STANDING COMMITTEE ON
ESTIMATES AND FINANCIAL OPERATIONS

MISCELLANEOUS PROCEEDINGS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 23 JUNE 2021

SESSION TWO
DEPARTMENT OF HEALTH

Members
Hon Peter Collier (Chair)
Hon Samantha Rowe (Deputy Chair)
Hon Jackie Jarvis
Hon Nick Goiran
Hon Dr Brad Pettitt

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Hearing commenced at 11.20 am

Dr DAVID RUSSELL-WEISZ
Director General, Department of Health, sworn and examined:

Dr ANDREW ROBERTSON
Chief Health Officer, sworn and examined:

Mr ROB ANDERSON
Assistant Director General, Purchasing and System Performance, Department of Health, sworn and examined:

The CHAIR: On behalf of the committee, I would like to welcome you to the hearing. Today's hearing will be broadcast. Before we go live, I would like to remind everyone that if you have any private documents on your desk, please keep them flat on the desk to avoid the cameras.

The committee acknowledges and honours the traditional owners of the ancestral lands upon which we meet today, the Whadjuk Noongar people, and pays its respects to their elders both past and present.

[Witnesses took the oath or affirmation.]

The CHAIR: You will have signed document entitled "Information for Witnesses". Did you read and understand that document?

The WITNESSES: Yes.

The CHAIR: These proceedings are being recorded by Hansard. A transcript of the evidence will be provided to you after the hearing.

Do you have an opening statement at all or is there anything you would like to say to us?

Dr ROBERTSON: Not at this stage.

The CHAIR: Good. For your benefit, the committee members are Hon Jackie Jarvis, Hon Samantha Rowe, Hon Nick Goiran and Hon Dr Brad Pettitt. We tend to share the love, and will be going around. I will start off with a couple of fairly general questions and then each member will be given an opportunity to ask any other questions.

First of all, it has been a difficult time and you have been very significant in terms of the role that you have played in Western Australia in making sure that we do feel that we are safe and in control, so thank you so much for that. Having said that, there is, of course, an enormous amount of uncertainty that still exists throughout the Western Australian community, nationally and globally. My question to you first of all: is there actual criteria that you use when you determine or provide advice to the government with regard to the management of COVID? Is it based on elimination or based on containment when you give advice to the government with regard to either closures or shutdowns, or whatever it might be?

Dr ROBERTSON: The advice that is provided to government is based on the national strategy of no community cases—that is, no community transmission. It is not an elimination strategy; it is based on a containment strategy.

The CHAIR: It is based on a containment strategy?

Dr ROBERTSON: Yes.

The CHAIR: I am voicing not the concerns but the confusion of some throughout the community that different jurisdictions appear to have different methodologies with regard to how they handle COVID. For example, in Western Australia it appears that we go automatically into lockdown in most instances; whereas, in a place like New South Wales, for example, much more emphasis will be placed on contact tracing et cetera and they will localise a particular area. Can you explain the difference between the jurisdictions in terms of their approach?

Dr ROBERTSON: I am not sure I can explain each of the jurisdictions and why they have made all of their decisions, but I think there is general consensus in most of the jurisdictions now that it depends on the circumstances. Each of the outbreaks is considered on the circumstances at the time, so, obviously, the case of a worker in quarantine who has not spread it more broadly is very different from the circumstance, for example, with Victoria, when they may have had multiple cases and they are not sure what the linkage is to the original case, which would suggest there was further spread that has occurred before the cases were detected. It is, obviously, adjusted depending on the situation at the time. But I think there is general consensus that lockdown has a key role to play, particularly in the first period of time—the first three to five days—to really give the opportunity to identify the cases, to lock down the spread of the disease during that period and to give our contact tracers and our testers the ability to do all of that contact tracing and to try to get on top of it and then to ease off the restrictions after that. That is the approach that we have taken, Queensland has taken, Victoria has taken and South Australia has taken. New South Wales has taken a slightly different approach, where they try to manage it. But what has happened in those circumstances is that we have seen—we saw this in the Avalon outbreak and we have seen it in a number of outbreaks—that while it is ultimately successful, the outbreak may go on for a longer period. It tends to go on while they are still trying to get on top of it. They are different approaches, and, obviously, that is the decision of governments.

