MANAGED ISOLATION AND QUARANTINE

Review into Absconder from MIQ Novotel Ibis Ellerslie 2 September 2021

20 September 2021

Contents

1. Executive summary

The Managed Isolation and Quarantine (MIQ) system was established as part of New Zealand's border defence against an outbreak or spread of COVID-19. It considerably relies on the willing compliance of those isolated or quarantined in MIQ facilities. Although community cases and border cases are held in MIQ under different legal regimes, once admitted to MIQ, it is intended that the quarantine requirements are the same whether they are border returnees or community referrals.

In the early hours of September 2nd a COVID-19 positive community referral, a 23-year-old man (Case X) absconded from the Novotel Ibis Ellerslie MIQ facility (MIQ Novotel).

Case X was admitted to the Novotel in the early evening of September 1st, and was quarantined in a bubble of 2. Between 10:30 and 11:00 the following morning the other bubble member notified facility management that Case X was no longer at the facility and had returned home.

An initial review of CCTV data revealed that Case X had left and returned to his room twice between 11:40pm and 12:40am and eventually departed his room a third time at 1:04am and, after scaling perimeter fencing, left the confines of the facility.

The MIQ Novotel has close-circuit cameras and other security measures and processes in place to manage and monitor the premises that should ensure that any non-compliance with requirements relating to people staying in their room is detected and responded to.

This review found that there was no one single point of failure resulting in Case X being able to abscond. However, a number of factors meant the security controls were not all operating as designed. CCTV alarms linked to stairwell door openings were not operating, staff did not escalate or respond as processes require when Case X was first seen to leave his room, and subsequent CCTV monitoring did not result in him being seen when he left the room again. Training and site induction processes may have also contributed. In addition, background information around Case X and his behaviour prior to arriving at MIQ Novotel, which was known to Police, was not fully understood by MIQ staff.

The Head of Managed Isolation and Quarantine – Operations commissioned this review to identify any system vulnerabilities. The terms of reference for the review are set out in appendix 1.

Managed Isolation and Quarantine system

MIQ was established to hold a central role in New Zealand's border response and COVID-19 elimination strategy by preventing community transmission of imported COVID-19 cases. It is a complex system of accommodation facilities, personnel, information systems, and testing regimes to ensure that positive COVID-19 cases are detected early after their arrival to New Zealand and to be isolated from the community.

In August 2021 there were 31 MIQ facilities located in Auckland, Hamilton, Rotorua, Wellington and Christchurch. The model is impacted by the type of facilities used and health system capacity, which limits its scalability. Prior to August there was one dedicated quarantine facility based in Auckland and four dual use isolation and quarantine facilities; one in Wellington and three in Christchurch.

Since establishment MIQ has taken in small numbers of positive community cases. However, the MIQ system was designed to manage border cases rather than large scale community outbreaks and the Auckland quarantine facility had previously not operated at above 50 percent of its capacity.

In late August, as the community outbreak spread, MIQ was asked to manage quarantine for the community outbreak. As quarantine room capacity limits were approached, it was necessary to convert isolation capacity into quarantine capacity quickly, whilst maintaining sufficient room availability for the border cases also booked to arrive.

Community referrals

Community referred cases have a different profile to border returnees. Border returnees have planned, booked and prepared for their stay in an MIQ isolation facility and are well aware that, if found positive, they will be transferred to a quarantine facility.

Community cases are most often completely unprepared for their stay. There is little time between finding out they have contracted COVID-19 and finding themselves in an MIQ facility, often separated from their whanau.

With the increase in numbers, it became clear that the expectations, needs, behaviours, wellbeing and risk profile of community cases was often different from the border cases MIQ had been established to service. These differences became apparent in the first week of admitting community cases, and required changes to approach for scale, and to cater for increased bubble sizes, language, dietary, spiritual, as well as increased resourcing to respond.

Operating context

The MIQ facility Novotel & Ibis Ellerslie (MIQ Novotel) was transitioned from an isolation facility to a quarantine facility in less than two days. The first referrals arrived after 2pm on the August 27th. Prior to this, MIQ Novotel had no experience of operating as a quarantine facility.

Staff at the MIQ Novotel include Ministry of Business Innovation and Employment (MBIE), New Zealand Defence Force (Defence), Aviation Security (AvSec) private security, Police, DHB and hotel staff. Prior to and during the transition period, 79 members of staff were required to self-isolate as close contacts of community cases outside of the MIQ, at one point leaving just 35 staff familiar with the facility. This gap was addressed by bringing in additional staff from across the country.

It is clear that the rapid turnaround of the facility, and the admission of 357 community cases in the first six days of operation put enormous pressure on staff and systems.

Notwithstanding the issues above, the staff were able to transition the facility and be operating near capacity in a very short amount of time. This included coming to understand a new operating model, procedural changes and managing an increased risk profile for their own working environment. It would not have been possible without their continued commitment and dedication.

