ALL OF GOVERNMENT PRESS CONFERENCE: TUESDAY, 14 APRIL 2020

Dr Ashley Bloomfield: Tēnā koutou katoa. Welcome to today's briefing. Today I'm very, very sad to report four additional deaths linked to COVID-19 infection. One of those was in Wellington and three are additional deaths from the Rosewood cluster in Christchurch. This brings the total number of deaths in New Zealand to nine, six of which involve Rosewood residents being cared for at Burwood Hospital. So the deaths I'm updating you on today are of a man in his 90s at Burwood Hospital, a man in his 80s at Burwood, another man in his 90s at Burwood, and the fourth death was of a man in his 70s in Wellington Hospital, and that latter death was associated with overseas travel.

We've previously signalled the underlying vulnerabilities of the Rosewood residents and that this group would continue to be at risk. That does make today's news any less sad. This is the largest number of deaths we have reported on any day in New Zealand from COVID-19, and it is a sobering reminder of what is at stake here.

I do want to acknowledge the families associated with these people who have passed and offer my sympathy and those, I think, of all New Zealanders and our support. Whether husbands, partners, fathers, grandfathers, brothers, uncles, cousins or friends, wherever they fit in their wider whānau, we are thinking of them and of you. I do ask that the privacy of families and friends associated with these deaths continues to be respected. And what I can say is that of the folk who died in Rosewood yesterday, they all had underlying conditions to some degree and were all confirmed cases of COVID-19. The man in Wellington was admitted to hospital on 22 March and has been quite unwell in ICU for some time. The district health board and staff have been working very closely with the man and his family over the time and will continue, of course, to provide support to the family.

As I've said earlier on previous briefings, the Rosewood group was transferred from a high-level psychogeriatric or dementia unit. The care they have been receiving is very consistent with the high level of care they were receiving at Rosewood and would have been provided there, and that does include end of life and palliative care.

And just before I make some more general remarks about what we are doing and how we're working closely with the aged residential care sector, I just wanted to pass on some feedback we've had today from the family of a Rosewood resident at Burwood who could not speak highly enough of the nursing staff: "They're just amazing, doing an incredible job. The communication with us was superb. We had lots of calls, including Facetime calls with Dad. We are so grateful." And from another of the families: "We couldn't speak more highly of the staff and care dad received both at Burwood and Rosewood. I skyped with dad and the nurse caring for him arranged for him to see a video the family had put together, and there were lots of phone calls."

So we know that aged residential care settings and facilities are very vulnerable—the populations there are very vulnerable if we get COVID-19 infection in those facilities. And so we have been particularly vigilant from early on in the presentation of this infection globally to work closely with aged residential care and act very quickly and pre-emptively. And what I would say is that we've had cases to date, or have cases, in six aged residential care facilities around the country, and this is out of a total of over 650 facilities nationwide.

I mentioned yesterday and on the preceding day the excellent care and preparation that is in place across that sector, and the fact that we have had relatively few of our facilities affected by this virus, in quite stark contrast to many other countries, I think, is testament to the work they have been doing. And again, to emphasise, we've been working with them very closely from early on in this outbreak. We early on provided advice around ensuring nobody came to their facilities who had any respiratory symptoms at all. They put in place visitor policies—no-visiting policies—much sooner than we went into alert level 4.

So I'd just like to outline some of the other measures we're working with them on, just so people understand. Every new arrival into an aged residential care facility goes into isolation for 14 days. There are no shared meals happening in the facilities. As I said earlier on, and for some time, no visiting allowed at the moment. I've asked all our DHBs to work with each of the facilities in their region to ensure they have good policies, procedures; that they have access to PPE that they need and good supply lines; and to identify what other support those facilities may need to help ensure we keep that high level of care and of preventing COVID-19 getting into those facilities. There is a low threshold for testing of any residents who might be symptomatic; and, of any new arrivals, if they have any symptoms whatever, a precautionary approach is taken—they are tested and they are not allowed into the facility unless they have tested negative—and also a low threshold for testing staff. And, obviously, staff who are sick have to stay home, and there's very careful observation of any symptoms of staff.

In addition, we're doing a number of other things, and last night I was on a video conference with the head of the Aged Care Association—both the chair and the chief executive—to talk about what else we are doing and can be doing with them. There will be announcements later in the week about funding for aged residential care to help offset some of the additional costs they are incurring to both prepare and look after people who may have or who do have COVID-19, for extra security and so on. We continue to work with them on making sure we are maximising the value of testing of both residents, of incoming admissions, and of staff.

