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COVID-19 Transmission in the Peppers Waymouth Hotel, Adelaide, November 2020

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INTRODUCTION

Background

Coronavirus disease 2019 (COVID-19) is caused by the novel coronavirus acute respiratory syndrome coronavirus 2 (SARS-CoV-2). Most cases have only mild symptoms, whereas others may experience severe illness requiring urgent and intense medical care and support. Symptoms of COVID-19 include fever or chills, cough, sore throat, runny nose, shortness of breath, diarrhoea and vomiting, and loss of taste or smell. SARS CoV-2 is typically spread through close contact with an infectious case via droplets or through touching surfaces that have been contaminated with droplets or secretions from an infected person. Transmission via aerosols may also be possible during aerosol-generating procedures and certain behaviours but is not considered the primary mode of transmission.

Setting

As part of the Commonwealth Government's national strategy to contain COVID-19, the Australian borders were closed to all non-citizens and non-residents from 20 March 2020, with Australians who were still overseas urged to return. Subsequently, dedicated quarantine facilities were established to facilitate a mandatory 14-day quarantine of returned international travellers. In South Australia, hotels were used in a medi-hotel model. Initially this involved one hotel, but was subsequently expanded to include the Peppers Hotel. The Peppers Hotel was constructed in 2001-2002 and is an establishment with 18 floors, with 12 rooms on each floor, six of these with balconies.

In November 2020, an outbreak of COVID-19 resulting in 33 associated cases occurred in Adelaide. The outbreak is also known as the Parafield Outbreak, and as subsequently shown by genomic analysis of case swabs started with transmission at the Peppers Hotel. Five clusters occurred as part of this outbreak, including the original cluster related to the Peppers Hotel. This hotel cluster consisted of 10 cases; three staff at the hotel, five family members of one of the staff and two returned travellers in quarantine at Peppers. Five cases will be discussed in this report; the three staff at Peppers Hotel and the two returned travellers.

Staff who worked at the hotel comprised of:

- > Australian Defence Force personnel
- > South Australian Police officers
- > Private security guards
- > Nursing staff
- > Hotel staff including cleaning staff.

Trigger

Since August 2020, South Australia had not recorded a COVID-19 case acquired in the community. Prior to November, cases had been notified in returned international or interstate travellers who were placed into mandatory 14-day quarantine within medi-hotels (or home quarantine for interstate travellers) upon their arrival into South Australia.

On the 15 November 2020, a confirmed COVID-19 case who was diagnosed in the community was notified to the CDCB. This initial case was a close contact of a cleaner at the Peppers Hotel who subsequently tested positive for COVID-19. Following this, all staff who worked at Peppers Hotel from 31 October 2020 were initially directed to undergo testing for COVID-19 and placed into 14-day

quarantine (from last exposure to the hotel) either at home or in a medi-hotel. This testing returned two positive results, identified as security guards from Peppers medi-hotel.

On 17 November, whole genome sequencing linked the cases to a returned traveller from the United Kingdom (UK) who arrived on 2 November. Therefore, quarantining of all staff at Peppers medi-hotel was changed to only include staff who worked from 2 November.

On 22 and 23 November, two international arrivals who had returned from overseas on the 11 November tested positive for COVID-19 during their quarantine at Peppers medi-hotel. One returned traveller was tested on 21 November after becoming symptomatic on the same day. The test was confirmed as positive on 22 November. The partner was then tested as a close contact on 22 November and returned a positive result on 23 November. Both had received an initial negative test upon arrival on 12 November. Serology for the couple was negative on 25 November.

By 24 November, all above cases were linked by whole genome sequencing to a returned traveller (the primary case), from the UK who had been in quarantine at Peppers Hotel since 2 November and was notified as a confirmed case on 4 November. While a small number of returned travellers from the UK have distantly related strains, no previous case in South Australia shared the same sequence with these six cases.

As the common sequence suggested potential transmission within Peppers, an urgent risk assessment was conducted, and a Peppers Hotel Outbreak Investigation Taskforce was initiated.