Findings

Our assessment found that a number of factors combined to mean Case X was able to abscond. Simple system issues, from an out-of-place cable, to a facility still adjusting to the change in designation, learning and embedding new processes, and the changing profile of those needing its services all contributed.

Our findings include:

Individual circumstances

- Case X was reluctant to enter quarantine.
- Case X confirmed he understood and would abide by his responsibilities while in quarantine.
- Case X later became determined to leave. He deliberately tested how far he could venture from his room, and when outside, concealed himself from detection before scaling the perimeter fences.

Communication and information

- Not all relevant information about Case X was known to MIQ staff. If the full information had been understood, management and security would have been able to prepare and respond accordingly.
- Some information provided was taken to mean that Case X was a lower risk than he was.
- Another significant incident involving an aggressive women accessing the reception and staff only areas occurred just prior to the time of Case X's admission may have distracted attention.
- There are no formal shift changeover briefings which may have improved the understanding of the operational settings. Noting that private security and NZDF are on different shift patterns.

Security measures

- The security controls in place should have cumulatively prevented Case X from being able to abscond.
- CCTV monitoring did identify the first time Case X left his room. However, escalation and response process when he was first seen in the hallway were not followed. CCTV door alarms did not sound when he entered the stairwell as the audio cable was in the wrong computer port.
- Some staff indicate more time is required to absorb and embed the training for operating the CCTV/alarm system for it to be operated well.

Policies and procedures

- While there are operating procedures to operate a quarantine facility, there is no standard operating procedure to convert from an isolation facility to a quarantine facility.
- The procedures necessary for the operation of the MIQ Novotel as a quarantine facility were being drafted as cases arrived.
- Staff availability was reduced and contingency was provided from within the region, and in the case of health staff from other parts of the country.
- Admission procedures for Case X were appropriately followed.
- The standard process for assessing the wellbeing of people arriving in MIQ requires completion at admission or as soon as possible thereafter (within 48 hours). This had not been completed for Case X and may have provided insight to his flight risk. Case X arrived in the evening and had only been in the facility 7 hours before absconding.
- If a change in admission processes is implemented to require welfare checks at the point of admission, as proposed by this review, then the resourcing model will need to be bolstered.

Recommendations

We acknowledge that the team at the MIQ Novotel and wider Auckland operations team immediately carried out a review and implemented improvements to its operational processes and systems to prevent a repeat occurrence. A summary of the immediate actions taken is provided in Section 5.

The following recommendations for improvement should be considered as learnings for implementation in both the MIQ Novotel and also for all isolation and quarantine facilities.

Community cases

Develop an 'MIQ Community Case Management framework' to address the following:

1. Ensure interagency protocols allow all relevant information relating to community cases to be shared to ensure safety, wellbeing and risk factors are understood.
2. Develop a wellbeing and risk profile assessment questionnaire for community cases.
3. Ensure that the wellbeing and risk assessment questionnaire is introduced to the admission processes to enable any additional issues to be addressed.
4. Assess the admission resourcing model for appropriateness once additional welfare checks are added.

Security measures

Update and improve site security plans and settings to address the following:

5. Ensure there is a shift supervisor for the security team.
6. A review of CCTV controls, establishing set standards for operation, e.g. day/night door alarm settings
7. Ensure all security staff receive a site induction and training at the start of each deployment including the after-hours requirements of the site security plan, and Local and Standard Operating Procedures.

Policies and procedures

8. Formalise a briefing process for the start of each shift.
9. Ensure staff on breaks are sufficiently away from operational areas so as not to cause a distraction.
10. Rationalise existing local procedures where possible to standard operating procedures to maintain consistency and strengthen the control environment.
11. Implement a clear repeatable process for establishing and maintaining local procedures with that integrates with the updated Operating Model.

Acknowledgement

We would like to acknowledge and thank the individuals who made themselves available for this review. We would specifically like to acknowledge the candour and cooperation of the operations teams, and all the agencies involved.

2. Timeline

Following is a visual representation of the activities and events relating to the incident.

KEY: **Case X** **MIQ** **Other relevant information**

MIQ Novotel Ibis Ellerslie starts transition to quarrantine facility — **August 25th**

MIQ Noveotel Ibis Ellerslie completes transition to quarrantine facility — **August 27th**

14:00 first Community Case referrals arrive

8 referrals comprising 13 people

32 referrals comprising 62 people — **August 28th**

38 referrals comprising 99 people — **August 29th**

37 referrals comprising 82 people — **August 30th**

30 referrals comprising 65 people — **August 31st**

28 referrals comprising 54 people — **September 1st**

14:21 Case X advised of his positive COVID – 19 status by Auckland Regional Public Health Service (APRHs). Denied that he could have COVID and hangs up.

Case X returns home and then leaves in car

Family ring Case X and advise to come home, he refuses

ARPHS Pacific Team call Case X, explain diagnosis and need for isolation. Case X agrees to transfer to MIQ

Case X family notify Police that Case X will not come home and doesn't want to go to MIQ. Police start to look for Case X vehicle

15:30 pm Police attend Case X address

16:42 – 17:45 incident in MIQ novotel reception. Unknown woman aggresively enters reception area. Goes behind reception and opens door to staff only area. Leaves and returns to room. CCTV review underway to identify and follow up with Police at room. Incident recorded in site security log.