The CHAIR: I will pick up on that. That is my point. When you look at somewhere like New South Wales, which has had what I would regard as a decidedly different approach to here in Western Australia. I think I heard this morning that there are 19 local cases.

Dr ROBERTSON: They had 16 new cases. They had 13 cases overnight.

The CHAIR: But they are not in lockdown.

Dr ROBERTSON: No. But in over seven of their LGAs they have gone to serious restrictions, including limiting the number of people in a house, the four-square-metre rule has come back into play, the use of masks and a number of other restrictions.

The CHAIR: Okay. I get the national cabinet et cetera and that it is a uniform approach but, as I said, that is decidedly different to here in Western Australia. For example, if you take February in Western Australia, when we had one case in Maylands—do you remember?—the entire metropolitan area and some of the south west was in lockdown. I assume that was your advice to government, to go into lockdown?

Dr ROBERTSON: Yes, it was.

The CHAIR: Why was that?

Dr ROBERTSON: That was the first case that we had had. Up until that period, we had had no community cases. With that particular case, he lived with seven other individuals in an apartment block. He was a young man who had been attending university, had been going out visiting various cafes and restaurants, as had his friends. In that case, there were only two others—one of whom was somebody who had been sharing a room with him, the other person was someone who had lived in the same house and had a meal with him. Fortunately for WA, he did not appear to be a

very effective spreader of the disease. There is an element of luck in this to a degree. What we have seen in the outbreak in Sydney is an individual go to a party in West Hoxton over the weekend—of 30 people at the party, 10 of them are already infected. That is obviously a couple of things—a more transmissible strain in the New South Wales case, but it is also the individual, too. Some people are very effective spreaders, some are not. We have to assume that he will be an effective spreader. He had been out in the community for a number of days and that we had to get on top of that. So the recommendation at the time was for five days to lock down, and we subsequently moved out of that quickly. For the subsequent two outbreaks—one was a lockdown for three days—I think we had a better understanding what we could achieve in those three days. It was a similar sort of outbreak. The third outbreak, we did not lock down. We were in restrictions at the time, so we felt that on those grounds there had been limited movement and we did not need to lockdown. We do adjust depending on the circumstances.

[11.30 am]

The CHAIR: With regard with your advice to government, on each and every occasion there has been a lockdown or a restriction that we have adopted in Western Australia, it has been on your advice?

Dr ROBERTSON: That is correct.

The CHAIR: With regard to the contact tracing, I asked some questions in the Parliament just recently with regard to the extension of the emergency powers legislation. The use of the app was in terminal decline until we had the outbreak in February.

Dr ROBERTSON: Yes.

The CHAIR: So, in effect, it was fairly ineffective, quite frankly. If we had had an outbreak in December—it had gone from something like 50 million to 12 million et cetera—how effective would our contact tracing strategies have been at that period of time?

Dr ROBERTSON: It is a little hard to calculate that. I certainly agree that an element of complacency had certainly crept in at that stage, and that was obviously a factor of the fact that we had no community cases at that stage. Obviously, the app has an important role to play, but it is not the only part of contact tracing—far from it. Most of the contact tracing is really around the interviews, the identification of who was at a particular event. To use our example from early on: who were his flat mates, what had they done and working through all of the sites and then testing people, and as we identify people, getting those quarantined and testing them going forward. We also use other means of identifying people who were in various areas, whether that is use of closed-circuit television within shopping centres, whether it is the use of credit cards to identify who may have paid at a particular restaurant or cafe during that time. They are all tools that we can use. The SafeWA app is an important tool, but it not the only tool. It complements us going forward. Obviously, it has been strengthened subsequent to December. That was obviously the first rollout. We identified a number of weaknesses in it, including the need to place more onus on the individual and not just on the store to get people to actually use the registers to go in.