And I have also decided to commission a review of the rest home facilities—or the aged residential care facilities—where we have had cases, because in some of those instances the cases have been able to be bounded very quickly with no further transmission, and others we've seen just how tricky this virus is and that it can spread quite rapidly. So we think it's a very good point in time to undertake a review of both the facilities where we have had cases—to learn about what's worked well and where we could improve—but also to look at some facilities that might be similar where they haven't had cases. And my hope is to do this in conjunction with the Aged Care Association so we can use those things to inform both what the facilities are doing and also what ourselves as a ministry and the district health boards can continue to do to support them.

I'll just move on now to the cases for the day. I'm just finding the right piece of paper here. So today, the total number of COVID-19 cases increases by 17. This comprises eight new confirmed cases and nine new probable cases. There are now 628 cases of COVID-19 infection that we can confirm have recovered—an increase of 82 on yesterday's number—and our recovered clearly now firmly dominate the cases overall. The new total combined number of confirmed and probable cases, therefore, today is 1,366. Today, there are 15 people in hospital—no change from yesterday. That includes three people in ICU—one each in Middlemore, Dunedin, and North Shore hospitals. The person in Dunedin hospital remains in a critical condition. Forty-eight percent of cases involve contact with confirmed case in New Zealand, including those in our clusters, while 39 percent have a link with overseas travel. Those that can be prescribed to community transmission are still just at 2 percent.

Yesterday, 1,572 tests were processed which is, again, a low number. So the rolling seven day average is just over 3,000—3,039—and, in total, 64,399 tests have been undertaken. Just to comment on that, at this morning's select committee hearing—the CBD select committee—the committee heard from Professor Brendan Murphy, who's the chief medical officer in Australia. And, as part of his comments, he also commented on the quite big reduction in testing that has been happening in Australia over the last few days, and, like me, he ascribed this to the fact that because they've got quite physical distancing measures and people staying at home, there are just less respiratory viruses circulating in the community of all sorts.

So it's interesting to see that Australia is seeing a similar pattern to us and a big reduction, also, in testing there. So in saying that, I sent a message out to all our DHBs today, and we

now have 70 community-based assessment centres, and I've suggested that they have a low threshold for testing anyone with respiratory symptoms over this coming week so that we can be sure that anyone with respiratory symptoms is not due to COVID-19. Our expectation is that cases will continue to remain low, but we want to be doubly sure, of course, that we are finding any cases that could be out there. You may well also have seen the reports that a number of DHBs are now using mobile testing, as well, to get out to communities who may not have direct access to those CBACs.

So I think I'll just leave my opening comments there, and I'm happy to open it up to questions.

Media: Dr Bloomfield, there have been reports that patients at Burwood have been, effectively, left alone to die. Can you confirm that?

Dr Ashley Bloomfield: Well, that certainly doesn't match with comments I just shared from families of people who are being cared for; they're, I think, in stark contrast. So that's certainly not anything that's been reported to me.

Media: You talked about palliative of end-of-life care: they're basically just being kept in a comfortable position before they die, is that right?

Dr Ashley Bloomfield: So end-of-life and palliative care is a very important part of the care that is provided in aged residential care facilities. Just to put this in context: about a third of our deaths in each year, annually, in New Zealand happen in aged residential care facilities, and the staff in those facilities are very well-trained in end-of-life and palliative care, and the residents who have been moved there would have been receiving that sort of care in this situation at Rosewood, and they are receiving very good quality care in Burwood.

Media: Can you explain why the patients who have been moved to Burwood from Rosewood are so over-represented in the number of people who have died?

Dr Ashley Bloomfield: So two comments there. First of all, of course, the deaths that are occurring now are a result of infections that happened at least a week—mostly one, two, even three weeks ago. Secondly, it's simply because this is a population where people are older—as I have mentioned today: two people in their 90s, one in their 80s—they're already frail, they have very low reserves to be able to fight off these sorts of infections, so that's why we are seeing them highly represented in the fatalities.

Media: Were they chosen specifically to be moved to Burwood—was the most vulnerable group out of that group shifted?