17:30Transport arrives to residence to transport Case X sibling to MIQ

Police advise transport that Case X and additional sibling should also transfer to MIQ

17:48 Case X arrives at MIQ Novotel perimeter double gate airlock

18:10 Case X enters reception for processing

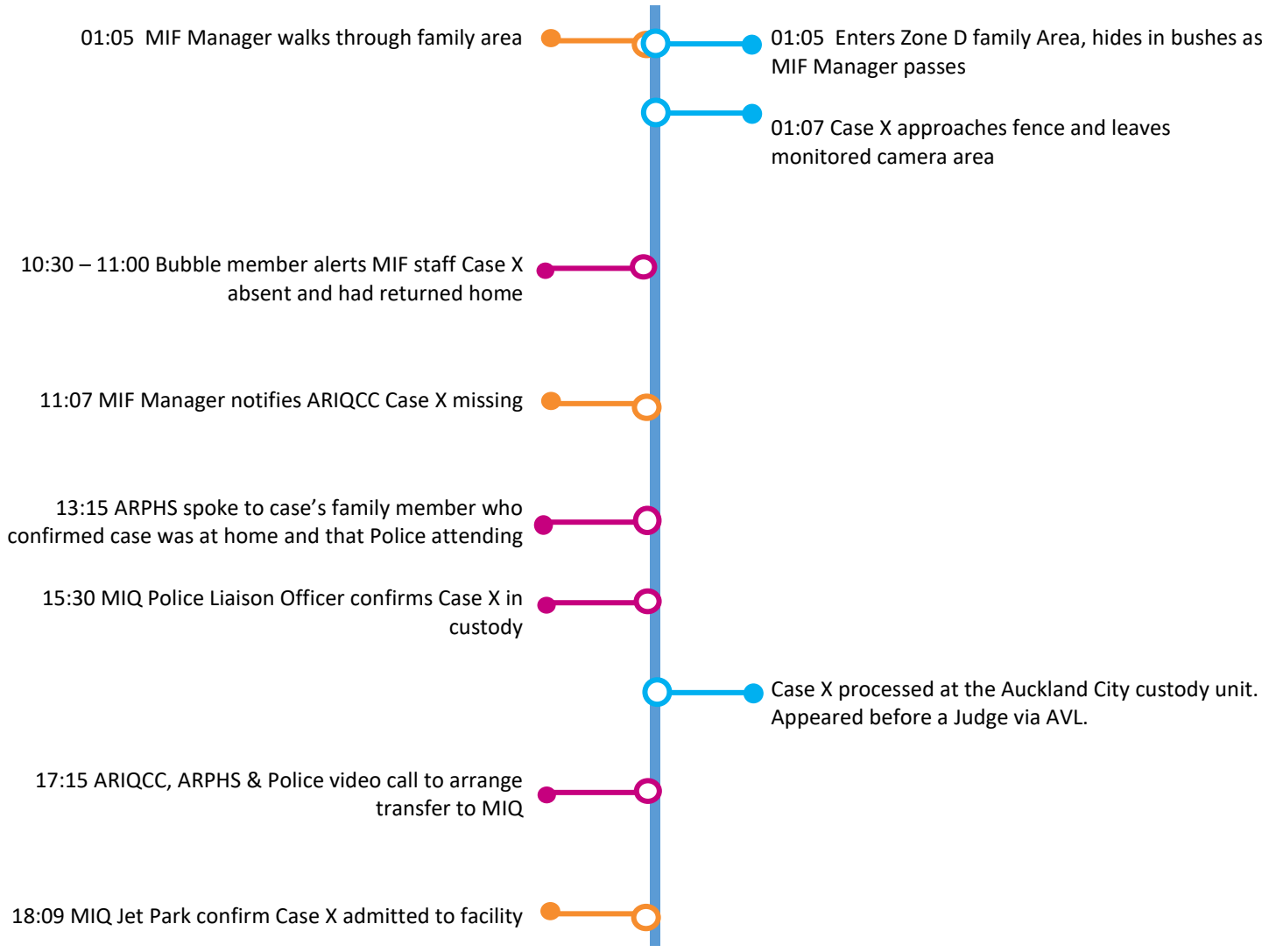
Case X observed on CCTV operator logs seeing guest walking up and down corridor, unconfirmed which room due to camera blind spot.