The CHAIR: It was evident, and I think since that period of time we again have seen a significant decline in the use of the app. The point I am making is, quite frankly, that we are relying very, very heavily on trust and people self-identifying with regard to being at a particular location. All the CCTV cameras in the world et cetera and credit cards are not going to resolve that issue if it is in a shopping centre or a picture theatre et cetera. It is not a criticism. It is just an observation that if we are going to have an effective contact tracing system, I think the use of the app needs to be accelerated again, but that is not the point I am making. Thanks anyway, doctor.

Hon JACKIE JARVIS: I will take Peter's lead with regard to question about the different approaches across states. Obviously, Western Australia is a much smaller population and it has a much larger geographical area. If I reflect on the lockdown in February, from my own recollection that was the last Sunday of the school holidays. I remember that because I was returning from Perth with my daughter to the south west and there was obviously a stream of traffic heading back the other way. How much do those things play into your decision-making around the decision to lockdown both Perth and Peel and the south west, even though there was no evidence that there had been contact with anyone within the south west?

Dr ROBERTSON: Certainly on that occasion, and, as you are aware, we did not do it on the next occasion. But it was felt that because of the timing and the likely movement of traffic to and from that area that if there had been substantial cases, there could easily be spread down into that area. Remembering, of course, at this stage, we were trying to get a hold on exactly what had happened and where the people had gone. But it was the most logical one at that stage so that is why that advice was provided.

Hon JACKIE JARVIS: Thank you.

Hon SAMANTHA ROWE: Each case that comes up, it is done on a case-by-case decision in terms of the process around lockdown and so forth.; is that right? Not every situation is the same. We had the lockdown in February and then the next time we did not need to. Do you analyse each case as it comes up and go "Okay, we're going to need to go into lockdown to give our contact tracers time to do the tracing"?

Dr ROBERTSON: Yes, it depends very much on the circumstances.

Hon SAMANTHA ROWE: Is there criteria that you have to follow for that or a process that you follow or is it just the information that you have?

Dr ROBERTSON: It is based on the information that we have. We have some broad guidance as to what the kind of restrictions we might do at certain levels are. It is, really, based on the case. For example, we have had cases within hotel quarantine. There is obviously no risk to the community if one room infects another room. While we have to take measures to make sure that that has not spread further, and we may need to test, for example, other people on that floor or retest staff on that floor, it does not pose a risk to the community and we are unlikely to take any restrictions in that kind of circumstance. But there are circumstances where we become aware that one or more individuals have been out in the community for a period of time, a number of days, while infectious. They may not know that they are infectious; they may be asymptomatic. Depending on their movements—and one of the things we have learnt from this is that some people have relatively low-risk movements. They go to a small cafe or maybe a grocery store and do very little else. Others, obviously, are a far higher risk. They might go to bars, to nightclubs or to large parties. Depending on that circumstance, then we would have to make an assessment as to whether we think—to use the West Hoxton example, that is obviously concerning to us because they had gone to this party. We know that at that party, there were a number of people who worked in the health industry and that they may have then gone out. Hopefully, they have caught them early enough because they were able to get onto details about that circumstance, but that gives you an example of the kind of considerations that we would work through and what the best way to manage that is.

Hon SAMANTHA ROWE: I do not know if you can answer this, but, given what has happened in New South Wales and the fact that the numbers keep increasing, do you think maybe they should have gone into lockdown?

Dr ROBERTSON: If I was in a similar circumstance—I cannot really speak for the New South Wales government—I would probably would have recommended that we consider a three-day lockdown. I think some of the measures they have put onto their LGAs are fairly onerous. They are not quite a lockdown, but they would pick up on a number of those measures that we might consider in a lockdown.

The CHAIR: That brings me back to the point that I raised earlier. In terms of uniformity of purpose with regard to the—we have the national cabinet. I assume you communicate with the chief health officers in the other jurisdictions.

Dr ROBERTSON: Yes, we do. The AHPPC—the Australian Health Protection Principal Committee—meets almost on a daily basis and we do discuss these all the time. But, ultimately, it is a decision by the respective governments. There are obviously chief health officers in the respective states and territories who will provide their advice and then the governments will act on that advice as they see fit.

The CHAIR: Given that then, by design, the chief health officer of New South Wales would have advised Premier Berejiklian to have a lockdown based upon what you just said.