Dr Ashley Bloomfield: It was because the infection was in the group that was in that psychogeriatric care unit that is part of a bigger facility. So there were no people—which is effectively closed off from the rest of the facility—and because of their high needs, and also because there were infections among staff members, it wasn't possible for them to keep staffing it and provide the level of care and support that was needed for those people who were probable or confirmed cases. So that was the reason for shifting that group to Burwood.

Media: Can I ask about that review, as well, that you talked about? Is that because you think that things might not have been done properly in some of these situations?

Dr Ashley Bloomfield: More specifically it's to look at—again, just put this in context, we've had a relatively small number of aged residential care facilities affected, and that's testament, I think, to the work that has gone on right across the sector to prevent infections getting in in the first place. I think it's just good practice, and now's a good time to do it, as we're informing what we need to be doing as we move out of alert level 4 down to alert level 3. And I think there will be things we can learn from what has happened, both in the facilities where there have been cases and also comparing those with some facilities where they haven't, just to help strengthen and improve our efforts.

Media: Do you, personally, think it's acceptable for hospital management to be telling nurses that they can't wear a mask at work?

Dr Ashley Bloomfield: Is there a specific example? If there's a specific example you can provide me, I'm happy to follow up on that.

Media: Yeah, we've heard of multiple examples of that happening. So is that acceptable to you?

Dr Ashley Bloomfield: Well, I think what is really clear is the advice that district health boards have got and the message that has gone out. And I know that our district health board managers are very aware of what that advice is. And I'm confident that they will be using that advice to inform their conversations with staff.

Media: A nurse at Burwood Hospital working on the COVID ward told us that she doesn't have access to foot protection or hair covers. Would you personally be comfortable to go on the COVID ward at Burwood Hospital without full PPE?

Dr Ashley Bloomfield: So I can't really talk about that specific example, but I'd be happy to look into that. The PPE that's generally required doesn't always include hair cover or foot covers, so I'd have to check as to what the situation was that that nurse was working in as to whether those were indicated. What I am confident is that the staff there will have access to the PPE they need depending on the role they play.

Media: But given that this is where a number of our most vulnerable patients are with COVID-19, shouldn't the full equipment be provided to those on the front line?

Dr Ashley Bloomfield: Yes, and I'd be confident it would be, and what I can't comment on is what the full equipment by be for that particular staff member in the role that he or she may be in at the time.

Media: More than a third of the new cases between Wednesday and Sunday were of healthcare workers. How concerned are you about that jump in numbers, and what does that suggest, if anything, about transmission within hospitals or other healthcare facilities?

Dr Ashley Bloomfield: Yes, thanks for that. Well, I'm concerned about any case in a healthcare worker, particularly where it happens in the workplace. And a couple of comments: one is we've got some information about the cases that are healthcare workers, and what I've asked the team for particular analysis of is, of the cases that have happened in the workplace, how was it that they were infected? So was that through being part of caring for someone or involved in the care of someone with COVID-19 or was it because they are part of a cluster where they may be a close contact of another staff member? I think that's the important thing. And then, by understanding that, we can get a better understanding of what else we may need to do to help ensure that our staff are protected in whatever setting.

Media: We've gone from the high 80s of new cases down to the high teens. Is it your perspective that New Zealand's past the peak of new cases?

Dr Ashley Bloomfield: I think it's clear that we are past the peak under this alert level. The key information we're looking for now is for each of those new cases, we want to know very quickly where have they come from? And if we can't immediately link them to an extant case or cluster, then we need to do a pretty forensic analysis and find out very quickly where they've come from and have a very quick and close look at all the possible contacts there and put a ring-fence around it. So yes, we've passed the peak; that seems to be clear now. We will be more confident once we know about each of those new cases that has been appearing really from the last week and as we go into this week, and, also, if we continue to get reasonable testing rates of people with any symptoms and we're still not finding additional cases, that will provide us with an even greater level of assurance.

Media: And looking forward, when did you think, based on modelling that you've seen, when we're going to get down to a level of maybe just nine or 10, or maybe one or two, three or four?

Dr Ashley Bloomfield: Well, as soon as possible, obviously, is what I would be looking for. And once we get down to that, not just the low number of cases, but are confident that through our testing we're not identifying further cases that seem to be popping up out of nowhere rather than being linked to existing cases. That's what we're really looking for.

Media: This morning at the select committee you spoke about testing in regions. Can you tell us more about that and when it started or has it started and where too?

