COVID-19
Hotel Quarantine Inquiry

COVID-19 Hotel Quarantine Inquiry Final Report and Recommendations

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COVID-19 HOTEL QUARANTINE INQUIRY

Final Report and Recommendations

Volume I

The Hon. Jennifer Coate AO
Board of Inquiry

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COVID-19
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21 December 2020

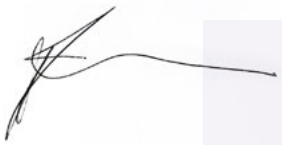
Her Excellency the Honourable Linda Dessau AC
Governor of Victoria
Government House
Melbourne VIC 3004

Your Excellency

In accordance with the Terms of Reference contained in the Order in Council made on 2 July 2020, and amended by the Order in Council of 29 October 2020, I present Volume I and Volume II of the Board of Inquiry into the COVID-19 Hotel Quarantine Program's (Inquiry) Final Report.

This Final Report contains an examination, findings and recommendations in respect of the decisions and actions taken in establishing and operating the Hotel Quarantine Program, based on evidence and information provided to the Inquiry. This Final Report is to be read in conjunction with the Interim Report presented to you on 6 November 2020.

Yours sincerely



The Honourable Jennifer Coate AO
Chairperson
Board of Inquiry into the COVID-19 Hotel Quarantine Program

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Preface

Throughout 2020, the COVID-19 pandemic has wreaked havoc, inflicting widespread catastrophic loss of life in its wake. It has been a challenging and distressing year all over the world. Some countries have been hit harder than others for a range of reasons that will be important to understand in time to come.

Our own nation has much to learn, as well as much for which it can be grateful, as this dangerous and highly infectious virus continues to overshadow our lives.

As noted in the Interim Report, the movement of the virus through Victoria placed our state in sadly unique circumstances in contrast to the rest of the nation.

By May 2020, active cases in the Victorian community had fallen to 57 from a peak of 541 as of 28 March 2020. But, in the wake of breaches of containment in the Hotel Quarantine Program operating in Victoria at the time, a second wave descended upon us with devastating consequences. Hundreds of lives were lost bringing suffering, sadness and grief to so many. Due to scientific evidence inextricably linking this second wave in Victoria to the transmission of infections stemming from returned travellers detained in the Hotel Quarantine Program, this Inquiry was established by an Order in Council dated 2 July 2020.

From the outset, it was clear to me that this Inquiry must be conducted in full public view. An Inquiry team of lawyers and necessary support staff was established and quickly commenced targeting and compiling material from a range of government departments, government agencies and private entities. An Inquiry office was established and a hearing venue was sourced. An opening statement was made by Senior Counsel Assisting the Inquiry on 20 July 2020, foreshadowing public hearings that were due to commence on 6 August 2020 in hearing rooms and facilities arranged at the Fair Work Commission in Melbourne.

On 2 August 2020, a State of Disaster in Victoria was declared and, shortly thereafter, stage 4 coronavirus lockdown restrictions were introduced in Melbourne, affecting our ability to conduct the hearings in a public venue. Determined to ensure we could continue our work and do so in public, considerable effort went into reorganising and operating the Inquiry remotely. To enable this to be done, the first public hearings were shifted to 17 August 2020.

I acknowledge and thank members of the public who contacted the Inquiry team and provided information, and I acknowledge and thank media organisations for their interest in, and comprehensive reporting of, the Inquiry's work, particularly as the public hearings were underway.

I thank all witnesses who appeared before the Inquiry, acknowledging that it is a considerable strain to do so.

I recognise that the Inquiry caused significant strain on the Victorian Public Service as it was leading Victoria's response to the COVID-19 pandemic while cooperating with the Inquiry. The Inquiry found no evidence of public servants acting in bad faith in regard to the Hotel Quarantine Program and I acknowledge and appreciate the work they have done to support Victoria and Victorians. There was considerable evidence of long hours and dedication to public service demonstrated by many public servants engaged to perform roles in response to COVID-19.

I also wish to acknowledge the many hundreds of people working on-site in hotel quarantine facilities, who put themselves in harm's way to perform their work, and the thousands of people who went through the Hotel Quarantine Program, an experience reported to be quite difficult for some.

In the early weeks of the Inquiry, the impact of the increased restrictions, the need to set up remote systems to receive and examine the thousands of documents that were being provided to the Inquiry, and the work involved in the set up and conduct of live streaming remotely, made it clear that it would not be possible to meet the original reporting date of 25 September 2020. I sought, and received, an extension from the Governor to deliver the Inquiry's final report by 6 November 2020. The Inquiry

was required to conduct a significant amount of work in a very short time frame. To do so, the original estimates of staffing and support for the Inquiry expanded considerably as the scale of the task and its complications became apparent.

As noted in the Foreword to the Interim Report, following the conclusion of its public hearings, the Inquiry began work to consolidate the information and evidence received in preparation for delivery of the Final Report by 6 November 2020.

After the public hearings were completed, final submissions by Counsel Assisting were made on 28 September 2020. Written submissions in reply were received by 13 parties with Leave to Appear on 5 October 2020. In the wake of the submissions in reply, the Inquiry was put on notice that there was additional material, of potential significance to the Inquiry, that had not been produced to it.

This caused a request for a further extension to the report date to 21 December 2020 so that this material could be gathered and considered.

Notwithstanding this disruption, to assist in the timely re-opening of international points of entry to Victoria, the Interim Report was prepared and delivered to the Governor on 6 November 2020.

In presenting this Final Report I acknowledge the contribution of every staff member who worked on this Inquiry. I particularly thank and acknowledge the outstanding work of Counsel Assisting the Inquiry: Mr Tony Neal QC, Mr Ben Ihle and Ms Rachel Ellyard, Ms Jess Moir and Mr Steven Brnovic. The Counsel Assisting team was supported by a hardworking and tireless legal team ably led by Mr Will Yates, who was seconded to the Inquiry from the Victorian Government Solicitor's Office.

I acknowledge the excellent work undertaken by the Intake and Assessment team, led by Ruth Baker, who endeavoured to ensure that every person who contacted the Inquiry felt heard and treated with respect. The team also provided broader support to witnesses across the Inquiry.

I also acknowledge the outstanding work of Shilpa Bhim and her team to whom so much is owed in the development and delivery of both the Interim Report and this Final Report.

The Inquiry drew on a range of skillsets from 34 staff engaged in legal work and a range of other tasks, including the technical support to undertake hearings, setting up and maintaining an electronic hearing book, setting up and maintaining the Inquiry website and publishing exhibits and transcripts as they were released, responding to phone calls and emails from the public and the media, and assisting in the preparation and delivery of these two Reports. To undertake this work in six months is no easy feat, and I am grateful for the diligence and hard work undertaken by each and every Inquiry staff member who helped to make this happen. I am particularly appreciative of the support and contribution of chief executive, Jo Rainford, to the Inquiry's operation.

I thank all Victorians for their patience and understanding as the Inquiry has undertaken its work. The second wave of COVID-19 cases led to a series of restrictions in the state and had devastating impacts on peoples' lives, livelihoods and mental health. It made what was already a difficult year far more difficult. We have endeavoured to provide as much clarity as possible to all Victorians on the operation of Victoria's Hotel Quarantine Program. While we cannot turn back the clock, we hope the Inquiry's findings and recommendations provide some assistance for the road ahead.

On behalf of the entire Inquiry team, I extend condolences to the families, friends and loved ones of each individual whose life has been lost to this terrible virus.

The Honourable Jennifer Coate AO
Chairperson
Board of Inquiry into the COVID-19 Hotel Quarantine Inquiry

Executive summary*

From early this year, the World Health Organization (WHO) and governments all over the world were grappling with how to reduce the spread of COVID-19 and avoid overburdening health systems and workers in such a connected world.

Commonly used measures to reduce the spread of COVID-19 throughout 2020 have included social distancing, lockdowns and restrictions on the movement of people in the community plus, in the case of people entering a country from overseas, a period of quarantine.

These measures have been, and continue to be, used across Australia. Of significance to the work of the COVID-19 Hotel Quarantine Inquiry was the 14-day period of mandatory quarantine that was announced on 27 March 2020 and implemented for all international arrivals into Victoria from 29 March 2020.

The stated purpose of mandatory quarantine was to try to slow the spread of COVID-19, with the majority of COVID-19 cases in Australia, at the time, attributed to returned travellers.[1] Across Australia, quarantine for returned travellers was (and continues to be) almost exclusively undertaken in hotels.

Within the first week of the Hotel Quarantine Program being established in Victoria, the number of returned travellers in the Program was between 1,550[2] and approximately 2,000.[3] At any one time, there were between 1,500 and more than 4,000 individuals in quarantine across 10–16 hotels.[4]

Victoria's Hotel Quarantine Program ran for three months from 29 March–30 June 2020. In this time, a total of 21,821 returned travellers went through the Program, with a total of 236 (1.1 per cent) of those returned travellers testing positive for COVID-19 while in quarantine.[5]

Despite the relatively low number of positive COVID-19 cases in the Hotel Quarantine Program, breaches of containment in the Program, in May and June 2020, were inextricably linked to the second wave of COVID-19 cases in Victoria,[6] with devastating social and economic consequences for the State.

Due to the established link between the second wave of COVID-19 cases and the outbreaks from a Hotel Quarantine Program, this Inquiry was established on 2 July 2020 to examine a range of matters related to the Program, including:

- decisions and actions of government agencies, hotel operators and private contractors
- communication between government agencies, hotel operators and private contractors
- contractual arrangements
- information, guidance, training and equipment provided to personnel in hotels
- policies, protocols and procedures.[7]

Within the first three months of the Inquiry being established, it held public evidentiary hearings over 27 days, acquired evidence from 96 witnesses and received more than 350,000 pages of documents. On 6 November 2020, the Inquiry delivered its Interim Report, which made recommendations for a more robust Quarantine Program for Victoria as the State began re-opening to international arrivals.

This Final Report is to be read in conjunction with the Interim Report. The recommendations from the Interim Report find their evidentiary basis and rationale in the contents of this Final Report, which examines why the Hotel Quarantine Program was established, decisions made and actions taken in its establishment, what went wrong, what went well and what could, and should, be done better. The further recommendations contained in this Final Report are to be read in conjunction with the recommendations contained in the Interim Report.

* This summary has been prepared to provide an overview of the contents of the Report and its conclusions. It is not a substitute for the contents of the Report or the conclusions contained therein.

The emergence of COVID-19

Chapter 1 of this Report summarises the background to COVID-19 in the international and national context.

After emerging in late 2019 in Wuhan, China, COVID-19 rapidly proliferated across the globe, leading the WHO to declare the virus a 'pandemic' on 11 March 2020.[8]

The first Australian case of COVID-19 was reported on 25 January 2020,[9] with 12 cases confirmed by 1 February 2020.[10] Local case numbers then continued to increase with more than 3,000 confirmed cases of COVID-19 in Australia by 27 March 2020.[11]

As these numbers continued to swiftly rise, so too did concern among government, medical and scientific communities, and the general public. As highlighted by Dr Annaliese van Diemen, Victoria's Deputy Chief Health Officer (DCHO), the anticipated trajectory of the virus posed a significant risk to public health.[12]

At a state level, the Victorian response included the activation of the State Control Centre (SCC)[13] and a declaration of a State of Emergency, after which came a series of Directions prohibiting various gatherings, and Directions to returning travellers to 'self-isolate' for 14 days upon their arrival into Victoria.[14]

At the federal level, the National Cabinet was established on 13 March 2020 with the stated aim of ensuring consistency in Australia's response to the COVID-19 pandemic.[15]

Many of the National Cabinet's agreed measures were aimed at addressing the concern that international arrivals were fuelling the rise in domestic COVID-19 case numbers. These measures included imposing a self-isolation requirement for international arrivals and a ban on foreign cruise ships,[16] as well as prohibiting the entry of non-citizens and non-permanent residents.[17]

It was in this context that the National Cabinet, at a meeting on 27 March 2020, resolved to implement a mandatory 14-day quarantine period for international arrivals,[18] setting the wheels in motion for the establishment of Victoria's Hotel Quarantine Program.

The science behind COVID-19

To understand the context of the Hotel Quarantine Program, it was important to understand the nature and the science of COVID-19, as outlined in Chapter 2.

While acknowledging that there is a continuous state of learning with respect to the COVID-19 virus, the weight of the expert knowledge, at the time, was that the COVID-19 virus had an incubation period of up to 14 days for the majority of patients, with most patients being non-infectious at the end of that 14-day period. On that basis, the 14-day quarantine period, imposed for the purposes of the Hotel Quarantine Program, was a reasonable and appropriate period.

There was a general understanding among the experts of the modes of transmission of the virus as of 29 March 2020. These included that:

A. the virus primarily spread from person-to-person via droplets, aerosols and fomites (for example, transmission by contact with a contaminated surface)

B. droplet transmission occurred when a person was in close contact (within one metre) with someone who had the virus

C. airborne transmission was possible in specific circumstances and settings in which procedures or support treatments that generate aerosols were performed.[19]

These methods of transmission were of critical importance when considering the use of hotels as facilities for mass quarantine.

Asymptomatic transmission (including by way of super spreaders) led to particular complexities for infection control and testing regimes in the Hotel Quarantine Program. The public health community had a knowledge of the risk of asymptomatic transmission of the virus by March 2020.

The weight of the expert evidence to the Inquiry was that between 17–20 per cent of cases would be asymptomatic, which had flow-on impacts in terms of appropriate testing requirements. To address the risk inherent in asymptomatic spread of the virus, it was necessary to require testing of all people at the end of their quarantine period, regardless of whether they were reporting symptoms. This issue had ramifications for the testing regime in place during the Hotel Quarantine Program.

Hotel quarantine's link to the 'second wave'

The expert evidence, based on genomic testing, was that 99 per cent of Victoria's second wave of COVID-19 cases in the community came from transmission events related to returned travellers infecting people working at the Rydges and the Stamford Plaza Hotel. The movement of the virus from these infected workers into the community was characterised by high rates of local transmission.[20]

Prior to the second wave, Victoria's COVID-19 cases were largely attributed to infection acquired overseas.

Mass quarantining and the science

The conclusions that can be drawn from the scientific evidence provided to the Inquiry are that three fundamental safety features must be built into any program that seeks to house together potentially infected people in a quarantine facility. They are:

A. the importance of expert advice, input and ongoing supervision and oversight of infection prevention and control (discussed in chapters 8 and 9)

B. the importance of a rapid and effective contact tracing regime (discussed in Chapter 9)

C. the importance of an evidentiary base for the testing regime (discussed in Chapter 10).

The state of pre-pandemic planning

Victoria's Hotel Quarantine Program was established over the course of one weekend in March 2020. Chapter 3 analyses the state of pre-planning for mandatory, mass quarantine in Australia prior to the Hotel Quarantine Program.

Both the State and Commonwealth governments were aware, prior to 2020, of the possibility of a pandemic and its potentially devastating consequences.

However, none of the existing Commonwealth or State pandemic plans contained plans for mandatory, mass quarantine. Indeed, the concept of hotel quarantine was considered problematic and, thus, no plans for mandatory quarantine existed in the Commonwealth's overarching plans for dealing with pandemic influenza.

Prior pandemic planning was directed at minimising transmission (for example, via voluntary isolation or quarantine at home) and not an elimination strategy. Professor Brett Sutton, Victoria's Chief Health Officer (CHO), accepted that:

> One of the issues in both the Australian Health Management Plan for Pandemic Influenza and the Victorian plan reflecting it is that there probably wasn't sufficient consideration of coronavirus as a virus of pandemic potential, nor was there such explicit consideration of a program of quarantine essentially for the purpose of keeping a jurisdiction entirely free of the virus.[21]

While this Inquiry had no remit or jurisdiction to examine any action or inaction by the Commonwealth, given the role of the Commonwealth through the Commonwealth Pandemic Plan and the lead that it provides to the states and territories, it would be unfair to judge Victoria's lack of planning for a mandatory quarantining program given the Commonwealth, itself, had neither recommended nor developed such a plan.

Significantly, the Commonwealth undertook a review of its health sector response in the wake of the H1N1 pandemic in 2009. The Commonwealth's *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009* recommended that the roles and responsibilities of all governments for the management of people in quarantine, both at home and in other accommodation, during a pandemic, should be clarified. The Review recommended that a set of nationally consistent principles could form the basis for jurisdictions to develop operating guidelines, including plans for accommodating potentially infected people in future pandemics and better systems to support people in quarantine. Further, this review recommended an examination of the policy on quarantine and isolation, including management, support systems and communication.[22]

The Commonwealth Pandemic Plan and the Victorian Pandemic Plan were updated following the *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009* in respect of evidence-based decision-making, use of existing governance mechanisms, a scalable and flexible approach and an emphasis on communication activities, with work regarding the policy on quarantine and isolation to be clarified. Despite this, the evidence to the Inquiry was that this work regarding the policy on quarantine and isolation was not undertaken following the Review being published in 2011.

Had the work proposed by the Commonwealth's *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009* been done, there would likely have been, at least, a set of guiding principles and a framework to support the establishment of the Hotel Quarantine Program, thus avoiding the Program needing to be set up in an *ad hoc* manner during a pandemic.

Just two weeks before the National Cabinet agreed to mass quarantining, Victoria published its 10 March 2020 *COVID-19 Pandemic Plan for the Victorian Health Sector*. It did not envisage the involuntary detention of people arriving from overseas. As with the Victorian Pandemic Plan, its focus, with regard to isolation or quarantine, was on the *voluntary* isolation of people in their own homes.

The lack of a plan for mandatory mass quarantine meant that Victoria's Hotel Quarantine Program was conceived and implemented 'from scratch', to be operational within 36 hours, from concept to operation. This placed extraordinary strain on the resources of the State, and, more specifically, on those departments and people required to give effect to the decision made in the National Cabinet and agreed to by the Premier on behalf of Victoria. This lack of planning was a most unsatisfactory situation from which to develop such a complex and high-risk program.

Given the future movement of people in and out of Victoria from across the nation, it is in Victoria's interests to advocate for nationally cohesive and detailed quarantine plans, as previously recommended in the *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009,* to clarify roles and responsibilities between different levels of government, management and support systems and communication protocols.

Pandemic planning exercises

Emergency incident exercises, specifically related to infectious disease pandemics, have been undertaken regularly. These exercises considered associated public health and emergency management plans and are undertaken within the Department of Health and Human Services (DHHS) and with other agencies.

There was a perceived gap in terms of provision of pandemic planning across the broader health sector. There can be no doubt that there is a role for the broader health sector to play in emergency planning. DHHS should review its pandemic planning processes and activities, so as to consider an appropriate level of involvement from the broader health sector.

What drove the decision for a Hotel Quarantine Program?

Chapter 4 considers the factors behind the shift to a program of mass, mandatory quarantine.

As of 15 March 2020, Victoria adopted the agreement reached at National Cabinet to make precautionary self-isolation directions for all international arrivals in order to reduce the risk of community transmission from those potentially carrying the virus into Australia from international locations. At that time, positive cases were starting to rise in Australia and in Victoria. By 15 March 2020, Australia had a total of 298, and Victoria 57, confirmed COVID-19 cases. Dr van Diemen, and other experts considered that, without effective intervention, those numbers would continue to rise exponentially.

By 27 March 2020, there was a total of 3,162 cases in Australia with 574 of those cases in Victoria. This represented a tenfold increase in Victorian cases. During this period, there had been an outbreak on the Ruby Princess cruise ship, which had docked in Sydney, with infected passengers permitted to disperse across the nation. This event was linked to 800 cases in Australia.

The view of National Cabinet, echoed by the Victorian Premier, was that the majority of cases in the community, at that time, were linked to the virus coming in via international arrivals.

Together with the considerable concern raised in relation to the Ruby Princess disembarkation, there was evidence that some returned travellers were not adhering to Directions to self-isolate at home. On closer examination during the Inquiry, as reported in Section 2 of the Interim Report, the evidence of intentional non-compliance with Self-Isolation Directions was not extensive. Further, the evidence of 'non-compliance' was, at least, partly referable to the poor dissemination of information to returning travellers who were being directed to self-isolate.

As of 27 March 2020, the Australian Health Protection Principal Committee (AHPPC) had only recommended to the National Cabinet enforced quarantine for 'high-risk' cases. Nevertheless, both the National Cabinet and, in turn, the Victorian Premier took the decision to direct the mandatory detention of all international arrivals into designated facilities which, in Victoria, were hotels. Both the CHO and the DCHO supported the decision based on the following:

A. an exponential increase in COVID-19 cases

B. a link between returned travellers and community transmission rates

C. perceived rates of non-compliance with Self-Isolation Directions

D. perceived inadequacy of the Self-Isolation Directions.

As of 27 March 2020, there was a proper and grave concern being expressed about the extent to which Victoria's health system might be overrun by COVID-19. The situation in many countries was already very grave, with substantial rates of infection and serious illness causing demand for hospital care to exceed existing medical services.

It is readily accepted that quarantining for international arrivals is likely to be required in Victoria for some time to come. In this context, the Interim Report addresses the option of a home-based quarantine program. Recommendation 58 of the Interim Report stated that, in conjunction with a facility-based model for international arrivals, the Victorian Government should develop the necessary functionality to implement a supported home-based model for those international arrivals assessed as suitable for such an option.

Section 2 of the Interim Report set out the reasons for recommendations for the development of a home-based model. One of the reasons set out in Section 2 is that a major risk of the hotel model is the daily movement of personnel in and out of the facility and then into communities in which they live. Even in a best practice model, which has dedicated personnel not moving between facilities, clinical and non-clinical personnel are, of necessity, coming in and out of a facility which, by definition, contains potentially infected people.

Minimising the numbers of people working in such environments, by only having in the facility those unable to quarantine at home, reduces this risk of transmission to the broader community.

The decisions made in establishing the Hotel Quarantine Program

Chapter 5 considers the evidence as to decisions made, and actions undertaken, in establishing the Hotel Quarantine Program over the course of a weekend, including which department was in charge and who was responsible for the decision to use private security as the enforcement model.

Initial decision-making

As a consequence of there being no pre-planning for the large-scale detention of international arrivals into a mandatory quarantine program when the Premier committed Victoria to Hotel Quarantine, those who would have to implement the program in Victoria were required to do so with very little warning and without any available blueprint for what was required. The situation was further complicated by the fact that the decision would come into effect just 36 hours later, at 11.59pm on 28 March 2020.

To put the scale in context, information provided by the Prime Minister on 27 March 2020 outlined that 7,120 people had arrived at airports around the country on 26 March 2020, the day before the announcement of hotel quarantine.

The Premier was aware there was no pre-existing plan for large scale quarantine in Victoria and there had been no discussion in the State Cabinet about the National Cabinet decision. However, he considered the Program feasible to achieve based on his knowledge of the availability of hotel rooms and the dedicated team of people at the operational level able to rise to this challenge.[23] The initial responsibility for setting up the Program was given to the Department of Jobs, Precincts and Regions (DJPR) in a telephone call made by the then Secretary of the Department of Premier and Cabinet (DPC) to the Secretary of DJPR on 27 March 2020.

Other than the sourcing of numbers of available hotel stock, DJPR had no preparation for, or relevant expertise to operate, an enforced quarantine program. The capability and capacity of the hotels in terms of the provision of security, cleaning and catering had not been a factor in the decision to allocate the lead to DJPR, nor had the capacity of the hotels to accommodate large numbers of people in a manner that would prevent transmission of COVID-19 to the community been considered.

It was not appropriate to conceive of the Hotel Quarantine Program as an extension of, or substantially similar to, existing accommodation programs, such as the COVID-19 Emergency Accommodation Program (CEA Program). The logic of tasking DJPR to source hotels on the basis of its work for the CEA Program did not extend to it sourcing hotels for quarantine purposes; the nature and purposes of the two programs were significantly different and involved different levels of risk. DJPR understood from the outset that it would need the assistance of DHHS for crafting the legal framework for the Program and arrangements for the health and wellbeing of the people in quarantine.

Within a few hours of that call to the Secretary of DJPR, and without knowledge of that call, the Emergency Management Commissioner and the State Controller — Health at DHHS were setting up a meeting at the State Control Centre (SCC) on the understanding that this Program would be operated using the emergency management framework.

By the afternoon of 28 March, at a meeting of a number of agencies at the SCC, the Emergency Management Commissioner, in conjunction with the DHHS State Controller — Health, made clear that DHHS was in charge as the control agency of the operation, which would become known as Operation Soteria, after the Greek goddess of safety, and that DJPR was a support agency.

DJPR continued to provide the contracting and organising of many logistical aspects of the Program including hotels, security, cleaning contractors and general logistics, such as transport and aspects of catering.

Notwithstanding this expressed position from the Emergency Management Commissioner, there remained an ongoing dispute between DHHS and DJPR as to who was in charge of the overall operation of the Program, which continued throughout the Inquiry. DJPR was clear that it was DHHS while DHHS was adamant that it was only responsible for parts of the Program and that DJPR was jointly responsible and accountable for its delivery. This was the source of considerable and significant problems with the way in which the Program operated. It also occupied an inordinate amount of time during the Inquiry.

The decision to embark on a Hotel Quarantine Program in Victoria involved the State Government assuming responsibility for managing the risk of COVID-19 transmission. But even though that risk was assumed by the Government, and as critical 'decisions' were made with respect to enforcement measures, there was no detailed consideration of the risks that would be involved in such a program. This was a failure in the establishment of the Program.

It is beyond doubt that many people worked incredibly hard, in extraordinary timeframes, to deal with an unprecedented set of circumstances. But that is not a total justification for the deficiencies in some of the actions taken, and decisions made, in that first 36 hours, and it does not excuse the deficiencies found in the Program.

Decisions on the enforcement model: the use of private security

This issue occupied a considerable amount of time during the Inquiry and generated a great deal of heated dispute. Somewhat ironically, it occupied a far greater amount of time and energy during the Inquiry than it did during the March 2020 meeting at the SCC. No person or agency claimed any responsibility for the decision to use private security as the first tier of security. All vigorously disputed the possibility they could have played a part in 'the decision'.

The evidence was that the use of private security did not raise any particular concerns during the weekend setup of the Program or produce any considered discussion about how the enforcement model should work. No doubt, in the wake of the evidence that has emerged as to the links between infected security guards and the second wave of COVID-19, and problems more generally with the use of that workforce, positions have hardened as to any 'ownership' of the decision to use private security.

Ultimately, the evidence did not identify that any one person decided to engage private security in the Program. However, there were clearly people who influenced the position that was found to have been adopted at the SCC meeting on the afternoon of 27 March 2020.

Chapter 5 goes through the detail of the exchanges and discussions in the lead up to this meeting.

In short, it concludes that, while no request was made to Victoria Police to provide the 'first tier' of the enforcement model for hotel quarantine, the then Chief Commissioner of Police was consulted and expressed a preference that private security perform that role and Victoria Police provide the 'back up' for that model.

That position, expressed by the senior police representative present at the SCC meeting that afternoon, was clearly persuasive to those at the meeting. There being no particular discussion or dissent, this set in motion the actions, that evening, by DJPR to commence contractual engagement with three security firms. Notwithstanding the multiple submissions from a number of agencies represented at the SCC meeting, the conclusion of Chapter 5 is that this SCC meeting was where and when the decision to engage private security was made as the first tier of enforcement, with Victoria Police as the 'back up'.