No further cases associated with the Peppers cluster were notified and the cluster was closed on 5 December. The overall community outbreak was closed 28 days after isolation of the last outbreak associated case on 23:59 on 23 December.

Objective

The objective of this investigation is to identify potential sources of transmission within the Peppers medi-hotel. This report will describe the epidemiological and laboratory investigation of the outbreak that occurred and provide recommendations to reduce the risk of transmission of SARS-CoV-2 within South Australian medi-hotels.

INVESTIGATION

Case definitions

The operational case definitions for this outbreak were:

Confirmed case: Any laboratory confirmed case (according the Series of National Guidelines (SoNG) definition) of COVID-19 notified to the South Australian Communicable Disease Control Branch since 14 November 2020 in a person who has resided, worked at or visited the Pepper's medi-hotel, or in a person who is epidemiologically linked to an infected person who has resided, worked at or visited the Peppers medi-hotel.

Suspected case: Any case of illness notified to the South Australian Communicable Disease Control Branch since 14 November 2020, with symptomology compatible with COVID-19, in a person who has resided, worked at or visited the Peppers medi-hotel, or in a person who is epidemiologically linked to an infected person who has resided, worked at or visited the Peppers medi-hotel, who has not had COVID-19 confirmed by laboratory testing.

Investigation and results

This outbreak was investigated using several methods. Laboratory testing, including whole genome sequencing, assisted with initial diagnosis and linking of cases. Further investigation into these links was facilitated by case interviewing, review of staffing rosters and Closed-Circuit Television (CCTV) footage, and examination of the ventilation and air-conditioning system and hydraulics at Peppers Hotel.

Whole Genome Sequencing

Whole genome sequencing by SA Pathology was used to establish possible links between cases based on similarity of individual case viral sequences.

All outbreak cases with adequate viral loads to obtain a sequence (31/33 cases) underwent whole genome sequencing. All sequences matched the infection of the primary case (not included in outbreak numbers).

While the outbreak clade belongs to a SARS-CoV-2 lineage that has been reported in the UK and several other areas internationally including the Middle East, this clade has not previously been detected in SA.

Both the primary case and the couple transited through Doha airport; therefore, it is possible that the three returned travellers may have acquired their infection overseas prior to arriving in SA. However, the degree of genetic similarity required a public health response and investigation into possible transmission within Peppers medi-hotel.

Case interviews

All cases of COVID-19 in South Australia undergo a standardised interview by contact tracers to identify their symptoms, medical risk factors, contacts, and a very detailed social history of their 14 days incubation period to identify their exposure, and detailed prospective history since their onset to identify contacts who have likely been exposed.

Interviewing and classification of contacts is undertaken in accordance with the CDNA SoNG for the Management of COVID-19 for Public Health Units.

All close contacts are directed to isolate for 14 days since their exposure to a confirmed case. CDCB conducts daily symptom checking with all close contacts to rapidly identify and request testing for potential cases.

All cases were interviewed several times by staff at CDCB and South Australian Police. Details were verified using phone geolocation data, staff rosters, CCTV footage and confirmation of CCTV footage stills with cases.

Contact Tracing summary

Contact tracing for the Peppers cluster included staff who worked at Peppers medi-hotel and returned travellers quarantined within Peppers medi-hotel.

- > 321 staff worked at Peppers medi-hotel since 2 November (date of arrival for the primary case). All staff were directed to quarantine and to present for testing as soon as possible and on the 12th day since their last date of exposure. These included:
 - 53 Hotel staff
 - 18 Australian Defence Force personnel
 - 46 Nursing staff

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- 89 South Australian Police officers
- 115 Private security guards

Of the 321 staff above, 258 staff who worked at Peppers medi-hotel since 11 November were additionally directed to present for a COVID-19 test between 23-25 November. This included:

- > 13 security guards who worked near confirmed COVID-19 cases or other security guards who may have been infected; all of whom returned negative tests.
- > 245 other staff who worked at the Hotel, all of whom returned negative tests.
- > Complete testing rates among this cohort suggest further undetected infection is unlikely.