Dr ROBERTSON: I am not saying that. I do not know —

[11.40 am]

The CHAIR: But if we do have that consistency of purpose across the nation, that is my point. I am not being pedantic here. I am just trying to ascertain why we do have these—because, as I said, in New South Wales, they will have a breakout and they will have limited restrictions et cetera and seem to come out of it. Whereas in Western Australia, we go completely down to the full lockdown for two or three days or a week in some instances. You are quite right, the chap in February—I thought he lived with four others, but only one of them got it. It was one of the most infectious strains of the virus and they did not get infected. Yet the entire metropolitan area and Peel and the south west were locked down. I guess that was advice, was it not?

Dr ROBERTSON: It is advice and, certainly, I think, as with all of this advice, it has continued to evolve over time, so the approaches that we had taken as a jurisdiction 12 months ago may be different to what we are doing now. To a certain degree, there is no right or wrong answer here. It is a different approach taken. At the end of the day, Victoria locked down for a period of time. It is now coming out. We have not had any community cases in Victoria for a week and we anticipate they will come out. I am sure that New South Wales will also get on top of this. It is just a slightly different approach that has been taken. We can review it at the end as to which is more successful.

The CHAIR: As I said, I am not targeting you at all. I am just saying that is the commentary. I am out in the community all the time and you get that all the time—why have we got this diversity of strategies?

Hon SAMANTHA ROWE: Each jurisdiction has to do what they think is right for their area and everyone is going to be a little bit different. We have been really lucky here in WA. We have pretty much gone on with life as per normal with COVID. We have been very lucky, touch wood. I think I will finish on that for now. Thanks, Peter.

Hon NICK GOIRAN: Chief Health Officer, it has been just over seven months since you last appeared before the committee. On that occasion, we discussed the provision of information that you had received during a week in October. Specifically, the period of time was 13 October to 20 October. You indicated to the committee at the time that government had only requested to you to provide communications that your office had received during that week. I asked you at the time whether you had been asked to provide communications, correspondence, emails that your office had

provided to the Premier's office during that same period of time. I will just quote your response from 17 November last year. You said —

> I am not aware of being asked for that. As far as I am aware, the request was for information that I had received from the Premier and other parties, not for information I may have provided to those parties.

In the seven months and six days that has since transpired, have you been asked to provide that information by government?

Dr ROBERTSON: Not that I am aware of. I provide advice to government all the time and much of my advice is now actually publicly available on the wa.gov.au website. In fact, I think almost all of my recent advice is available on that website.

Hon NICK GOIRAN: Yes. This is in respect to a particular period of time—13 October to 20 October. How much time would it take for your office to be able to source that information and to provide it to this committee? It specifically relates to information that you had provided—that is communications, correspondence, emails—to the Premier's office and the Minister for Health's office during that one week. How much time would it take your office to source and provide that information to the committee?

Dr ROBERTSON: It is a bit hard to say, but certainly we should be able to do it within two weeks if we can get an opportunity to go back and look through that—

Hon NICK GOIRAN: If we said three weeks, that would be okay?

Dr ROBERTSON: Yes, that should be fine.

Hon NICK GOIRAN: Can we take that on notice, Mr Chairman?

The CHAIR: That is question 1.

Hon NICK GOIRAN: Mandatory contact registers were required in our state from 5 December last year. Was that a decision based upon your advice to government?

Dr ROBERTSON: There was a lot of discussion at that stage about the benefits of such registers. I believe that I probably did provide advice that they should be mandated going forward. I would need to check that.

Hon NICK GOIRAN: Would you be able to take that on notice; and, if it is the case, provide a copy of that advice?

Dr ROBERTSON: Certainly.

The CHAIR: That is question 2.

Hon NICK GOIRAN: At that time, Chief Health Officer, was it your understanding that such records that were maintained pursuant to this mandatory contact registers would only be able to be accessioned for COVID-19 contact tracing purposes?

Dr ROBERTSON: That was my understanding at the time.

Hon NICK GOIRAN: How did you come to that understanding at the time?

Dr ROBERTSON: When it was mandated as part of the initial discussions, that was my understanding that that information would be used for contact tracing purposes purely.