23:40 Case X first active on cameras, walks corridor, enters stairwell returns to room 3 minutes later

September 2nd

00:33 Case X makes way down stairwell, enters family zone, returns room 5 minutes later

01:04 Departs room final time enters stairwell



3. Background

Transition to a quarantine facility

MIQ was established to hold a central role in New Zealand's border response by preventing community transmission of imported COVID-19 cases. In late August as the community outbreak spread, MIQ was asked to manage quarantine and close contact isolation for community cases. As quarantine capacity limits in Auckland were approached, it was necessary to convert isolation capacity into quarantine capacity. The MIQ Novotel operated as an isolation facility until August 25th 2021. Until then it had provided isolation accommodation only for border returnees. With the Delta community outbreak, it was decided to transition the MIQ Novotel to a quarantine facility to cater for the increased demand. Preparations commenced on Wednesday, August 25th however this was impeded in part by the 111 departures occurring that day, with the last person departing at 7:30pm. A further impediment was the loss of 79 staff to self-isolation, as they were deemed close contacts to community cases. This included the MIF Manager, the Operations and Security Manager (OSM), a Wellbeing Coordinator, and 3 facility Duty Managers. The MIF Manager was replaced and a relieving OSM took over.

The relieving OSM was also required to self-isolate from the 26th with the Regional Operations and Security Manager acting as replacement. By the end of the 26th most of the necessary physical works had been carried out to create red and green zones in accordance with IPC requirements, and the working space required to operate as a quarantine facility and a large team of cleaners had completed a deep clean of the facility.

An experienced team from the Jet Park quarantine facility and Auckland Regional Isolation and Quarantine Coordination Centre (ARIQ) helped with processes and knowledge transfer. Health staff arrived from Christchurch and a new coordinator arrived from NZDF. At 9:45pm a letter to all staff was received stating that the Head of MIQ had re-designated the facility that day, and it would commence operations as a quarantine facility.

ARIQCC provided more staff on the morning of August 27th. Building works were completed, other than the staff accommodation, and the revised procedures and processes were implemented but remained a work in progress with each new community referral. Core staff were in place for the 28th with 1 Wellbeing Coordinator and the MIF Manager handling all referrals, with a temporary OSM for the day. On the 29th four additional experienced staff were provided to manage the surge of referrals and the OSM role was split between two facilities.

Community Referrals

Community referral cases started arriving at the MIQ Novotel, after being referred by Auckland Regional Public Health Service (APRHS), from 2pm on the afternoon of Friday, August 27th. It was not always clear ahead of arrival how many people were included in each referral from APRHS. There could be one or multiple people arriving for each referral. This created planning, operational and logistical issues for each multi person admission. Each individual person could take up to 30 minutes to complete, with additional logistical issues and time taken up trying to keep whanau together in their bubbles.

Over the six days leading up to and including Case X's arrival, there were 173 referrals for 375 community cases. Case X was part of the 24th referral on the day he arrived. The referral notification advised the facility to prepare for 1 person and 3 arrived. The following table shows the number of referrals and people admitted to the MIQ Novotel from August 27th to September 1st when Case X was admitted.

Day	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday		**Totals**
Date	27/08/2021	28/08/2021	29/08/2021	30/08/2021	31/08/2021	1/09/2021		
Referrals	8	32	38	37	30	28		**173**
People	13	62	99	82	65	54		**375**

4. Detailed findings and recommendations

Case X

Case X was notified by ARPHS by phone that he had tested positive for COVID-19 at 2:21pm on September 1st. Case X stated he was at Seaside Park, Otahuhu. He did not disclose his exact location. Case X denied that he could have COVID-19 (as he was asymptomatic) and hung up on ARPHS staff. Case X returned home, then left again by vehicle, dropped it at a friend's house, then returned home again. A sibling of Case X had tested positive and was aware of Case X's status. The family had called Case X and advised him of the need for him to come home, however he refused. The family then decided to notify police, who responded by conducting area patrols to look for the vehicle he left in.

The family continued to call Case X and was told that he was going to do some shopping. The family advised Police of this and where Case X liked to shop. Police undertook active patrol of all shops in the Otahuhu area which were open. About 30 minutes later, the family advised Police that Case X had arrived home on foot. Case X refused to tell the family where the vehicle was. Police later found the car at Case X's friend's house, approximately 10 minutes' walk from Case X's home. The friend was a close contact from a separate exposure and was isolating.

Around 3:40pm the ARPHS Pacific Team called Case X while he was at home, they further explained his diagnosis and the need for isolation in a facility. Case X agreed to transfer to MIQ. Police had arrived at Case X's address and consulted by phone with ARPHS. As transportation was being arranged for Case x, APRHS advised Police they weren't required to support. Police decided to stand by until the transportation arrived, as they were concerned about Case X's previous behaviour.

Transportation arrived to transfer Case X's sibling. It is unclear if the same transportation was also intended for Case X, but after discussion between the transport provider and Police, Case X and his two siblings were transferred to MIQ Novotel. Given his previous behaviour, Police escorted the transport to MIQ Novotel to ensure the transfer was completed without incident. Case X arrived at the MIQ Novotel at approximately 5:45pm.

On arrival to the MIQ Novotel, the security at the gate informed the staff within the facility that a transport with passengers had arrived and that Police had escorted the transport. MIQ Police liaison officers (PLO) at this facility then went to the gate and discussed the circumstances and the potential flight risk of Case X with the escort. The PLO returned to the facility donned Personal Protective Equipment (PPE) and then went onto the transport to attend the in vehicle briefing of Case X. The PLO observed that Case X was acting 'a little belligerent' and deliberately allowing his face mask to fall down.