Linkage between the couple from overseas and the outbreak using whole genome sequencing prompted a third round of testing of all staff and returned passengers who had been at the medi-hotel since 11 November 2020 to assess if further transmission had occurred. This testing was conducted on all relevant staff in quarantine between 23 and 25 November and returned no positive results.

CCTV footage and rosters

CCTV footage from outside the primary case's room was reviewed by multiple staff at CDCB, including the Infection Control Service, with the aim to identify issues with infection control practice and a plausible route of transmission from the primary case to either security guard or the cleaner. Staff rosters were used to target days and times of the footage.

CCTV footage was also used outside the room of the two cases who were in quarantine from overseas, again with the aim of identifying breaches in infection control practice and a plausible route of transmission from the staff to the couple. Again, rosters were used to target specific days and times.

The Infection Control Service at CDCB reviewed the CCTV footage.

Importantly, there was no observed significant breach in personal protective equipment (PPE), and no direct contact between guests and medi-hotel staff. However, on multiple occasions the primary case opens the room door without wearing a mask, including while Security guard 1 is stationed outside the door and when the cleaner is in the corridor, and the primary case touches the door/handle regularly without cleaning in between. A small amount of airflow from the room of the primary case out into the corridor, primarily under the door, due to inadequate air exhaust from the room (rectified at the time of review) and a lack of door seals was also noted (see Ventilation below). This may have created heavier contamination of the environment immediately adjacent to the room (e.g. when door is opened), increasing the risk of transmission.

Different infection control practices were also noted to be put in place once a guest is identified as having COVID-19 (i.e. red-dot system), which creates the potential for more relaxed practices prior to a guest testing positive. CCTV footage of the common areas and tea rooms for staff to determine the interaction between all three cases was not available.

Ventilation

An investigation into the ventilation and air-conditioning at the Peppers Hotel was undertaken by a desktop review and a site visit. The site visit included:

- > Confirmation of installation matching to the design documents
- > Smoke test on sample rooms to confirm airflow and to identify potential leakage pathways
- > Assessment of any potential for contamination between hotel levels

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- > Verification of the nature of supply and extract plant, and
- > Assessment of potential and absolute limitations to adjust existing mechanical system for improvement of system safety

The air in each guest bedroom suite is changed over via the toilet exhausts extracting air from the bedroom suite, which is replenished via the fresh air supplied via the corridor plenum with 1.5-2 air exchanges per hour estimated. This is equivalent to the minimum requirements for standard hospital inpatient bedrooms.

Smoke testing indicated that the airflows between the bedroom suites and the corridors was variable and directly linked to bedroom fan coil unit's fan speed. When the bedroom fan speed was set to high or medium, air generally flowed into the corridor under the bedroom suite entrance door. With the fan speed set to low, the air generally flowed from the corridor into the bedroom.

During an inspection of room XXX, smoke testing indicated the toilet exhaust had reduced flow of air into the exhaust system, and a small volume of air flowing under the entry doorway into the corridor even with the bedroom's fan coil unit turned off.

Room XXX occupied by the couple who became secondary cases was also inspected. The air conditioning, airflows and room sealing appeared to be consistent with all other bedrooms – i.e. there were no identified deficiencies. Smoke testing validated that the airflow into the toilet exhaust was reasonable and airflows under the entry doorways was consistent with other bedrooms; with the dedicated bedroom fan coil unit speeds set to medium and high the flow of air was generally into the corridor from the bedroom, with the fan coil unit turned off or with the fan speed set on low the flow of air was generally into bedroom from the corridor.

There is no possibility of transmission between the primary case in room XXX and room XXX via the air conditioning system.

Hydraulics

Discussion with architects and technicians regarding the plumbing of the Peppers Hotel occurred to determine if there could be transmission between rooms via plumbing. Service penetrations at Peppers Hotel were smoke tested, this included service penetrations associated with shower heads, toilets and other hydraulic fixtures.