At no time on 27 March 2020 did it appear there was any consideration of the respective merits of private security versus police versus Australian Defence Force (ADF) personnel in that first-tier role. Instead, an early mention of private security rather than police grew into a settled position, adopted by acquiescence at the SCC meeting.

There was no actual consideration of whether ADF personnel would have been a better option. The assessment that ADF was not needed on the ground at the hotels was an assessment made without any proper consideration of the anterior question of what would be the best enforcement option.

As of 27 March 2020, the decision not to request the assistance of the ADF for a role in the quarantine hotels was made by the Emergency Management Commissioner. It was open to be made in the sense that, once it was agreed private security would be used at the hotels, there was no longer a 'need' for ADF but, as there had not been any proper analysis of that private security arrangement, it was an assessment that proceeded without investigation.

As noted in Chapter 5, it is important to acknowledge the haste with which these decisions were being made. However, the fact remains that not one of the more than 70,000 documents produced to the Inquiry demonstrated a contemporaneous rationale for the decision to use private security as the first tier of enforcement, or an approval of that rationale in the upper levels of government. Such a finding is likely to shock the public. Unlike the formal application through the Expenditure Review Committee process for the funding for the CEA Program, no such process was uncovered for the use of private security in the Hotel Quarantine Program.

Chapter 5 concludes that the people of Victoria should understand, with clarity, how it was that such a decision to spend millions of dollars of public money came about. The people should be able to be satisfied that the action to proceed in this way was a considered one that addressed the benefits, risks and options available in arriving at such a decision. There was no evidence that any such considered process occurred, either on 27 March 2020 or in the days and weeks that followed, until the outbreaks occurred.

Chapter 5 notes that the decision to engage private security was not a decision made at the Ministerial level. The Premier and former Minister Mikakos said they played no part in the decision. Minister Neville was aware of the proposal but not responsible for it and Minister Pakula appears not to have been told until after private security had been engaged. Enforcement of quarantine was a crucial element of the Program that the Premier had committed Victoria to adopting, but neither he nor his Ministers had any active role in, or oversight of, the decision about how that enforcement would be achieved.

In his evidence, the Premier agreed that the question of how this occurred should be capable of being answered.[24] As the head of the Victorian Public Service at the time, the then Secretary of DPC acknowledged it was a fair point that, if no one knew who made the decision, there was an obvious risk that no one would understand that they had the responsibility for revisiting the decision if time and experience showed that it was not the correct one.[25] This was what occurred here. The decision was made without proper analysis or even a clear articulation that it was being made at all.

On its face, this was at odds with any normal application of the principles of the Westminster system of responsible government. That a decision of such significance for a government program, which ultimately involved the expenditure of tens of millions of dollars and the employment of thousands of people, had neither a responsible Minister nor a transparent rationale for why that course was adopted, plainly does not seem to accord with those principles.

The conclusions contained in Chapter 5 find that the decision as to the enforcement model for people detained in quarantine was a substantial part of an important public health initiative and it cost the Victorian community many millions of dollars. But it remained, as multiple submissions to the Inquiry noted, an orphan, with no person or department claiming responsibility.

The procurement and role of private security

Chapter 6 discusses the use of private security in the Hotel Quarantine Program. It finds that there were problems from procurement through to the scope of the role of security guards.

Chapter 6 concludes that there was no a basis to find anything other than the overwhelming majority of security guards who worked in the Hotel Quarantine Program did so honestly and with goodwill. None of those workers went to work to get infected with COVID-19. However, systemic governmental failings led to problems.

Decisions were not made at the right levels and with the right information

Chapter 6 concludes that outsourcing such a critical function warranted closer scrutiny from senior public servants and the Minister. Those who negotiated the terms of the contracts, and those who 'supervised' them, were doing so without any clear understanding of the role of security in the broader Hotel Quarantine Program and had no expertise in security issues or infection prevention and control. They had no access to advice from those who had been party to the decision to use security and had limited visibility over the services being performed.

Failings in the procurement process

Chapter 6 concludes that the process by which the security firms were selected was not appropriate or sufficiently rigorous. It was made in haste and without any risk assessment, led by staff that did not have the requisite experience and knowledge, and without any public health oversight or input. The speed with which security had to be contracted was some explanation, though not a sufficient explanation, for why the initial contacts were made in the way they were.

Chapter 6 also concludes that there were failures of proper procurement practice on the part of DJPR.

The first was a failure to make use of the State Purchase Contract (SPC) for security services when making initial arrangements for security over the weekend of 28 to 29 March 2020. Those involved in procuring security firms were not aware of that SPC or the existence of publicly available details of security service providers that were regularly used by the Government via the SPC arrangements. Those involved were also unaware of the applicable critical incident procurement policy and protocols, and that an exemption from the SPC was not needed.

Procurement policies are there for a reason. The existence of procurement policies in general, and the SPC specifically, reflect principles of value for money, as well as accountability, suitability and capacity to properly provide services, transparency and probity.[26] These contracts for security services represented tens of millions of dollars; it stands to reason that decisions made to spend public money on these providers should have been consistent with practices that are based on general procurement principles. That should have involved, as far as possible, reliance on existing SPC arrangements.

While it is true that there was a critical incident procurement policy that provided DJPR with the flexibility to source services outside of the SPC Panel, it did not follow that proper procurement practices and decision-making were irrelevant. Indeed, the Department of Treasury and Finance provided evidence that the Victorian Government Purchasing Board's communication to departmental procurement teams was that, wherever possible, SPCs should continue to be used during the pandemic.[27]

The second failure noted in Chapter 6 was in DJPR contracting longer term with the private security provider, Unified Security Group (Australia) Pty Ltd (Unified), despite advice that it was preferable to use those who were part of the SPC panel of providers.

Those tasked with procuring security services for the Hotel Quarantine Program should have heeded the specific procurement advice they were given, as to the risks of informally engaging a non-panel firm to provide quarantine security. They should have considered whether Unified was suitable to remain a service provider in light of their knowledge of the SPC arrangement.

Chapter 6 concludes that the third failure in the procurement process was in not making evidence-based decisions about the allocation of work between the three contractors with whom contracts were signed.

Even allowing for the use of Unified in the short term, it was a failure of government decision-making to contract a firm that had previously been refused admission to the SPC for security services for, what became, very significant sums of money, and then to allocate so much work to that firm.

There was a preference within DJPR for Unified. The preference appears to have been based on what was seen as a willingness by Unified to do the work asked of it, despite some of that work being outside the role it was engaged to perform.

The role of private security

The role performed by private security was ill-defined from the beginning and was, ultimately, a role not suited, without close monitoring and extensive and continued training, to the cohort of guards that was engaged.

The role of security guards changed over time, from 'static guarding' at the outset, to facilitating fresh air breaks later on. The expanded roles increased the risk of security guards being infected through contact with potentially infected guests and through contact with possibly contaminated surfaces in circumstances where overall infection prevention on the site was completely inadequate.

The introduction of those additional functions should have occurred following a proper re-evaluation of the infection control measures in place and an assessment of the increased risks to staff that they posed. No such assessment occurred because no person or agency regarded themselves as responsible and accountable for either the hotel site or the decision to use private security. Responsibility for revisiting the scope of the duties to be performed by security guards lay with DJPR as the contract manager. DJPR did not see that to be the case.

Contract development and management

The conclusions on this issue in Chapter 6 are that DJPR should not have been responsible for contract management throughout the Hotel Quarantine Program. DHHS was the appropriate body to manage those contracts and should have done so as control agency with overall responsibility for the Hotel Quarantine Program.

The contracts should have made clear that security guards were subject to the direction of DHHS in supporting their enforcement functions.

Explicit provision in the contracts would have provided greater clarity and certainty as to who was in charge of security services personnel, which may have led to a greater focus on supervising the work of those personnel.

It was not appropriate that the contracts placed responsibility for training and supervision, in relation to PPE and infection prevention and control, on the contractors in the manner they did. That should have been a responsibility that remained with the State as the architect of the Hotel Quarantine Program.

The contractual requirement for security services personnel to complete the Commonwealth Government Department of Health's COVID-19 online training module was an inappropriate mechanism to properly mitigate the risk of COVID-19 transmission in a hotel quarantine context. Commendable as it was to require training to be undertaken as a precondition of engagement in the Program, it was a failure in preparing those contracts that the content of such training was not based on advice specific to the risks at hotel quarantine sites. COVID-19-related training should have been specifically tailored for non-health professionals working at the quarantine hotels. That it was not, and that it was potentially confusing, meant that it was even more important that contractual requirements as to PPE and training were clear, specific and relevant.

Not having clear, consistent training and PPE requirements led to contractors having different levels of knowledge and sophistication when it came to the use of PPE: at one end of the spectrum, Wilson Security Pty Ltd (Wilson) had a significant suite of policies, practices and supports to mitigate the risk of virus transmission, and at the other, Unified was particularly reliant on DHHS to provide training and information.

Subcontracting security services

The heavy reliance on subcontracting posed a significant risk to the success of the Hotel Quarantine Program in terms of the quality and competence of security guards actually recruited. Notwithstanding this, DJPR did not have adequate oversight of the use of subcontractors in the Hotel Quarantine Program. That was due, in part to DJPR not being aware of the extent to which the head contractors would rely on subcontracting.

DJPR should have been more vigilant and proactive in requiring the security service providers to seek written prior approval for the engagement of subcontractors, as per their respective contracts. But so, too, should the security services providers have complied with their subcontracting obligations at the required time. The consequence of this was that DJPR did not give proper oversight to those performing security services.

It is a significant deficiency that DJPR was not in a position to know the extent to which the security providers actually engaged in subcontracting throughout the duration of the Hotel Quarantine Program, let alone be confident as to who was providing the services and whether they were properly equipped to do so.

Private security guards should not have been engaged without close monitoring

Security guards were not the appropriate cohort to provide security services in the Hotel Quarantine Program without close monitoring and extensive and continued training.

Consideration was not given to the appropriateness or implications of using a largely casualised workforce in an environment where staff had a high likelihood of being exposed to the highly infectious COVID-19. This, of course, had flow on impacts in terms of the spread of the virus.

That is not to say that staff, whether those who contracted security providers or the security staff themselves, acted in bad faith. However, greater consideration ought to have been given to the environment in which security staff were working and their prior infection control knowledge and training.

As an industry, casually employed security guards were particularly vulnerable because of their lack of job security, lack of appropriate training and knowledge in safety and workplace rights, and their susceptibility to an imbalance of power resulting from the need to source and maintain work. These vulnerabilities had previously been identified by the Government.

A fully salaried, highly structured workforce with a strong industrial focus on workplace safety, such as Victoria Police, would have been a more appropriate cohort, which would have minimised the risk of outbreaks occurring and made contact tracing an easier job in the wake of an outbreak.

The use of hotels and cleaners

Chapter 7 analyses the use of hotels and cleaners in the Hotel Quarantine Program.

Decision to 'stand up' hotels for the Hotel Quarantine Program

Once the decision had been made to adopt a universal quarantine program for all international arrivals within some 36 hours, the decision to use hotels as the designated facilities for the purpose of Victoria's quarantine program was an obvious enough choice.

Hotels were chosen because they were available, could be stood up quickly, would accommodate large numbers of returned travellers and would provide economic benefits. Even if afforded careful prior contemplation, hotels presented as the only readily available option in the absence of a purpose-built quarantine facility.

But that is not to make a virtue of necessity. Hotels were not designed as 'quarantine facilities'. The physical limitations of hotels, together with the highly infectious nature of the virus and the state of knowledge about transmission, meant that constant attention to all of the necessary infection prevention and control measures was needed to run the Program with minimum risk to the people in quarantine and those working in the Program.

Procurement and contracting of hotels

It is beyond doubt that the organisation of the hotels and the cleaning companies for the Program involved a significant logistical undertaking. DJPR entered formal agreements with 29 hotels (20 hotels were ultimately used for the Program).[28] It engaged three professional cleaning companies for specialised cleaning, initially only for those rooms that had been used by people who were known to be COVID-positive.[29]

There is no controversy that those contracts between the State and the hotels and cleaning companies were prepared and executed, on behalf of the State, by DJPR.[30] DJPR maintained the obligation of contract management throughout the period from March until July 2020, at which time primary control of the Hotel Quarantine Program transferred to the Department of Justice and Community Safety (DJCS).[31]

While DJPR had responsibility for management of the contracts, in a number of important respects, especially in relation to infection prevention and control measures, direction and management of those contractors was based on advice from DHHS. This resulted in a situation where those responsible for ensuring compliance with the contracts (DJPR) were not the ones with sufficient expertise to understand whether the contracts were being performed as they should. This was an unnecessarily complicated and unwieldy situation, and not a safe system of infection prevention and control. It was compounded by the internal management structures and available public health resources of DHHS that are discussed in Chapter 8.

Important information directed to infection prevention and control — the cornerstone of this Program — was merely transferred to the contractors via DJPR which, in turn, was obtaining such information as was available from DHHS; as a result, it created too many opportunities for its import to be diluted or, even, lost.

Additionally, this contractual framework complicated and obscured what was the necessary and appropriate, albeit apparently lacking, 'ongoing supervision and oversight'[32] by DHHS of the operational aspects of the Hotel Quarantine Program.

Insofar as those aspects were being delivered, or, at least, were intended to be delivered, by the hotels and cleaners who had been engaged, it is apparent that the DHHS Public Health Team and the infection prevention and control (IPC) expertise available to DHHS had little direct insight into how the Program was being administered and, indeed, no oversight.[33] At most, DHHS submitted that 'the Public Health Team had responsibility for the availability of infection prevention and control and PPE advice and guidance'.[34]

DHHS accepted it could have addressed this issue by taking over responsibility for the contracts. The impact of fragmenting responsibilities in this way as between DJPR, DHHS and the private contractors added to, or increased, the vulnerabilities inherent within the Hotel Quarantine Program in Victoria. The provision of policy advice and guidance on IPC measures, such as proper cleaning standards and methods, to DJPR, which had no expertise in the area and, therefore, no ability to oversee the correct implementation of these requirements, was not a safe way to minimise the risk of infectious outbreaks in hotel quarantine sites.

Apparently, with a realisation as to the unwieldy nature of the Program, from 3 July 2020, DHHS assumed responsibility for both the selection and contracting of all hotels in the Program.[35] Existing agreements with hotels were amended to reflect this transfer of responsibility from DJPR to DHHS.[36]

At a much earlier stage in the Program, DHHS and DJPR should have arranged for the transfer to DHHS of responsibility for the administration of contracts. This would have brought the department with public health expertise into a direct role in administering essential components of the Program and facilitated clear lines of accountability, responsibility and supervision of roles. Importantly, given it was an unplanned and untested Program with high risks, one agency overseeing the Program would also have likely embedded a proper, ongoing review of the Program in its operation.

Decisions to contract with hotels were made with reliance on DHHS's requirements as to what hotels were suitable; despite this, DJPR did not receive any specific documents from DHHS regarding whether hotels were assessed as suitable from an infection control perspective. The key consideration for such an assessment should have been the extent to which infection control measures could be successfully implemented.

Infection prevention and control in hotels: the ever-present risk of cross-infection

IPC measures are essential to a successful quarantine program. It was necessary to have those with the expertise in infection prevention and control deliver that training. Nothing short of constant reinforcement, supervision and oversight from those with the necessary expertise was what was required in such a highly infectious environment.

There were no infection prevention and control experts stationed at the hotel sites to give guidance, oversight or supervision on the range of risks to which hotel staff would be exposed and what they needed to do to mitigate those risks.

DHHS witnesses made clear that knowledge about the virus and its modes of transmission was evolving.[37] Dr Simon Crouch, a senior medical adviser in the Communicable Diseases Section of the Health Protection Branch of DHHS, gave evidence that:

> The understanding of COVID-19 continues to develop. As this has happened, so too has my understanding of the virus and its modes of transmission. I am not convinced that we yet fully understand how it is transmitted.

Given what Dr Crouch stated, it made it even more unsatisfactory that hoteliers were contracted to provide their own PPE, training and infection prevention and control. This was a wholly inappropriate situation.

The importance of cleaning

There was an inadequate focus, in the design and implementation of the Hotel Quarantine Program, on the need for specialised and rigorous cleaning to address the risk of virus transmission through environmental contact.

Given that the guidance from the WHO, in March 2020, specifically identified fomite transmission as a recognised method by which infection might occur, the Program should have been informed by the development of proper and authoritative guidance that dealt specifically with rigorous 'environmental cleaning and disinfection'.

This was especially so given the movement of people in quarantine, and the workers and staff and personnel working on-site, in and out of the hotels.

PROCUREMENT OF COMMERCIAL CLEANING COMPANIES FOR 'SPECIALISED CLEANING'

The requirement that hotels undertake specialised cleans of COVID-positive rooms was flawed. It was based on a presumption, upon rooms being vacated, that it would be known which people in quarantine were COVID-positive and which people were not.

Because of the possibility that people infected with COVID-19 might be asymptomatic or experience only mild symptoms, which they may not recognise or report, and because testing was initially not universal nor compulsory, it was reasonably possible that a person's COVID-positive status might not have been discovered. In such a case, a room that previously held a person infected with COVID-19 would potentially be cleaned by hotel staff or subcontractors rather than the specialised cleaners.

Irrespective of the contracting arrangements and who carried out the cleaning, it was imperative that proper auditing checks were conducted with due care, particularly given the known risk of environmental transmission.[38] There was no evidence that this was done.

CLEANING STANDARDS AND QUALITY CONTROL

There was no comprehensive, specific cleaning advice tailored to the Hotel Quarantine Program until 16 June 2020, when the document titled *Hotel Quarantine Response – Advice for cleaning requirements for hotels who are accommodating quarantined, close contacts and confirmed COVID-19 guests – Update'* was issued by DHHS.

It would have been prudent for advice that dealt specifically with hotels in the quarantine environment to have been provided as early as possible into the commencement of the Program. It could not have been expected that those DJPR officials engaging the cleaning contractors had sufficient IPC knowledge to know whether generic guidance was appropriate in that specific context. Where DJPR had made requests of DHHS for tailored hotel-quarantine advice and policies, those requests were reasonable.

The consequences of the 'split' as between DHHS and DJPR included delays in providing proper cleaning advice and services, hampering the ability of those within hotels to deal quickly with issues as they arose.

OVERSIGHT OF SPECIALISED CLEANING IN QUARANTINE HOTELS

Putting to one side the efficacy of the policies that were provided, as has already been noted, the lack of an on-site presence by those with expertise in infection prevention and control, supervising, monitoring and overseeing the implementation of those policies was a systemic flaw given the highly infectious nature of this virus and its risks of transmission including by indirect surface (fomite) contact.

DHHS assumed the management of all cleaning contracts (other than in relation to the Brady Hotel) in quarantine hotels from 1 July 2020.[39] Had DHHS taken over that function at an earlier point in time, it would likely have been more proactive in directing and managing hotels and cleaners in relation to IPC practices. The demarcation of roles resulted in a diffusion of responsibility, and led to an absence of appropriate oversight and leadership within the Program, in respect of this central tenet of IPC.

From the outset of the Program, there should have been a fuller implementation of processes that adequately identified the known risks of transmission. Whether this lack of full implementation arose due to the contractual arrangements, or the division of responsibilities between DHHS (as control agency and the department with the specific public health expertise) and DJPR (as the contracting party), or for some other reason, it is clear that this was an aspect of the Program that was inadequate.

The expertise to ensure proper standards were embedded and maintained did not lie with the contracting agency. This was a structural problem that permeated the Program. DHHS should have been responsible for ensuring implementation of its own standards.

VULNERABILITIES WERE CREATED BY THE ARRANGEMENTS WITH HOTELS AND COMMERCIAL CLEANING COMPANIES

It was not appropriate for the State to place contractual responsibility for infection prevention and control on hotels and commercial cleaners.

Contracts entered into by DJPR on behalf of the State allocated to hotels and cleaners key responsibilities for worker safety, including the need to provide PPE and to manage infection prevention and control.

It was not appropriate for the State Government to seek to impose the risk of transmission of COVID-19 onto the hotel and cleaning providers in the way in which these contracts purported to do. The Hotel Quarantine Program was not just a workplace or a private arrangement between employer and employee, or contractor and principal. It should not have been seen solely through that lens. It was, fundamentally, a measure to protect the public from a significant health threat.

There was simply too much at stake for the State to have conferred such responsibilities on private service providers, whose ordinary roles were so far removed from infection prevention and control measures.

The conclusions reached on this issue echo the evidence of the Premier, who stated that it would 'absolutely' be a concern if the relevant departments 'didn't take an active role in ensuring that there was proper infection control and prevention measures in place', especially where the State had assumed such risk by bringing members of the public into the hotels.[40]

DHHS as the control agency

What became clear through the course of this Inquiry was how complex and unclear the governance structures surrounding, and relevant to, the Hotel Quarantine Program truly were, and the intractable problems this caused throughout the Program. Indeed, the complexity of those governance structures presented like a Gordian knot that developed from the early days of the Hotel Quarantine Program. This matter is examined in detail in Chapter 8.

The commencement of the Hotel Quarantine Program in DJPR, during that March weekend, created the first fracture in the lines of accountability and governance from which aspects of the operation did not recover. Even though the Program was quickly reset within Victoria's emergency management framework, that DJPR held the contracts for hotels, security guards and aspects of cleaning contributed to the firmly held view in DHHS that it was in a model of 'shared accountability' with DJPR for the operation of the Hotel Quarantine Program.

Victoria's emergency management framework contains an extensive array of legislation, documents, manuals and plans that endeavour to address the range of emergencies that could transpire, and it sets out structures by which to respond to those various types of emergencies. One of the aims of the emergency management framework is to establish efficient governance arrangements that clarify roles and responsibilities of agencies, and to facilitate co-operation between agencies.

The emergency management framework classifies emergencies into different classes depending on the type of emergency being faced. The framework also specifies which agency will be designated as the 'control agency' depending on the expertise required to respond to that emergency. The COVID-19 pandemic is a Class 2 emergency and DHHS is designated the control agency for such emergencies.

The use of the emergency management framework to respond to the COVID-19 pandemic was the first time it had been used in Victoria for a large-scale Class 2 emergency.

While there was a range of plans in place to support this framework, none of those plans contemplated the mass mandatory quarantine of people in response to a Class 2 emergency.

While there was no controversy about the appointment of DHHS as the control agency for this Class 2 emergency, there was considerable controversy that persevered throughout the Inquiry as to what it meant to be the control agency.

A 'control agency' is the agency identified in the arrangements that is the **primary agency responsible** for responding to a specific form of emergency. The control agency's responsibilities are set out in the Emergency Management Manual Victoria (EMMV) and include the appointment of 'controllers' for the specific form of emergency.

The importance of having a control agency in emergency management is to ensure clear lines of command and control, as this is critically important to lead and manage the emergency, coordinate the response and ensure there is no ambiguity about who is accountable for the management of the emergency.

Notwithstanding that DHHS acknowledged it was the control agency, it characterised its role in the Hotel Quarantine Program as one in which it had a 'shared accountability' with DJPR. It relied on several lines of reasoning to characterise its role in this way. First and foremost, it relied on the concept that the overall response to the pandemic and the Hotel Quarantine Program fell within the meaning of a *complex emergency* as contained in the EMMV. In such circumstances, the need for 'shared accountability' is referred to but the reference goes on to make clear that, in these collaborative responses as between agencies, there is a need for a single agency to be responsible as the lead agency.

To the detriment of the operation of the Hotel Quarantine Program, DHHS did not accept that role or responsibility of being the single lead agency during the running of the Program or, indeed, even on reflection, during this Inquiry. This left the Hotel Quarantine Program without a government agency taking leadership and control and the overarching responsibility necessary to run a complex and high-risk program. DHHS was the government agency that had this responsibility. Not only was it the control agency in emergency management terms, but it was the repository of public health expertise and it was the government department that had responsibility for the legal powers exercised to detain people in quarantine.

Notwithstanding this fundamental mischaracterisation of its role and function, adopting the structure and language of the emergency management framework, DHHS appointed a range of 'controllers' and 'commanders' inside complex and, at times, inexplicable internal governance structures that served to complicate and obfuscate reporting lines and accountabilities rather than create clarity of role definition and lines of command.

Prior to the commencement of the Hotel Quarantine Program, the then Secretary to DHHS, on the advice of one of her deputy secretaries, departed from the expectation of the emergency management framework that the CHO would be appointed State Controller for a public health emergency and, instead, appointed two emergency management experts as State Controllers. This was despite the CHO's disagreement with this course of action.

This decision was taken on the basis that the CHO would not have the 'bandwidth' to fulfil all of the functions he had in the context of the state-wide emergency, and on the basis that the role required emergency management logistics (hence, the appointment of two such experts).

The impact of this decision had three important ramifications. First, it contributed to the mischaracterisation of the operation of the Hotel Quarantine Program as a 'logistics' and 'compliance' exercise rather than a public health program. Second, it created another fragmentation in governance of the Program, as it removed the head of the DHHS Public Health Team from much-needed operational oversight of the Program. Third, it meant that those in leadership roles for the Program were not people with public health expertise.

Both the CHO and DCHO expressed concern within DHHS that people were being detained using the legal powers authorised by them in circumstances where they did not consider they had sufficient authority, oversight or awareness in respect of how the operation was being run 'on the ground'. There was also considerable disquiet expressed from some senior members of the Public Health Team inside DHHS about there being a lack of clarity in the command structures adopted by DHHS for the operation of the Program.

Inside the DHHS internal governance structures, there was not an agreed view or consistent understanding between emergency management executives and the public health senior members as to who was fulfilling what functions and roles, and who was reporting to whom. In the context of the operation of the Hotel Quarantine Program, this created confusion and fragmentation in governance structures and, apparently, tension and frustration.

The mischaracterisation of the Hotel Quarantine Program as a 'logistics' and 'compliance' exercise meant that focus did not fall on the need for expert infection and prevention oversight to be embedded into the Program.

The impact of the pandemic and its demands on the Public Health Team inside DHHS revealed, among other shortages, a significant lack of much-needed public health infection prevention expertise employed by DHHS.

By mid-April 2020, it was recognised that the Hotel Quarantine Program would likely be in place for 12–18 months and therefore needed to be taken out of an emergency management response structure and run as a departmental program. To that end, a centre was set up, ironically called the Emergency Operations Centre, and run by DHHS 'commanders'. Unfortunately, DHHS did not take this opportunity to rethink its operation but, rather, continued to see itself as coordinating the day-to-day operation of the hotel sites without taking overall responsibility for the Program.

DHHS executives continued to see DHHS as responsible for providing 'broad' policy support, supporting the health and wellbeing of people being held in quarantine, obtaining advice and guidance from the public health arm of DHHS and passing that on to various agencies on-site, including DJPR, hotel operators and private security firms, in the firm view that each agency was responsible for its own operation on-site.

The on-site presence that DHHS did have was through its Team Leaders and Authorised Officers. Neither of these roles had functions of oversight or direction or supervision. The Team Leaders were seen as problem solvers or liaison points on-site. The Authorised Officers were responsible for the exercise of legal powers to detain people in quarantine. They exercised these legal powers to grant leave and exemptions and discharge people from quarantine at the end of their 14-day period. Neither had any role, authority or expertise in supervising the safety of the site generally.