Dr Ashley Bloomfield: Yes, so the lab testing analysis we published last week, I've asked the team to get another extract today so we can update that. As of last week it was about 49,000 tests that they had analysed. Actually, it showed quite good spread across the regions with some lower testing rates in some regions, particularly around Whanganui District Health Board and Tairāwhiti District Health Board. So we're looking to get the numbers of testing up there. And really, there's good access to CBACs, and I know that both DHBs have been making sure that testing is widely available. What I've said to them and to all the DHBs is just have a really low threshold: so anyone with respiratory symptoms, whether upper respiratory symptoms—which could just be a sore throat or a runny nose—test those people anyway. They don't necessary have to have lower respiratory tract symptoms—so a cough, or phlegm, or fever.

Media: The man who passed away in Wellington hospital, was he related to the Ruby Princess incident at all?

Dr Ashley Bloomfield: No, he wasn't.

Media: And the Ruby Princess cluster grew by two on Monday to 18. The two new cases are not in the Hawke's Bay, I understand. So are those new cases people who were passengers on the ship, or are they believed to have been infected by the ship's passengers or crew?

Dr Ashley Bloomfield: The information I have—this was from yesterday—was that it was actually, I think, a tour guide and a household contact of that tour guide, and it is from Wellington.

Media: Sir David Skegg says Cabinet could be playing Russian roulette with Kiwi lives when making a decision on the COVID-19 if we don't ensure rapid contact tracing and complete surveillance testing. How confident are you that we won't be in a risky, sort of, unclear position come Monday?

Dr Ashley Bloomfield: Well, we will make sure that we can provide really robust advice to Cabinet and that we are confident in the extent of and the pace of our contact tracing. We've got some analysis coming through about what the current speed is with which people who are contacts are identified and tested, and we've seen that time decline. I'm just waiting for the final information on that; and, likewise, I think Professor Sir David talked about the surveillance testing and making sure that we've been very deliberate about getting wide testing across a range of population groups, and that's why we're increasing the testing this week to complement the over 60,000 that we've already tested. So it's about 1.1 percent of New Zealanders have been tested already, and we're going to try and increase that further, just to get a really good picture.

Media: Can you confirm that the private function cluster in Auckland was a stag party?

Dr Ashley Bloomfield: That's my understanding.

Media: Can I ask about contact tracing. Way back in the day when we had a small number of cases, you were able to do this to 100 percent accuracy—all the people with

contacts. Do you have a rough figure for how many contacts are being traced now as we've got so many more cases?

Dr Ashley Bloomfield: That we've got so many more cases, did you say?

Media: Well, we've got, like, 1,400 cases, or something like that.

Dr Ashley Bloomfield: Right.

Media: I'm talking about when we had 50 cases—you were able to trace all the contacts with 100 percent accuracy. Do you have a rough figure, ballpark figure, on how many contacts you're able to trace now?

Dr Ashley Bloomfield: That we're able to trace now, so we're able to trace—well, we've got 220 staff available to trace, so we would have the capacity to trace between 50 and 100 new cases per day. I would say the capacity now is around 100. What I can say is that, of course, our number of cases per day is now much smaller, and also the number of close contacts is, on average, around four to five, rather than what was a much higher number before the alert level 4 restrictions came in. So far, that close contact centre has traced several thousand people, but that's over the two to three weeks since it was stood up.

Media: Just regarding the app—the idea that we're going to develop this app and it's going to do a lot of that contact tracing for you through Bluetooth—how many percent of people would need to take up that app, in your view, for that to be effective?

Dr Ashley Bloomfield: Yep, just to pick up the point about trace a lot of the people, actually, it will be very much supplementary. The fundamental way to identify and trace close contacts will still be the routine process we have, which will be better, because we'll have that electronic and be able to link it to NHI. The Bluetooth and other apps will be supplementary to that. Professor Murphy talked about this, because Australia is looking at this, and their view is they would need to have over 80 percent of people using that technology. Now, that doesn't mean, necessarily, they need to be using a single app, but they need to be using an app which can use that Bluetooth-type technology and exchange of information, so that when a case is identified, you can pull out the data from the person's phone to find out what other phones they may have been close to during the infectious period.

Media: Would the family of the man who died last night at Burwood want to know why they couldn't put on PPE gear and be with him in his final moments?

