MINISTRY OF BUSINESS, INNOVATION & EMPLOYMENT
HĪKINA WHAKATUTUKI

MINISTRY OF HEALTH
MANATŪ HAUORA

# Briefing

## MIF COVID-19 Incident Joint Review: Grand Mercure Auckland

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|---|---|---|---|
| **Date due to MO:** | 7 May 2021 | **Action required by:** | N/A |
| **Security level:** | IN CONFIDENCE | **Health Report number:** | 20211093 |
| **To:** | Hon Chris Hipkins, Minister for COVID-19 Response | | |
| **Copy:** | Hon Ayesha Verrall, Associate Minister of Health | | |

## Contact for telephone discussion

| Name | Position | Telephone |
|---|---|---|
| **Sue Gordon** | Deputy Chief Executive, COVID-19 Health System Response, Ministry of Health | s 9(2)(a) |
| **Megan Main** | Deputy Secretary, Managed Isolation and Quarantine, Ministry of Business, Innovation and Employment | s 9(2)(a) |

## Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

# MIF COVID-19 Incident Joint Review: Grand Mercure Auckland

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| **To:** | Hon Chris Hipkins, Minister for COVID-19 Response | | |
| **Copy:** | Hon Ayesha Verrall, Associate Minister of Health | | |

## Purpose of report

1. This memo provides an overview of the final COVID-19 Incident Review of the in-MIF transmission at the Grand Mercure Auckland managed isolation facility (MIF).
2. Attached is the final report which consolidates findings and recommendations from across a series of ventilation reviews, rapid reviews and debriefs on these incidents at the Grand Mercure.
3. Also attached is the Joint Terms of Reference and an Action Plan which combines the five recommendations that have emerged from the findings of the review.

## Summary

4. As part of the usual process, an internal review was undertaken into the Auckland February 2021 Outbreak, that led to two Alert Level Three lockdowns in Auckland on 14 February and 28 February respectively.
5. The review highlights that the overall response was strong there was no onward transmission from the secondary case identified in the managed isolation facility.
6. The review makes five recommendations and identified actions to be undertaken in each area. The relevant teams are aware of the actions, and the report outlines progress against these, to date. Consistent with our overall approach we have already amended or strengthened some key pressures and systems, based on the learnings. These have been referenced in the Action Plan.

## Recommendations

We recommend you:

a) **Note** that the Ministry of Health and Ministry for Business Innovation and Employment have undertaken a joint incident review of the Grand Mercure Auckland managed isolation facility which provide recommendations to further strengthen the ongoing COVID-19 response at the border.

b) **Indicate** whether you would like the Ministries to proactively release the report on their website. We will provide you with a communications pack to support this decision, if you decide to do so. **Yes/No**

Sue Gordon
**Deputy Chief Executive**
**COVID-19 Health System Response**
**Ministry of Health**

Date: 6 May 2021

Megan Main
**Deputy Secretary**
**Managed Isolation and Quarantine**
**Ministry of Business, Innovation and Employment**

Date: 6 May 2021

Hon Chris Hipkins
**Minister for COVID-19 Response**
Date:

# MIF COVID-19 Incident Joint Review: Grand Mercure Auckland

## Context

7. There were two separate, but associated incidents at the Grand Mercure MIF in March 2021.
    a. On the 21 March 2021, the Ministry of Health was notified by Auckland Regional Public Health of a Day 12 positive test (secondary case) which was genomically linked to a previous Day 12 positive test (index case) on 19 March 2021.
    b. A breach in protocol occurred in that the secondary case went for an offsite managed isolation walk via bus on Sunday 21 March. This was the result of a procedural failure in that the case's blue band was not removed after reporting symptoms. In addition there was a breach in the bus protocols and SOPs regarding transport to and from the offsite MIW.

## Review process

8. An interagency team was assigned to conduct the internal review after these two incidents occurred at the Grand Mercure, and 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 and ensure that the necessary procedures are followed for managed isolation walks (MIW).
9. The review team undertook a desktop analysis of previous review material, debrief documentation and independent assessments to examine the circumstances of the two incidents that occurred.
10. The review was presented and approved by both the Managed Isolation and Quarantine Technical Advisory Group (MIQ TAG) and the Risk, Quality and Assurance Advisory Group RQAAG).

## Key Findings

11. 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. A full on-site ventilation assessment of the Grand Mercure validated this hypothesis.
12. The risk of downward airflow between rooms via the mechanism outlined by the ventilation experts, appears to be unique to the Grand Mercure Auckland.[1] (MBIE are undertaking ventilation reviews at all MIQ facilities and these are expected to be completed shortly. Whether or not this mechanism is unique will be verified by this analysis).
13. 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.

[1] This is unique among MIFs, because the fan coil-units at the Grand Mercure, atypically have fresh air vertical risers that pass between rooms.

14. A number of actions were recommended and immediately undertaken to reduce the risk of further transmission within the MIF and/or the risk of onward transmission to the community.

15. A breach in normal procedure resulted in the secondary case's blue wrist band not being removed in error and this returnee attended a MIW whilst presenting minor symptoms, later to return a positive COVID-19 test.

16. A breach in bus protocols and non-compliance with the Standard Operating Procedures (SOPs) for the MIW programme led to the 14 returnees, classified as close contacts of the secondary case, staying an additional 14-day period in managed isolation.

17. Various debriefs, rapid reviews and audits were conducted to review the circumstances and offer recommendations for the MIW programme. There were numerous improvements recommended, many of which were immediately implemented. These are outlined in the action plan in the report at appendix one.

## Recommendations

18. There are five recommendations identified as a result of the Grand Mercure MIF incident review. These are part of a wider action plan to build on existing efforts and improve the system approach to the managed isolation and quarantine function.

    a. Assess and address the risk in in-MIF transmission via the ventilation system at the Grand Mercure Auckland MIF.

    b. Mitigate the risk of onwards transmission of infection from close contacts of positive COVID-19 cases.

    c. Improve processes for managing symptomatic returnees in a MIF.

    d. Improve the Managed Isolation Walk (MIW) programme including the procedures, process and implementation.

    e. Improve the protocols of specifically the bus transport, to and from, the MIW locations.

## Communications Approach

19. The release of the report is likely to generate moderate public and media interest.

20. If you choose to publicly release the report, we will provide you with a communications pack to support your decision.

## Next steps

21. The Ministry of Health and the Ministry of Business, Innovation and Employment (MBIE) will continue to review MIQ facilities, with a view to continuously improve operations. The actions that are underway will continue to be monitored and assessed as per normal review processes, i.e. IPC audits, ventilation reviews etc.

22. MBIE is continuing to work with the Grand Mercure hotel owners to identify a maintenance plan to address the ventilation concerns as outlined in the assessment report.

23. We will update you following the consideration of the ongoing sustainability of the MIW programme, including whether to decommission hotels that require this programme for their returnees.

ENDS.

# Appendix 1: MIF COVID-19 Incident Joint Review: Grand Mercure Auckland

The Joint Review is publicly available here: www.miq.govt.nz/assets/MIQ-documents/grand-mercure-incident-review.pdf

The Terms of Reference is publicly available here: www.health.govt.nz/system/files/documents/pages/04-appendix-3-grand-mercure-joint-incident-review-draft-terms-of-reference-redacted.pdf