Hon NICK GOIRAN: Was that discussions that you had had with other individuals that resulted in this understanding being formulated?

Dr ROBERTSON: It would have been discussions with my own staff at the time, but I would need to go back and look at if I had any records of those discussions.

Hon NICK GOIRAN: Were you ever present at a meeting with the Premier or the Deputy Premier where that understanding was established and communicated?

Dr ROBERTSON: I would have to check that. Certainly, my understanding was that at that time. We were subsequent to become aware that obviously they were subject to legal requirements, legal requests.

Hon NICK GOIRAN: Yes. So the assurance that was provided to the Western Australian people that it would only be accessed for COVID-19 contact tracing purposes, how significant did you consider that assurance?

Dr ROBERTSON: I believed that the assurance was what had been given at the time. I believed that that was the case and that it would only be used for contact tracing. Part of the discussion at the time had been around where it should sit and who should have access to it. Obviously, early on, and it was made very clear in the development of it that the only people who could access it were our contact tracing people. I mean, I do not have access to that data because I have no need to have access to it. It was literally a subset of the Department of Health people who had a need for that information, and it was primarily in response to a contact tracing event.

Hon NICK GOIRAN: So that assurance that was provided in December last year by the Premier resulted in, from your perspective, even yourself as the Chief Health Officer not being able to access that data. So significant was this assurance and so controlled was the group that could access this data that even the Chief Health Officer was not expecting to be able to access that data. Is that right?

Dr ROBERTSON: That is correct.

Hon NICK GOIRAN: When did you first become aware that this data was being made available outside the remit of that assurance, specifically to Western Australian police?

Dr ROBERTSON: I would have to check when I first became aware, but it would have been after—it was not until we had a request, I think, from the police. I would have to go back to the dates of those, but I think when they first requested it, it was in the follow-up to the murder —

Hon NICK GOIRAN: I think the first request was on 14 December last year.

Dr ROBERTSON: Yes.

Hon NICK GOIRAN: So that would have been the first time that you were made aware of it?

Dr ROBERTSON: It would have been after that, yes. That request did not come to me specifically. It came to my contact tracers and they would have made me aware after that. I would have to check as to exactly when I became aware, but it would have been probably not on the day but after that date.

Hon NICK GOIRAN: So if I am saying it is 14 December, to the best of your recollection, would you say that you were first made aware of it before Christmas last year?

[11.50 am]

Dr ROBERTSON: I am not sure about that. I was actually on leave for a couple of weeks over Christmas, and that lead-up to Christmas was when we had a number of outbreaks, so it may not have been brought to my attention at that stage. I may not have become aware of it until early January, but I would need to go back and check that.

Hon NICK GOIRAN: Can we take that on notice, Mr Chairman?

The CHAIR: Yes.

Hon NICK GOIRAN: For the purposes of our consideration today, Chief Health Officer, you are indicating that you were probably first aware of this matter in early January. Obviously, you have taken that on notice and will come back to the committee. When did you first make the director general of Health aware of this matter?

Dr ROBERTSON: Again, I would have to check exactly when that was. It may have been the acting director general of Health who was covering for Dr Russell-Weisz, but it was around that period of time that I believe I became aware of it and he became aware of it.

Hon NICK GOIRAN: In and around January at least anyway?

Dr ROBERTSON: Yes. That is my recollection.

Hon NICK GOIRAN: If you could take that on notice, Chief Health Officer, that would be appreciated.

The CHAIR: That is the same date. We can include that with question 3.

Hon NICK GOIRAN: At what point did you first communicate this problem to the Minister for Health?

Dr ROBERTSON: I think we wrote to him formally in March—was it?

Dr RUSSELL-WEISZ: Yes. The briefing note at 30 March.

Hon NICK GOIRAN: There has been some suggestion of 31 March. Certainly, I have certainly sighted a briefing note that has been signed by the health minister dated 31 March this year. Were there any verbal discussions with the Minister for Health between you and he any time since he was first alerted to this issue in January?

Dr ROBERTSON: Not that I can recall, but there was a bit of discussion going on at that stage with us and police, initially just to see if we could resolve this initially to put some protocols in place. So there were some initial discussions with police to see if using policy measures we could actually require this—not prevent it from happening but meet what we believe was the intent of the actual mandatory contact register.