Just as DHHS did not see itself as the control agency responsible for the Program, it did not see itself as 'in charge' on-site. This left brewing the disaster that tragically came to be. This complex and high-risk environment was left without the control agency taking its leadership role, which included the need to provide on-site supervision and management. This should have been seen as essential to an inherently dangerous environment. That such a situation developed and was not apparent as a danger until after the two outbreaks, tragically illustrated the lack of proper leadership and oversight, and the perils this created.

MINISTERIAL BRIEFINGS

During the course of the Inquiry, the issue of Ministerial briefings by senior public servants arose on more than one occasion.

It was a matter beyond the remit of this Inquiry to engage in an examination of the Westminster system of ministerial and public service lines of accountability and responsibility. However, evidence that emerged on this issue during the Inquiry signalled that an appropriate agency or entity should undertake an examination of what occurred to assess what action may be necessary. This is addressed in Recommendation 76.

Outbreaks at the Rydges and Stamford hotels

The 'second wave' of COVID-19 cases in Victoria was linked to outbreaks in two hotels — Rydges Hotel in Carlton (Rydges) and the Stamford Plaza Hotel in Melbourne's CBD (the Stamford). Chapter 9 analyses these outbreaks.

THE DESIGNATION OF A 'HOT HOTEL'

The idea of cohorting positive COVID-19 cases together in a single location or a 'hot hotel' was a sound public health measure. If appropriately and effectively done, it would have ensured that others in quarantine, who were not infected, had a reduced chance of being infected by reason of their quarantine.

Once the decision was made to establish a hot hotel, it behoved those involved in deciding to implement that concept to pay particular attention to the IPC measures deployed at that location, to ensure that the standards and policies were appropriate and that there was appropriate compliance and adherence to them. They should have had particular regard to the make-up of the workforce and habits of those undertaking duties there.

There were no documents before the Inquiry that answered the question as to who made the decision to use Rydges as a 'hot hotel' and why that decision was made. This is yet another instance of where it could not be made clear to the Inquiry who was responsible for critical decisions in the Program.

At the time the decision was made to cohort COVID-positive cases at Rydges, insufficient regard was paid to infection prevention and control standards across the entire Program and, particularly, to that location, given the appreciable and known increased risk of transmission commensurate with concentrating positive cases in one location.

ADDITIONAL SAFEGUARDS REQUIRED IN A 'HOT HOTEL' ENVIRONMENT

IPC expertise was not sufficiently embedded in the design of Rydges as a 'hot hotel.'

As many staff working in the Hotel Quarantine Program were engaged on a rotating rostered basis until at least 28 May 2020, the provision of episodic training sessions was inadequate to mitigate against the risks posed by not only a hot hotel environment, but any quarantine hotel.

What was necessary was a comprehensive and ongoing training program for all on-site personnel that was overseen by a supervisor, and on-site monitoring for compliance.

EPIDEMIOLOGICAL AND GENOMIC EVIDENCE

Breaches of containment in the Program, in May and June 2020, contributed to the 'second wave' of COVID-19 cases in Victoria, with all of its catastrophic consequences to life, health, wellbeing and the economy of the State.

As set out in Chapter 2, around 90 per cent of COVID-19 cases in Victoria since late May 2020 were attributable to the outbreak at Rydges. Just under 10 per cent of positive cases in Victoria since were attributable to the outbreak at the Stamford in mid-June.

The evidence does not provide the basis to find, with certainty, what specific event caused the transmission from infected traveller to worker. But it does show the likely mode of transmission at Rydges was through environmental transmission, particularly in light of the evidence of poor cleaning products, poor PPE use by security guards, security guards being used to provide some cleaning services and the lack of education around cleaning practices.

The evidence does not permit a conclusive finding as to whether the Stamford outbreak was due to person-to-person contact or environmental transmission.

Issues in respect of poor IPC practices at the Stamford mirrored what had been observed during the investigation into the Rydges outbreak.

Notwithstanding the considerably higher number of frontline staff who became infected at the Stamford, measures taken, whether by way of prompt and appropriate cleaning or because of the immediate and swift quarantining of all staff, or both, were more effective in preventing the spread of the virus into the community.

THE GENESIS OF EACH OUTBREAK

Infection prevention and control measures at both hotels were inadequate, namely in terms of cleaning, PPE use, and staff training and knowledge. Those inadequacies contributed to the transmission of the COVID-19 virus from returned travellers to those working in the Program. In particular, there were pervasive issues identified with delays in deep cleans and in quarantining exposed staff that may have also contributed to the outbreaks.

The need to quickly quarantine exposed staff was significant. As DHHS was aware of the risk posed by fomite transmission, and given there was no reliable data to exclude or limit its likelihood, a more prudent, safety-based approach would have been to furlough every member of staff that had been exposed to all reasonably perceived primary and secondary sources of transmission. This was a reasonable option that would have been apparent to those with the mandate to contain the virus. That this would have required effectively shutting down the hotel or bringing in a replacement cohort of staff (with corresponding substantially increased PPE and infection prevention and control measures) ought not to have been persuasive arguments against such cautious measures. The former approach was taken merely days later without apparent adverse consequence. The delay to isolate the staff earlier resulted in a lost opportunity to curb the further spread of this virus from the exposed workforce into the community.

With respect to contact tracing, timely and accurate information is vital to efforts to contain outbreaks. Detailed information about the movements of cases and close contacts is particularly vital to contact tracers.

A ‘two way’ flow of information is important for contact tracing. Just as it is important for individuals to be forthcoming with public health authorities, it is important for health authorities to provide individuals and private entities with information that would enable those individuals and entities to take appropriate action in the event of a possible exposure.

Although the use of hotels as a setting for mass quarantine may have been unprecedented, factors that played a part in the outbreaks from Rydges and the Stamford should have been foreseen had there been an appropriate level of health focus in the Program. It was an inescapable conclusion that the second wave that hit Victoria was linked to transmission events out of both of those hotels from returned travellers to personnel on-site and then into the community.

The testing regime in the Hotel Quarantine Program

Testing of those detained in the Hotel Quarantine Program was clearly an important aspect of its stated aim, being to minimise the possibility of COVID-19 transmission into the community via returning travellers. Chapter 10 of the Report considers the testing regime.

Initially, only those who showed symptoms were offered a test, and testing in the Hotel Quarantine Program remained entirely voluntary until July 2020. The mandatory testing powers contained in the *Public Health and Wellbeing Act 2008* (Vic) were considered but not used.

A new approach was implemented, in July 2020, when an additional 10 days of quarantine was introduced for those who refused testing on Day 11. This new approach was justified and appropriate.

It is understood that this will be bolstered in the revised hotel quarantine program with mandatory testing of staff and all on-site personnel working in the program, along with voluntary testing of their families and household contacts.

Both approaches represent substantial improvements to the initial testing program that risked undermining, at least to some degree, the efficacy and intentions of the Hotel Quarantine Program and, in doing so, risked transmission of COVID-19 from those detained in the Program into the community.

To further protect against these risks, the legal basis for, and utility of, a testing regime requiring returned travellers who refuse testing at the conclusion of their 14-day quarantine period to undergo mandatory testing should be further explored.

The pivot to a health hotel model

Chapter 11 discusses the shift, in late June 2020, from the Hotel Quarantine Program run by DJPR and DHHS to a health hotel model, with sole responsibility for the Program sitting with DJCS.

Notwithstanding the various explanations and justifications given in evidence, the Government's decision to remove the operation of this public health program (Hotel Quarantine) away from the department responsible for public health, DHHS, led to the conclusion that the Government formed a view, by July 2020, that a single department needed to run the Program and that it did not have confidence that DHHS was capable of running the Program on its own at that time.

The pivot created a governance framework whereby DJCS had clear and direct supervision and control over — and accountability for — those working within the Program, compared to the fragmentation and obfuscation of responsibility in the earlier iteration of the Program.

DHHS was slow to realise it needed to bring a greater clinical focus to the Hotel Quarantine Program. It was aware of, at least, some of the deficiencies in the Hotel Quarantine Program well before June 2020; it could, and should have, remedied them sooner.

By late June, after the second outbreak, only one hotel — the Brady Hotel — was operating under a model whereby Alfred Health provided clinical and infection prevention and control services to that hotel. An approach to Alfred Health could have been made sooner and the training and clinical governance developed by Alfred Health implemented more broadly than at one hotel.

The decision made by DHHS, in late June, to seek an alternative workforce to replace private security indicated that DHHS had the power and authority to make that decision and could have done so earlier, either by consultation with DJPR or by having the contracts transferred to itself.

The 24/7 police presence at the 'health' hotels recognised the value of a trained, salaried security presence that had supervised occupational health and safety operating procedures as required by a strong industrial advocate in the Police Association, and a recognition by Victoria Police of the need for worker safety operating procedures.

The involvement of unions and industrial advocates in the planning of the new model — there were multiple references in Crisis Council of Cabinet submissions to the importance of consultation with the Community and Public Sector Union, the Transport Workers Union and the Police Association — reflected the greater degree of concern attached to workplace health and safety for those government employees than appeared to have been the case when planning for workplaces that were to be largely staffed by private contractors.

Building consideration of returned travellers' rights and welfare into a future program

Chapter 12 analyses whether and how the rights and welfare of returned travellers were approached in the Hotel Quarantine Program and considers how a future quarantine program could be strengthened in this regard.

THE VICTORIAN CHARTER OF HUMAN RIGHTS AND RESPONSIBILITIES

Chapter 12 concludes that Dr van Diemen, in making mandatory detention orders, did give serious and proper consideration to her Charter obligations, in the circumstances, and she assessed her obligations with the evidence available to her at that time.

While it is accepted there were extraordinary pressures and concerns impacting upon the decision to impose the mandatory Hotel Quarantine Program in March 2020, a more considered and orderly approach to finding measures that are the least restrictive should now be properly undertaken for the next iteration of a quarantine program for returning travellers.

The recommendations made in Section 2 of the Interim Report regarding the option of a home-based quarantine model are adopted for this purpose.

Mandatory home-based quarantine or a hybrid model involving initial reception into a quarantine hotel for a form of 'triage', taking into account all relevant factors for each returned traveller, with increased compliance mechanisms, should be given consideration, consistent with Charter requirements.

Such a model may also be, at least, as effective at achieving the objective of containing the virus and balancing the Charter obligations with the need to protect the health and wellbeing of all Victorians.

PSYCHO-SOCIAL IMPACTS OF QUARANTINE ON RETURNED TRAVELLERS

The health and welfare needs of people in the Hotel Quarantine Program had a considerable impact on the manner in which the Program operated and developed.[41] These needs created many problems for those in quarantine, in circumstances where the Program had to be deployed to receive hundreds of people at great speed, with little or no information about returning travellers before they arrived.[42]

In some instances, the manner in which these needs were handled increased the risk of transmission,[43] detrimentally affected the health and wellbeing of people detained in quarantine and created considerable strain on those working in the Program.

The health and wellbeing needs of returned travellers included the need to not be unnecessarily exposed to a risk of infection while being transported from the airport to the quarantine hotel. It was necessary that proper IPC measures be implemented with respect to the transit of returned travellers to their hotels, just as those measures were required to be implemented in hotels.

The health and wellbeing needs of those in quarantine must be a central feature of a future quarantine program.

In the Hotel Quarantine Program, expert advice should have been obtained in order to understand and account for the health and wellbeing risks that this type of quarantine arrangement posed to people and to provide guidance to the Program on how to best manage them. Such expertise could have spoken to the challenging behaviours that would likely be encountered as a result of the deprivation of liberty involved in the Program, and the measures that were needed to proactively account for them and other health and welfare issues.

The fact that such advice was not obtained was likely to be attributable to factors including the speed with which the Program had to be set up, that there was no developed plan or experience for holding people in mass quarantine facilities and, what has been found to be, the disproportionate focus of those designing and implementing the Hotel Quarantine Program on logistics, when health should have been given greater attention. What this evidence showed was that there was some, but not sufficient, attention given to the mental health and overall wellbeing of returned passengers. While the focus on health and wellbeing did increase as the Program developed, there were shortcomings or systemic gaps in meeting the health and human needs of those in quarantine, including:

A. not initially understanding, or adequately addressing the fact that:
    I. being detained in quarantine in a hotel room for 14 days would be a very difficult and stressful experience for some
    II. a percentage of the people held in quarantine would have significant health needs, either physical or mental, or both, and would need particular support
    III. having no access to fresh air or exercise would be extremely difficult for some people
B. the information provided by airlines and/or Commonwealth officials to allow the State to make proper preparations to accommodate people's health and wellbeing needs was limited and inadequate
C. the State had no control of the numbers arriving at short or no notice, which made the health and wellbeing aspects of the Program very difficult to address adequately
D. transport arrangements on arrival at airports created an immediate stressor for some people as PPE was not consistently available or worn and buses were reported by some to be crowded
E. clear, consistent and accurate information was necessary but difficult to find or not available, or in a language that was not accessible. The system for acquiring and maintaining information on people in quarantine was inadequate
F. there was no clear, consistent and communicated process for people to raise issues and concerns about health and wellbeing and receive a timely response.
G. the process for accessing applications for leave and/or exemptions was not clear or consistent.

The difficulties these posed were not sufficiently revisited over time. That was particularly the case in the context of communication and the degree of responsiveness when those in quarantine attempted to resolve issues. There was a distinct lack of consistent, easily accessible and transparent information available to people detained in the Program regarding the circumstances of their detention and the policies that applied to it.

The Inquiry accepts that efforts were made to keep returning travellers safe and comfortable and to offer appropriate support to them. But meeting the health and wellbeing needs of such a wide range of returned travellers is a complex and nuanced task that needs proper attention. Those responsible for the welfare of people in quarantine needed to have been continuously mindful of performing their roles in a way that did not impose greater stresses than those already imposed by reason of a highly stressful and unusual situation.

Victoria's Quarantine Program: future options

This Inquiry investigated why the Hotel Quarantine Program was established and how it was managed. It identified failings in the Program's design and administration, including with respect to where focus, responsibility and accountability lay.

Fundamentally, this Inquiry highlighted that the Hotel Quarantine Program was administered without the focus on infection prevention and control that was necessary to properly contain the COVID-19 virus and the catastrophic consequences of its spread into the community.

This Inquiry has not been solely about identifying deficiencies or finding fault. To do so would be to miss opportunities for improvement in Victoria's future quarantine program.

There was evidence from some witnesses not just about what went wrong but, also, what could have been done better. Where deficiencies have been identified throughout the course of this Inquiry, it has given rise to lessons that can be learned. It has also given rise to 81 recommendations.

The Inquiry's Interim Report recommended options for the future quarantining of international arrivals. Those recommendations, which are adopted into this Final Report, set out two models that would operate concurrently: the first being a facility-based model and the second being a home-based model.[44]

Those models were proposed having taken into account, and in response to, the issues that were raised during the Inquiry.

A full list of the Inquiry's recommendations, flowing from the Interim Report and this Final Report are set out at pages 38–49.

Endnotes

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3 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 5 [15].

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5 National Review of Hotel Quarantine, 'Attachment A - Quarantine – National Statistics', 34-35 <https://www.health.gov.au/sites/default/files/documents/2020/10/national-review-of-hotel-quarantine.pdf>.

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9 Federal Minister for Health, 'First Confirmed Case of Novel Coronavirus in Australia' (Media Release, 25 January 2020) <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/first-confirmed-case-of-novel-coronavirus-in-australia>.

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16 Prime Minister 'Coronavirus Measures Endorsed by National Cabinet' (Media Release, 16 March 2020) <https://www.pm.gov.au/media/coronavirus-measures-endorsed-national-cabinet>.

17 Prime Minister 'Update on Coronavirus Measures' (Media Statement, 20 March 2020) <https://www.pm.gov.au/media/update-coronavirus-measures-0>.

18 Prime Minister 'Update on Coronavirus Measures' (Media Release, 27 March 2020) <https://www.pm.gov.au/media/update-coronavirus-measures-270320>.

19 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 7 [27]; World Health Organization, 'Modes of transmission of virus causing COVID-19: implications for IPC precaution recommendations: scientific brief' (Brief, 29 March 2020) <https://www.who.int/news-room/commentaries/detail/modes-of-transmission-of-virus-causing-covid-19-implications-for-ipc-precaution-recommendations>.

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25 Transcript of day 21 hearing 21 September 2020, 1770.

26 See Exhibit HQI0073_P Witness statement of Ms Hayley Baxter, 4 [15], 8–9 [28(c)], 12 [47].

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28 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 7 [23].

29 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 3 [15].
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31 Exhibit HQI00035_RP Operation Soteria Operations Plan, DOJ.504.010.8488 (version 1.0); Exhibit HQI0126_RP Annexures to witness statement of Ms Melissa Skilbeck, DHS.0001.0001.1527 (version 2.0); DHS.0001.0001.2254 (version 3.0); Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 49 [252]–[254].
32 Exhibit HQI0126_RP Annexures to witness statement of Ms Melissa Skilbeck, DHS.0001.0001.1525.
33 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 4-5 [24].
34 Submission 03 Department of Health and Human Services, 31 [166].
35 Exhibit HQI0049_RP Witness statement of Unni Menon, 10 [37].
36 Exhibit HQI0041_RP Witness statement of Mr Shaun D'Cruz 4 [16].
37 Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, 7 [37].
38 See Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 9 [42].
39 Exhibit HQI0128_RP Witness statement of Mr Michael Girgis, [13].
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41 Submission 03 Department of Health and Human Services, 59-64 [329]–[344].
42 Exhibit HQI0162_P Witness Statement of Ms Andrea Spiteri, 15 [59]; Submission 03 Department of Health and Human Services, 60 [330].
43 Exhibit HQI0191_RP Initial response to the Board of Inquiry from DHHS, 8; Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 8-9 [22(c)]; Exhibit HQI0075_P Witness statement of Mr Noel Cleaves, 14 [76(a)-(b)]; Transcript of day 13 hearing 4 September 2020, 912-913.
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COVID-19 Hotel Quarantine Inquiry Recommendations

The COVID-19 Hotel Quarantine Inquiry delivered its Interim Report and Recommendations to the Governor of Victoria on 6 November 2020.

The Interim Report underpins this Final Report with recommendations that support the development and implementation of a robust quarantine system for the State of Victoria.

The Final Report incorporates and adopts the 69 recommendations presented in the Interim Report set out below. The Final Report recommendations flow on from the Interim Report and, as such, are numbered from Recommendation 70 onwards.

Interim Report Recommendations (Recommendations 1–69)

The Quarantine Program (Section 1 of the Interim Report)

Purpose of the Quarantine Program

1. The Quarantine Program for international arrivals into Victoria be clearly defined as a public health measure to address the need to contain the transmission of COVID-19 into the community while ensuring that the health and wellbeing of those placed into quarantine is properly addressed together with the need to ensure the safety of all personnel working in the Program.

Control of the numbers

FACILITY-BASED MODEL

2. To achieve an orderly and manageable process, the Victorian Government must do all things possible to ensure appropriate and necessary processes are put in place to control the numbers of international arrivals at any given time, informed by the availability of fully operational facilities that are ready and able to receive the agreed numbers.

HOME-BASED MODEL

3. The numbers of international arrivals also be controlled to make practical and achievable the individual engagement and suitability assessments required for home-based quarantine (see Recommendation 59).

Information gathering

4. The Victorian Government takes all possible steps to obtain the co-operation and assistance of Commonwealth agencies and officials, to ensure that the best available and most relevant information is provided to State officials as far in advance as possible for each international arrival, in order to facilitate an informed suitability assessment for appropriate placement in the Quarantine Program (including suitability to quarantine at home).

Electronic record-keeping

5. The Victorian Government liaises with the Commonwealth to develop a process whereby such information about each international arrival bound for a Victorian point of entry can be placed in an electronic file made available to the state authorities as expeditiously as possible prior to the arrival, and for that file to contain targeted information for State officials to assist in the management of the necessary quarantine arrangements.
6. All necessary actions be taken to have that electronic file follow the individual from international arrival through to the completion of their quarantine obligations and include all relevant information to assist in that person's safe transition into the community.

Safe and suitable physical environment for a quarantine facility

7. Given there are currently no identified specific purpose-built quarantine facilities in Victoria, that hotels remain a reasonable and viable option for international arrivals needing to be placed into quarantine. Relevant criterion for selecting suitable locations as quarantine facilities include:
    A. sufficient proximity to a hospital
    B. being within commuting distance for adequate numbers of appropriately skilled personnel for the facility
    C. the facility's:
        I. ability to allow for the physical separation of people
        II. ability to properly implement all necessary infection control requirements, as far as practicable
        III. capacity to make necessary modifications and additions to minimise the risk of transmission, as far as practicable
        IV. ability to provide safe access to outside areas for fresh air and exercise breaks
        V. ability to provide for specific needs such as mobility issues or the need to cater for infants.

Governance structure

8. The Victorian Government ensures that at the ministerial and departmental level, clear control and accountability structures are in place for the operation of the Quarantine Program (including the facility-based program together with any home-based program),to be operated by one Cabinet-approved department, with support from other departments as necessary, but in accordance with a clear line of command vesting ultimate responsibility in the approved department and Minister.

9. The Victorian Government ensures that the Minister and department approved as the single agency to be accountable for the operation of the Quarantine Program is the department that is the sole agency responsible for any necessary contracts.
10. The responsible Minister ensures that the departmental structure for the operation of the Quarantine Program has clearly defined roles that have the necessary expertise and advice embedded at appropriate levels of seniority in the operational structure (the departmental governance structure).
11. The responsible Minister ensures that the appropriate senior members of that governance structure form a body ('Quarantine Governing Body') that meets regularly, is chaired by the Secretary to the responsible Minister, maintains records of its meetings including records of all decisions reached, and provides reports to the Minister from those meetings including in respect to decisions reached.
12. The responsible Minister ensures that the Quarantine Governing Body provides regular, timely and accurate reports to the Minister as to the operation of the Quarantine Program, across all sites, and including all aspects of the entire Quarantine Program, including full and accurate reports as to compliance, monitoring and risks measured against the Purpose (as set out in Recommendation 1).
13. The responsible Minister ensures that the Quarantine Governing Body sets clear and consistent lines of accountability across all individual sites operating as quarantine facilities.
14. The Quarantine Governing Body ensures that each individual quarantine facility site has provided role clarity to all personnel working on-site.
15. The Quarantine Governing Body ensures that each quarantine facility has a Site Manager responsible for the overall operation of that facility, who is accountable to the Quarantine Governing Body.
16. The Site Manager role should be filled by a person who has experience in the management of complex healthcare facilities.

On-site role clarity

17. The Site Manager ensures that all personnel working in the quarantine facility understand their role and responsibilities.
18. The Site Manager ensures that all personnel on-site understand to whom they report and all lines of reporting and accountability on-site.

Appropriate mix of personnel on-site

19. The model contained in paragraph 21 of Section 1 be considered an appropriate model for the operating structure of a quarantine facility.
20. The Chief Commissioner of Police be requested to provide a 24/7 police presence on-site at each quarantine facility.
21. The responsible Minister and Quarantine Governing Body ensure that infection prevention and control expertise is embedded in each quarantine facility site, together with the necessary clinical personnel, to meet the mental and physical health needs of people in quarantine. To this end, the model presented and expanded upon at paragraph 21 of Section 1 [of the Interim Report] should be considered a good basis for all quarantine facilities.

Dedicated personnel

22. Accepting the need to bring in expertise, every effort must be made to ensure that all personnel working at the facility are not working across multiple quarantine sites and not working in other forms of employment.
23. To achieve the aims of Recommendation 20,every effort should be made to have personnel working at quarantine facilities salaried employees with terms and conditions that address the possible need to self-isolate in the event of an infection or possible infection, or close contact exposure, together with all necessary supports, including the need to relocate if necessary and have a managed return to work.

Infection prevention and control unit on each site

24. The Quarantine Governing Body ensures that each quarantine facility has a properly resourced infection prevention and control unit embedded in the facility with the necessary expertise and resources to perform its work.

Training and workplace culture

25. The Site Manager be responsible for ensuring that all personnel working on-site are inducted into a culture of safety, focussed on infection prevention and control provided by those with the expertise to deliver such training.
26. The culture of safety to be fostered by the Site Manager should encourage collaboration, open discussion as to mistakes and oversights and speaking up about concerns and potential health and safety risks.
27. The Site Manager be responsible for ensuring that all personnel working on-site are engaged in ongoing training in infection prevention and control provided by those with the expertise to deliver such training tailored to the specific roles to be performed on-site.
28. The Site Manager ensures that the personnel on-site who have the expertise in infection prevention and control are engaged in ongoing monitoring and supervision of all of the requirements in place for infection prevention and control, which includes matters such as individual behaviour, the use of personal protective equipment (PPE) and cleaning practices.

Acquisition and use of PPE

29. The Site Manager ensures that the infection prevention and control experts direct the acquisition, distribution and use of PPE with specific, clear and accessible directions to all personnel on-site (acknowledging that such instructions may vary according to role).

Cleaning practices in quarantine facilities

30. The Site Manager ensures that all cleaning practices throughout the site are developed, directed and overseen by personnel with infection prevention and control expertise, and include 'swab' testing as directed by the infection prevention and control experts.

Independent safety auditing

31. The Quarantine Governing Body ensures that each quarantine facility site has regular, independent safety audits performed (as against the Purpose set out in Recommendation 1) with reports from those safety audits to be provided to both the Site Manager and the Quarantine Governing Body.

Period of quarantine

32. A 14-day period in quarantine is appropriate, unless the current state of expert opinion changes, or as otherwise directed by the Chief Health Officer or their delegate.

Cohorting of positive cases

33. Any decision to cohort known positive cases at a particular quarantine facility should only occur after proper consultation with the appropriate experts as to suitability of the facility, any necessary adjustments to the facility, and the experts being satisfied that all necessary infection prevention and control precautions are in place at that facility.

Testing

34. All people in quarantine, whether facility or home-based, should be tested on such days as directed by the Chief Health Officer or their delegate, regardless of reported symptoms.
35. For those assessed as suitable for home-based quarantine, it should be a condition of such placement that a person agrees to be tested, as directed by the Chief Health Officer or their delegate.

Clinical equipment on-site

36. On advice from the appropriate experts, adequate and readily accessible on-site clinical equipment to address the range of possible health needs of those in quarantine should be placed at each quarantine facility, together with the necessary resources to effectively sanitise any such equipment.

Safe transport arrangements

37. Given the possible COVID-19-positive status of an individual in a quarantine facility or home-based quarantine, arrangements and protocols for the safe transporting of a person for either urgent or non-urgent health reasons should be developed.

Contact tracing unit

38. That the Quarantine Governing Body ensures that each quarantine facility has a contact tracing unit embedded in the facility that can build familiarity and trust with on-site personnel and has accurate and up-to-date information for such personnel, to enable a rapid and efficient response to any possible outbreak and provide ongoing training to all personnel as to what is required in the event of potential or actual infection.

Evacuation procedure on-site

39. Each Site Manager should develop an emergency evacuation plan for the site and ensure it is well understood and regularly rehearsed by all personnel working in the facility and communicated to each of those placed in the quarantine facility.

Health and wellbeing of people in quarantine

Daily health and welfare checks

40. The Quarantine Governing Body ensures that daily health and welfare checks be embedded into the operation of each quarantine facility.

41. Site Managers arrange standard daily health and welfare checks on people in quarantine, to be conducted with the assistance of available technology, such as a visual telehealth platform, where the individual is willing and able to participate in this way or as otherwise directed by the Clinical Manager (as per the model in paragraph 21 of Section 1).