Smoke testing of service penetrations associated with shower heads, toilets and other hydraulic fixtures, indicated that these penetrations were well sealed and presented very limited risk of leakage pathways.

Air movement within the sewer system is controlled by gully traps (P-Trap or Bottle Trap) and this is a requirement of plumbing codes. These traps introduce a water barrier at each waste connection which prevents the movement of air within the pipework. The operation of the trap as intended (and that the water barrier has not dried out through lack of use) could be validated by a lack of unpleasant sewer odours in the room.

The risk of airborne transmission through the sewer system or via associated hydraulic penetrations are non-existent.

Figure 2: Timeline of events at Peppers Hotel, November 2020 (note, does not include 5 cases in household contacts of security guard 2)



DISCUSSION

In Australia where COVID-19 has been largely eliminated, transmission of SARS-CoV-2 from quarantining returned travellers to quarantine facility staff remains the highest risk of re-introduction into the community. Transmission from medi-hotels has been reported in Victoria, New South Wales, Western Australia and New Zealand previously. From October 1 to 15 November, an estimated 2,667 international returned travellers were quarantined in a medi-hotel in South Australia. Of this group, 58 travellers (2.2%) tested positive for SARS-CoV-2 during their quarantine period, including 7 assessed as historical infection presenting no risk. The fact that more transmissions from medi-hotels has not occurred despite the high number of infectious returned travellers suggests that South Australia has a robust medi-hotel system and a high standard of infection control practices. Thorough investigation of this outbreak has not identified a clear mode of transmission from the primary case to the staff, and then from the staff to the couple returned from overseas. It appears more likely that a series of lower-risk events and factors, in combination, has created the potential for transmission of SARS-CoV-2 within Peppers medi-hotel.

Of note, the interaction between the primary case, security guard 1 and the cleaner does not meet the definition of close contact according to the Communicable Disease Network of Australia (CDNA) Series of National Guidelines (SoNG). Neither does the interaction between security guard 1 and the couple returned from overseas. This was also true for other cases in the Parafield Outbreak, not directly related to the Peppers medi-hotel cluster, indicating that other factors aside from duration of contact with an infectious case may have been important in this outbreak for example.....transmissibility of virus and transmission through surface contact and consideration of airborne spread.

Since February, the World Health Organisation (WHO) recognised droplets and fomites from a person infected with SARS-CoV-2 as the predominant modes of human-to-human transmission, noting that “airborne spread has not been reported...” and “is not believed to be a major driver of transmission based on available evidence” (1). As further evidence emerged and following medical experts’ appeal, WHO has recognised airborne transmission as one of the possible modes of transmission (2). When aerosolised, SARS-CoV-2 has been evaluated to remain viable for at least 3 hours and potentially propagated through long distances (3-6). Importantly, the distinction of droplets and aerosols have been disputed; and an underestimation of airborne transmission also highlighted (7, 8). As the exhaust fan in the primary case’s room was not functioning adequately, this may have led to airflow from the bedroom suite to the corridor, rather than the designed airflow from the corridor into the bedroom suite. This could potentially explain the transmission to both security guard 1 stationed close to the door and the cleaner when walking past the room of the primary case, just after the door had been opened. Supportive computational studies and COVID-19 outbreaks attributing propagation of infected droplets to air flow had also been reported (10-14). This supports the recommendation to monitor, fix and maintain the efficacy of the exhaust fans.

Further, when the primary case opened the door from the bedroom suite into the corridor he was not wearing a mask. A study on masks and face coverings found substantial reduction in outward emission of particles when surgical masks or particulate filter respirators (e.g. P2 or N95 masks) were used, and to a lesser extent when cloth and paper masks were used (15). This supports the recommendation for guests to wear masks when opening bedroom suite doors, a recommendation that was in the medi-hotel policy at the time of the outbreak. While it reduces outward emission of particles, it is inconclusive whether mask wearing prevents infection of COVID-19 (16-18).