Case X and his siblings were admitted to the facility at approximately 6:10pm. He and one sibling were escorted to their accommodation as one bubble and were provided a briefing in the room that included the mask wearing requirements, obligations for staying in the room, and not opening the door for anything other than food deliveries or MIQ staff attending the room. They were directed to further information provided in the room and both acknowledged that they understood and would follow the requirements.

Police end of shift notes record that the information around Case X's transport escort and flight risk were forwarded to the nightshift replacement, and that Case X and details of an earlier incident concerning a bubble breach of an aggressive women at reception were discussed with the MIF Manager. The MIF Manager recollected that the details were initially unclear and incomplete as to why Police had escorted the Case X transport, but that they understood he was now compliant. NZDF reported later that they were unaware of the risk with Case X and there wasn't a briefing. Nothing is recorded in the security log around Case X's arrival or flight risk.

A subsequent review of CCTV showed that Case X first left his room at 11:40pm entering the corridor and then the stairwell. A few minutes later he returned to his room. At 12:33am he left his room again, went down the stairwell and entered the outside family fresh air area via the fire exit door, then shortly after returned through the exit and back to his room. Guests are not issued with key cards so Case X either wedged the door open, or was let in, to be able to re-enter his room. The door itself was in a CCTV blind spot.

As part of the facility transition to a quarantine facility, a wall was built to segregate the staff accommodation from the referred community cases. This resulted in the stairwell fire exit door becoming the main entrance for staff to access their accommodation. The door was a 'one-way door' in that, as a fire exit, it is able to be opened from the inside but is locked from the outside. With the changes to the accommodation the door was wedged open to allow staff entry, as keys were not available. People are able to exit through the door in any circumstances, but not able to re-enter, if the door was not wedged open. The door was not alarmed and therefore no notification would be sent to security.

At 1:04am Case X left his room a final time and made his way outside again, after briefly hiding in bushes to avoid detection from staff walking in the area, he left the monitored area by climbing the perimeter fences.

The following morning, the sibling Case X shared his room with notified MIQ staff that Case X was missing from the room and that he had returned home.

Key points

1. Case X was reluctant to attend quarantine. At the time of admission, Case X was not expected at the MIQ Novotel. The referral from ARPHS was for one person. Immediate focus for MIQ staff was in confirming the identity and health status of the additional passengers in the shuttle and admitting them to the facility.
2. The Novotel PLO notes he discussed with the MIF Manager that Police had escorted the transport for Case X as he had initially refused to come to MIQ. The information about Case X's behaviour throughout the day was only partly known by MIQ staff. The MIF Manager recalls being told that Case X was now 'compliant' which may have been taken to mean he was low risk. The PLO recorded that he later forwarded information to the (Police) nightshift replacement about Case X and indicated he was a flight risk, along with information about another incident that had occurred shortly before Case X arrived.
3. We were advised that it is not clear to Police and MIQ staff if the information sharing agreements in place cover the disclosure of all information known about community cases known to the Police.
4. Community cases are not covered by Section 316 of the Customs and Excise Act 2018 - under which Police are provided with advanced passenger information of incoming flights going into MIQ from across the border. Police receive information in advance to ensure wellbeing risks or risk posed by individuals is mitigated, or eliminated if possible. Information is provided to the relevant MIQ PLO if there are any concerns.
5. On the day of arrival, or as soon as possible (within 48 hours of arrival), returnees must undergo an arrival health and wellbeing screen. At a minimum, the screen must include a COVID-19 symptom check, an assessment of temperature, public health COVID-19 questions, and questions around non-COVID-19 related physical health, mental health, addiction, and welfare needs. This check was not yet completed for Case X and therefore any welfare needs or concerns that he may have held were unable to be addressed.

Recommendations

Develop an 'MIQ Community Case Management framework' to address the following:

1. Ensure interagency protocols allow all relevant information relating to community cases to be shared to ensure safety, wellbeing and risk factors are understood. Providing Police, name and date of birth information for community cases would enable the same process for community cases as for border people.
2. Develop a wellbeing and risk profile assessment questionnaire for community cases.
3. Ensure that the wellbeing and risk assessment questionnaire is introduced to the admission processes to enable any additional issues to be addressed.
4. Assess the admission resourcing model for appropriateness once additional welfare checks are added.

Security overview

The MIQ Novotel has a comprehensive Site Security Plan (SSP) in draft, which sets out the security measures for the facility. It also sets out the responsibilities, induction and deployment details. The SSP requires that all security personnel must be inducted and oriented onsite including on the job training for their duties. The SSP sets out that all security staff will raise non-urgent concerns through their team leads. All urgent and reportable events must be reported to the OSM and MIF Manager. In the absence of the OSM, decisions surrounding deployment will be provided by the MIF Manager, and afterhours through the NZDF team lead.