42. The Quarantine Governing Body provides direction, advice and resourcing as to the use of visual telehealth platforms to enable a case management approach to an individual's health needs, which may enable family, interpreters, existing or preferred healthcare professionals and supports to participate in case conferencing directed to the health and wellbeing of those in quarantine facilities.

43. That the daily health and welfare checks be conducted by appropriately skilled personnel who are also able to screen for any unmet needs or concerns, rather than limited to a check on COVID-19 symptoms.

44. Suitable health and welfare checks by appropriately skilled personnel should be conducted on those in home-based quarantine.

FRESH AIR AND EXERCISE BREAKS

45. The Quarantine Governing Body ensures the ability to provide daily fresh air and exercise breaks for people placed in quarantine facilities is factored into not only the physical layout, but also the staffing of the facility, to ensure there is provision for safe, daily opportunity for people in quarantine facilities to have access to fresh air and exercise breaks.

COMMUNICATION WITH AND TO PEOPLE IN QUARANTINE FACILITIES OR PRIOR TO ENTRY INTO THE QUARANTINE PROGRAM

46. The Quarantine Governing Body ensures that each facility program operates on an understanding and acknowledgment that a number of people placed in quarantine facilities will experience a range of stressors as a result of being detained in a quarantine facility for 14 days.
47. The Quarantine Governing Body ensures that all reasonable steps are taken to assist those who will be particularly vulnerable and require additional skilled support by reason of their being held in quarantine.
48. The Quarantine Governing Body ensures that every effort is made to provide multiple forms of communication of information throughout the period of quarantine to assist in reducing the distress and anxiety that some people will experience in quarantine.
49. The Quarantine Governing Body should address the need to provide accurate, up-to-date and accessible information to all people seeking to enter Victoria through international points of entry, including in community languages, to ensure best efforts at communication are made for all international arrivals.
50. Site Managers ensure that clear, accessible and supportive styles of communication should be regularly used to enable people to have consistent and accurate information about what supports are available to them and who to contact if they have a complaint, a concern or an enquiry while quarantined in a facility.
51. To assist in creating support for people in quarantine facilities and ensuring that there is information available in a range of formats and languages, Site Managers should assign a role to an appropriate person who can coordinate communications and use various platforms (for example visuals, signs, social media, etc.) to encourage those in quarantine facilities to connect with one another. These platforms can also be used to regularly communicate general and relevant information.

Exemptions and temporary leave

52. Authorised Officers ensure that each person placed in quarantine, whether facility or home-based, is made aware of the process for requesting temporary leave or an exemption and the criteria upon which such requests will be assessed.
53. Authorised Officers make decisions about whether or not to grant an exemption or temporary leave as promptly as practicable.
54. Authorised Officers ensure that any conditions or restrictions on such grants should be clearly communicated to the person making the request, address the need to manage the risk of transmission of COVID-19 while that person is in the community and is monitored for compliance.
55. To assist Authorised Officers and enhance consistent decision-making, that each Authorised Officer be provided with a checklist and guidance material on all relevant considerations when determining applications for exemptions and temporary leave applications.

Language is important

56. Language such as ‘resident’ rather than ‘detainee’ be used to reduce the risk of such language having a negative effect on the culture of the facility and to reflect that quarantine is a health measure and not a punitive measure.

Transitioning out of quarantine facilities

57. People leaving quarantine facilities should be offered an opportunity for a ‘de-brief’ to assist with their transition out of the facility and also to enable the opportunity for feedback to be passed to the Site Managers to assist in maintaining a culture of continuous improvement.

Home quarantine model (Section 2 of Interim Report)

Home quarantine as an option

58. In conjunction with a facility-based model program for international arrivals, the Victorian Government develops the necessary functionality to implement a supported home-based model for all international arrivals assessed as suitable for such an option.

Control on numbers arriving

59. The Victorian Government does all things possible to ensure that appropriate controls are put in place to limit the number of international arrivals at any given time to make the necessary individual engagement and assessment for a home-based model practical and achievable.

Assessment of risk factors for home quarantine

60. The Victorian Government engages the appropriate expertise to develop a list of risk and protective factors to be used in the assessment of individual suitability for the home-based model.

61. To assist the Chief Health Officer and Authorised Officers in making such assessments, the Victorian Government engages personnel with the appropriate expertise and training, supported by the necessary resources, to support the Chief Health Officer and Authorised Officers to apply those risk factors to the individual circumstances of international arrivals.

62. The Victorian Government ensures that the Chief Health Officer and Authorised Officers are provided with the capacity and necessary resources to efficiently confirm the accuracy of information being provided for individual assessments of international arrivals.

Individual engagement

63. The Victorian Government takes all necessary steps to address the language and cultural needs of all international arrivals to ensure that accurate information is both obtained for assessment purposes and received and understood by the person subject to the Home Quarantine Directions.

64. The Victorian Government takes all reasonable steps to assess and provide any reasonable supports that may assist an individual or family to quarantine at home.

Conditions of Home Quarantine Direction accepted in the form of a personal undertaking

65. Accepting the need to do all things necessary to mitigate against the risk of non-compliance with a Home Quarantine Direction made by the Chief Health Officer or Authorised Officer, the Chief Health Officer or Authorised Officer could consider making the Home Quarantine Direction conditional upon the eligible person entering into a written undertaking, which could contain specific requirements that they must agree to, including (but not limited to):

    A. to submit to such COVID-19 testing during the period of home quarantine as is specified by the Chief Health Officer or Authorised Officer

    B. to allow such people as are required to carry out such testing to enter the premises at which the person is detained to conduct such testing

    C. to provide during the period of detention such information as is reasonably required by the Chief Health Officer or Authorised Officer in order to review whether their detention continues to be reasonably necessary.

66. Further, to underscore the gravity of any non-compliance, such an undertaking or agreement could also include an assurance from each person (over the age of 18 years) that they understand and agree to comply with each of the conditions of their quarantine and have understood the penalties that apply to any breaches.

Monitoring and compliance

67. The Victorian Government considers enhancing the range of methods for monitoring compliance with Home Quarantine requirements, such as electronic monitoring using smart phone technology and the use of ankle or wrist monitoring systems.

Penalties for non-compliance

68. The Victorian Government, in recognition of the risks to public health associated with any non-compliance with the Home Quarantine Directions, considers whether the current penalty regime is sufficiently weighted to enforce compliance.

69. The Victorian Government, in recognition of the risks to public health associated with any non-compliance with the Home Quarantine Directions, considers whether an offence should be created to apply to any person who knowingly enters a place where a person has been directed to Home Quarantine, unless that person has been authorised by the Chief Health Officer or Authorised Officer to do so.

Additional Final Report Recommendations (Recommendations 70–81)

Pre-pandemic planning (Chapter 3)

70. The Victorian Government, through the various national structures available to the Premier, the Minister for Health, the Secretary to DHHS and the Chief Health Officer, advocates for necessary action to be taken to address the recommendations from the *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009* as to clarity on roles and responsibilities between different levels of government, management, support systems and communication and policy on quarantine and isolation.

71. The Secretary of DHHS engages with the appropriate representative bodies from the medical profession with a view to developing agreed plans as to the availability of medical expertise and resources in the event of a public health emergency and the need for future surge demands.

72. The Secretary of DHHS ensures that future pandemic planning exercises should specifically address the need for clarity of roles, structures and accountabilities to ensure the necessary detailed focus and preparedness as to the importance of these issues is widely understood and well-rehearsed.

73. The Secretary of DHHS, in consultation with representative bodies from the broader health sector, reviews the range of participants currently invited to pandemic planning exercises to assess how the range of representative participants could be expanded to include the broader health sector.

Role of the control agency and Ministerial accountability (Chapter 8)

74. The Emergency Management Commissioner clarifies the language used in the Emergency Management Manual Victoria to ensure that there is no possibility of any ambiguity about the role and responsibility of the control agency, including a more fulsome definition of what constitutes a complex emergency and the role of the designated control agency in a complex emergency.

75. The Secretary of DHHS engages in discussions with the President of the Australian Medical Association to address the availability of medical expertise to meet current and future surge and planning demands for public health emergencies.

76. That the Public Sector Commissioner examines the evidence that emerged in this Inquiry as to the lines of accountability and responsibility as between Departmental heads and Ministers and gives guidance across the public service as to the obligations, both in law and in practice, on heads of departments and senior public office holders.

77. The Emergency Management Commissioner, in collaboration with the Chief Health Officer, the Secretary of DHHS and other relevant agencies, reviews the suitability of the Emergency Management Manual Victoria framework to Class 2 public health emergencies, including how the Emergency Management Manual Victoria intersects with the *Public Health and Wellbeing Act 2008* (Vic).

Testing regime (Chapter 10)

78. To provide clarity to the Chief Health Officer and his delegates on the circumstances in which mandatory testing powers may be exercised and, to further minimise the risks of community transmission arising from the revised hotel quarantine program:

    A. the Responsible Minister should obtain detailed legal advice from the Solicitor-General on the range of circumstances in which ss 113 and 200(1)(d) of the *Public Health and Wellbeing Act 2008* (Vic) may be exercised to require that those refusing testing at the conclusion of their quarantine period undertake mandatory testing

    B. the request for such advice should provide a detailed list of practical scenarios that commonly arise, or are expected to arise, in the context of returned travellers refusing to undergo testing in the Hotel Quarantine Program

    C. recognising that it will not be possible to provide absolute certainty on the range of circumstances in which these powers may be available, the advice should provide practical guidance to the Chief Health Officer and Authorised Officers in their exercise of the powers under ss 113 and 200(1)(d) and consider matters including those listed above in paras 41.a–41.h

    D. the request for advice should also include a request for a 'checklist' to be developed in order to assist those working in the Hotel Quarantine Program to determine when mandatory testing powers and/or the option of imposing an additional 10 days' quarantine should be exercised

    E. to accompany this advice, the Responsible Minister should identify an appropriate person who will be available to provide legal advice, at short notice and when required, to the Chief Health Officer and delegates, on the exercise of mandatory testing powers and/or the option of imposing an additional 10 days' quarantine.

79. To protect against the risk of infection spreading to the community via staff or personnel working in the program who have contracted the virus from returned travellers, the Responsible Minister should ensure, or continue to ensure, that:

    A. all on-site staff and personnel, including frontline workers and cleaners, are required to undergo daily saliva testing and weekly nasal swab testing

    B. family and household members of such frontline staff and personnel are provided with, and given support to access, voluntary testing on, at least, a weekly basis.

Returned travellers' rights and welfare (Chapter 12)

TRANSITIONING INTO QUARANTINE FACILITIES

80. The Quarantine Governing Body (called COVID-19 Quarantine Victoria) should ensure proper infection prevention and control measures are applied in the transit of returned travellers to their quarantine facility, in the same manner as those measures are applied at hotels. Those measures should include proper social distancing, cleaning and PPE practices.

81. To further reduce the risk of transmission during transit, the Quarantine Governing Body should require that:

    A. buses used to transport returned travellers to quarantine facilities must be used only for that purpose and not to provide non-quarantine related transport services to members of the public

    B. every effort be made to ensure that drivers of buses used to transport returned travellers to quarantine facilities are not permitted to work in other forms of employment (or to drive buses for any other purpose), consistent with Recommendation 22.

About this Report

The COVID-19 Hotel Quarantine Inquiry was established on 2 July 2020 to examine matters related to Victoria's Hotel Quarantine Program.

Specifically, the Inquiry was tasked with looking into decisions by, actions of and communication between government agencies, hotel operators and private contractors involved in the Hotel Quarantine Program, along with associated contractual arrangements, information, guidance and training, and policies, protocols and procedures.

The Inquiry's Final Report examines the workings of Victoria's Hotel Quarantine Program and provides associated findings and recommendations based on evidence and information tendered to the Inquiry.

The Final Report is to be read in conjunction with the Inquiry's Interim Report, which was delivered on 6 November 2020 and contained 69 recommendations that supported the development and implementation of a robust quarantine system for the State of Victoria. As explained in the Interim Report, those recommendations were based on the evidence and information before the Inquiry at that time. The Interim Report was delivered to the Governor to assist in developing and implementing a future quarantine program for the proposed re-opening of international points of entry into Victoria.

The Final Report incorporates and adopts the 69 recommendations presented in the Interim Report, as set out in the previous section. The Final Report recommendations flow on from the Interim Report and, as such, are numbered from Recommendation 70 onwards.

Evidence and information contained in this Report

To inform its work, the Inquiry received evidence from 96 witnesses (with 63 of these witnesses appearing at hearings to give evidence) and sat for 27 hearing days, during which 263 exhibits were tendered into evidence. There were 30 parties with Leave to Appear, from whom 414 pages of closing written submissions were received.

While all of this material has been considered, only those parts of the evidence or submissions necessary to explain reasoning or findings or recommendations are referred to in the body of the Report. The fact that a piece of evidence or a submission is not referred to in this Report does not mean that regard was not had to it.

Intake and Assessment Team received a considerable range of information

From 15 July 2020, the public was able to make contact with the Inquiry via telephone and email channels as per details provided on the website (see Chapter 14: How we went about our work).

The Inquiry had an Intake and Assessment Team whose role it was to receive and respond to those who contacted the Inquiry. In this way, the Inquiry received information from a range of people involved in the Hotel Quarantine Program, including returned travellers, nurses and security guards.

Information provided to the Inquiry from some of these sources has been included in the Report in the form of narratives and quotes. Some of the narratives contain the full story of a person's experience in the Hotel Quarantine Program as reported to the Intake and Assessment Team; some of the quotes in the Report are a snippet of an experience.

The information provided to the Inquiry and included in the narratives and quotes is important and valuable. However, it is noted that, generally, this information was not provided to the parties with Leave to Appear to respond to or test. As such, these narratives and quotes are not referenced as 'evidence' but are, instead, referenced as 'information provided to the Inquiry'.

Terms of Reference

You are required to inquire into, report and make any recommendations considered appropriate in relation to the following terms of reference:

1. The decisions and actions of Victorian government agencies, hotel operators and Private Service Providers, including their staff/contractors and any other relevant personnel involved in the Quarantine Program (each Relevant Personnel), relating to COVID-19 Quarantine Containment;
2. Communications between Victorian government agencies, hotel operators and Private Service Providers relating to COVID-19 Quarantine Containment;
3. The contractual arrangements in place across Victorian government agencies, hotel operators and Private Service Providers to the extent they relate to COVID-19 Quarantine Containment;
4. The information, guidance, training and equipment provided to Relevant Personnel for COVID-19 Quarantine Containment and whether such guidance or training was followed, and such equipment was properly used;
5. The policies, protocols and procedures applied by Relevant Personnel for COVID-19 Quarantine Containment; and
6. Any other matters necessary to satisfactorily resolve the matters set out in paragraphs 1 to 5.

CHAPTER 1

Background

1.1 Introduction

1. A fair and constructive examination of what happened in Victoria with its Hotel Quarantine Program must be put into a national and international context. To do otherwise would not be helpful to the way forward, nor fair to those hundreds of people who worked tirelessly in our state to help keep us all safe. Further, to not examine the Program and its component parts measured in response to the growing threat of the novel coronavirus pandemic engulfing the world by early 2020, and the state of knowledge at that time, would be an injustice to those who were tasked with implementing and operating the Hotel Quarantine Program. I do not want that to be the legacy of this Inquiry.
2. Aspects of the Program had serious fault lines through them that need to be identified. Decisions made and not made, and actions taken and not taken, also must be examined. This Inquiry aims to do that for the benefit of all.
3. With that in mind, this section of the Report aims to set out that international and national context, in summary form, as the background to the emergence of the COVID-19 pandemic.

1.2 COVID-19 — The emergence of a pandemic

A new virus is identified in China

4. In late 2019, the world's attention was being drawn to China where reports were emerging of an unknown pneumonia-like disease.
5. On 31 December 2019, the World Health Organization (WHO) country office in the People's Republic of China was alerted to cases of 'viral pneumonia' in Wuhan City, Hubei Province, China.[1]
6. By 3 January 2020, reports of 44 patients with a pneumonia of an unknown cause had been made to WHO by national authorities in China. Of the reported cases, 11 were identified as being severely ill. At this stage, the reported clinical signs of this pneumonia included fever with some patients having difficulty breathing. Chest radiographs also identified invasive lesions in both lungs.[2]
7. The newly identified virus, provisionally named 2019-nCoV[3], was later renamed 'severe acute respiratory syndrome coronavirus 2' (SARS-CoV-2) by the International Committee on Taxonomy of Viruses.[4] The disease caused by SARS-CoV-2 became known as COVID-19.[5]
8. The initial cluster of patients was linked to the Huanan Seafood Market in Wuhan and, at the time, no evidence of significant human-to-human transmission had been reported.[6] While some dispute about origins of COVID-19 currently remains, the weight of available information leans towards the first case of animal-to-human transmission of the virus occurring in China.[7]

9. The WHO confirmed, on 11 January 2020, that it had received the genetic sequences for the novel coronavirus from China and expected these to soon be made publicly available. These would be used to support other countries in developing specific diagnostic kits.[8]

10. By 14 January 2020, the first case of COVID-19 outside China had been reported. The patient was linked to Wuhan and located in Thailand.[9] The potential for human-to-human transmission between confirmed cases was also highlighted for further investigation.[10]

11. On 16 January 2020, the Japanese Ministry of Health, Labour and Welfare informed the WHO of a confirmed case of novel coronavirus in a person who had travelled to Wuhan.[11] This was the second confirmed case detected outside China. The WHO stated, not surprisingly, that, considering global travel patterns, additional cases in other countries were likely to occur.[12]

12. On 20 January 2020, Chinese authorities included COVID-19 in the notifiable report of Class B infectious diseases and border health quarantine infectious diseases, leading to the adoption of control measures such as temperature checks, healthcare declarations and quarantine at transportation depots.[13] By that date, the WHO had been notified of 282 confirmed cases of COVID-19 in China, Japan, the Republic of Korea and Thailand.[14]

13. As of 22 January 2020, a total of 581 COVID-19 cases had been reported globally. Of these cases, 571 were reported in China and 375 were linked to the Hubei Province. Seventeen deaths had also been reported from the Hubei Province. Global cases were all linked to Wuhan and were reported in Thailand, Japan, Hong Kong Taipei Municipality, China, Macau, the United States of America and the Republic of Korea.[15]

The WHO declares a public health emergency

14. On 30 January 2020, the WHO Director-General, Dr Tedros Adhanom Ghebreyesus, convened a meeting of the Emergency Committee on the novel coronavirus under the International Health Regulations (2005). The Committee advised the Director-General that the outbreak now met the criteria for a public health emergency of international concern.[16]

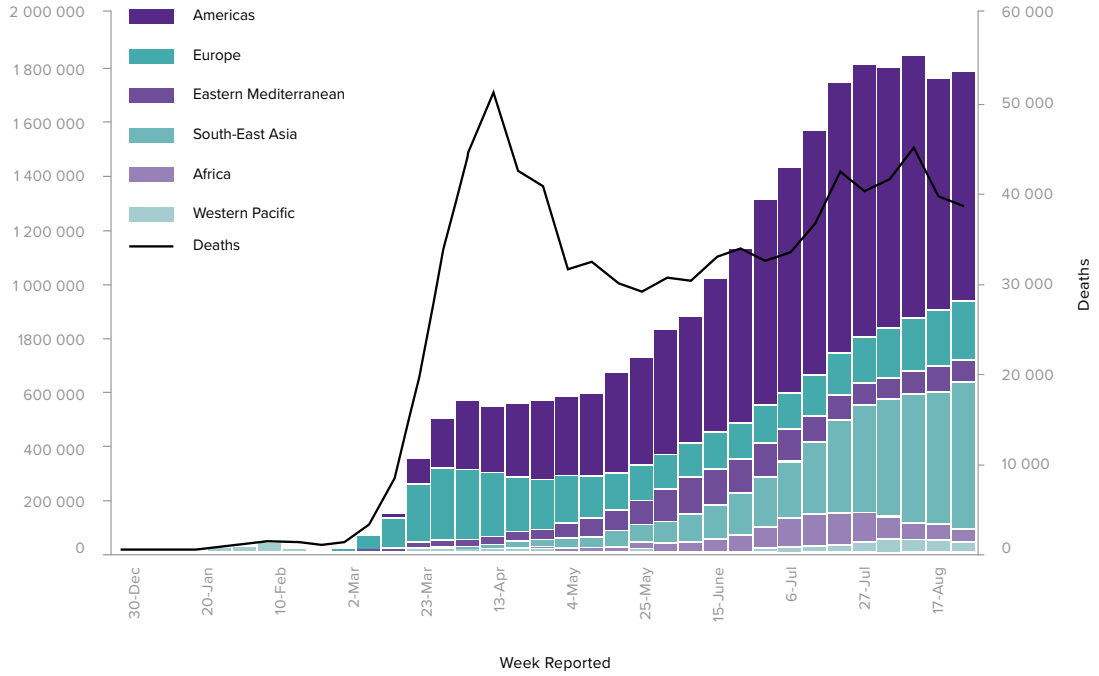
15. At that time, there were 7,711 COVID-19 cases confirmed in China and 83 cases were reported in 18 other countries (including Australia). Confirmed cases of human-to-human transmission were reported in three countries outside China.[17]

COVID-19 is declared a pandemic

16. By 11 March 2020, Dr Tedros reported that the number of cases of COVID-19 outside China had increased 13-fold compared with the number of cases two weeks earlier.[18] The number of affected countries had tripled. Specifically, there were 118,319 cases in 114 countries, including China, and 4,292 deaths had been recorded.[19]

17. Dr Tedros also noted that the number of cases, the number of deaths and the number of affected countries were expected to climb higher. It was in this context that the WHO declared COVID-19 a pandemic.[20]

Figure 1.1: Global number of reported COVID-19 cases and deaths 30 December 2019–30 August 2020



Source: WHO COVID-19 Weekly Epidemiological Update, 30 August 2020, <https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200831-weekly-epi-update-3.pdf?sfvrsn=d7032a2a_4>.

What is a pandemic?

18. A pandemic is defined by the WHO as the worldwide spread of a new disease.[21] For example, an influenza pandemic occurs when a new influenza virus emerges and spreads around the world and most people do not have immunity.[22]

19. When declaring COVID-19 a pandemic on 11 March 2020, Dr Tedros highlighted that this was the first pandemic caused by a coronavirus and noted countries would need to strike a balance between protecting health, minimising economic and social disruption, and respecting human rights in managing the virus.[23]

20. The WHO called on countries to 'detect, test, treat, isolate, trace, and mobilise their people' to change the course of the pandemic.[24] In addition, and consistent with health advice provided since January 2020, the WHO reiterated basic principles to reduce the general risk of transmission, including:

    A. avoiding close contact with people suffering from acute respiratory infections

    B. practising socially distant greetings such as a wave, nod or bow

    C. frequent handwashing, especially after direct contact with ill people or their environment

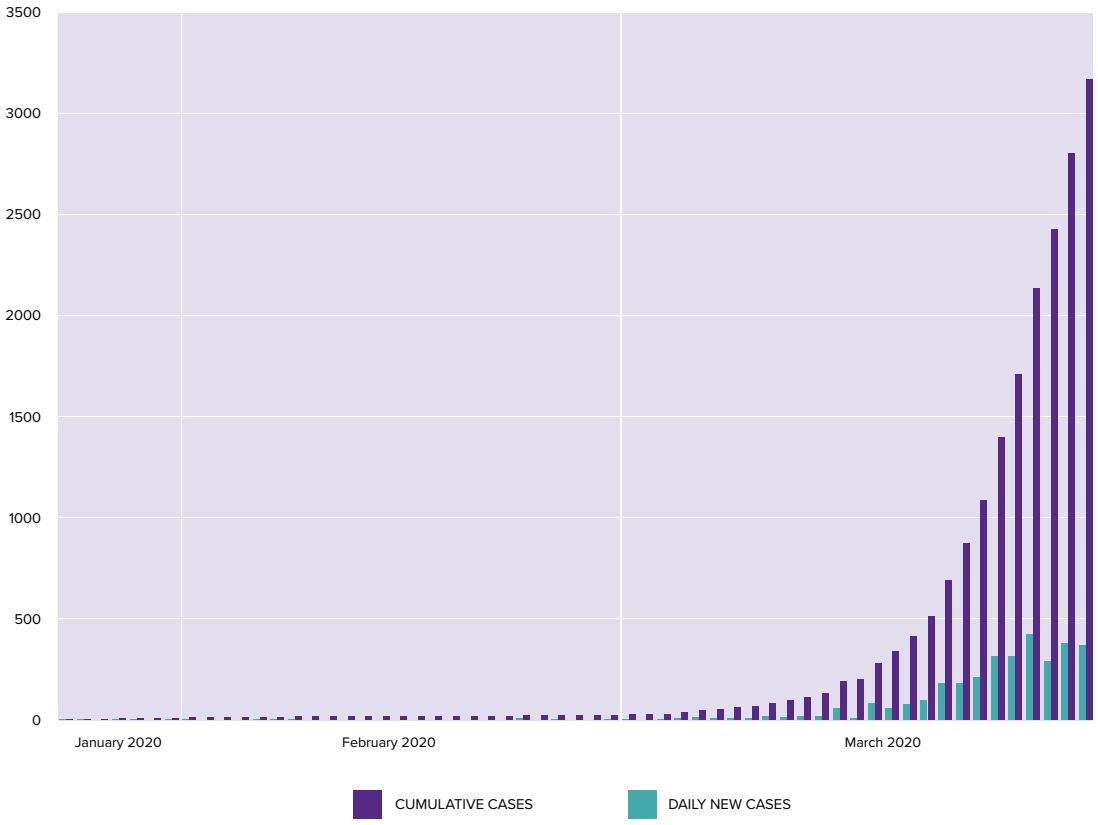
    D. regular cleaning of high touch surfaces in a home environment

    E. practising cough etiquette (maintain distance, cover coughs and sneezes with disposable tissues or clothing, and wash hands)

    F. enhance standard infection prevention and control practices in hospitals, especially in emergency departments.[25]

1.3 The Australian response to COVID-19

Figure 1.2: Total COVID-19 cases in Australia 25 January 2020–27 March 2020



Source: COVID-19 current situation and case numbers, Department of Health, <https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-current-situation-and-case-numbers#daily-reported-cases>; WHO COVID-19 Daily Situation Reports 25 January–27 March 2020: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports>.

Table 1.1: Total COVID-19 cases in Australia as of 31 August 2020

Juristiction	Total Confirmed Cases	Deaths
Australia	25,746	652
Breakdown of Figures by State and Territory		
ACT	113	3
NSW	4,050	52
NT	33	0
QLD	1,122	6
SA	463	4
TAS	230	13
VIC	19,080	565
WA	655	9

Source: Department of Health, <https://www.health.gov.au/sites/default/files/documents/2020/09/coronavirus-covid-19-at-a-glance-31-august-2020.pdf>.

