2021. This includes the **Fishing Vessel Playa Zahara** which arrived at Lyttleton Port on 18 July, the **Fishing Vessel Viking Bay** which docked into Queens Wharf in Wellington Harbour on 12 July and **Container Ship MS Mattina** which arrived in Bluff on 18 July.

It is important to note that, throughout all four maritime incidents, there has been no transmission to the community. Our systems, processes and elimination strategy has continued to keep New Zealand safe.

However, each of the recent maritime incidents have comprised a diverse set of circumstances which make it difficult to have a pre-determined process for responding. We expect this to continue to be the case with any future outbreaks on vessels as each will present varying levels of complexity. These challenges will be further explored in a joint review alongside NZ Customs that investigate all four Mariner cases in greater detail. This is underway and is due for completion by November 2021.

# **RIO DE LA PLATA - CASE SUMMARY AND TIMELINE**

#### FIRST CASE AND INITIAL ASSESSMENT

On 3 August 2021, the Ministry Incident Management Team (IMT) was advised that a marine pilot previously onboard Rio De La Plata (RDLP) from 21 July to 23 July 2021 had tested positive for COVID-19 in Queensland, Australia. The pilot is reported to have had an onset of symptoms from 31 July 2021 and returned a positive test result for COVID-19 on 1 August 2021.

The RDLP departed Botany Bay, New South Wales, Australia on 25 July 2021 and subsequently berthed in Tauranga on 4 August 2021. However, further investigations in the following days

determined the case to have the Delta variant and the working hypothesis of Queensland health official was the pilot was infected while onboard the RDLP.

An initial discussion was held on 3 August 2021 involving an internal official and clinician from the Office of the Director of Public Health regarding the infectious period of the pilot and their potential to have infected the crew, and whether all onboard the vessel were asymptomatic. In conclusion the ship was deemed to be of low risk to New Zealand. This decision was due to the number of days the pilot was onboard the ship and the fact that, at the time of notification, their infectious date was deemed from 1 August 2021, and therefore was not onboard while infectious.

On 3 August 2021 Australian Maritime Safety Authority (AMSA) advised Maritime New Zealand of the positive case notified the Ministry, Port of Tauranga and Regional Harbourmaster. Crew members on board the ship began to unload its cargo upon arrival on 5 August 2021, however this was immediately stopped following the decision of the Bay of Plenty District Health Board (DHB) to cease operation upon the notification of detection from an abundance of caution. Information was provided the next morning by the Ministry to NZ Customs, Port of Tauranga, and Bay of Plenty DHB which resulted in crew members recommencing unloading cargo the same day.

FURTHER CASES INDENTIFIED ON RDLP

RDLP was due to arrive in Napier on 9 August 2021. Napier Port specified that the crew members were required to complete a COVID-19 test prior to arrival. On 7 August 2021 PCR and serology tests were completed for all 21 crew members at the Port of Tauranga.

On 8 August 2021 results returned positive tests for 10 crew members and one indeterminate result which was treated as a positive case.

The ship had been anchored off the coast of Tauranga throughout the response. The shipping agent requested permission to dock in Napier Port on 10 August, however this request was declined. The shipping agent then confirmed that the ship would be heading to Malaysia to continue their journey to avoid disruption. On 10 August 2021, the RDLP left New Zealand shores.

# CONTACTS AT THE PORT OF TAURANGA

As a result of the 10 positive cases on RDLP, a total of 73 contacts were reported at the Port of Tauranga. The contacts identified included two pilots, one Ministry for Primary Industries (MPI) officer and 70 stevedores. The pilots were treated as close contacts and required to self-isolate for 14 days; the stevedores and MPI officer were tested on 13 August 2021 which all returned negative test results.

In response to the incident, wastewater testing was also undertaken. Two 24-hour composite samples, one in Tauranga and one in Mt Manganui, were collected on 9 August and 10 August. No

samples detected SARS-COV-2. Further samples were collected on 11 August, which also did not detect SARS-COV-2.