Deployment of security staff

The night shift is a blended workforce of NZDF, private security and hotel staff including a duty facility (hotel) manager. There is no individual who is in charge of the shift with the NZDF and security staff self-managing. The MIF Manager is on site 24 hours, seven days a week, on a seven days on seven days off rota. The MIF Manager works through the day and is on call in the evenings, but if asleep will need to be woken to attend issues. The OSM works Monday to Friday 8 – 4. The regular OSM was not released from self-isolation until 31 August and started back at the facility on September 1st. Until then a temporary OSM was in place with the role covering two facilities.

To support staff wellbeing and fatigue management, the SSP requires all agencies to operate on a single post and deployment rotation roster. Rotation at each post should be every 30-40 minutes. This is to ensure that a good percentage of the MIF security staff are familiar, and experienced with all facets of security tasks, roles and responsibilities.

There is a formal operations briefing each morning, however there is not an afternoon or evening briefing for shift changes and on-coming shifts are expected to be passed relevant information from the previous shift. For internal communications staff use word of mouth and the Signal app. Some workforces cannot use this app on their work phones. By example, NZDF people connect using Signal on their personal phones.

CCTV and door alarms

The CCTV system is a network of 85 internal and external cameras. Camera coverage extends from each end of the accommodation corridors and recording is motion activated. There is a central control point for the CCTV system in the Operations Room which is manned 24 hours per day. In addition, stairwell doors are armed with 'Reed Switches'. The Reed system is a system that connects doors that are alarmed to the CCTV system so if a door is opened an alarm is activated making a beeping noise on the CCTV console and will also direct the relevant CCTV camera to the area of interest. The operator will acknowledge the alarm and when satisfied the alarm has been responded to appropriately, will process the alarm. The SSP states that *"If the operator cannot establish if the access is authorised, a physical check of the area must be carried out. The MIF Manager and Operations and Security Manager must be notified if there is a Security Breach and the absconder incident response process must be invoked"*

Responding to breaches

If an Operator believes a non-serious breach (e.g. procedural breaches, low risk bubble breaches) has occurred the following steps must be taken:

1. Send a Security staff member to further investigate if safe to do so
2. Resolve the breach if able. E.g. If a returnee has left a box of goodies outside their room, ensure the box has been removed, the returnee has been educated
3. Record the breach in the log book, detailing time, camera number and returnee
4. Report the breach to the MIF Manager and OSM (message after hours, call if serious breach)

If a breach is high risk or serious (e.g. bubble breach classed as close contact, attempted absconding), the MIF Manager and OSM must be notified immediately. In the case of a death, abscond, violent event the NZPOL staff member onsite must be immediately notified to respond.

Events of September 1st

On August 31st the MIQ Novotel security detail was increased in response to the increase of community cases. This resulted in an increase in the NZDF numbers from 3 to 6 with a further 2 guards provided by private security. The new staff that arrived did not receive an induction to the site. While induction is an OSM responsibility, the OSM had asked the outgoing shift to induct the new staff coming on board, but this is not a normal function at the end of a shift. The NZDF staff later noted that they were not aware that there were potentially higher risk people staying at the facility. The NZDF staff were not all trained on the CCTV system.

There was no assigned shift leader however, on the evening of the September 1st, the NZDF person who took responsibility for running the team had recently come over from another facility, although they had been on one previous shift at the MIQ Novotel. Reviewing the entries on the security logs indicates that the team did not appreciate the requirement for the additional staff, and decided between them that four of the six security tasks would not be tasked. CCTV monitoring was in place but two observation tasks, for the vehicle and pedestrian access gates, were combined to be completed from one position. Roving patrols were not in place. These issues did not contribute directly to Case X absconding.

There were a series of issues relating to the operation of the CCTV system. Although the CCTV system was on, an operator had not logged onto the system. There is a common login for all operators. Not having an operator logged in would have the practical effect of disabling the auditable alarm, and the camera does not activate on screen to the alarm site. Although in this instance, not being logged in was not a material issue. It was later found that the CCCTV audio cable was plugged into an incorrect computer port so the audible alarm would not have sounded in any case. This may have occurred during the period when the CCTV monitoring area was shifted to accommodate the new operations space as no alarms are logged as being 'processed' between 27 August and 2 September. CCTV motion detection was working correctly, that means that when movement is detected in the corridors the system starts recording. This feature is not impacted by an operator being logged in or not.

Around 4:25pm a female community case had left her room and made her way to reception. Acting aggressively, and after yelling at staff, she forcibly entered the space behind reception and opened a door into a staff only area encountering a member of staff (dressed in PPE). The person then returned to their room before being identified. To determine where the person had come from, a review of the CCTV was undertaken and the room number and occupant identified. Police attended the room and spoke with the person involved. During the CCTV review an unidentified person was noticed in the corridor. The MIF Manger immediately deployed a guard in full PPE equipment to monitor the corridor until things were settled down and the incident was resolved. These follow up activities were happening at the same time as Case X arrived at the facility.