Security guard 1 stationed in proximity to the case's room during the case's infectious period was wearing a mask at all times. However, it is plausible that when rubbing his eyes/touching his face without performing hand hygiene prior, self-inoculation occurred (19).

Investigation into the activities of staff at Peppers medi-hotel did not show any significant contact between the cleaner and the security guards. All staff have access to a communal staff kitchen, but each staffing group spent meal times in separate break room areas. This suggests that both the cleaner and security guard 1 may have been infected separately by the primary case. Security guard 1 worked several shifts with security guard 2, who returned a positive result on 15 November. Whilst they were stationed on separate floors, interaction in the security guard break room area, or staff kitchen may have led to transmission. The security guards do not associate outside of work.

For transmission from the staff to the returned travellers from overseas, the only contact with an infectious case was on 13 November when the security guard sat outside their room. The couple opened the door multiple times without wearing masks and regularly touched the door and door handles while holding the door open to collect food or other deliveries. As the air flow in the hotel generally flows from the corridor into the room, there may have been transmission via contamination of the room door, or into the room itself. However, security guard 1 was observed on CCTV to be wearing a mask (while in view), which would have significantly reduced the potential for this to occur. The other possibility is that the couple acquired their infection prior to arriving at Peppers medi-hotel (e.g. overseas on in transit to South Australia). The high degree of genomic sequence similarity with other cases in the Peppers cluster makes this hypothesis less likely. No other plausible alternative hypothesis could be established.

RECOMMENDATIONS

1. All guests in a medi-hotel must be treated as potentially COVID-19 positive
 - > Increased PPE requirements, with eye protection to be worn in addition to surgical masks by any staff member entering the corridors (i.e. orange zone) regardless of distance from a case, distance from a door or any level of contact anticipated with guest.
 - > Review and clarification of zone signage and PPE requirements for each zone.
 - > Enhance enforcement that all guests must wear a mask when opening their room door, and improve guest signage.
2. Re-enforce PPE protocols and infection control practices for staff
 - > All staff must again be made aware not to touch their face, nose, eyes and mouth and the importance of hand hygiene to reduce risk of self-contamination.
 - > Hotel housekeeping (cleaning) staff must be made aware and be trained in the use of PPE.
 - > Staff maintain >1.5m distance when interacting with guests and other staff, with assistance of floor markings.
3. Improve infection control practices for housekeeping
 - > Increase regular cleaning of outside guest door surface/handles and other high-touch points (e.g. lift buttons).
 - > Improve use of 'clean' trolleys and trays when delivering/collecting food and rubbish, reduce potential for mixing 'dirty' and 'clean' items on the cleaning trolleys (for room clean prior to guests entering).

4. Reduce interaction between staff and guests
 - > Greater usage of actively monitored CCTV, door alarms and roving security on all guest floors and other critical areas, rather than have staff stationed on quarantine floors.
5. Air flow
 - > Action recommendations from Medi-Hotels Ventilation and Air-Conditioning Investigation (SA Health Infrastructure) to improve air flow from corridor into the room, including ensuring all guest rooms have adequate door seals and ensure building exhaust fans are set to high.
 - > Recommend not using blow heaters and fans.
 - > Continued regular maintenance of hotel HVAC systems.
6. Transfer of all COVID-19 cases to dedicated medi-hotel facility
7. Commence testing of all medi-hotel staff

CONCLUSION

No single event or significant breach in infection control practices appears to be clearly responsible for the transmission of SARS-CoV-2 from the primary case to medi-hotel staff or the other guests (couple from overseas). Rather a combination of events and factors, including minor breaches in infection control practices and airflow, are considered most likely to have created an environment where the potential for transmission could occur. A number of recommendations have been made to address these factors and reduce the risk of transmission occurring again within a medi-hotel. While the overall risk remains low, transmission within a medi-hotel remains one of the highest risks for re-introduction into the South Australian community, and requires ongoing vigilance and system quality assurance.

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