Hon NICK GOIRAN: Those discussions with police, did they include the police commissioner?

Dr ROBERTSON: They did, yes.

Hon NICK GOIRAN: Okay. On at least one occasion you discussed this issue with the police commissioner yourself?

Dr ROBERTSON: I am just trying to think whether it was discussed directly with him. I believe it was at one stage but it was certainly with some of his senior staff.

Hon NICK GOIRAN: Would you have a record of when you would have first discussed the matter with the police commissioner?

Dr ROBERTSON: I would have to check my records.

Hon NICK GOIRAN: You would have to check your records but you would have a record —

Dr ROBERTSON: I may have a record. I keep notes of meetings, and if we have discussed it, it may come up in those notes. But I may not have the exact dates or times.

The CHAIR: That is question 4.

Hon NICK GOIRAN: You considered this, Chief Health Officer, to be a significant issue, and a significant assurance you indicated earlier. When the assurance was provided by the Premier, it appears on your advice at the time, to implement a mandatory contact register, you considered the assurance provided to Western Australians as a significant assurance. You were first made aware of

this, it appears, in January, but the health minister is not informed about this until March. You are having discussions with the police commissioner, it appears. I would have thought given the significance of the matter, you would be keeping a note of this in a diary or in some form.

Dr ROBERTSON: I may have, yes. I certainly may have. I would have to go through my diary as to exactly the events and who the discussions were with at what time.

Hon NICK GOIRAN: I accept that you have taken that on notice already, and I appreciate that.

Hon Dr BRAD PETTITT: My question is in relation to the vaccine rollout. I am interested in the implications of the recent announcement for Pfizer only in terms of over 50s now. What do we expect in terms of the vaccine rollout? I do not know whether the term "herd immunity" is something that is used or it is just a media term but what is the necessary level of vaccination in terms of allowing from a public health perspective an opening up? I am quite interested in the kinds of delays. Obviously there are supply issues with Pfizer now that that also has to be supplied to people between 50 and 60 as well. Do you have a sense of the kinds of delays that will cause in terms of reaching those required levels of vaccination?

Dr ROBERTSON: I think there are probably a couple of comments to make there. Obviously we have been trying to utilise all the vaccines that we currently have. When we started to vaccinate the 30 and 40-year-olds, we had a small stockpile of vaccine that would enable us to do that, and that was part of the decision. When the decision was made to vaccinate the 50 to 59-year-olds, we obviously pivoted our supplies. But we have sufficient supplies to be able to do that over the six-week period to the end of July, which is when, at that stage, we had the best advice of how many vaccines we would be getting. The challenge has been the Pfizer primarily, not the AstraZeneca. We have adequate supplies of AstraZeneca. In fact, the demand on AstraZeneca, as you would imagine, has fallen. Although we are still getting reasonable demand for second doses. It has really been working with the commonwealth to look beyond July, from August onwards, at what our supplies will be. We had some advice over the weekend, late Saturday, of what the anticipated supplies would be going forward. They are still very broad, but they indicated that certainly from July until the end of September we would see increases and then further increases from October and beyond. That has been our challenge. Ramping up vaccines has been going quite well. We actually vaccinated 6 345 people yesterday, including 5 177 with their first dose of Pfizer and 349 with a second dose of Pfizer, so that is 5 526 given yesterday. So we are ramping up, and that is the commitment we made we would do when we moved over on Friday last week.

Dr RUSSELL-WEISZ: Just to add, member, the Chief Health Officer and myself obviously meet with the commonwealth and all other jurisdictions in relation to the vaccine rollout. I think one thing to add is that where we have seen a potential increase in Pfizer vaccine going forward in August–September, general practice is going to get a bigger proportion than potentially the state clinics. That is what we are seeing. We are actually supportive of that because we want patients to go to their GPs. So you can get both vaccinations at GPs and respiratory clinics—or you will be able to do that, be that AstraZeneca and Pfizer—as well as us. We will scale up and scale down as we need to but at the moment we are seeing that the commonwealth is pivoting a little bit more towards general practice than it is to the state clinics. We do not have any, not surety, but definitive numbers on supply in August as yet.