21. According to the Prime Minister, Australia had clearly been monitoring the increase in COVID-19 cases in China and other parts of the world, and was alert to the need to begin preparing for COVID-19 cases to potentially enter the country.[26]

22. On 20 January 2020, the Australian Health Protection Principal Committee (AHPPC), which comprises the Chief Medical Officer of Australia and all state and territory Chief Health Officers, met for the purposes of considering a national response to COVID-19.[27]

23. On 21 January 2020, the then Chief Medical Officer for the Australian Government, Professor Brendan Murphy — the Commonwealth Chief Medical Officer — in his capacity as Director of Human Biosecurity, made a written determination pursuant to s. 42 of the Commonwealth's *Biosecurity Act 2015* (Cth) that COVID-19 (designated 'human coronavirus with pandemic potential') should be included as a 'listed human disease'.[28] This determination provided authority for the Federal Minister for Health to impose enhanced border screening measures for all travellers entering and departing Australia.[29]

24. On 25 January 2020, Australia confirmed its first case of COVID-19, a man from Wuhan who had travelled from Guangdong to Melbourne on 19 January 2020.[30]

25. The Australian Government subsequently raised the level of travel advice for Wuhan and Hubei Province to 'Level 4–Do Not Travel' and introduced precautionary measures for travellers arriving in Australia from China to detect unwell travellers and to ensure all returning travellers were provided with information about COVID-19 and the steps to take should they develop symptoms.[31]

26. At the same time, Australia was advised that Chinese authorities had put a stop to transport out of Wuhan city. According to the Prime Minister, flight MU 749, which landed at Sydney Airport on the morning of 23 January 2020, was the last flight out of Wuhan to Australia. All passengers on this flight were met, on arrival, by biosecurity and health officials and received information about the virus.[32]

27. According to the Prime Minister, enhanced health advice was provided at every port of entry to Australia for all modes of travel (airline and sea).[33] The Commonwealth Chief Medical Officer stated that every state and territory health department had established designated isolation and testing facilities with clearly established protocols for getting people to these facilities.[34] It was reported that, in Victoria, initial potential and positive cases were treated at Monash Medical Centre in accordance with infection control procedures.[35]

28. Knowledge of symptoms of the virus had apparently progressed from a fever with some patients having difficulty breathing, as identified by the WHO on 3 January 2020,[36] to 'fever, cough, sore throat, vomiting and difficulty breathing'.[37]

Escalating confirmed COVID-19 cases in Australia

29. By 1 February 2020, there were 12 confirmed COVID-19 cases in Australia.[38] The Department of Foreign Affairs and Trade (DFAT) upgraded its travel advice for China to 'Do Not Travel'.[39] Restrictions were also placed on people travelling or returning to Australia from China:

> Foreign nationals (excluding permanent residents) who are in mainland China from today forward, will not be allowed to enter Australia for 14 days from the time they have left or transited through mainland China ...
>
> Any foreign nationals who do arrive in Australia notwithstanding the prohibition, and who choose not to immediately return to their port of origin, will be subject to mandatory quarantine.
>
> We will also be requiring Australian citizens, permanent residents and their families who do enter Australia and who have been in mainland China to self-isolate for 14 days from the time they left mainland China.[40]

30. The Prime Minister announced that a plan was also established to provide assisted departures for isolated and vulnerable Australians located in Wuhan and the Hubei Province in China, with individuals to quarantine for 14 days at Christmas Island.[41]

31. The 14-day period was based on medical advice around the incubation period of the virus.[42]

32. By 29 February 2020, 24 confirmed COVID-19 cases had been reported by states and territories in Australia.[43] Of these cases:

    A. 15 had a direct or indirect link to Wuhan City, Hubei Province, China

    B. nine cases were associated with the Diamond Princess repatriation flight from Japan to the Northern Territory on 20 February 2020.[44]

33. An additional case with recent travel history to Iran, where the largest number of reported deaths had occurred outside of the Hubei Province in China, was also confirmed by the Prime Minister in his media release of 29 February 2020. DFAT subsequently upgraded the travel alert for Iran to 'Do Not Travel'.[45]

34. In the context of increasing cases of COVID-19 in Australia, the National Cabinet was established.[46]

Establishment of the National Cabinet: A governmental response to the pandemic

35. On 13 March 2020, in recognition of the unprecedented scale and potential consequences of the pandemic, the National Cabinet was established following a meeting of the Council of Australian Governments (COAG).[47]

36. It was stated by the Prime Minister that the National Cabinet was created to address and ensure consistency in Australia's response to the COVID-19 pandemic. Like COAG, it comprised the Prime Minister, Premiers and Chief Ministers of the States and Territories.[48] It first met on 15 March 2020.[49]

37. The key advisory bodies to the National Cabinet included the AHPPC, led by the Commonwealth's Chief Medical Officer and comprising the chief health and medical officers from each jurisdiction, and the National Coordination Mechanism (NCM), convened by the Department of Home Affairs. The work of the NCM was described as working across all jurisdictions, industry and key stakeholders to ensure a consistent approach to managing the impacts of the pandemic beyond immediate health issues.[50]

38. In addition to reiterating the health advice around proper hand hygiene and social distancing measures, the National Cabinet announced a range of measures to limit or reduce the transmission of COVID-19 in Australia.

Decisions made by National Cabinet

15 MARCH 2020

39. In the wake of its first meeting on 15 March 2020, the Prime Minister announced that the National Cabinet agreed that its core objective was to slow the outbreak of COVID-19 in Australia by taking additional steps to reduce community transmission.[51] To help 'stay ahead of the curve' the Commonwealth Government imposed a 'universal precautionary self-isolation requirement on all international arrivals', effective from 11.59pm that day.[52]

40. Further, the National Cabinet implemented a ban on cruise ships from foreign ports (including round trip international cruises originating in Australia) arriving at Australian ports for an initial 30 days, from 11:59pm Sunday 15 March 2020.[53] Arrangements were made for cruise ships already in transit to enable Australian citizens and permanent residents to get off those ships.[54]

41. The National Cabinet also endorsed the advice of the AHPPC to introduce further social distancing measures, including the requirement that non-essential, organised public gatherings of more than 500 people should not occur.[55] It should be noted that Victoria applied these decisions through its declaration of a State of Emergency on 16 March 2020.[56] Further detail on this is provided at paragraph 58 below.

17 MARCH 2020

42. At its meeting on 17 March 2020, the National Cabinet accepted AHPPC advice that non-essential indoor gatherings of greater than 100 people (including staff) no longer be permitted from Wednesday 18 March 2020.[57] This was applied in Victoria under the State of Emergency declared on 16 March 2020.[58]

19 MARCH 2020

43. On the morning of 19 March 2020, the cruise ship Ruby Princess had disembarked into Sydney. It came to be understood that around 39 per cent of the ship's passengers from Australia and 17 per cent of its crew had contracted COVID-19.[59]

44. The passengers from that vessel had been allowed to disperse, immeasurably compounding the task of contact tracing and infection control.

45. 28 deaths were later found to be associated with passengers from the Ruby Princess.[60]

20 MARCH 2020

46. On 20 March 2020, the National Cabinet met and agreed, amongst other restrictions and safety measures, to endorse the Commonwealth Government's decision to stop the entry of non-citizens and non-permanent residents and their immediate families into Australia after 9.00pm that day.[61]

47. Most relevant to this Inquiry is the decision made by the National Cabinet on 27 March 2020.

27 MARCH 2020

48. By 27 March 2020, according to information provided via the Prime Minister's media release there were more than 3,000 confirmed COVID-19 cases in Australia and 13 deaths. The majority of cases were in New South Wales, Victoria and Queensland.[62] There was considerable concern that the majority of cases across the nation were coming in via international points of entry.

49. On 27 March 2020, the National Cabinet met and agreed to further restrict the movement of incoming travellers and increase compliance checks on travellers already self-isolating. Notably, the National Cabinet agreed that, as soon as possible, but no later than 11.59pm on 28 March 2020, all travellers arriving in Australia would be required to undertake mandatory 14-day self-isolation at 'designated facilities'.[63]

50. Hotels were given as an example of a designated facility, but the exact facilities to be designated and the implementation of the quarantine program was a matter for each state and territory government. The National Cabinet agreed that:

    A. travellers would be transported directly to designated facilities after appropriate immigration, customs and enhanced health checks

    B. designated facilities would be determined by the relevant state and territory government and would ordinarily be in the city of entry where the traveller had cleared immigration, but facilities in other areas could be used if required

C. these requirements would be implemented under state and territory legislation and would be enforced by state and territory governments, with the support of the Australian Defence Force (ADF) and Australian Border Force (ABF) where necessary

D. the Commonwealth would provide support through the ADF and ABF for these arrangements across Australia, with states and territories meeting the costs and determining any contributions required for travellers arriving within their jurisdictions.[64]

51. Later, on 30 March 2020, the National Cabinet agreed that state and territory governments could consider exceptional circumstance exemptions to the requirement to serve the 14-day quarantine in a hotel or other designated facility in order to enable vulnerable or at-risk individuals to self-isolate at home.[65]

1.4 Victoria's response to the COVID-19 pandemic

52. As early as 10 January 2020, Victoria's Chief Health Officer (CHO), Professor Brett Sutton, issued a health alert with respect to patients who had travelled to Wuhan, China and who experienced the onset of fever and respiratory symptoms within two weeks of their return. The alert acknowledged concern that what was referred to as viral pneumonia may be a novel coronavirus.[66]

53. On 1 February 2020, recognising that COVID-19 (being a human disease) was a Class 2 emergency, as that term is used in the Emergency Management Acts and the Emergency Management Manual Victoria, a designated State Controller — Health was appointed.[67] Notwithstanding that, under the Victorian State Health Emergency Plan, the State Controller — Health is presumptively the CHO,[68] the Director of the Emergency Management Branch within the Department of Health and Human Services (DHHS) was actually appointed to the role.[69] The significance of this is the subject of analysis later in this report.

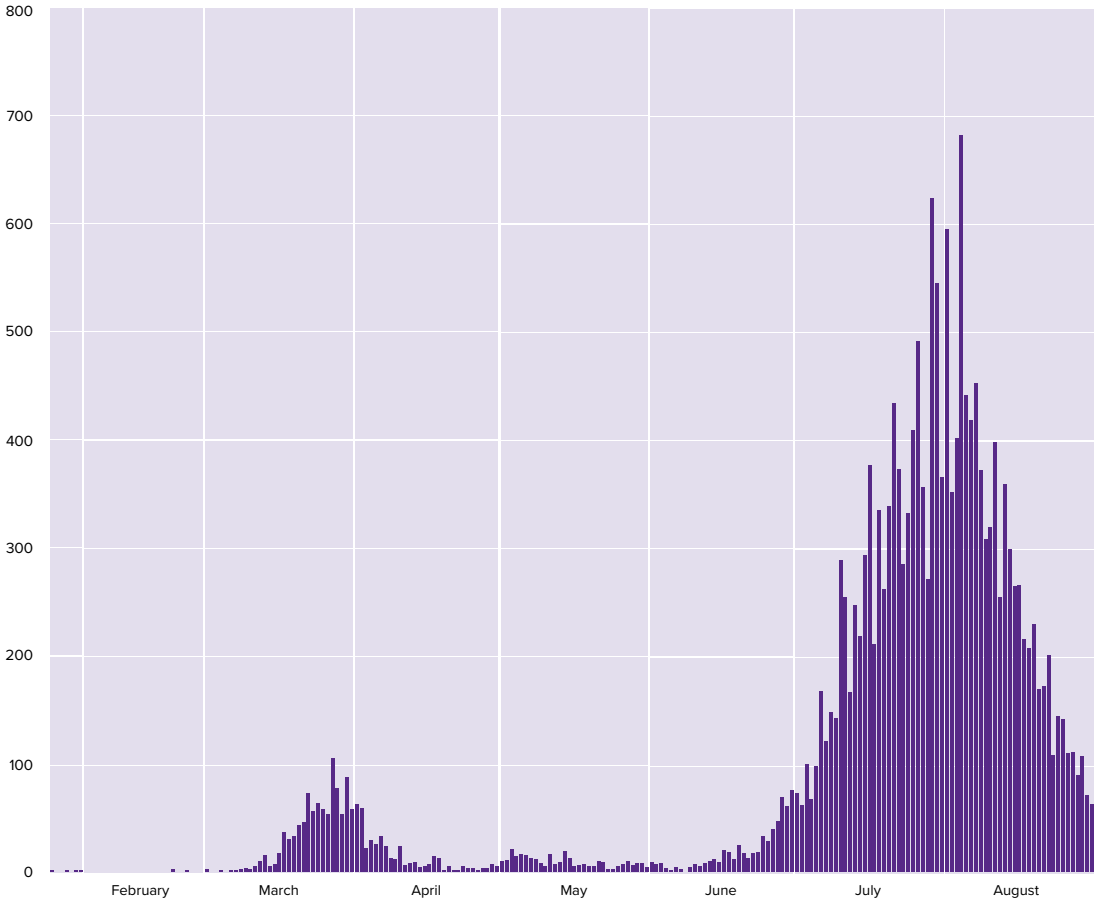
54. On 10 March 2020, the State Control Centre was activated to oversee and co-ordinate Victoria's response to the spread of COVID-19.[70]

55. By the start of March 2020, Victorians were nightly watching distressing scenes across the world where alarming numbers of people in international locations were contracting the virus and a catastrophic number of lives were being lost.

56. Predictions about the potential for the spread of COVID-19 throughout the community were being made by experts, including Victoria's Deputy Chief Health Officer, Dr Annaliese van Diemen.

57. Dr van Diemen's evidence was that she had observed, primarily through international experience, the disease spread rapidly with very high fatality rates.[71] Further, there was no vaccine, nor was there treatment to mitigate the effects of COVID-19. The virus therefore became an 'exceedingly significant risk to public health'.[72]

Figure 1.3: Daily new COVID-19 cases in Victoria 25 January 2020–31 August 2020



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Declaration of a State of Emergency in Victoria

58. On 16 March 2020, a State of Emergency under the *Public Health and Wellbeing Act 2008* (Vic) (PHW Act) was declared in Victoria by the then Minister for Health, the Hon. Jenny Mikakos MP, on the advice of the CHO and after consultation with the Minister for Police and Emergency Services and the Emergency Management Commissioner under the *Emergency Management Act 2013* (Vic), due to the serious public health risk posed by COVID-19.[73] This activated the emergency management powers and enabled the CHO to issue orders and directions, including enforcing 14-day isolation requirements for all travellers entering Australia and cancelling mass gatherings of more than 500 people as agreed by the National Cabinet.[74]

59. The initial State of Emergency was implemented for a four-week period, as specified in the PHW Act. Thereafter, successive sets of Directions (State and Commonwealth) were issued up to, and including, 28 March 2020 as set out below.

Table 1.2: Declarations and directions issued ahead of the Hotel Quarantine Program being established

Date	Declaration or Direction	Detail	Government (Victoria/ Commonwealth)
16 March 2020	Declaration of a State of Emergency Issued under s. 198(1), *Public Health and Wellbeing Act* (Vic)	Declaration activated the emergency management powers and enabled the Chief Health Officer to issue orders and directions, including social distancing measures and quarantining of groups of people.	Victoria
	Direction from the Chief Health Officer in accordance with emergency powers arising from declared state of emergency Issued under s. 200(1)(b) and (d), *Public Health and Wellbeing Act* (Vic)	Direction contained two parts that: • prohibited non-essential mass gatherings (Part 1): • directed persons arriving in Victoria from overseas to undertake a 14-day period of 'self-quarantine' (Part 2).	Victoria
18 March 2020	Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) Declaration 2020 Issued under s. 475, *Biosecurity Act 2015* (Cth). Varied under s. 476, *Biosecurity Act 2015* (Cth)	Declaration made by the Governor-General established that there was an existing Human Biosecurity Emergency by the name of COVID-19 or SARS-CoV-2. The declaration gave the Health Minister expansive powers to issue any direction to any person (s. 478) and set any requirements (s. 477) provided that these actions were to prevent or control the entry, emergence, establishment or spread of the outbreak (ss 477(1), 478(1)). This was the first time these powers under the *Biosecurity Act 2015* (Cth) were used.	Commonwealth
	Airport Arrivals Direction Issued under s. 200(1)(b) and (d), *Public Health and Wellbeing Act* (Vic)	Direction replaced Part 2 of the Direction from the Chief Health Officer (Communicable Disease) in accordance with the emergency powers arising from declared State of Emergency issued on 16 March 2020. Issued to people arriving in Victoria from overseas (between 5.00pm 18 March 2020 and midnight 13 April 2020) directing that they must go into immediate compulsory isolation for 14 days at a 'premises that it suitable for the person to reside in for a period of 14 days'.	Victoria
	Mass Gatherings Direction Issued under s. 200(1)(b) and (d), *Public Health and Wellbeing Act* (Vic)	Direction replaced Part 1 of the Direction from the Chief Health Officer in accordance with emergency powers arising from declared state of emergency issued on 16 March 2020. Prohibited gatherings of 500 people or more in a single undivided outdoor space and gatherings of 100 people or more in a single undivided indoor space.	Victoria
19 March 2020	Cruise Ship Docking Direction Issued under s. 200(1)(b) and (d), *Public Health and Wellbeing Act* (Vic)	Direction applied to any person who disembarked at a port in Victoria from an international cruise ship or an Australian cruise ship between midday 19 March 2020 and midnight 13 April 2020. Directed that returnees must travel from the port in Victoria to a premises suitable for the person to reside in for a period of 14 days.	Victoria

Date	Declaration or Direction	Detail	Government (Victoria/ Commonwealth)
21 March 2020	Mass Gatherings Direction (No. 2) Issued under s. 200(1)(b) and (d), *Public Health and Wellbeing Act* (Vic)	Direction replaced the Mass Gatherings Direction made on 18 March 2020. Directed that a gathering of fewer than 100 people was only permitted in a single undivided indoor space where the space had minimum of four square metres per person or where the space was a private residence, a private vehicle or a commercial passenger vehicle.	Victoria
	Visitors to Residential Aged Care Facilities Direction Issued under s. 200(1)(b) and (d), *Public Health and Wellbeing Act* (Vic)	Direction prohibited people visiting residential aged care facilities between 6.00pm on 21 March 2020 and midnight 13 April 2020 except for certain groups of people, including: • employees or contractors of the facility • people visiting the facility for the purpose of providing a care and support visit to a resident (of no longer than 2 hours, by one person or two people made together) • people attending for the purpose of providing health, medical, pharmaceutical goods or services to a resident • people visiting for the purpose of providing end of life support to a resident • prospective residents.	Victoria
23 March 2020	Non-Essential Business Closure Direction Issued under s. 190(1)(a) and 200(1)(d), *Public Health and Wellbeing Act* (Vic)	Direction prohibited the operation of the following non-essential businesses or undertakings between noon 23 March 2020 and midnight 13 April 2020: • businesses characterised as pubs, bars or clubs that supply alcohol • hotels, except to the extent they provided accommodation, bottle shop or meal takeaway or delivery services • gyms • indoor sports centres • casinos • cinemas, nightclubs or entertainment venues of any kind • restaurants and cafes (other than meal takeaway or delivery services) • places of worship, other than for the purposes of weddings or funerals.	Victoria
	Hospital Visitors Directions Issued under and s. 200(1)(b) and (d), *Public Health and Wellbeing Act (*Vic)	Direction prohibited non-essential visits to hospitals in the State of Victoria between midnight 23 March 2020 and midnight 13 April 2020.	Victoria

Date	Declaration or Direction	Detail	Government (Victoria/ Commonwealth)
25 March 2020	Isolation (Diagnosis) Direction Issued under s. 200(1)(b) and (d), *Public Health and Wellbeing Act* (Vic)	Direction issued to people who have tested positive to COVID-19 between midnight 25 March 2020 and midnight 13 April 2020, requiring that they self-isolate until: • written clearance from self-isolation had been provided by an officer of DHHS; • they met criteria for discharge from self-isolation.	Victoria
	Non-Essential Activity Direction Issued under s. 190(1) (a) and (g) and 200(1) (d), *Public Health and Wellbeing Act* (Vic)	Direction replaced the Non-Essential Business Closure Direction made on 23 March 2020, and extended and further particularised restrictions on non-essential business in the State of Victoria, including introducing restrictions to non-essential retail facilities such as beauty and personal care facilities and animal facilities such as zoos and aquariums.	Victoria
	Prohibited Gatherings Direction Issued under s. 200(1)(b) and (d), *Public Health and Wellbeing Act* (Vic)	Direction replaced the Mass Gatherings Directions (No. 2) made on 21 March 2020, and added two new categories of prohibited gatherings: • social sport gatherings • weddings and funerals.	Victoria
25 March 2020	Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) (Overseas Travel Ban Emergency Requires) Determination 2020 Issued s. 477(1) of the *Biosecurity Act 2015* (Cth)	Determination prohibited Australian citizens and permanent residents from leaving Australian territory by air or sea as a passenger. It also prohibited the operator of an outgoing aircraft or vessel from leaving Australian territory with an Australian citizen or permanent resident on board as a passenger. This overseas travel ban did not apply to the following persons: • a person who was ordinarily a resident in a country other than Australia • a person who was a member of a crew of an aircraft or vessel but was travelling as a passenger on another aircraft or vessel • a person engaged in the day-to-day conduct of inbound and outbound freight • a person whose travel is associated with essential work at an offshore facility (for example, offshore oil rigs) • a person who was travelling on official government business (including a member of the Australian Defence Force). This entered into force at noon 25 March 2020, 15 hours after it was announced following a meeting of the National Cabinet.	Commonwealth
26 March 2020	Non-Essential Activity Direction (No. 2) Issued under s. 190(1) (a) and (g) and 200(1) *(d), Public Health and Wellbeing Act* (Vic)	Direction replaced the Non-Essential Activity Direction made on 25 March 2020, and: • removed hair salons and barber shops from the list of non-essential retail facilities, as well as the 30-minute time limit, thereby permitting those facilities to operate so long as they comply with the density, cleaning and signage requirements • added 'sex on premises' venues to the list of non-essential entertainment facilities.	Victoria

Date	Declaration or Direction	Detail	Government (Victoria/ Commonwealth)
28 March 2020	Revocation of Airport Arrivals Direction and Cruise Ship Docking Direction Issued under s. 200(1)(b) and (d), *Public Health and Wellbeing Act* (Vic)	Direction revoked the Airport Arrivals Direction and Cruise Ship Docking Direction with effect from midnight 28 March 2020. If the Airport Arrivals Direction or the Cruise Ship Docking Direction, as the case required, applied to a person before the revocation of that Direction by subclause (1), the direction continued to apply to the person after that revocation as if the Direction had not been revoked.	Victoria
	Direction and Detention Notice (No. 3) Issued under s. 200, *Public Health and Wellbeing Act* (Vic)	Direction issued to people arriving in the State of Victoria from overseas (on or after 11:59pm on 28 March 2020) advising that they must go into immediate compulsory quarantine for 14 days. It noted that the person was detained due to the serious risk posed by COVID-19 and the fact that their detention was reasonably necessary for the purpose of eliminating or reducing the serious public health risk. Direction also outlined that: • detainees must not leave their room under any circumstances unless they had permission • detainees must not permit any other person to enter their room, unless the person was authorised to be there for a specific purpose (for example food or medical reasons) • a person's detention be revisited every 24 hours to determine that it was still necessary.	Victoria

Source: Victorian Government Gazette Archives <http://www.gazette.vic.gov.au/gazette_bin/gazette_archives.cfm?bct=home|searchgazettes|recentgazettes|gazettearchives>; Federal Register of Legislation — Legislative Instruments <https://www.legislation.gov.au/Browse/ByTitle/LegislativeInstruments/InForce/0/0/Principal/>

Victoria's hotel quarantine program commences

60. It was in this context that Victoria's Hotel Quarantine Program, later known as 'Operation Soteria', was established, following the National Cabinet's decision on 27 March 2020 requiring returned travellers to undertake mandatory quarantine.

61. The Deputy Chief Health Officer issued Direction and Detention Notice No. 3 on 28 March 2020, as set out in the Table 1.2 above, thus creating the detention orders that mandated all international arrivals into Victoria into hotel quarantine after 11.59pm on 28 March 2020. The detail of the set up for Victoria's Hotel Quarantine Program, over the weekend of 28 and 29 March 2020, is contained in Chapter 3.

1.5 Conclusions

62. Following its emergence in late 2019, COVID-19 rapidly proliferated across the globe, leading the WHO to declare the virus a pandemic on 11 March 2020.[75]

63. The first Australian case of COVID-19 was reported on 25 January 2020,[76] with 12 cases confirmed by 1 February 2020.[77] Local case numbers then continued to increase, with there being more than 3,000 confirmed cases of COVID-19 by 27 March 2020.[78]

64. Understandably, as these numbers continued to swiftly rise, so too did concern among government, the medical and scientific community, and the general public. In the view of Dr van Diemen, the anticipated trajectory of the virus posed a significant risk to public health.[79]

65. At a state level, the Victorian response included the appointment of a State Controller — Health,[80] the activation of the State Control Centre[81] and a declaration of a State of Emergency.[82] At the federal level, the National Cabinet was established on 13 March 2020, with the stated aim of ensuring consistency in Australia's response to the COVID-19 pandemic.[83]

66. Many of the National Cabinet's agreed measures were aimed at addressing the concern that international arrivals were fuelling the rise in domestic COVID-19 case numbers. These measures included imposing a self-isolation requirement for international arrivals and a ban on foreign cruise ships,[84] as well as prohibiting the entry of non-citizens and non-permanent residents.[85]

67. It was in this context that the National Cabinet, at a meeting on 27 March 2020, resolved to implement a mandatory 14-day quarantine period for international arrivals,[86] setting the wheels in motion for the establishment of Victoria's Hotel Quarantine Program.