#### **REVIEW METHODOLOGY**

This internal review of the 'August Rio De Plata Tauranga Mariner Incident' encompasses findings from a debrief held on 12 August 2021 which included various Ministry officials, chaired by the Manager, Planning and Programme Management within the Ministry's COVID-19 Health System Response Directorate. This debrief identified strengths as well as possible areas for improvement within the Incident Management Team (IMT) and wider Ministry's response to the August Rio De Plata Tauranga Mariner Incident. This review also outlines information derived from the *Daily COVID-19 situation update key facts and figures*.

#### VACCINATION STATUS OF PORT WORKERS

The majority of RDLP contacts identified were unvaccinated with only 20 contacts having received a vaccine. Six of the stevedores were partially vaccinated; and 12 of the stevedores, one of the pilots and the MPI officer were fully vaccinated. The COVID-19 Public Health Response (Vaccinations) Order 2021 has recently been amended to now include required vaccination of port personnel who undertake high risk work, and therefore vaccination of workers is not assessed in this review.

# SUMMARY OF KEY FINDINGS

The review found that the Ministry response has continued to operate under a process of ongoing improvement and agility throughout the maritime responses, which has proved effective in responding to the incident.

#### THE INCIDENT MANAGEMENT TEAM RESPONSE

The Ministry's IMT manages and coordinates the overall response to COVID-19 incidents and outbreaks, which involves various public health experts, subject matter experts and other internal personnel. IMT is also the point of contact for public health units (PHUs), district health boards (DHBs), Ministers, the Ministry's Executive Leadership Team, and other stakeholders. IMT is activated upon identification of a community case of COVID-19 and has a range of expertise from across the Ministry including from the Māori and Pacific Health teams and also involves organisations outside the Ministry, such as the Department of the Prime Minister and Cabinet, Toi Te Ora Public Health and New Zealand Customs.

In this instance, the IMT controller did not escalate a request which had implications on the response process. The request was provided through the National Focal Point (NFP) regarding the incident. The formal notification held limited detail, and as a result a request for testing members onboard the RDLP was not registered. It is not regular practice to test vessels that arrive in New Zealand due to implications posed on exporting and importing goods. To mitigate this risk, port

authorities and their workforces have established safety protocols such as use of PPE and IPC measures to treat each ship as if there were COVID-19 cases onboard. As the request was not registered, directives were made without the latest information at hand. However, appropriate measures have been taken to resolve this, including the improvement of the information assessment and sharing process to ensure appropriate risk assessment, informed decision making and ensure appropriateness of actions undertaken.

#### COMMUNICATION AND COORDINATION

There were multiple agencies involved in the response and therefore conflicting priorities impacted activities and notifications of the initial situation, developing situation and actions undertaken were not received collectively. Therefore, not all relevant parties were not aware of decisions and actions undertaken. An improvement in communicating between agencies and relevant stakeholders to provide detailed understanding of the situation will enable quick decision making and appropriate planning for a coordinated response.

#### PROCESSES AND STANDARD OPERATING PROCEDURES (SOPS)

Although there are processes and standard operating procedures (SOPs) available to activate the IMT to manage New Zealand alert levels or the air border, specific amendments have not been made for a maritime case response.

In each of the four maritime border incident responses across July and August 2021, the response has brought new and differing elements to manage and account for in the decision-making processes.

Establishing fit for purpose processes and internal Ministry SOPs will provide a cohesive response by reducing time to enable management of any risk to public health, action additional resourcing if surge capacity is necessary and improve inter-agency communication. Resolving these issues would assist in responding to the potential risk of COVID-19 positive crew arriving from a foreign port.

#### **ROLES AND RESPONSIBILITIES**

Clarity of roles and responsibilities will aid in cross government engagement to ensure the success of a response to incidents or outbreaks. Providing this clarity in response to a maritime case at the border would ensure a consistent All-of-Government maritime response.

Agreement is required that the overall ownership of managing and coordinating incidents sits with the IMT; the management of the incident within the region is the responsibility of the local PHU and DHB; and operational activity is led by NZ Customs, alongside other border agencies (Maritime New Zealand, Ministry of Primary Industries etc.). The agreement needs to be confirmed by the relevant agencies. This clarification of roles and responsibilities is expected to facilitate more accurate and faster communications between the agencies dealing with incidents at the maritime border.