Hon Dr BRAD PETTITT: So then it is hard to know in that sense when you will get to a point of herd immunity for lack of a better phrase?

[12.00 noon]

Dr ROBERTSON: We probably will not aim for herd immunity. It is very hard to judge what percentage of the population you need vaccinated for herd immunity because that will vary depending on whether children are vaccinated—what percentage of adults are vaccinated. What we are obviously looking for is trying to get at least the adult population vaccinated up to between 70 and 80 per cent. The reason for those figures is because the modelling shows that if we can get 80 per cent of the population vaccinated up to that kind of percentage, then even if we do get an outbreak, the chance of it becoming a large outbreak is reduced quite considerably. Before then, we could still get quite large outbreaks, and I think that is the issue we are starting to see in New South Wales at the moment. There is still the potential with variants like the Delta and Kappa variants, which are a lot more transmissible, and that is something we have to take into account.

Hon SAMANTHA ROWE: If someone is going to get their Pfizer vaccination in mid or end of July, will there still be enough Pfizer for them to get their second dose?

Dr ROBERTSON: Yes. There is a guarantee that there will be. The way the commonwealth supplies us is that they supply the first doses and then three weeks later they supply us basically sufficient for the second doses as well as the first doses for that week.

Hon Dr BRAD PETTITT: It is a follow-up question. On that 70 to 80 per cent adult rate, do you have a sense, knowing your current estimate of supply of vaccines, when that will be reached?

Dr ROBERTSON: We are looking towards the end of the year to reach that. It is obviously not just a factor of us. We provide a portion of it but it also involves primary care, particularly the general practitioners who obviously do a lot of the vaccinations and the Aboriginal controlled health organisations, and probably will include pharmacists and other groups going forward, particularly in the second half of the year.

Dr RUSSELL-WEISZ: We have been told to get ready for September–October when there are large supplies of Pfizer coming in from the commonwealth to the states. Moderna will come as well but that will just go to general practice. Obviously, the other thing to say would be that we need people to take it up. We need people to get to 70 to 80 per cent. We do not want to plateau at 60 per cent.

Hon JACKIE JARVIS: On the SafeWA app, Dr Robertson, I was in Tasmania in April on a family holiday and I noticed that they had a similar QR code-type app but I was incredibly surprised that it was not used in shops. I think I used it at a sporting venue. When I went to use it in a cafe as I was getting takeaway coffee, the staff actually said, “You don’t have to worry about that because you’re not sitting down.” It was an interesting take on it. In your opinion, how effective has the SafeWA app been in assisting your agency with contact tracing?

Dr ROBERTSON: It has been quite effective. I think one of the decisions we made was that originally we did not include shops, and it was only as a later iteration of that app that we actually included shops. I think a number of other jurisdictions—I do not think Queensland has included shops either until recently. They have now seen their latest outbreaks as an opportunity to include shops. I think what we have identified, and we are seeing it in the Bondi Junction outbreak, is that a number of contacts are in shops. Two of the individuals, for example, were in Myer at the same time. They were unknown to each other and they were picked up in Myers and they were able to identify them. We have used it quite a lot to identify our close and casual contacts, and that has been very useful. Obviously, once we have identified close contacts, we can often identify that they might be there with their family, for example, or a friend or whatever and we can identify others who may not have signed in. It certainly has been very useful for our contact tracers.

Hon NICK GOIRAN: You may have answered this earlier. You mentioned Moderna; when do you expect that to be available in Western Australia?

Dr ROBERTSON: I think we are looking at the fourth quarter.

Dr RUSSELL-WEISZ: Yes, in September–October. But the initial advice is that it is just going to GPs or respiratory clinics, not to the states. That is the initial advice from the commonwealth.

Hon NICK GOIRAN: It is just going to the GPs?

Dr RUSSELL-WEISZ: Yes.