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CHAPTER 2

COVID-19 — The science

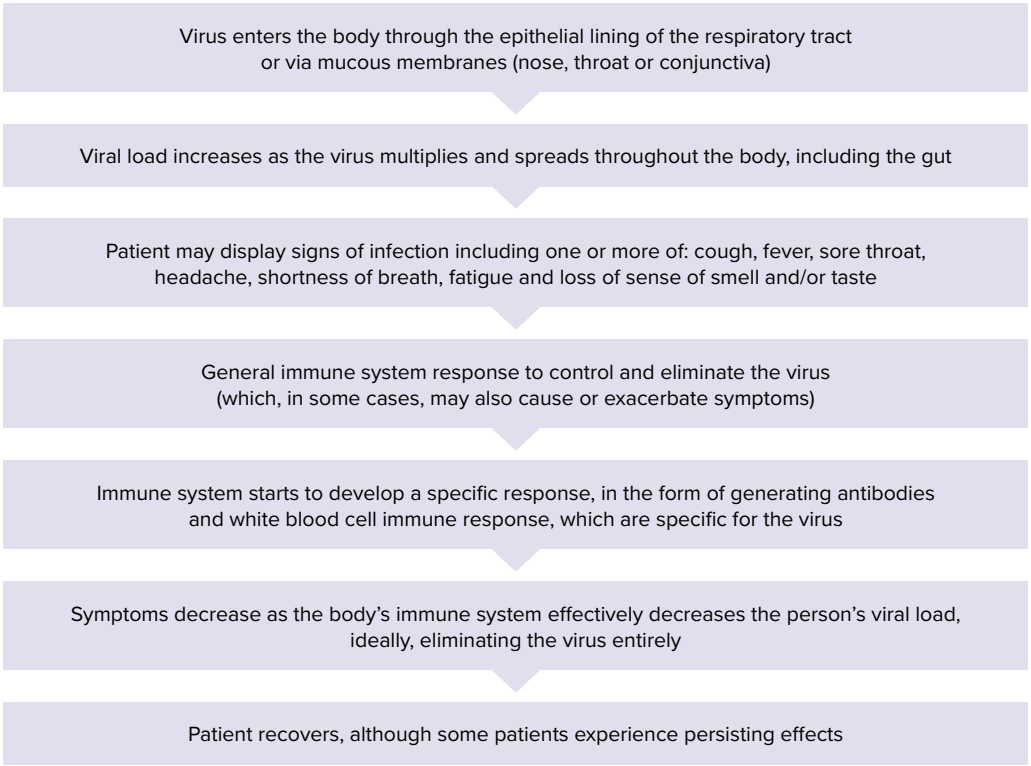
2.1 Introduction

1. As highlighted in the Background section of this report, SARS-CoV-2 is a new virus and information about it continues to emerge as the pandemic progresses. While the scientific and medical communities across the world work to learn more about the virus, the current general understanding of what it is, how it spreads and how it can broadly affect people is useful to set out here, particularly to give context as to why it was that the Hotel Quarantine Program was considered necessary.
2. Further, to assist in ascertaining the links between what has become known as the 'second wave' of COVID-19 cases in Victoria and the Hotel Quarantine Program, it was necessary to understand the science behind the COVID-19 virus, as it is currently understood, and the appropriate mechanisms for managing and controlling it.
3. To do that, evidence was called on 17 and 18 August 2020 from three scientific and medical experts regarding the nature of the COVID-19 disease, infection control, epidemiology and genomic sequencing.
4. The scientific and medical experts were:
    A. Professor Lindsay Grayson — a clinical physician specialising in infectious diseases and infection control. Prof. Grayson provided evidence based upon his years of clinical experience, current scientific and medical information and his first-hand experience managing infection control for COVID-19 at Austin Health as Director of the Infectious Diseases Department, a role he has held since 2000[1]
    B. Professor Ben Howden — a medical microbiologist with expertise in genomic sequencing. Since 2014, Prof. Howden has been the Director of the Microbiological Diagnostic Unit Public Health Laboratory (MDU PHL) at the University of Melbourne. In his role as Director, he leads a team of scientists, computer scientists and epidemiologists who conduct genomic sequencing and analyse and report on genomic sequencing data in Victoria[2]
    C. Dr Charles Alpren — an expert epidemiologist. Since June 2019, Dr Alpren has been employed by the Department of Health and Human Services (DHHS) as an epidemiologist and is one of the leads in the Intelligence Section (Intelligence) of the COVID-19 Public Health Incident Management Team. His role is to oversee the entry, management, epidemiological analysis, interpretation and reporting of data pertaining to COVID-19 that is collected through the DHHS notifiable diseases surveillance system. He reports to the Deputy Public Health Commander for Intelligence.[3]
5. The evidence and expertise of these three witnesses was not contested during the Inquiry's hearings. I accept their evidence regarding genomic sequencing, the nature of COVID-19, quarantine and associated testing and infection control protocols relating to COVID-19.

2.2 The nature of COVID-19

6. The proceeding paragraphs summarise the current state of knowledge about the COVID-19 virus, how it spreads, for how long people are infectious, the effect on different age groups and what is currently known about immunity. It must be noted, however, as was observed regularly during the Inquiry, that state of knowledge is still developing.

Figure 2.1: Lifecycle of the virus



Source: Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 5 [23].

What is COVID-19?

7. Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) is the strain of coronavirus that causes coronavirus disease 2019 (COVID-19). Prof. Grayson gave evidence that coronaviruses are a family of viruses thought to only affect mammals.[4]

8. COVID-19 is considered to be highly infectious, particularly as it can be transmitted before the onset of symptoms and because those who are infectious may be entirely asymptomatic or have only trivial symptoms.[5]

9. Prof. Grayson's evidence was that COVID-19 is in the same family of viruses as SARS and MERS-CoV, the Middle Eastern coronavirus. He explained that SARS in 2003 was different to the current COVID-19 virus strain in that almost all patients who contracted the virus were very symptomatic and it had a substantially higher death rate.[6] Likewise, while MERS exhibited some asymptomatic carriage, person-to-person transmission was relatively low.[7]

Symptoms of COVID-19

10. It was Prof. Grayson's evidence that respiratory symptoms are a common feature of COVID-19 and can include fever, dry cough, sore throat, tiredness and shortness of breath.[8] An additional, unique symptom is the loss of both smell and taste. Prof. Grayson noted that a loss of sense of smell is common when one has any upper respiratory tract viral infection, but to lose sense of smell *and* taste is definitive of this particular infection. While it does not occur in all cases, when it does, it has been shown in various studies to be highly suggestive of COVID-19.[9]

11. Dr Alpren stated that approximately 17.9 per cent of cases experience asymptomatic infection. This means that some people who are infected will not experience any symptoms and may not know they are sick. He explained that, as symptomology can vary throughout the course of the infection, the overall proportion of cases that remain asymptomatic throughout the course of infection is unknown.[10]

What is known about the infectious nature of COVID-19?

12. Prof. Grayson's evidence was that, for COVID-19 illness to occur, a person must be exposed to a sufficient amount (the viral load) of the SARS-CoV-2 (also referred to as the COVID-19 virus). Exposure occurs through *viral shedding*.[11]

13. He stated that viral load is a measure of the number of virus particles in a given sample. For example, it may refer to the amount of virus present in a person's tissues or bodily fluids (such as respiratory droplets) or the amount of virus to which a person is exposed.[12]

14. He explained that viral shedding occurs when a person who has the virus present in their body expels infectious fluid from their body; for example, by sneezing or coughing.[13]

15. Those with the virus are thought to be at their most infectious (the maximum point of viral load) for up to 48 hours before they show any symptoms, for those who have symptoms. However, Prof. Grayson noted that this timeframe is variable amongst different people; some may be infectious for a longer period before symptom onset and others for a shorter period. Notwithstanding this variability, 48 hours is considered to be a reasonable average timeframe and is similar to many other viral infections.[14]

Incubation period

16. Prof. Grayson agreed with the generally-held medical opinion that the COVID-19 virus has an incubation period of up to 14 days, with an average incubation period of about five to seven days.[15] This means that for those who are exposed to the virus, the majority will develop symptoms (where symptoms show) within 14 days of exposure to the virus. He explained that there have been reports of some individuals not showing symptoms for up to 24 days after exposure to the virus, but 14 days is considered the upper limit for the majority of patients.[16]

17. Prof. Grayson stated that most symptomatic COVID-19 patients resolve their symptoms in approximately 10–14 days and are considered likely to be non-infectious at the end of that time.[17] As noted by Prof. Grayson, '[a]lthough statistics vary from country to country, present data suggests that, for every 100 Australians who test positive for the virus, up to 20 per cent may require admission to hospital, up to 10 per cent may require intensive care support, and between 1.4 to 3.4 per cent may die'.[18]

Modes of transmission

18. The issue of the modes of transmission of the virus is still the subject of varying expert opinions, particularly as between aerosol and fomite transmission. Fomites are defined by Prof. Grayson as surfaces or objects (including hands) which may become contaminated (e.g. through contact with an infected person) and serve as an intermediary vehicle for transmission. According to Prof. Grayson, COVID-19 enters the body through mucous membranes, including the conjunctiva of the eyes and the membranes of the nose and the mouth, and via the lining of the lungs.[19]

19. He explained that the COVID-19 virus can be transmitted through direct contact with infected people via respiratory secretions (droplets and aerosols). It can also be transmitted through fomites. Examples of fomites cited by Prof. Grayson included thermometers or other shared equipment.[20]

20. Prof. Grayson explained in evidence that COVID-19 is a predominantly respiratory virus.[21] That is, it mainly transmits when 'a person inhales droplets or particles that have been expelled by an infected person, either from coughing, sneezing, talking, singing or by breathing. In each case, the virus particle is suspended in the saliva or mucous particles (in droplet or aerosol form) which are ordinarily expelled by each of these actions'.[22]

21. He stated that while the COVID-19 virus may be airborne (particularly when expelled in aerosol format), it appears to have less potential for distant transmission (for example, via an air conditioning system where air is partially recirculated such as in large office buildings, hospitals or hotels). There have been reports of airborne transmission in places that are crowded and likely to be inadequately ventilated, such as restaurants and fitness classes, but Prof. Grayson noted that short-range aerosol transmission cannot be ruled out in these instances. It was his view that were the COVID-19 virus capable of substantial distant airborne transmission, localised outbreaks that are larger than what have been experienced would likely have occurred.[23]

22. Prof. Grayson stated that, regarding fomites, studies have demonstrated that the COVID-19 virus could survive on certain surfaces (such as plastic, cardboard and stainless steel), outside of a body, for up to 72 hours. As an example of how transmission may occur via a fomite, Prof. Grayson said that 'an infected person may cough on a door handle, which is then touched by another person. Should that second person then touch their mouth, there is transmission from the infected person to the second person'.[24]

23. It is relevant to note that, while medical and scientific experts are continuing to develop an understanding of the COVID-19 virus and its modes of transmission, the evidence provided to the Inquiry about the possible modes of transmission of COVID-19 was known as of 29 March 2020, at the time the Hotel Quarantine Program was established. Guidance provided by the WHO on 29 March 2020 and titled 'Modes of transmission of virus causing COVID-19: implications for IPC precaution recommendations: scientific brief' was drawn upon by DHHS staff to inform their knowledge of COVID-19.[25]

24. The WHO guidance stated:

> According to current evidence, COVID-19 virus is primarily transmitted between people through respiratory droplets and contact routes … Droplet transmission occurs when a person is in close contact (within 1 m) with someone who has respiratory symptoms (e.g. coughing or sneezing) and is therefore at risk of having his/her mucosae (mouth and nose) or conjunctiva (eyes) exposed to potentially infective respiratory droplets. Transmission may also occur through fomites in the immediate environment around the infected person. Therefore, transmission of the COVID-19 virus can occur by direct contact with infected people and indirect contact with surfaces in the immediate environment or with objects used on the infected person … In the context of COVID-19, airborne transmission may be possible in specific circumstances and settings in which procedures or support treatments that generate aerosols are performed … [26]

Rate of transmission — the concept of R_0

25. Prof. Grayson explained the concept of R_0 in his witness statement as follows:

> R_0 is the average number of people who are likely to contract a contagious disease, from one other person with that disease, within a sample population. For a contagious disease to maintain spread throughout a population, R_0 needs to be greater than 1. A R_0 of 1 means that, in a community of people, one person is likely to infect only one other person. If that occurs, the virus remains in the community, as it is passed along a chain of infected persons. Where the R_0 is greater than 1, the infection is spreading.[27]

26. Essentially, R_0 provides a value to assess transmissibility in the broader community to guide decisions about what precautions and policies should be implemented. Precautions taken in the community are considered fundamental to reducing the R_0 value for COVID-19.[28]

27. The COVID-19 virus is considered to have a potential R_0 value of approximately 2–3, noting that this can vary based on region, health standards and controls. As at 1 August 2020, the R_0 value for COVID-19 in Australia was estimated to be about 1.05, although the R_0 value for Victoria, where the pandemic was changing rapidly, was not publicly available as of that date.[29]

28. As a comparison, Prof. Grayson stated in his witness statement that measles is considered to have an R_0 value of between 12 and 18. That is to say, that for every one person who has measles, an average of between 12–18 other people will be infected (where they are not vaccinated).[30]

29. The evidence was that the R_0 represents an average rate of transmission in the community. It does not define an individual's actual potential for infecting others. Some individuals will have a rate of transmissibility that is higher than the average.[31] These individuals are referred to as 'super spreaders' as defined in paragraphs 30–32 below.

'Super spreaders' and asymptomatic transmission

30. The concept of 'super spreaders' refers to individuals who infect a disproportionately large number of contacts.[32] These individuals may have a higher viral load, and are therefore likely to be more infectious, or they may be asymptomatic and therefore less likely to self-isolate as they may be unaware that they have COVID-19. Prof. Grayson stated that some recent overseas studies have suggested that possibly 10–20 per cent of COVID-19 infected patients may be responsible for 80 per cent of all cases.[33]

31. Super spreaders are not unique to COVID-19. In his witness statement, Prof. Grayson highlighted that during the SARS-CoV outbreak in 2003, the index patient of the Hong Kong epidemic was associated with at least 125 secondary cases.[34]

32. The concept of asymptomatic super spreaders raises important issues that go to the complexity of COVID-19 from an infection control and testing perspective, particularly in a quarantine environment. Prof. Grayson noted that testing for COVID-19 is crucial given that up to approximately 20 per cent of cases can be asymptomatic.[35]

33. The rationale for a 14-day quarantine period, as noted above, is that most people will develop symptoms within 14 days of exposure to the virus, although some individuals have not shown symptoms until up to 24 days after exposure.[36] This variation in incubation period, and given what is known about asymptomatic COVID-19 cases, led Prof. Grayson to conclude that it would be sensible to test all people at the end of their quarantine period to see whether they were infected with the virus, irrespective of symptoms. He noted that if the sole determinant for whether people were released from quarantine was that they were not showing symptoms after 14 days, a proportion of those who were infected with the virus and potentially infectious, but who remained asymptomatic, could be released into the community.[37] The testing regime that developed throughout the course of the Hotel Quarantine Program is discussed in more detail in Chapter 10.

34. It is important to note that, while knowledge of COVID-19 continues to develop, and evidence of asymptomatic transmission has developed more recently, there was knowledge of asymptomatic transmission as early as 29 January 2020.[38] Indeed, an AHPPC statement on COVID-19, published on 29 January 2020, indicated knowledge of 'very recent cases of novel coronavirus who are asymptomatic or minimally symptomatic' and 'reports of one case of probable transmission from a pre-symptomatic case to other people, two days prior to the onset of symptoms'.[39]

Effect of COVID-19 on different age groups

35. In general terms, Prof. Grayson stated that the current state of learning is that children are less affected by COVID-19 (asymptomatic or experience mild symptoms) compared with adults. Observations suggest that about a third of younger people may be asymptomatic or only trivially symptomatic'.[40]

36. As noted by Prof. Grayson, adults and those with a weakened immune system appear to be more affected in terms of symptoms and associated severity of illness. The older one is, the more one's mortality is impacted. But Prof. Grayson stated that it is unclear, at this stage, whether COVID-19 affects older members of the community simply due to age or whether the immune system in general weakens as one gets older.[41]

Immunity

37. According to Prof. Grayson, an immune response is triggered when there is a foreign substance in the body. He explained that, generally speaking, antibodies interact with proteins on the surface of the foreign particles, known as antigens, which are specific to the type of foreign substance detected. Once the body recognises an antigen (either as new or because it has already been exposed to it in the past) it triggers the production of antibodies and enlists the assistance of key white blood cells to fight the infection and develop immunity.[42]

38. Prof. Grayson noted that antibodies also remain in the body to enable it to continuously detect the antigen and eliminate future infections. This is why the body is generally more effective in eliminating foreign particles to which it has been exposed in the past (either via infection or vaccination).[43]

39. The evidence is that work continues to be undertaken to understand the nature and spread of the COVID-19 virus (including asymptomatic transmission), and the body's immune response (including possible reinfection), to support vaccine development.[44]

40. Indeed, as Prof. Grayson noted in his witness statement, current data seems to indicate that some of the vaccines in development may only be effective (in terms of an adequate antibody response) for a limited period of some months, but this varies with the nature of the candidate vaccine, the number of 'booster' doses given and the adequacy of the recipient's immune system to respond to the vaccine. After that time, the immune system's 'memory' wanes, meaning that the COVID-19 specific antibodies may not remain in the body at adequate immediate concentrations and need either time to recover (via immune 'memory mechanisms') or further 'booster' vaccinations.[45]

41. Prof. Grayson stated that it is not yet clear whether a person who has been infected with, and recovered from, COVID-19 will not be infected again. Some examples have arisen where an individual has been infected with the virus, recovered and contracted the virus again with the same symptoms. However, further work needs to be undertaken on whether, in these cases, the infected people caught the same virus strain twice.[46]

42. Prof. Grayson highlighted in his evidence that each virus and each disease is different, which makes vaccine development an interesting but complex field. In terms of vaccine development for COVID-19, he explained that part of the challenge is creating a vaccine that is effective for the relevant strain and any subsequent variants, and provides immunity for an extended period of time.[47]

43. The next step in understanding the science of COVID-19 for the Inquiry's purposes related to epidemiology and genomic sequencing.

2.3 Epidemiology

What is it and why is it undertaken?

44. Dr Charles Alpren, epidemiologist, defined epidemiology, in a general sense, as the study of the patterns and determinants of disease in specific populations. Medically speaking, he noted that epidemiology and public health medicine are different from patient-specific medicine 'as they advise and implement broad interventions on large groups of people to achieve overall health benefit'.[48]

45. Dr Alpren stated that epidemiologists play a role in both understanding and controlling the spread of communicable diseases (diseases that can spread from person-to-person) by:

    A. analysing data to look for patterns that can forecast the trajectory of disease

    B. informing interventions to alter that trajectory.[49]

46. As outlined by Dr Alpren, epidemiologists integrate key facts about a disease, including mechanisms of transmission, incubation and the infectious period, with the spatial and temporal patterns observed within a population.[50]

47. As an example, Dr Alpren noted that the work of epidemiologists could 'involve a group of infected people in a defined location with disease onset between set dates. An analysis of that group and the circumstances of their interactions can reveal how diseases spread, which can then allow us to understand and inform changes ..'.[51] By understanding how and why disease is spread, advice can be provided on how to interrupt the spread of disease.[52]

48. Dr Alpren explained that epidemiology informs an understanding of the risk factors that are characteristic of people or environments that place individuals at higher risk of acquiring or becoming affected by disease. It can, therefore, make broad predictions about people or circumstances that present a higher risk of disease. It can also predict disease trajectory under known parameters and assumptions, and outline what could happen if, for example, restrictions are placed on a population.[53]

What are epidemiological methods used for?

49. Epidemiology supports the detection, surveillance and control of communicable diseases. This involves the collection and analysis of information and data, with the outcomes of this analysis informing contact and communications with people affected by an outbreak, advising next steps and required actions.[54]

50. Dr Alpren explained that inside DHHS, broadly in Victoria, this work is split into streams including: (1) Intelligence and (2) Case, Contact and Outbreak Management. At a high level, Intelligence is responsible for data collection, entry and classification, undertaking data analysis and modelling, and providing associated advice within the Department and to government to support decision-making and planning.[55]

51. Work undertaken by Intelligence supports the work of the Case, Contact and Outbreak Management Team where contact tracing is undertaken. Contact tracing involves the 'identification, assessment and management of people who have potentially been exposed to disease and are at a higher risk of developing and spreading disease'.[56]

52. Dr Alpren explained that contact tracers work with people to interrupt the spread of a disease by ascertaining who might have been exposed to a disease (via interviews with possible contacts and examination of data sources, such as employment rosters) and informing them of their responsibility to quarantine. Contact tracers also work with epidemiologists to identify patterns and risk factors involved in disease transmission.[57] Difficulties with contact tracing in the context of Victoria's hotel quarantine outbreaks is discussed in more detail in Chapter 9.

2.4 Genomic sequencing

What is genomic sequencing?

53. Prof. Howden gave evidence about the science of genomic sequencing, a process by which the whole genetic signature of a pathogen is recovered. A pathogen is defined as a microorganism that can cause a disease, such as a virus.[58]

54. A genome is defined by Prof. Howden as an organism's complete set of genes or genetic material, comprising DNA or RNA. COVID-19, which is a viral genome, is made up of RNA, whereas the human genome, bacterial genomes and some viral genomes are made up of DNA.[59]

55. As outlined in Prof. Howden's statement, whole genome sequencing is the process to determine the complete sequence (DNA or RNA) of an organism's genome and can be broken down into two distinct processes:

    - first, there is an analytical process undertaken in a specialised genome sequencing laboratory, using sophisticated laboratory hardware, to determine the complete genome of an organism in a single reaction
    - then, this genome sequence is investigated and compared with other genome sequences using bioinformatic software.[60]

56. Regarding COVID-19, Prof. Howden explained that this virus has a genome size of approximately 30,000 bases, which is effectively 30,000 letters in a row. When undertaking genomic sequencing of the virus, the aim is to recover the majority of the 30,000 letters in their correct sequence, providing the genetic code.[61] He explained that the sequencing process can recover and reconstruct up to 99.8 per cent of the SARS-CoV-2 genome, but this percentage varies based on several biological and testing factors.[62]

Why is genomic sequencing undertaken?

57. Through the process of genomic sequencing, inferences can be made about genomic clusters and the presence of any mutations.[63] This creates an understanding of where a virus sample may have originated and relationships between virus samples. Further, for COVID-19, there is no alternative to genomic sequencing to identify, and discriminate between, clusters.[64]

58. As explained by Prof. Howden, if there are two virus samples that have the same sequence, they would cluster together during the analysis stage. In a genomic context, this means that the samples are identical or highly related.[65] Where sequences are highly genomically related, then an epidemiological link is likely; for example, cases where the virus has been transmitted between members of a household.[66] The interaction between genomic sequencing and epidemiology is discussed from paragraph 67.

59. Prof. Howden explained that, by contrast, sequences that have different patterns of mutations are not closely related by genomics; for example, as seen with returned travellers who acquired COVID-19 in different countries.[67]

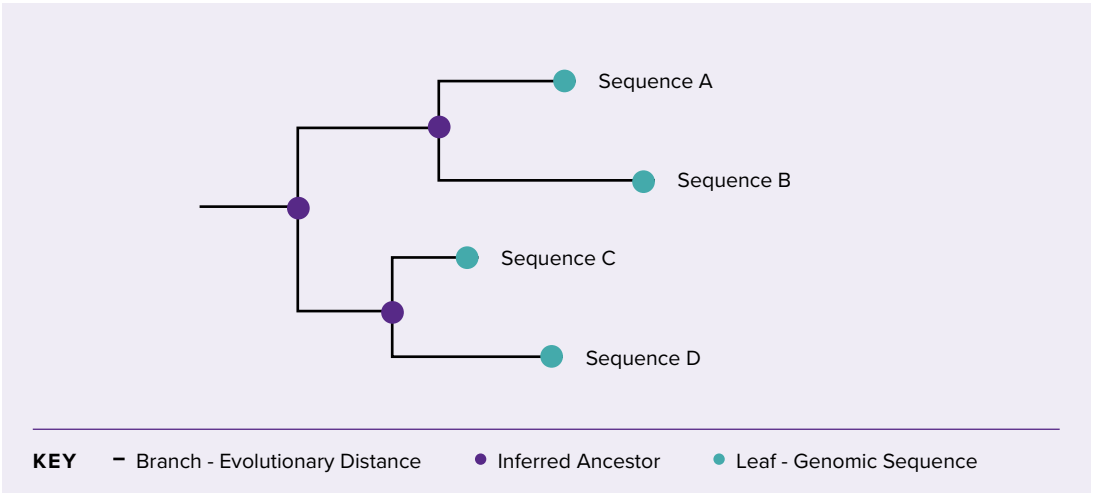
60. A genetic mutation is a permanent alteration in the genetic makeup of an organism and plays a role in the evolution of the organism.[68] All pathogens acquire mutations over time at different rates.[69]

61. As an example of genetic mutation, Prof. Howden explained that if one exposes bacteria to an antibody it will develop a mutation that helps it survive in the case of an antibiotic.[70] With COVID-19, mutations could occur at any point in the 30,000 letters of the genome. As mutations accumulate over time, and Prof. Howden notes that mutations in the COVID-19 genome have been occurring slowly,[71] they can act like a 'passport stamp' for the virus. This allows bioinformatic analysis to determine where a virus sample may have been previously.[72]

62. Prof. Howden outlined that 'once a mutation occurs in the genome of a virus, it is copied to and shared by all its descendant copies, creating groups of viruses that share a mutation because of their shared ancestry ....[73]

63. This shared ancestry informs phylogenetic analysis, used to understand the evolutionary history of an organism.[74] Figure 2.2, provided by Professor Howden, is an example of a phylogenetic tree, which is a visual representation of the likely evolutionary relationships between samples or sequences.

Figure 2.2: Annotated phylogenetic tree describing the evolutionary relationships between sequences



Source: Exhibit HQI0005_P Witness Statement of Prof. Ben Howden, 8 [46].

64. In Figure 2.2, the green dots are explained by Prof. Howden as the leaves of the tree and represent a sample or a sequence. The branches represent the genetic distance between the sequence and its inferred ancestral or parent sequences. The distance between the leaves (samples) on the horizontal lines represents the genomic distance between the samples. In this example, sequence A has a much shorter horizontal distance from sequence B, compared with sequences C or D. This means that sequence A is much more closely related, at a genomic level, to sequence B than it is to sequence C or D.[75]

What is genomic sequencing used for?