Dr Ashley Bloomfield: Yes, so I think this goes to the issue of the current approach under alert level 4, which is not to allow visitors to people in hospital. This is clearly a very distressing time for family members, and this is something I've asked my team to look at very specifically, is about the visiting policy for people who not just are dying, but others in hospital. And another example raised with me this morning in select committee, of course, is new mothers as well. So we are having another look at that and to see what are the things we could put in place to ensure that we could maintain the safety of both the person in hospital as well as the visitors and the staff there. So that's being actively looked at.

Media: The national distribution model is supposed to be rolled out today. Has that gone to plan, and can you give us a little bit more detail on how that will exactly work?

Dr Ashley Bloomfield: I can't give you a lot of detail, I'm sorry. What I can say is that there are two elements to that national distribution. There's the distribution from a single point out to the district health boards in the health sector. From there, they distribute on to the providers in their area. And then, separately, there's a single distribution network for non-healthcare essential worker organisations, and that is happening in parallel to ensure that essential workforces who need PPE for their work are able to get it and it's distributed out through that mechanism.

Media: Does that come into effect today as planned—is that now being rolled out?

Dr Ashley Bloomfield: That's my understanding, but I will check that, and we'll make sure we include that in our media release that goes out subsequently.

Media: Do you have any updates at all just on the chartered flights that were supposed to be bringing the stocks in? Do you have any numbers on how many flights are coming and what they've been bringing in?

Dr Ashley Bloomfield: Of PPE?

Media: Yeah, of PPE.

Dr Ashley Bloomfield: What I can say is that there was the order of the, I think, 40 million masks, and they have started to come in this week. So yes, they're on the way. We'll get some more detail about the exact flights and when they're arriving.

Media: Just a follow-up on the earlier question: if you changed the criteria around PPE for family members who have a loved one with COVID in a critical condition, do you recognise how devastating that will be for the families who weren't able to be there with their loved ones who have died to date?

Dr Ashley Bloomfield: Well, I think, regardless of whether the policy has changed, it clearly has a big impact on families, and I can absolutely understand that. That's one of the reasons why we want to look at it very specifically. The key priority here—

Media: But shouldn't that have been done much sooner, then?

Dr Ashley Bloomfield: We have all been doing things under alert level 4 that we felt were necessary to break the chain of transmission and stop, for the whole country, this sort of situation where we've seen in other countries that haven't acted quickly and gone quite hard, as we have, because you end up with a much bigger problem. It's not just access to loved ones; it's the fact that we end up with many, many more cases and many, many more deaths. I really—you know, I genuinely, for someone who has had both parents pass away, I absolutely understand how people must be feeling, and that is why we are looking specifically at that policy.

Media: Dr Bloomfield, you mentioned the Whangarei DHB and Tairāwhiti DHB as two DHBs with low testing. You said yesterday that the Tairāwhiti was one of the areas with low total cases of COVID-19. Is it possible that those low cases could actually be higher but it's not identified because of the low testing in that area?

Dr Ashley Bloomfield: It's possible. The testing numbers and rate are lower, and the positivity rate is lower, and I know that DHB is going to some lengths to go out and ensure that there is testing available to try and increase the number of tests. So that's exactly what we want to rule out. We want to be sure that we're not missing cases.

Media: And so with the Tairāwhiti DHB and the Whanganui, why would their testing be lower than other DHBs?

Dr Ashley Bloomfield: I think the main reason for this is they simply have a lower number of cases, and that is because most of—well, actually, all of our cases have been associated with either people coming in from overseas and/or spread from those people. So all of our cases—ultimately, the index case was an import from overseas, so I think it's just there has been less travel to those regions, particularly early on when we saw cases popping up in other places like in Auckland, like in Queenstown, or associated with events like the wedding in Bluff, where the link was to overseas travel as well. So I think that's the reason, but we want to be assured that there are not cases out there that we're missing, and that's why we're doing testing—

Media: For a number of days now, you've been saying that this event in Auckland couldn't be named because of privacy reasons. However, today you've outlined that it was a stag party. What changed to make you be able to tell us what exactly it was?

Dr Ashley Bloomfield: Well, that doesn't change what it was—it was a private event. I was specifically asked the question, and I replied because I knew the information.

Media: Can you name the latest rest home in Auckland that has a cluster?