Hon NICK GOIRAN: As in you have to be a general practitioner to qualify to have the —

Dr RUSSELL-WEISZ: No, no. It is to give. We will get Pfizer. We have got AstraZeneca. But, as I said, slightly increased doses it looks like from the commonwealth to the GPs, and Moderna going to the GPs. Again it could change. This stuff changes regularly from the commonwealth and we have to adapt.

Hon NICK GOIRAN: But you expect that in September–October this year?

Dr RUSSELL-WEISZ: Yes.

Hon NICK GOIRAN: Is it expected that there will be an age threshold to be eligible to obtain the Moderna vaccine?

Dr ROBERTSON: It is a very similar vaccine to Pfizer. As a messenger RNA vaccine we would anticipate the same sort of requirement, but that would be subject to further ATAGI advice nationally. The decision would then obviously be made by the Australian government on ATAGI advice. It may change but that will obviously depend on further advice.

Hon NICK GOIRAN: Would you expect than that the Pfizer would also be available via GPs at that point?

Dr ROBERTSON: Yes. The Pfizer is already available by some GPs. A number of the GP respiratory clinics are already providing Pfizer. As of 5 July, they will start rolling out Pfizer to, I think, initially 55 GP practices within WA. There will be a further 55, I believe, about two weeks later and they will continue to roll it out. So it is progressively rolling out through July to those GP practices.[1]

Hon NICK GOIRAN: Is there any benefit for a Western Australian to wait for the Moderna jab rather than taking the Pfizer?

Dr ROBERTSON: They are very similar vaccines. There are no real advantages in waiting for one or the other. It just gives us additional supplies, really. I think it is more around the additional supplies of an MRNA vaccine.

Hon NICK GOIRAN: But there are different risks and complications, or not?

Dr ROBERTSON: They are very similar. The Moderna and the Pfizer both have similar efficacy. All vaccines have some mild adverse effects. They have similar pitches of adverse effects as well. For an individual there is not much difference between the two.

Hon NICK GOIRAN: What is the criteria that you will be using to determine whether international travellers can change from hotel quarantine to home quarantine?

Dr ROBERTSON: A lot of this work is currently being modelled at the moment. The criteria will be around the risk to the community of getting an outbreak or getting a release of disease into the community. If we use 14 days of hotel quarantine as what we believe is an acceptable risk, what is

[1] A letter of clarification about this part of the transcript can be accessed on the committee webpage.

the risk, for example, if all the people are vaccinated and have to do 14 days in hotel quarantine? What happens if they did 14 days in home quarantine? What is the risk from that? From the initial work that we have seen, 14 days in hotel quarantine is obviously the optimal, but 14 days for fully vaccinated people, not unvaccinated, may be an option if we can get the compliance right. The problem is that if people do not comply—that is, they do not stay at home and they go out into the community. They have been looking at if you have 50 per cent compliance, 90 per cent compliance or full compliance, and what would that look like? Some of the initial work suggests that if you have full compliance, then obviously that might be an option going forward. But the compliance is the issue here. Because if people go out into the community, whilst they are vaccinated, they can still be infectious and they can still deliver it. They can still pass the disease on. We have seen that particularly in recent outbreaks, where people have been vaccinated and they have spread the disease on. They are not as effective and it is likely to reduce it, and certainly some of the research is suggesting it might be a reduction of 90 per cent—that is, it is probably a 10 per cent chance of an unvaccinated person spreading it—but they still can and that is an issue and obviously that could lead to an outbreak.

Hon NICK GOIRAN: When do you expect that initial work to be completed?

Dr ROBERTSON: A lot of the modelling is going on at the moment, but I would have thought within the next few weeks.

The CHAIR: Thanks so much again for attending. It is very, very much appreciated.

A transcript of this hearing will be sent to you for correction. If you believe that there are typographical or transcription errors in your transcript of evidence, please indicate your suggested corrections on the transcript. Errors of fact or substance must be corrected in a letter to the committee. When you receive your transcript of evidence, the document will also indicate the questions that you have taken on notice and when the responses are due back to the committee. If you want to provide additional information or elaborate on particular points, you may provide supplementary evidence to committee for consideration when you return your corrected transcript of evidence. Please speak to the committee staff if you have any further queries. Once again, thank you very much for taking the time met with us.

Hearing concluded at 12.10 pm