At 11:40pm the CCTV operator observed a male, later identified as Case X, walking up and down the corridor. The NZDF debrief recorded that the operator logged this occurrence, but did not report the observation, as he didn't see the person walk down the stairs and assumed that they had returned to their room. Later during his rotation, hotel staff in the operations room asked the operator if he had observed any 'camera alarms.' He interpreted this to mean when the camera comes on due to motion. The operator claimed he had not seen an alarm. He then also assumed that the hotel staff were aware of the person in the hallway, as it had been discussed, therefore he felt it had been elevated sufficiently. Case X left his room again at 12:33am but this was not noticed by the operator. There was a change in operator from 12:40am.

Case X left his accommodation at 1:04am and made his way down the stairwell and outside to the family area and eventually climbed the perimeter fences. The movements were not observed by the operator who did not see any movements during his rotation.

Both operator rotations were for a period of one hour and twenty minutes while the SSP calls for 30 minutes. The extended time was a result of the team deciding the tasks and rotation length. Other staff observed that the security staff that were not tasked were resting, or at leisure on personal devices, in the same vicinity as the CCTV operations station. Subjectively, the rotation length and people in close proximity may have been a distraction to the CCTV operators, making it difficult to maintain concentration.

Key points

1. The CCTV was not operating as intended, a cable was plugged into the wrong port and an operator was not logged in. This nullified the alarm notification to the operator for a door breach which would've notified the operator of Case X entering the stairwell.
2. NZDF persons were not inducted to the site correctly.
3. The shift did not have a supervisor or shift leader and staff working made decisions outside of their remit regarding the guarding duties that would or would not be performed.
4. NZDF persons were not sufficiently trained on monitoring CCTV.
5. The task of monitoring CCTV was nearly four times the rotation length set out in the Site Security Plan (SSP), the plan was not being followed.
6. The escalation processes set out in the SSP and Operations framework relating to breaches and escalation were not followed
7. Security staff that were not tasked were resting or at leisure on personal devices in the same vicinity as the CCTV operations station.
8. The facility wasn't secured in line with the requirements of the site security plan with an exit door wedged open.

Recommendations

Update and improve site security plans and settings to address the following:

5. Ensure there is a shift supervisor for the security team.
6. A review of CCTV controls, establishing set standards for operation, e.g. day/night door alarm settings
7. Ensure all security staff receive a site induction and training at the start of each deployment including the after-hours requirements of the site security plan, and Local and Standard Operating Procedures.

Policies and Procedures

Prior to the MIQ Novotel being established as a quarantine facility for community cases, there was only one dedicated quarantine facility and a small number of facilities that provide dual isolation and quarantine accommodation and services. As previously noted, managing community cases was not the primary role of MIQ and additional capacity was required. While, there are operating procedures for operating a quarantine facility, there was no standard operating procedures (SOP) for converting from an isolation facility to a quarantine facility. The Infection Prevention and Control (IPC) requirements are covered in an IPC SOP. In the transition stage the local area procedures (LAPs) from the MIQ Jet Park were brought to the MIQ Novotel to be adapted. Given the time available this was an appropriate approach. At the time of the review the LAPs for MIQ Novotel were still in development. We note that the MIQ Novotel has a bespoke suite of LAPs, similar to other MIQ facilities. While not an impact on this incident, to maintain consistency in managing risk and a consistent control environment, where possible LAPs should be avoided unless absolutely necessary. SOPs should be preferred to maintain the control environment, provide a standard experience, and enable any staff redeployed between facilities to be able to understand the common requirements for each facility.

The MIQ Novotel has a comprehensive site security plan (SSP) although it is still in draft. While not a contributing factor to Case X absconding, we noted some parts of the plan such as the fencing specifications, are different to those at the facility, but we are advised that the standard for Auckland has been implemented. The SSP is a key control document for the operation of the facility, it clearly sets out the security footprint, processes, and tasking. However, it is clear that some processes are not widely understood or delivered on.

As previously noted, the procedure for admitting community cases is based on border returnees as MIQ was not established for managing community cases. Catering for community case referrals with differing risk, welfare and wellbeing profiles may take more time to complete. Staff estimate that an admission process including a welfare check at admission may take up to 30 minutes per person. To allow for a comprehensive welfare check to be completed consideration would need to be given to the admission resourcing available, given the additional time welfare checks would require.

Key points

1. Local area procedures (LAPs) relative for a quarantine facility were still being adapted for the MIQ Novotel. There is no standard operating procedure (SOP) given that previously there was only one dedicated quarantine facility.
2. The variation of local area procedures may weaken the control environment.
3. Site security plan is in draft and not widely understood and actioned.

Recommendations

1. Formalise a briefing process for the start of each shift.
2. Ensure staff on breaks are sufficiently away from operational areas so as not to cause a distraction.
3. Rationalise all existing LAPs where possible to SOPs to maintain consistency and strengthen the control environment.
4. Implement a clear repeatable process for establishing and maintaining LAPs with SOPs that integrates with the updated Operating Model.