### RECOMMENDATIONS

As a result of the above findings, outlined below are recommendations to streamline and enhance the response to future incidents. The key themes identified to strengthen planning for, and execution of, future responses are:

- 1. Effective and timely information flow to stakeholders involved in the response
- 2. Strengthening internal decision-making process to ensure all relevant staff are aware or consulted in order to reach timely and thorough resolutions
- 3. Refinement of internal information related processes to allow for rigorous assessment and sound decision making
- 4. Clear allocation of responsibilities across agencies and sectors for when COVID-19 incidents occur at the maritime border
- 5. **Engaging with port workers**, regionally and nationally to ensure these groups are sufficiently informed and vaccinated.

Many of these recommended actions were already underway or put in place during or shortly after the response was concluded. Undertaking this review and identifying system recommendations, provides the Ministry with an opportunity to further strengthen its response processes and procedures. These recommendations are underway and set to be completed in the near future.

# NEXT STEPS

Identified actions to be implemented as a result of the key recommendations discussed can be found in Appendix 1.

In addition, the Ministry's practice to review and reflect on each incident has developed a culture of continuous improvement. As a result, actions will continue to be tracked and updated as part of our business-as-usual processes which includes sharing this review and the identified recommendations with the COVID-19 Independent Continuous Review, Improvement and Advice Group and Minister for COVID-19 Response.

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# **APPENDIX 1: RECOMMENDATIONS TABLE**

#### **RECOMMENDATION 1: Effective and timely information flow to stakeholders involved in the response**

Action	Owner	Progress	Status and timeframe for completion as of 31 August 2021
Provide more awareness to relevant PHUs involved in the response to a mariner case or incident through efficient communication	d GM Response	The Ministry has amended its process regarding its communication with PHUs to enable further situational awareness through the direct contact of the Office of the Director of Public Health, Clinical Advisors and relevant stakeholders when the case or incident is evolving	Underway – due for completion September 2021
		The Ministry will continue to build relationships with PHUs, ports and other local authorities required to support incidents and/or outbreaks to ensure fluid information sharing and communication	Completed

**RECOMMENDATION 2**: Strengthening internal decision-making process to ensure all relevant staff are aware or consulted in order to reach thorough and timely resolutions

Action	Owner	Progress	Status and timeframe for completion as 31 August 2021
Ensure the correct individuals are consulted during the decision-making process	GM Response	The Ministry is in the process of developing an IMT internal decision register which will involve the Office of the Director of Public Health, clinical advisors, PHUs and relevant stakeholders	Underway – due for completion September 2021

#### **RECOMMENDATION 3:** Refinement of internal information related processes to allow for rigorous assessment and sound decision making

#### IN CONFIDENCE

Action	Owner	Progress	Status and timeframe for completion as of 31 August 2021
Refining information assessment and sharing processes	GM Intelligence and Surveillance	The Ministry is refining its information assessment and sharing process, specifically by managing the timeliness, format, logging and actioning of information received by NFP to allow early assessment and decision making.	Completed

#### RECOMMENDATION 4: Clear allocation of responsibilities across agencies and sectors for when COVID-19 incidents occur at the maritime border

Action	Owner	Progress	Status and timeframe for completion as of 31 August 2021
Produce a framework that outlines and specifies the roles and responsibilities of each agency involved in maritime responses	GM Response/GM Maritime Customs	The Ministry will develop, in collaboration with border agencies, a framework for management of COVID-19 vessels that clearly define the roles and responsibilities from across government	Underway – due for completion October 2021
Clear mandate regarding Public Health Risk Assessments as part of the response to maritime cases and/or incidents	GM Response/ODPH	The Ministry has created a process to formally include Public Health Risk Assessments in potential mariner cases, involving clinical advisors from the COVID-19 Directorate and the Office of the Director of Public Health.	Completed

#### RECOMMENDATION 5: Engaging with port workers, regionally and nationally to ensure these groups are sufficiently informed and vaccinated

Action	Owner	Progress	Status and timeframe for completion as of 31 August 2021
Engaging with port workers, regionally and nationally to ensure these groups are sufficiently informed and vaccinated.	GM CVIP/GM Maritime Customs	The Ministry will work with providers to supply further service of vaccinations for port staff. This will also include information sessions with port workers, with clinicians available to answer queries.	Completed