Dr Ashley Bloomfield: Ah, no, I can't, and I don't have the name of that rest home. What I can say, though, is that that cluster includes—half the cases are involved in a rest home and half are in the community. And what's not clear is just yet quite the relationship between that, and whether it originated in the rest home or it just happens to involve a rest home. As soon as we think it's appropriate, we will name the rest home facility.

Media: Can you tell us the number of cases and the condition of patients at the rest home?

Dr Ashley Bloomfield: I don't have that information, sorry.

Media: Just a follow-up question, will you be providing rest homes with testing kits?

Dr Ashley Bloomfield: Not testing kits per se. As I said, we're having a very active discussion about appropriate use of testing, very low threshold for testing, and they wouldn't need to have the testing kits per se. They may do the swabbing there or they may need someone to come in and do the swabbing. The testing would be done at one of our laboratories, and low threshold for testing any symptomatic resident, low threshold for testing any admission who may have symptoms, and also staff who may have symptoms suggestive of COVID.

Media: Would it make sense to do widespread swabbing in rest homes?

Dr Ashley Bloomfield: It does if you've got an outbreak, but clearly the vast majority of our aged residential care facilities have not had COVID-19 cases, they've got excellent policies and procedures in place, and we'll keep working with them to make sure we keep that the situation.

Media: You worked for the World Health Organization previously. To what extent do you think its post-SARS guidance around border closures, specifically that they weren't effective in dealing with the spread of that virus, influence any nations sort of delaying border closures in response to COVID-19? And, with the benefit of hindsight, do you think it was a mistake for countries or the WHO to lean on that post-SARS advice?

Dr Ashley Bloomfield: That's quite a big question. What I will say is that early on in this outbreak, even before it was declared as a pandemic, the WHO was asking countries to be thoughtful about the role of border closures but still saying it's also up to you, and we saw many countries, in fact, implemented border closures. New Zealand was one of those, as was Australia and a number of other countries. What also became apparent—and one of the reasons our advice to the Government, and the Government moved quite quickly around the use of border restrictions and then closures, is because it became clear that this virus was quite different to the SARS virus in terms of its infectivity. And what we've seen, both here and overseas, is that it can spread so rapidly and it's quite tricky as a virus. So I think what is clear is that border closures have been a really important part of countries, including our own, being able to maintain a very strong "keep it out, stamp it out" approach. So I am sure WHO will continue to review its own advice on this and also inform its future advice around managing these sorts of situations globally.

Media: That patient that you mentioned in the North Shore in ICU, do you know the age of that person?

Dr Ashley Bloomfield: No, I don't have any more details on any of the people in ICU, I'm sorry.

Media: Can anything be done and should anything be done about the unused capacity that's opening up as the number of tests that's being done declines?

Dr Ashley Bloomfield: Well, what I can say is it's very good we've got the capacity we need, because testing will continue to be a really important part of our ability to stay confidently in lower levels of alert—so 3 or even 2—if we are able to test rapidly and identify early any cases of COVID-19. And so that would be, again, moving to having a low threshold for testing anyone who's got respiratory symptoms. We've now got capacity to do over 6,000 tests should they be needed.

Media: Are you not thinking—I suppose if we can do 6,000 and we're doing 1,000, are you not thinking about every day putting that 5,000 window to use somewhere or opening up appropriately?

Dr Ashley Bloomfield: Not for testing asymptomatic people. So what we now have is a situation where we've got capacity to test pretty much anyone who has got symptoms of a respiratory illness, so a low threshold for testing, and that is the most important—and also to have capacity to do quite wide testing where we get cases where we're not sure what's going on, and particularly in settings like a healthcare setting.

Media: Would you encourage people with very minor symptoms then to go and get tested?

Dr Ashley Bloomfield: Well, if anyone's got symptoms that they think may be suggestive, then there's always a clinical assessment, but I think a low threshold—I think the clinician will always apply some judgment in these situations if it's very, very clear there's actually no risk of COVID-19 and the symptoms are not in the slightest bit suggestive, but at the moment we'd rather over test than under test, quite clearly.

Media: [*Inaudible*] why the two people who died at Burwood weren't sent to ICU in Christchurch?

Dr Ashley Bloomfield: Weren't sent to ICU? Because they and their families—in discussions with clinicians, and, in fact, probably with the facility they were already in—would have already made a decision about whether they wanted active intervention, including ICU - type care, if they got into this situation. And, as I say, a third of people every year in New Zealand die in aged residential care facilities and the care they receive is appropriate for where they are and the decisions they've made about what sort of care they would like to receive.