5. Improvements implemented

Following the discovery of Case X, the Operations Team completed an incident review and immediately made improvements to the security footprint and systems. The CCTV improvements should be adapted as a standard for the site security plan and applied to other facilities.

Area of improvement	Summary
CCTV	Monitoring of CCTV screens (NZDF) rotation cadence reduced from 80-minute session to 30-minute session before rotation.
CCTV	Motion detection sensitivity increased in corridors.
CCTV/Alarms	All corridor motion detection and Fire doors alarm 8pm to 7am automatically as opposed to requiring a manual setting if they had been turned off in the preceding shifts.
CCTV/Alarms	Guest floor fire doors and exits alarmed 24 hours 7 days
CCTV	Overall alarming arming/disarming and processing of alerts simplified thus providing a simplified user experience and reduced technical level of competency necessary to operate the system
CCTV	Alarm system updated to allow more granular arming of individual floors and some individual doors for high use periods. Previous settings only allowed for entire section of facility to be armed or not. Automatic setting adjusted to alarm all doors from 8:30pm.
CCTV	Further training of operators by Optic and OSM in CCTV operation.
NZDF	NZDF appointed a senior shift lead of a different rank per shift.
Security	Static guard placed in 4 x stairwells (fire exits) 24 per day
Security	Overall increase from 31 security staff to 43 per day.
Perimeter	Perimeter fencing at point used by Case X to exit facility increased from 2 meters to 3 meters for a distance of 2 meters at the point where the security fence butts against the hotel wall. Thus not allowing the hotel wall to assist any further absconding attempts.
Health workforce	8 extra nursing staff, and 3 Health Care Assistants / Primary Care Assistants
Hotel Guests	Additional outside fresh air time and additional outside smoking time for Quarantine guests is being facilitated by the extra staff at site.
CCTV	Quote to increase corridor cameras to cover possible blind spots in corridors.
CCTV	A second monitoring station setup (2 screens cameras only) to monitor outdoor and smoking areas.

6. Appendices

Terms of Reference

MIQ Incident Review – Novotel Ellerslie September 2nd 2021

September 2021

Purpose and Overview
The Head of Managed Isolation and Quarantine (MIQ) Operations has commissioned this review to identify system vulnerabilities in relation to a managed isolation resident's unauthorised departure from a facility. The MIQ operational system involves a number of agencies, which all have individual accountabilities in the management of managed isolation facilities. MBIE has overall responsibility for delivery of the MIQ system as lead agency. Each agency works in harmony to provide a safe environment to for people that are required to stay in a Managed Isolation or Quarantine to protect COVID 19 spreading in the community. Therefore, the purpose of the rapid assessment is to provide focussed insight into the circumstance of a MIQ resident departing the facility without consent. The objective is to establish the circumstances, identify any process gaps and to provide observations to improve the MIQ environment and processes to ensure compliance with isolation orders.
Background
In the early hours of September 2nd 2021, a COVID -19 positive person left the Novotel Ellerslie Quarantine Facility in Auckland by climbing a security fence. The individual (23) arrived on the evening of September 1st, around 18:30. At approximately 11:00am September 2nd, staff at the facility were notified by the individual's brother that he had left the facility and had gone to his family home. New Zealand Police (Police) were immediately notified and responded. The individual was located at his family home and was returned to the Novotel Ellerslie after a court appearance.
Approach & Scope
It is expected that the review will have a limited number of recommendations to address the key scope points. The review will: • Review relevant policies and procedures; • Interview relevant personnel, and collect relevant information from each agency involved;

- Review evidentiary artefacts such as, but not limited to, logs, CCTV, records and reports;
- Confirm the chronology of events in relation to the arrival and departure of the individual – from the point of arrival in the quarantine facility to the point when they were returned on the evening of September 2nd;
- Understand whether the policies and procedures that are in place for the management of MIQ residents were followed;
- Understand whether there are any opportunities for improvement to the practices and policies in regards to MIQ residents to ensure continuous improvement; and
- Understand if there are any broader factors that contributed to this event.

Out of Scope

The following areas will be out of scope for this rapid assessment:

- activities of the MIQ resident outside of the facility
- Police response and investigation

Deliverables and Timing

The review to be undertaken will commence September 3rd and will be delivered in line with the following schedule:

- A draft report, which will be available for comment no later than 7 days from the date of commencement. The draft report is to be shared with relevant business owners to provide commentary and feedback (including that from key participating stakeholders and relevant agencies) before it is finalised.
- A final report, which will be issued to the Head of Managed Isolation and Quarantine Operations and the Deputy Chief Executive, Managed Isolation and Quarantine no later than two weeks after the draft report.
- The final report will present the findings from the review and the recommendations for MIQ to consider and implement moving forward.
- An appropriate communication plan will be put in place for any subsequent dissemination of the report and its findings.

MIQ Service Quality and Assurance will act as the point of the contact for the reviewers to assist with facilitating interviews and documentation reviews.

Contributors to review

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