65. Prof. Howden explained that MDU PHL uses genomic sequencing of SARS-CoV-2 to identify genomic clusters that are likely to be epidemiologically linked.[76]

66. More broadly, as explained by Prof. Howden, genomic sequencing is used for pathogen surveillance and outbreak detection and investigation. It also supports findings around the resistance of a pathogen to antibiotics, how a pathogen is evolving, whether a pathogen is bringing in new genes and what the disease-causing potential is of a given pathogen.[77]

The interaction between genomic sequencing and epidemiology

67. Dr Alpren and Prof. Howden explained that genomic sequencing and epidemiology go hand-in-hand, and genomic sequencing data is not fully informative without epidemiological data. Genomic sequencing supports the identification of possible transmission networks and the likely origin of cases. Epidemiological investigations support the hypotheses generated by genomic sequencing.[78]

68. Incorporating information from epidemiological investigation (contact tracing) with genomic science allows further inferences to be drawn about transmission networks and the mechanisms and risks associated with viral transmission. As an example, Dr Alpren stated healthcare workers are known to be at higher risk than others in the community for acquisition of COVID-19.[79]

69. Identifying genomic and epidemiologic clusters supports targeted investigation of cases within the cluster to identify and remove the source of infection or disrupt transmission chains. In this context, a cluster refers to a group of people or samples with a condition or disease that share some similarity, suggesting they may have acquired the condition from each other, from a common source or due to a common cause.[80]

70. A detailed definition of epidemiological and genomic clusters was provided by Prof. Howden, as follows:

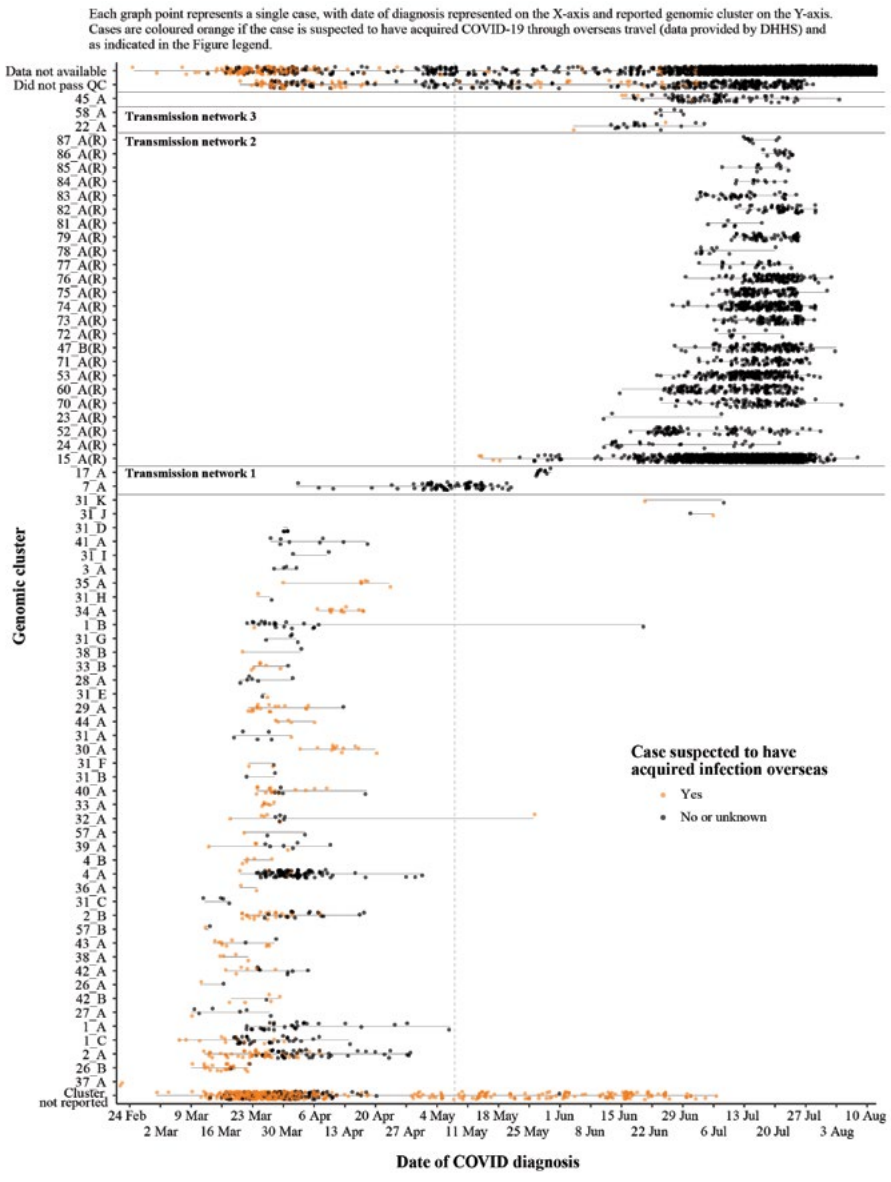
    - **Epidemiological clusters** are based on similarity in the epidemiological characteristics of person (for example, demographics), place (for example, attending the same location) and time or a combination of these.
    - **Genomic clusters** are based on the degree of genomic similarity between the pathogens (such as a virus or a bacteria). Genomic clusters indicate the sequences contained within the cluster are more related to each other than they are to any other sequences in the dataset.[81]

2.5 Genomic sequencing, epidemiology and COVID-19 cases in Victoria

71. Prof. Howden provided his uncontested expert opinion as to the results of the genomic sequencing completed by the MDU PHL of COVID-19 cases in Victoria between 21 February and 11 August 2020.

72. Figure 2.3 below, produced by Prof. Howden, represents COVID-19 cases in Victoria during this timeframe. Prof. Howden explained that each dot represents a case, with orange dots representing cases likely to have acquired infection overseas and the black dots representing cases that are likely to have been locally acquired (via community transmission). The date of diagnosis for each case is located on the X-axis and the reported genomic cluster is located on the Y-axis.

Figure 2.3: Genomic clustering of Victorian COVID-19 cases diagnosed between 21 February and 11 August 2020



Note: A transmission network, in this context, represents a group of very closely related genomic clusters with a most recent common ancestor. Each transmission network is thought to represent a separate but single importation of the virus into Victoria, with genomic diversity, which is well supported but small in magnitude, arising in Victoria as the virus has circulated within the community and resulting in mutliple closely related genomic clusters.

73. Figure 2.3 was provided by Prof. Howden when giving his oral evidence on 17 August 2020 and is an updated version of the graph that appeared in his witness statement (dated 4 August 2020), which contained data from 21 February to 23 July 2020. As at 29 July 2020, 65 genomic clusters had been identified, ranging in size from 2 to 1,071 cases (with a median of 10 cases per cluster).[82]

74. As at 14 August 2020, 72 genomic clusters had been identified (as located on the Y-axis in Figure 2.3 above), with the additional seven clusters included since 29 July linked to transmission network 2.

75. Reported genomic clustering on the graph is broadly categorised into two periods, represented by the vertical dotted line running through the graph:

    A. **Period 1** — which contains cases from 1 March to 7 May and is characterised by many diverse genomic clusters with each cluster containing a small number of cases.

    B. **Period 2** — which contains cases from 8 May onwards and is characterised by the expansion of three transmission networks and an additional new cluster (45_A). Each transmission network is a group of closely related genomic clusters with a common recent ancestor and is believed to represent a single importation of the virus into Victoria, supported by epidemiological clustering and travel history data.[83]

76. Each transmission network, marked on the graph by the dark horizontal lines, is categorised as follows:

    A. **Transmission network 1** — first identified in March and expanded rapidly throughout May. No further cases have been identified within this transmission network since 30 May 2020

    B. **Transmission network 2** — first identified in mid-May in a group of returned travellers (as identified by the orange dots). Additional cases were identified within this transmission network throughout June and July. This network included 24 clusters that appeared to have originated from the earliest cluster (15_A) based on the data available to date

    C. **Transmission network 3 and cluster 45_A** — both first identified in returned travellers during June, with additional cases identified throughout June and into July.[84]

77. As identified on the graph, and subsequently confirmed by Prof. Howden during his oral evidence, more than 99 per cent of all cases in Victoria as of August 2020, where genomic sequencing data was available, were derived from transmission network 2, predominantly, as well as transmission network 3 and cluster 45_A.[85]

78. Of note was the increase in cases that were likely to have been acquired locally during Period 2 (from 8 May onwards) compared with Period 1 (1 March–7 May), where a significant proportion of cases were attributed to infection acquired overseas.

79. The question that remained was what caused the significant increase in locally acquired cases? The answer lay with the epidemiology and the contact tracing methods used to ascertain the source of a case.

Increase in COVID-19 cases in Victoria and links to the Hotel Quarantine Program

80. Through the combination of genomic sequencing and epidemiological investigation undertaken by DHHS, Dr Alpren concluded that Victorian COVID-19 cases, as at 4 August 2020, were connected with times, transmission events or locations related to the Hotel Quarantine Program, noting that since this transmission occurred further community transmission may also have been exacerbated in additional settings, such as public housing towers and aged care homes.[86]

81. Specifically, Dr Alpren concluded that approximately 99 per cent of COVID-19 cases in Victoria, as at 4 August 2020, had arisen from outbreaks at the Rydges Hotel in Carlton (Rydges) or the Stamford Plaza Hotel (Stamford).

82. What led to the outbreaks, and their impact, is considered in detail at Chapter 9. For present purposes, the outbreak at Rydges can be traced back to a family of four that returned to Australia on 9 May 2020. Each member of that family eventually tested positive to COVID-19 and were moved to Rydges where, 10 days later, two security guards and one member of staff working at Rydges became symptomatic and were subsequently diagnosed with COVID-19.[87]

83. The Stamford outbreak can be traced back to a traveller returning to Australia on 1 June 2020 and entering quarantine at Stamford. That traveller became symptomatic and was diagnosed with COVID-19.[88] On 10 June 2020, a member of staff became symptomatic.[89] A day later, a couple, who were returned travellers quarantining at the Stamford, became symptomatic. Those two travellers and the staff were diagnosed with COVID-19 over the course of 14–16 June 2020.[90]

84. While Dr Alpren noted that he cannot be precise in the exact number or proportion to have arisen from each outbreak separately, he stated that it was likely that the large majority — approximately 90 per cent or more — of COVID-19 infections in Victoria as of 4 August 2020 could be traced to Rydges. It is likely that a small proportion — approximately 10 per cent or less — of COVID-19 infections in Victoria as of 4 August 2020 could be traced to Stamford.[91]

2.6 Conclusions

85. While acknowledging that there is a continuous state of learning with respect to the COVID-19 virus, the weight of the current expert knowledge is that the COVID-19 virus has an incubation period of up to 14 days for the majority of patients, with most patients being non-infectious at the end of that 14-day period. On this basis, the 14-day quarantine period imposed for the purposes of the Hotel Quarantine Program was a reasonable and appropriate period.

86. The evidence established that, while scientific and medical communities continue to develop an understanding of the modes of transmission for the COVID-19 virus, including what asymptomatic transmission may mean in terms of testing in a quarantine environment, there was a general understanding of the modes of transmission of the virus as at 29 March 2020 among the experts. This included that:

    - the virus primarily spread from person-to-person via droplets, aerosols and fomites
    - droplet transmission occurred when a person was in close contact (within one metre) with someone who had the virus
    - airborne transmission may have been possible in specific circumstances and settings in which procedures or support treatments that generated aerosols were performed.[92]

87. These methods of transmission were of critical importance when considering the use of hotels as facilities for mass quarantine, what adaptions needed to be made to ensure the safety of those being placed in quarantine and those working on-site at the hotels, and what needed to be put in place by way of appropriate infection prevention and control standards to address and minimise the risk of the virus spreading in quarantine hotels.

88. Asymptomatic transmission (including by way of super spreaders) led to particular complexities for infection control and testing regimes in the Hotel Quarantine Program. The public health community had knowledge of the risk of asymptomatic transmission of the virus by March 2020.

89. The weight of the current expert evidence to the Inquiry was that between 17 and 20 per cent of cases experienced asymptomatic transmission, which had flow-on impacts in terms of appropriate testing requirements. That evidence led to the conclusion that to address the risk inherent in asymptomatic spread of the virus, it is necessary to require testing of all people at the end of their quarantine period regardless of whether they are reporting symptoms.

Hotel quarantine's link to the 'second wave'

90. Dr Alpren's evidence, based on genomic testing, was that 99 per cent of Victoria's second wave of COVID-19 cases in the community have come from transmission events from returned travellers infected with the virus to people working at the Rydges and the Stamford hotels. The movement of the virus from these infected workers into the community was characterised by high rates of local transmission.[93]

91. Prior to the second wave, Victoria's COVID-19 cases were largely attributable to infection acquired overseas. All cases in transmission network 1 had ceased by 30 May 2020.[94]

Mass quarantining and the science

92. The conclusions that could be drawn from the scientific evidence provided to the Inquiry were that three fundamental safety features needed to be built into any program that sought to house together potentially infected people in a quarantine facility. They were:

    A. the importance of expert advice, input and ongoing supervision and oversight of infection prevention and control

    B. the importance of an evidentiary base for the testing regime

    C. the importance of a rapid and effective contact tracing regime.

93. Each of these areas were important topics in and of themselves and subject to their own conclusions. Accordingly, they are dealt with in more substance throughout this Report:

    A. the importance of expert advice, input and ongoing supervision and oversight of those within the Hotel Quarantine Program, is dealt with in chapters 8 and 9, in the context of the outbreaks at the Rydges and Stamford and the structure and governance of the Program

    B. the importance of a rapid and effective contact tracing regime, is also dealt with in Chapter 9

    C. the importance of an evidentiary basis for the testing regime, is considered in Chapter 10.

Endnotes

1 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 1–3; Exhibit HQI0002_RP Curriculum vitae of Prof. Lindsay Grayson.
2 Exhibit HQI0005_P Witness statement of Prof. Ben Howden, 1–4; Exhibit HQI0006_P Curriculum vitae of Prof. Ben Howden.
3 Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 1–3.
4 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 3 [9]–[10].
5 Ibid 10–11 [47(c)].
6 Transcript of day 3 hearing 17 August 2020, 33.
7 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 10 [47(b)].
8 Ibid 3 [14].
9 Transcript of day 3 hearing 17 August 2020, 34.
10 Transcript of day 4 hearing 18 August 2020, 100; Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 14 [57(d)].
11 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 3 [12], 4 [17]–[18].
12 Ibid 4 [17].
13 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 4 [18]; Transcript of day 3 hearing 17 August 2020, 35.
14 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 4–5 [20].
15 Transcript of day 3 hearing 17 August 2020, 36; Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 14 [57(b)].
16 Transcript of day 3 hearing 17 August 2020, 36; Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 12 [55].
17 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 4 [20]–[22].
18 Ibid 5 [24].
19 Ibid 3 [11].
20 Ibid 8–9 [38]–[42].
21 Transcript of day 3 hearing 17 August 2020, 39.
22 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 8 [39].
23 Ibid 9 [44]–[45].
24 Ibid 9 [42].
25 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 7 [27]
26 Ibid, quoting World Health Organization, 'Modes of transmission of virus causing COVID-19: implications for IPC precaution recommendations: scientific brief', 29 March 2020 <https://www.who.int/news-room/commentaries/detail/modes-of-transmission-of-virus-causing-covid-19-implications-for-ipc-precaution-recommendations>.
27 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 7 [33].
28 Ibid 8 [36]–[37].
29 Ibid 7 [34].
30 Ibid 8 [35].
31 Ibid 8 [36].
32 Transcript of day 3 hearing 17 August 2020, 35.
33 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 4 [19].
34 Ibid, citing Riley et al, 'Transmission Dynamics of the Etiological Agent of SARS in Hong Kong: Impact of Public Health Interventions' (2003) 300(5627) Science 1961.
35 Transcript of day 3 hearing 17 August 2020, 43.
36 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 12 [55].
37 Ibid 12 [55]–[56].
38 Australian Health Protection Principal Committee (AHPPC) statement on novel coronavirus on 29 January 2020 <https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-novel-coronavirus-on-29-january-2020-0>.
39 Ibid.
40 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 4 [16].
41 Transcript of day 3 hearing 17 August 2020, 34.
42 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 6 [26]–[28].
43 Ibid 6 [29]; Transcript of day 4 hearing 18 August 2020, 100.
44 Ibid 7 [32].

45 Ibid 7 [31].
46 Transcript of day 3 hearing 17 August 2020, 37–38.
47 Ibid 38, Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 7 [32].
48 Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 3 [17].
49 Ibid 3 [18].
50 Ibid.
51 Transcript of day 4 hearing 18 August 2020, 5.
52 Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 3–4 [18]–[20].
53 Ibid 4 [21]–[22].
54 Transcript of day 4 hearing 18 August 2020, 95.
55 Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 5 [27].
56 Ibid 9 [38].
57 Ibid 9–10 [38]–[44].
58 Transcript of day 3 hearing 17 August 2020, 74–75.
59 Exhibit HQI0005_P Witness statement of Prof. Ben Howden, 4 [22].
60 Ibid 4 [24]–[25].
61 Transcript of day 3 hearing 17 August 2020, 76.
62 Exhibit HQI0005_P Witness statement of Prof. Ben Howden, 6 [35].
63 Ibid 4 [28].
64 Ibid 5 [30].
65 Transcript of day 3 hearing 17 August 2020, 76.
66 Exhibit HQI0005_P Witness statement of Prof. Ben Howden, 7 [39].
67 Ibid 7 [40].
68 Ibid 5 [31]–[33].
69 Transcript of day 3 hearing 17 August 2020, 76.
70 Ibid.
71 Exhibit HQI0005_P Witness statement of Prof. Ben Howden, 6 [36].
72 Transcript of day 3 hearing 17 August 2020, 76.
73 Exhibit HQI0005_P Witness statement of Prof. Ben Howden, 5–6 [33].
74 Ibid.
75 Ibid 8 [47]; Transcript of day 3 hearing 17 August 2020, 78.
76 Exhibit HQI0005_P Witness statement of Prof. Ben Howden, 9 [52].
77 Ibid 9 [51].
78 Exhibit HQI0005_P Witness statement of Prof. Ben Howden, 9 [52]–[54]; Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 12–13 [49]–[53]; Transcript of day 4 hearing 18 August 2020, 98.
79 Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 12 [50].
80 Exhibit HQI0005_P Witness statement of Prof. Ben Howden, 7 [41]–[44].
81 Ibid 7 [42]–[43].
82 Exhibit HQI0005_P Witness statement of Prof. Ben Howden, 18 [95].
83 Ibid 20 [101]–[103].
84 Ibid 21 [104].
85 Transcript of day 3 hearing 17 August 2020, 86.
86 Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 19 [78].
87 Ibid 20 [86].
88 Ibid 21 [95].
89 Ibid 22 [97].
90 Ibid 21–22 [96].
91 Ibid 28 [130].
92 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 7 [27]; World Health Organization, 'Modes of transmission of virus causing COVID-19: implications for IPC precaution recommendations: scientific brief' (Brief, 29 March 2020) <https://www.who.int/news-room/commentaries/detail/modes-of-transmission-of-virus-causing-covid-19-implications-for-ipc-precaution-recommendations>.
93 Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 28 [130]; Transcript of day 3 hearing 17 August 2020, 86.
94 Exhibit HQI0006_P Witness statement of Prof. Ben Howden, 21 [104].

CHAPTER 3

The state of pandemic planning in Australia and Victoria and the envisaged use of quarantining

1. Any proper analysis of the decision to adopt a mandatory quarantine program for all international arrivals, to commence within a period of some 36 hours, cannot be divorced from an understanding of Victoria's planning for, and readiness to undertake, such a program.

2. The possibility of an epidemic or pandemic, particularly with a highly contagious viral infection, had been recognised for decades both in Victoria and nationally. Since 1999, state and territory governments and the Australian Government had developed and refined a series of plans to guide Australia's response to an influenza pandemic.[1]

3. The *Commonwealth Government's Australian Health Management Plan for Pandemic Influenza* (the Commonwealth Pandemic Plan) is intended to provide overarching guidance and a framework for a nationally consistent approach to managing an influenza pandemic.[2] The guidance provided in the Commonwealth Pandemic Plan is reflected in state and territory pandemic plans, which are tailored to local contexts.[3] In Victoria, the relevant plans are the *Victorian Health Management Plan for Pandemic Influenza 2014* (the Victorian Pandemic Plan)[4] and the *Victorian Action Plan for Influenza Pandemic 2015*.[5] Plans at both levels of government (Commonwealth and State) sit within a complex framework of emergency management strategies, plans and guidelines.

4. Professor Lindsay Grayson, Director of Infectious Diseases and Microbiology at Austin Health, gave evidence that most pandemic planning had focused on strategies aimed at influenza, given the history of the Spanish Flu a century ago and more recent outbreaks of avian influenza (H5N1) and swine flu (H1N1). However, despite that focus, Prof. Grayson stated that the principles and operational framework of these influenza pandemic plans were known to be applicable to other respiratory viral infections, including COVID-19.[6]

5. Given the existence of pandemic plans at the Victorian and Commonwealth level, a question before the Inquiry was whether, prior to the announcement and establishment of the Hotel Quarantine Program in Victoria, there was planning for a mass quarantine program that could have informed this Program.

6. In short, there was not. That was despite a review of the Commonwealth's response to the (H1N1) pandemic, published in 2011, recommending an examination of the policy on quarantine and isolation. This matter is examined in further detail in the context of the Commonwealth and Victorian pandemic plans.

3.1 The Commonwealth Pandemic Plan

7. The Commonwealth Pandemic Plan describes pandemics as unpredictable and presenting a significant risk to Australia.[7] The report states that pandemics have the potential to cause high levels of disease and death and disrupt the community, both socially and economically.[8] The Commonwealth Pandemic Plan, which was developed in consultation with states, territories and health sector stakeholders, outlines Australia's strategy to manage an influenza pandemic and minimise its impact on the health of Australians and the health system.[9] To support the management of an influenza pandemic, the Commonwealth Pandemic Plan seeks to:

    A. clarify the roles and responsibilities within the health sector of the Australian Government and state and territory governments

    B. identify areas where national guidance and coordination will be provided and how this will be achieved

    C. support decision-makers to respond in a manner that is flexible, informed and proportionate to the circumstances at the time.[10]

8. The Commonwealth Pandemic Plan recognises that the operational aspects of public health responses sit with state and territory governments. Some examples of the operational aspects of a public health response include implementing social distancing measures as per national recommendations and local risk assessment, implementing infection control guidelines and healthcare safety and quality standards, and undertaking contact tracing.[11]

9. The Commonwealth Pandemic Plan also sets out an ethical framework to guide health sector responses and actions taken under it. Some principles or values to be taken into account include providing care in an equitable manner, ensuring that the rights of the individual are upheld as much as possible and ensuring that measures taken are proportionate to the threat.[12]

10. Given states and territories have operational responsibility for public health responses, the Commonwealth Pandemic Plan notes that the majority of operational detail will be found in state and territory plans.[13] The Victorian plans are considered below.

Context and legal framework for the Commonwealth Pandemic Plan

11. The Commonwealth Pandemic Plan sits under the *Emergency Response Plan for Communicable Disease Incidents of National Significance*, which is one of four plans under the *Australian National Health Emergency Response Arrangements*. It also supports the *Emergency Response Plan for Communicable Disease Incidents of National Significance: National Arrangements.*[14]

12. The Commonwealth Pandemic Plan sets out measures to respond to an influenza pandemic, some of which rely on the exercise of coercive powers conferred by statute onto the Commonwealth Government. It identifies the following statutes as relevant to supporting pandemic actions:[15]

    A. The *Biosecurity Act 2015* (Cth) — which authorises activities used to prevent the introduction and spread of target diseases into Australia.

    B. The *National Health Security Act 2007* (Cth) — which authorises the exchange of public health surveillance information (including personal information) between the Australian Government, states and territories and the World Health Organization.

C. The International Health Regulations 2005 (incorporated into Australian law through the *Biosecurity Act 2015* (Cth) and the *National Health Security Act 2007* (Cth)) — which commits Australia and other signatory countries to take action to prevent, protect against, control and provide a public health response to the international spread of disease. As a signatory, Australia has a range of obligations, including reporting and maintaining certain core capacities at designated points of entry.

13. Those statutes are part of the suite of legislation available to the Commonwealth to support pandemic response activities. In addition, state and territory governments have powers under their respective jurisdiction's legislation to implement biosecurity arrangements within their borders, and which complement Commonwealth Government biosecurity arrangements. States and territories have a broad range of public health and emergency response powers available under legislation for responding to public health emergencies. Further detail on relevant legislation in Victoria is provided at paragraph 40.

Isolation, quarantine and mandatory detention for returned travellers in the Commonwealth Pandemic Plan

14. The Commonwealth Pandemic Plan does not provide specific guidance for a program of mandatory detention or quarantine for returned travellers. It does not refer to a mass program of mandatory quarantine to the scale of the Hotel Quarantine Program.

15. It does, however, provide guidance and analysis regarding *voluntary* isolation of ill travellers who do not require hospitalisation, and possible quarantine of contacts of ill travellers at the border (though this option is not recommended).[16]

Voluntary isolation of ill travellers: hotel quarantine seen as 'problematic'

16. The objective and rationale for voluntary isolation of ill travellers, as outlined by the Commonwealth Pandemic Plan, is to reduce exposure to the disease by managing the entry of ill travellers at the border.[17]

17. It states that returning Australians may isolate at home, but other arrangements would be required for other travellers.[18] The Commonwealth Pandemic Plan also states that voluntary isolation should commence when notified of sustained human-to-human transmission of a novel virus and that it must be used early to be effective in limiting entry of the disease into the community.[19]

18. The Plan considers voluntary self-isolation experiences during the SARS outbreak and the pandemic (H1N1) in 2009. It notes that compliance with self-isolation during the outbreak was high in most countries.[20] Notwithstanding that, the Commonwealth Pandemic Plan identifies that isolation may be difficult to enforce, self-regulated isolation may not be complied with and support for isolated cases is resource intensive.[21]

19. The Commonwealth Pandemic Plan identifies that the use of hotels to quarantine returned travellers is **problematic** (emphasis added), though it does not go so far as to say why this is so. Costs are noted as high if travellers are isolated in hotels; this is attributed to accommodation, food, servicing, medical support, security, entertainment and a support system to monitor people isolated.[22]

20. Voluntary self-isolation of cases more broadly (cases not limited to travellers) is recommended as a measure, particularly as the clinical severity of the disease increases. The Commonwealth Pandemic Plan states it is to be used in conjunction with infection control measures to reduce the risk of transmission to household contacts. Voluntary self-isolation is said to be most likely to influence the course of the pandemic when clinical severity is high and transmissibility is low.[23]

21. In the case of COVID-19, Prof. Grayson stated that COVID-19 is considered to be 'highly infectious, particularly as it can be transmitted before the onset of symptoms and because those who are infectious may be entirely asymptomatic or have only trivial symptoms'.[24] The nature of COVID-19 is discussed in detail in Chapter 2.

Quarantine of contacts not recommended

22. The Commonwealth Pandemic Plan does not recommend quarantining contacts of ill travellers at the border[25] in the context of pandemic influenza.

23. That is because, according to that Plan, quarantining contacts has minor effectiveness, imposes a significant burden on health and other systems, and places high costs and significant imposts on travellers and services. The Commonwealth Pandemic Plan states that extensive infrastructure would be needed, including databases, information and surveillance hotlines, and staff, to enforce quarantine.[26]

24. The Plan states that it would be highly complex to arrange and maintain a quarantine program, and that ethical issues may arise from confining individuals, as well as stress arising as a result of confinement. Notwithstanding this point, the Commonwealth Pandemic Plan provides that, if quarantining contacts of ill travellers at the border is to be used as a response strategy, the agency controlling the health response should commence its operation when it is 'notified of sustained human-to-human transmission of a novel virus. It must be used early to be effective…'[27]

25. Voluntary quarantine of contacts more broadly (cases not limited to travellers) is recommended as a measure, particularly where consequences of infection are high.[28]

26. Overall, the Commonwealth Pandemic Plan notes that the effectiveness of isolation and quarantine depends on a number of factors. Specifically, as the Plan deals with voluntary isolation and quarantine, it considers that factors influencing its effectiveness include perception and understanding of risk associated with infection and illness, and financial considerations.[29] It also states that early and transparent communication to the public is an important component of implementation.[30]

27. While these factors are relevant in the context of a voluntary program, they are obviously important in a program of mandatory quarantine with respect to both those placed into mandatory quarantine and those working at quarantine sites.

Updates to the Commonwealth Pandemic Plan following the Review of Australia's Health Sector Response to the (H1N1) Pandemic 2009

28. The most recent version of the Commonwealth Pandemic Plan was updated on 21 August 2019.[31] The Commonwealth Department of Health notes that this version of the Plan incorporates minor amendments, such as incorporation of the decommissioned 'Fluborderplan' throughout the document, and updated references to legislation, terminology and committee names.[32]

29. Prior to the most recent update, the Plan went through a significant update in 2014 following the Commonwealth Department of Health and Ageing's *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009*, which was published in 2011.[33]

30. This review recommended a substantial change to the approach of the Commonwealth Pandemic Plan. Some of the key aspects of the new approach included:

    A. wherever possible, using existing systems and governance mechanisms, particularly those for seasonal influenza, as the basis of the response

    B. applying a flexible approach, which can be scaled and varied to meet the needs experienced at the time

    C. making decisions based on available evidence

    D. linking with emergency response arrangements

    E. emphasising communication activities as a key tool in management of the response

    F. provision of detailed guidance on the collection of national surveillance data.[34]

Recommendations from previous reviews regarding quarantine and isolation

31. What was of particular interest in the *Review of Australia's Health Sector Response to the (H1N1) Pandemic 2009* was the recommendation for an examination of the policy on quarantine and isolation, including management, support systems and communication.[35]

32. This was because the Australian response to the (H1N1) outbreak in 2009 identified that quarantining non-residents arriving in Australia was an issue, as:

    A. many hotels refused to provide accommodation to individuals under quarantine

    B. the purpose of voluntary quarantine was not well understood, was inconvenient, unappealing and difficult to enforce

    C. policy and operational plans for managing people in quarantine had not been finalised (at the state, territory and national level) when the pandemic emerged

    D. information provided to people in quarantine was insufficient and conflicting, and support was slow to be provided to them.[36]

33. The review found:

> The roles and responsibilities of all governments for the management of people in quarantine, both at home and in other accommodation, during a pandemic should be clarified. A set of nationally consistent principles could form the basis for jurisdictions to develop operating guidelines, including plans for accommodating potentially infected people in future pandemics and better systems to support people in quarantine.[37]

34. Professor Brett Sutton, Victoria's Chief Health Officer, gave evidence that no work had been done, nationally or in any jurisdiction of Australia, to implement this recommendation since it was made in 2011.[38] The implications of this work not being undertaken are discussed further at paragraphs 53–55.