Media: Does the frailty of the residents at Burwood Hospital—or the rest home residents who were taken there—does that really limit, sort of, the medical interventions that can be made in terms of coronavirus?

Dr Ashley Bloomfield: Those people would receive all the medical interventions and care that was appropriate for them—to both relieve symptoms and, if appropriate, to treat their illness. However, they will have already had an agreement in place. And I should say also just a reminder that the medical care for those residents, while they are being looked after at Burwood, is still being overseen by the general practitioner who would look after them if they were still at Rosewood.

Media: Just a follow up from Craig's question, with the lower threshold in testing: what's your message to the public? Is it if you have a runny nose or a tickly throat, you should go and get tested?

Dr Ashley Bloomfield: Well, the advice to the public is, if you have any symptoms you're concerned about, ring Healthline, ring your GP, or you can go to the CBAC, and the locations of those are made available. That doesn't mean you will automatically be tested, but, as I said, the message out to those running the CBACs is have a low threshold for testing for anyone with upper respiratory tract symptoms or lower respiratory tract symptoms.

Media: Do you know, roughly, how many people were at that stag do?

Dr Ashley Bloomfield: I don't, sorry.

Media: Do you know how many Air New Zealand staff have tested positive for COVID-19?

Dr Ashley Bloomfield: No. I don't have that number. Would you like us to get that number?

Media: That'd be great, thank you. Do you have wider concerns around airline staff as potential vectors?

Dr Ashley Bloomfield: I don't have concerns; what I have asked my team to look at is specifically, now we have the very strong border restrictions in place for every person who travels in other than airline staff to going into 14 days quarantine, effectively, to make sure that our position around our airline staff—what precautions they have to take—are still appropriate. And, having looked at the advice for airline staff, which is very thorough, I think precautions are appropriate to reduce the risk of them being infected and/or introducing infection into the country. Perhaps the last couple of questions.

Media: You spoke this morning about ethnicity testing. Can you tell us a bit more about that and a bit about how sentinel testing—planning for that—is going?

Dr Ashley Bloomfield: OK, on ethnicity, what we've seen from the testing to date is there's quite good coverage across the different ethnic groups. It's not exactly in proportion to the population, but it's quite close. We will be looking, over this next week, for good spread of testing by both region and by ethnicity to make sure that we are not undertesting in certain populations.

And the issue of sentinel testing is an interesting one, and I'm intending to follow up with Professor Murphy from Australia about what approach they are planning to take to sentinel testing. And, at the moment, the wide testing we are doing—and especially if we, essentially, are testing most people who have respiratory symptoms, you could argue is, in a way, almost population sentinel testing. The question is still about whether there is a need to test people without symptoms, and none of the advice we've received from all of the experts is that we should be doing that at this point. So it's really having that low threshold for testing anybody with even low-level symptoms.

Media: Are you totally ruling out, in the future, testing asymptomatic people?

Dr Ashley Bloomfield: Not at all. No. That may well play a place in the future, and it may be in two ways. It could be with the diagnostic testing, but, in particular, once we get antibody testing, that could play a role then in looking to test people who we think—or to see what level of past infection there has been in the population or to find out whether someone has been infected and therefore is over an infection.

Media: You say that you have no concerns about airline staff. Have you seen that report that an airline staffer might be the index case in the Bluff cluster? And, if that's the case, shouldn't that person have simply stayed at home if she had symptoms?

Dr Ashley Bloomfield: Yeah. I don't think I said I have no concerns about airline staff. I think what we need to do is make sure that airline staff—the measures that they are taking are protecting both them and ensuring we're not introducing cases into the country. That's going to be very important. In the case of the Bluff cluster, what I can say is I know that the infection there originated from overseas, but I don't have enough information to say whether it was one or another person or what the occupation of the person was.

Media: Do you have any comment on—this morning, Australia says that they are able to contact trace cases within two to three days? Do you have an idea of when New Zealand will be at that capacity, and do we need to be at that capacity before lockdown is ended?

Dr Ashley Bloomfield: Yes. We're at that capacity now. We're at that capacity with the current number of cases, or even more. What we want to make sure is that we have that capacity to do that even if we have a much larger number of cases, and that's why we've trained extra people and also why we're looking at the digital solutions as well.

Look, thank you very much. I appreciate your ongoing interest and support.

conclusion of press conference