3.2 The Victorian Pandemic Plan

35. The Victorian Health Management Plan for Pandemic Influenza (the Victorian Pandemic Plan) is the local reflection, and replicates much, of the Commonwealth Pandemic Plan.[39] The stated aim of the Victorian Pandemic Plan is to provide an effective health response framework to minimise transmissibility, morbidity and mortality associated with an influenza pandemic and its impacts on the health sector and community.[40]

36. The Victorian Pandemic Plan describes activities needed to reduce the impact of an influenza pandemic in Victoria, including:

    A. surveillance systems to rapidly and efficiently identify the emergence of new strains of influenza in the Victorian community

    B. timely implementation of measures seeking to limit or prevent the transmission of pandemic influenza in the various stages of a pandemic

    C. continuing surveillance to monitor the status of the outbreak

    D. maximising the use of resources

    E. public health strategies to best meet the needs of the current situation based on the best surveillance data

    F. informing staffing needs and requirements

    G. implementing policies on the use of personal protective equipment (PPE) and antivirals

    H. communicating accurate, consistent and comprehensive information about the situation to the general public, the media, our partners in the health sector and other key stakeholders.[41]

37. The *Victorian Action Plan for Influenza Pandemic 2015* (Action Plan) is the Emergency Management Victoria pandemic plan. It articulates Victoria's strategic approach to reducing the social and economic impacts and consequences of pandemic influenza on communities.[42] It is, effectively, a plan to help manage the operations of government departments and other organisations in a pandemic.

38. The Action Plan is stated to help departments and organisations complete or review their pandemic influenza plans. It sets out:

    A. Victorian arrangements for pandemic influenza planning and response

    B. key agencies and their roles and responsibilities

    C. relevant governance structures

    D. incident response guidance for departments and agencies.[43]

39. In February 2020, with the onset of COVID-19 infections in Victoria, the Department of Health and Human Services (DHHS) developed the *COVID-19 Pandemic Plan for the Victorian Health Sector*.[44] This plan, which was published on 10 March 2020, set out a four-stage response to COVID-19 for the health sector that included initial containment, targeted action, peak action and stand down and recovery.[45]

Legal framework and relationship of the Victorian Pandemic Plan and the Action Plan with other plans

40. As with the Commonwealth Pandemic Plan, State Acts and Regulations authorise actions under the Victorian Pandemic Plan and the Action Plan. In addition to the national legislation set out at paragraph 12, the key pieces of Victorian legislation available to support pandemic actions in Victoria include:

    A. the *Public Health and Wellbeing Act 2008* (Vic) and *Public Health and Wellbeing Regulations 2009* — which aim to protect the health and wellbeing of the population and establish provisions for managing infectious diseases

    B. the *Emergency Management Act 1986* (Vic) — which authorises authorities to take control of specific aspects of an emergency when declared by the Premier

    C. the *Emergency Management Act 2013* (Vic) — which implements a series of reforms such as establishing the State Crisis and Resilience Council, Emergency Management Victoria and the Emergency Management Commissioner.[46]

41. The Victorian Pandemic Plan is also guided by the same ethical framework established under the Commonwealth Pandemic Plan to guide health sector responses and actions taken.[47]

42. The Victorian Pandemic Plan and the Action Plan interact. They relate to a specific type of pandemic. Victoria's pandemic response arrangements, more generally, involve the following key plans (in addition to the Commonwealth Pandemic Plan):[48]

    A. the State Emergency Response Plan (SERP) as contained in the Emergency Management Manual Victoria. The State Emergency Response Plan describes the arrangements for controlling a response to specified types of emergencies, and the roles of the agencies who control and support the control of that response. The Emergency Management Manual Victoria also sets out the arrangements for emergency management in Victoria more generally[49]

    B. the State Health Emergency Response Plan (SHERP) — a sub-plan of the State Emergency Response Plan that outlines the arrangements for coordinating a health response to health emergency incidents that go beyond day-to-day business arrangements.[50] The details of the Victorian emergency management framework, its use and how it worked in the Hotel Quarantine Program are discussed in detail in Chapter 8.

Isolation, quarantine and mandatory detention for returned travellers in the Victorian Pandemic Plan

43. As is the case with the Commonwealth Pandemic Plan, the Victorian Pandemic Plan does not provide specific guidance for a program of mandatory detention or quarantine for returned travellers, nor does it refer to a mass program of mandatory quarantine to the scale of the Hotel Quarantine Program.

44. The Victorian Pandemic Plan states, consistent with the Commonwealth Pandemic Plan, that voluntary isolation of ill travellers and voluntary quarantine of contacts can assist to control the transmission of disease into the community.[51]

45. It provides that, voluntary and home-based isolation should be considered as part of the preparedness, initial and targeted-response stages.[52] The Plan states that in the targeted response stage, benefits will be reassessed contingent on evidence as to the transmissibility of the virus and severity of the illness. The Victorian Pandemic Plan also refers to the Commonwealth Pandemic Plan for further details on isolation and quarantine.[53]

46. The *COVID-19 Pandemic Plan for the Victorian Health Sector* also does not envisage the involuntary, large scale detention of people arriving from interstate or overseas. As with the Victorian Pandemic Plan, its focus, with regard to isolation or quarantine, is on the *voluntary* isolation of people in their own homes.[54]

47. Notably, it states the following under the heading of Quarantine:

> Quarantine refers to home isolation of well people who are deemed at risk of COVID-19 due to travel location or contact with a case. As the COVID-19 response has progressed there has been varying requirements for returned travellers to quarantine after being in a high-risk location.[55]

Updates to the Victorian Pandemic Plan, consideration of a mass quarantine program and applicability to a coronavirus with pandemic potential

48. The Victorian Pandemic Plan was prepared in 2007 and updated in 2014 in line with the Commonwealth Pandemic Plan, and in response to lessons learned from the (H1N1) pandemic, based on the *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009*.[56]

49. As noted at paragraphs 31 to 34, the review recommended that an examination of the policy on quarantine and isolation, including management, support systems and communication, be undertaken.[57] Prof. Sutton gave evidence to the Inquiry that this work had not been undertaken, either nationally or at the state or territory level. When questioned on this matter by Counsel Assisting the Inquiry, Prof. Sutton agreed that had this work been undertaken, it would have been very useful for establishing the Hotel Quarantine Program in a pandemic situation.[58]

50. Dr Annaliese van Diemen's (Deputy Chief Health Officer for Victoria) evidence was that she had never turned her mind to the concept of a large-scale quarantine program for returned travellers prior to late March 2020.[59] Before this point in time, and as illustrated by the evidence in the preceding paragraphs of this section, pandemic plans considered isolation or quarantine in the context of a home-based program for cases or contacts.[60]

51. It was only following the announcement of a quarantine program by National Cabinet and during subsequent conversations about implementing the decision did Dr van Diemen consider the concept of a mandatory, mass quarantine program.[61]

52. In a similar vein, not surprisingly, Ms Kym Peake, the then Secretary of DHHS since November 2015, gave evidence that, prior to late March 2020, she had not turned her mind to such a concept and only did so for the very first time following National Cabinet's announcement.[62] Ms Peake stated that, in her view, the Commonwealth Constitution envisages that quarantine will primarily sit as a responsibility of the Commonwealth Government.[63] As such, as at March 2020, it was not 'on the radar' for DHHS in Victoria that there would be a mass quarantine program required at a state level.[64]

53. Notwithstanding the Commonwealth's (H1N1) review in 2011 noting that the roles and responsibilities of all governments for the management of people in quarantine during a pandemic should be clarified,[65] this recommendation had not been addressed by the Commonwealth, which provided the model for the states and territories to adopt.[66] (See Recommendation 70 below.)

54. Despite updates having been made recently to the Victorian Pandemic Plan (and the Commonwealth Pandemic Plan) to reflect lessons learned from the (H1N1) pandemic, a key recommendation to review the policy on quarantine and isolation (Recommendation 13)[67] was left unaddressed. Evidence provided by Prof. Sutton provides some insight as to why this may have been the case.

55. During his evidence, Prof. Sutton stated that, in his view (with the benefit of hindsight), it was an issue that the pandemic plans prior to the COVID-19 pandemic gave insufficient consideration of the pandemic potential of a coronavirus and no explicit consideration of a program of quarantine to keep a jurisdiction entirely free of the virus.[68]

56. Prof. Sutton noted that it was always an assumption that a pandemic influenza (the basis of the Commonwealth plans) would reach every country and the purpose of quarantine was to minimise the peak of the pandemic and the resulting pressures on the health system.[69] Prof. Sutton stated that, following what happened in Wuhan, and reflecting that the COVID-19 pandemic had the greatest severity seen since the Spanish Flu, the impetus was for a quarantine program that would keep the virus out of the community to the fullest extent possible. Prof. Sutton's evidence, in this regard, was that prior pandemic planning was directed to minimising transmission, rather than eliminating transmission via a system of quarantine.[70]

No 'off-the-shelf' plan for mass quarantining of international arrivals

57. Significantly, for Victoria, this left the State with no pre-planned structure or arrangements for mass quarantining of international arrivals.

58. During the course of the hearings, several witnesses gave evidence about the fact there was no 'off-the-shelf' plan for mass quarantine and that, accordingly, after the announcement of National Cabinet on 27 March 2020, the Hotel Quarantine Program needed to be stood up in a mere 36 hours.[71] This meant that decisions were made under enormous pressure and plans for a complex system were developed in haste. Detail on the establishment of the Hotel Quarantine Program within this short timeframe is dealt with in Chapters 4 and 5 of this report.

Pandemic planning exercises

59. Under the *Emergency Management Act 2013* (Vic), major health emergencies and biosecurity emergencies (unless linked to an act of terrorism) are defined as a 'Class 2' emergency.[72]

60. According to the evidence of Ms Peake, Class 2 emergencies have been comparatively rare in Victoria.[73] Ms Peake stated that DHHS 'regularly undertakes emergency incident exercises where the emergency management regime and the State Health Emergency Response Plan are performed'.[74] The evidence of DHHS witnesses was that such exercises are undertaken on a regular basis and often include other agencies.[75]

61. According to Prof. Sutton, pandemic planning exercises are an opportunity to test the efficacy of the arrangements and to practice performing the roles, activities and deliverables of each person and agency with responsibilities.[76]

62. The Inquiry has heard evidence of exercises that featured infectious disease scenarios. While it may be so that it is not possible to predict the exact nature, scale and type of an infectious disease emergency and to rehearse a response to that emergency, Prof. Sutton stated that these exercises, nevertheless, have the benefit of testing the efficacy of response arrangements, practising the performance of allocated roles and to engage all areas and agencies in doing so.[77]

63. The evidence as to the most recent exercises undertaken in relation to an infectious disease pandemic included:

    A. 'Exercise Teapot' — undertaken in September 2019 and led by the Health Protection Branch and Emergency Management Branch in DHHS, with representatives from more than 16 agencies.[78] This was described as a discussion exercise that explored a complex multiagency emergency involving widespread outbreaks including of Middle Eastern Respiratory Syndrome coronavirus.[79]

    B. 'Exercise Alchemy' — undertaken in August 2018 and led by Emergency Management Victoria.[80] The stated purpose of this exercise was to assess state-level communications processes during a biosecurity emergency that transitioned to a pandemic emergency.[81]

64. Feedback from Exercise Alchemy identified that the role and function of any team or structure needed to be clearly defined and practical given that Class 2 emergencies have unique challenges.[82] In the context of the Hotel Quarantine Program, given the time constraints and lack of an overarching plan for mass, mandatory quarantine, the lessons from Exercise Alchemy were not applied when they should have been. The implementation of the Hotel Quarantine Program is discussed further in chapters 5 and 8.

65. Whereas Ms Peake and Prof. Sutton gave evidence that emergency incident exercises specifically related to infectious disease pandemics are undertaken regularly, there were views expressed by doctors outside DHHS about not being sufficiently included in pandemic planning exercises for the medical profession more broadly. Dr Nathan Pinskier, director of Onsite Doctor Pty Ltd, which was engaged to assist with the provision of medical services and support to returned travellers in the Hotel Quarantine Program,[83] raised questions about pandemic planning exercises across the health sector more broadly.

66. Dr Pinskier is a Melbourne-based GP with nearly 40 years of involvement in primary health, tertiary care, digital health, accreditation, medical deputising services and practice management.[84] Dr Pinskier stated that, in the course of his professional life, the occurrence of a pandemic had never been discussed at any of the professional forums he had attended across Australia, other than a 'zombie apocalypse' workshop he attended in October 2014 that dealt broadly with the issue of a pandemic.[85]

67. Based on this experience, Dr Pinskier concluded that 'given the lack of ongoing systemic planning, no-one was remotely prepared for the pandemic and when it did arise the response was, in consequence, cobbled together in an ad hoc manner'.[86]

68. Dr Julian Rait, President of the Australian Medical Association (AMA) gave evidence in the form of a statement to the Inquiry[87] in which he, too, raised concerns about the level of engagement from DHHS with the medical profession more broadly in the context of emergency medicine. This subject is outside the Terms of Reference of this Inquiry. Nevertheless, given the evidence of such an experienced GP who was engaged in the Hotel Quarantine Program in his professional capacity and the concerns and issues expressed by Dr Rait as the President of the AMA, I consider that the issues raised by Dr Pinksier and Dr Rait as to the engagement of DHHS with the medical profession and the medical profession's ability to collaborate with DHHS and be a source of potential resources to DHHS in public health emergencies, should be the subject of follow up by DHHS (see Recommendation 71).

3.3 Conclusions

69. The Commonwealth Pandemic Plan describes pandemics as unpredictable and presenting a significant risk to Australia and having the potential to cause high levels of disease and death and disrupt the community, both socially and economically. The Commonwealth Pandemic Plan, which was developed in consultation with states and territories, outlines Australia's strategy to manage an influenza pandemic and minimise its impact on the health of Australians and the health system.

70. The Plan is intended to provide overarching guidance and a framework for a nationally consistent approach to managing an influenza pandemic. The guidance provided in the Commonwealth Pandemic Plan, consistent with this intention, is reflected in Victoria's relevant plans. It is the responsibility of the states and territories for the majority of the operational detail to be in their plans.

71. The Commonwealth Pandemic Plan does not provide any specific guidance for a program of mandatory detention or quarantine for returned travellers. It does not refer to a mass program of mandatory quarantine.

72. It does provide guidance and analysis regarding *voluntary* isolation of ill travellers who do not require hospitalisation, and possible quarantine of contacts of ill travellers at the border (though this option is not recommended).

73. The Plan considered voluntary self-isolation experiences during the SARS outbreak and the pandemic (H1N1) in 2009. It notes that compliance with self-isolation during the outbreak was high in most countries. Notwithstanding that, the Commonwealth Pandemic Plan identifies that isolation may be difficult to enforce, self-regulated isolation may not be complied with, and support for isolated cases is resource intensive.

74. The Commonwealth Pandemic Plan specifically identifies that the use of hotels to quarantine returned travellers is **problematic** (emphasis added), though it does not go so far as to say why this is so. Costs are noted as high if travellers are isolated in hotels, attributable to the costs of accommodation, food, servicing, medical support, security, entertainment and a support system to monitor people isolated.[88]

75. The Plan states that it would be highly complex to arrange and maintain a quarantine program, and that ethical issues may arise from confining individuals, as well as stress arising as a result of confinement. Notwithstanding this point, the Commonwealth Pandemic Plan provides that, if quarantining contacts of ill travellers at the border is to be used as a response strategy, the agency controlling the health response should commence its operation when it is 'notified of sustained human-to-human transmission of a novel virus and that it must be used early to be effective.

76. Voluntary quarantine of contacts more broadly (cases not limited to travellers) is recommended as a measure, particularly where consequences of infection are high.

77. The Commonwealth Pandemic Plan notes that the effectiveness of isolation and quarantine depends on a number of factors. Specifically, as the Plan deals with voluntary isolation and quarantine, it considers that factors influencing its effectiveness include perception and understanding of risk associated with infection and illness, and financial considerations.

78. It is clear that both the State and Commonwealth governments were aware, prior to 2020, of the possibility of a pandemic and its potentially devastating consequences.

79. However, none of the existing Commonwealth or State pandemic plans contained plans for mandatory, mass quarantine. Indeed, the concept of hotel quarantine was considered problematic and thus, no plans existed in the overarching Commonwealth plans for hotel quarantining.

80. Similarly, as of 27 March 2020, when the National Cabinet announced the mass quarantining of returning travellers, Victoria had no plan for large-scale mandatory quarantine of people arriving into the State via international points of entry.

81. Prior pandemic planning was directed at minimising transmission (for example, via voluntary isolation or quarantine at home), and not an elimination strategy. Prof. Sutton accepted that:

> One of the issues in both the Australian Health Management Plan for Pandemic Influenza and the Victorian plan reflecting it is that there probably wasn't sufficient consideration of coronavirus as a virus of pandemic potential, nor was there such explicit consideration of a program of quarantine essentially for the purpose of keeping a jurisdiction entirely free of the virus.[89]

82. While this Inquiry has no remit or jurisdiction to examine any action or inaction by the Commonwealth, given the role of the Commonwealth through the Commonwealth Pandemic Plan and the lead that it provides to the states and territories, it would be unfair to judge Victoria's lack of planning for a mandatory quarantining program given the Commonwealth, itself, had neither recommended nor developed such a plan.

83. Significantly, the Commonwealth undertook a review of its health sector response in the wake of the (H1N1) pandemic in 2009. The Commonwealth's *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009* recommended that the roles and responsibilities of all governments for the management of people in quarantine, both at home and in other accommodation, during a pandemic should be clarified. The review further recommended that a set of nationally consistent principles could form the basis for jurisdictions to develop operating guidelines, including plans for accommodating potentially infected people in future pandemics and better systems to support people in quarantine. Further, this review recommended an examination of the policy on quarantine and isolation, including management, support systems and communication.[90]

84. Despite the Commonwealth Pandemic Plan and the Victorian Pandemic Plan being updated following the *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009* to ensure evidence-based decision-making; use of existing governance mechanisms; a scalable and flexible approach and to emphasise communication activities, an important piece of work regarding the policy on quarantine and isolation, including management, support systems and communication and the roles and responsibilities of all governments for the management of people in quarantine during a pandemic to be clarified, the evidence to the Inquiry is that this work was not undertaken.

85. Had the work proposed by the review been undertaken, there would likely have been, at least, a set of guiding principles and a framework to support the establishment of the Hotel Quarantine Program, thus avoiding the program needing to be set up in an ad hoc manner during a pandemic.

86. Just two weeks before the National Cabinet agreement to mass quarantining, Victoria published its 10 March 2020 *COVID-19 Pandemic Plan for the Victorian Health Sector*. It did not envisage the involuntary detention of people arriving in from overseas. As with the Victorian Pandemic Plan, its focus with regard to isolation or quarantine was on the *voluntary* isolation of people in their own homes.

87. The lack of a plan for mandatory mass quarantining meant that the Hotel Quarantine Program was conceived and implemented 'from scratch' to be operational within 36 hours from concept to operation. This placed incredible strain on the resources of the State and, more specifically, on those Departments and people required to give effect to the decision of the National Cabinet. This was a most unsatisfactory situation from which to develop such a complex and high-risk program.

88. Given the future movement of people in and out of Victoria from across the nation, it is in Victoria's interests to advocate for nationally cohesive and detailed quarantine plans as previously recommended in the wake of the *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009* as to clarity of roles and responsibilities between different levels of government, management and support systems and communication. Recommendations 2, 3, 4, 5, 49 and 59 identify and address specific issues of liaison and communication as between the State and Commonwealth agencies. Recommendation 70 addresses this issue as between Victoria and the Commonwealth.

PANDEMIC PLANNING EXERCISES

89. The evidence shows emergency incident exercises, specifically related to infectious disease pandemics, are undertaken regularly. These exercises consider associated public health and emergency management plans and are undertaken within DHHS and with other agencies.

90. 'Exercise Alchemy' in August 2018 identified that the role and function of any team or structure needed to be clearly defined and practical, given that Class 2 emergencies have unique challenges. The need for clarity in roles and structure was a valuable result from the exercise which was an opportunity to address this issue. Given the conclusions from this Inquiry, it should be given due focus when developing future emergency response activities. (See Recommendation 72 and see also Chapter 8 for issues more generally as to role clarity).

91. There was a perceived gap in terms of provision of pandemic planning across the broader health sector. There can be no doubt that there is a role for the broader health sector to play in health emergency planning. DHHS should review its pandemic planning processes and activities so as to consider an appropriate level of involvement from the broader health sector (see Recommendation 73).

3.4 Recommendations

70. The Victorian Government, through the various national structures available to the Premier, the Minister for Health, the Secretary to DHHS and the Chief Health Officer, advocates for necessary action to be taken to address the recommendations from the *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009* as to clarity on roles and responsibilities between different levels of government, management, support systems and communication and policy on quarantine and isolation.

71. The Secretary of DHHS engages with the appropriate representative bodies from the medical profession with a view to developing agreed plans as to the availability of medical expertise and resources in the event of a public health emergency and the need for future surge demands.

72. The Secretary of DHHS ensures that future pandemic planning exercises should specifically address the need for clarity of roles, structures and accountabilities, to ensure the necessary detailed focus and preparedness as to the importance of these issues is widely understood and well-rehearsed.

73. The Secretary of DHHS, in consultation with representative bodies from the broader health sector, reviews the range of participants currently invited to pandemic planning exercises to assess how the range of representative participants could be expanded to include the broader health sector.

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CHAPTER 4

Understanding Victoria's decision to set up a Hotel Quarantine Program

1. Effective as of 11:59pm Sunday 15 March 2020, the National Cabinet agreed to a 'precautionary self-isolation requirement' on all international arrivals. The rationale for this decision was stated by the Prime Minister as being to reduce community transmission to 'help stay ahead of the curve'.[1]

2. The overall intent of the decision was clear. It was 'about reducing the spread of the virus in Australia and saving lives'.[2]

3. The National Cabinet position was reflected in a Direction from the Chief Health Officer (CHO), issued on 16 March 2020, requiring overseas travellers to '... travel from the airport to a premises that is suitable for the person to reside in for a period of 14 days' (the Self-Quarantine following Overseas Travel Direction).[3] A further Direction (the Airport Arrivals Direction), in substantially similar terms, was issued by the Deputy Chief Health Officer (DCHO) on 18 March 2020.[4] In this Chapter, I refer to these Directions collectively as the 'Self-Isolation Directions'. For most returning Victorian residents, the Self-Isolation Directions would have meant self-isolating at home. The penalty for non-compliance was substantial ($19,826.40).[5]

4. As noted in the previous chapter of this Report, no plan for a mass quarantine program existed in Victoria[6] or in Australia more broadly.[7]

5. Yet within 12 days of 16 March 2020, Australian states and territories had transitioned from self-quarantine to mandatory mass quarantine at 'designated premises'.

6. This transition occurred as a result of National Cabinet agreeing to a mass quarantine program for all returned travellers to Australia from 11.59pm on 28 March 2020.[8]

7. Victoria reflected the national decision when the DCHO issued a Direction and Detention Notice to all overseas travellers arriving in Victoria from 11.59pm on 28 March 2020. The penalty for non-compliance remained at $19,826.40.[9]

8. According to both the Prime Minister and the Premier, the rationale for a mandatory mass quarantine program at designated premises was to reduce community transmission of the COVID-19 virus.[10]

9. It is relevant to the Inquiry's Terms of Reference to understand why there was a shift in Victoria from a requirement to self-isolate at suitable premises to a mandatory, mass quarantine program, particularly in the context of there having been no prior planning for a mass quarantine program.

4.1 Events leading to 27 March 2020

10. As outlined in Chapter 1 of this Report, the COVID-19 pandemic was seen to be escalating rapidly in the early months of 2020, from Australia's first case on 25 January 2020 to 112 cases some six weeks later.[11]

11. The evidence of Victoria's DCHO, Dr Annaliese van Diemen, highlighted how quickly COVID-19 cases were increasing in March 2020. Dr van Diemen stated that:

> We were increasing our case numbers by four times every week, week on week, from the first week of March. We had a four-fold increase every week, which put us on track to somewhere in the vicinity of 32,000 cases within a couple of weeks.[12]

12. Dr van Diemen also noted that every introduction of COVID-19 would increase that exponential growth.[13]

13. Given the increase of COVID-19 cases in Victoria, and the growth in cases globally (as outlined in Chapter 1), it is not surprising that the National Cabinet was established on 13 March 2020 with its stated aim to address and ensure consistency in Australia's response to the COVID-19 pandemic.[14]

14. By 15 March 2020, when the National Cabinet's 'universal precautionary self-isolation requirement on all international arrivals' was implemented,[15] Australia had a total of 298 confirmed COVID-19 cases, with 57 of these cases in Victoria.[16]

The shift from self-isolation to mandatory, mass quarantine

15. What, then, led to the shift from the precautionary self-isolation requirement on 15 March 2020 to a mandatory quarantine program, only 12 days later?

16. It appears that an exponential increase in COVID-19 cases in Australia played a role in this shift. By 27 March 2020, there was a total of 3,162 COVID-19 cases in Australia, with 574 of these cases in Victoria.[17] This represented an approximate eleven-fold increase in COVID-19 cases in Australia and a ten-fold increase in COVID-19 cases in Victoria since 15 March 2020.

Table 4.1: Cumulative COVID-19 cases in Australia and Victoria between 15 March and 27 March 2020

Date	**COVID-19 cases in Australia** (cumulative total)	**COVID-19 cases in Victoria** (cumulative total and subset of Australian total)
15 March 2020	298	57
16 March 2020	352	71
17 March 2020	437	94
18 March 2020	559	121
19 March 2020	685	150
20 March 2020	872	178
21 March 2020	1,074	229
22 March 2020	1,368	296
23 March 2020	1,694	355
24 March 2020	2,118	411
25 March 2020	2,415	466
26 March 2020	2,795	520
27 March 2020	3,162	574

Source for Australian COVID-19 figures: Department of Health (Commonwealth) COVID-19 current situation and case numbers: daily reported cases, https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-current-situation-and-case-numbers#daily-reported-cases'; Source for Victorian COVID-19 figures: https://www.dhhs.vic.gov.au/media-hub-coronavirus-disease-covid-19 (figures extracted from media releases 15 March – 27 March 2020).

17. Moreover, during this period, there had been an outbreak on the Ruby Princess cruise ship, which had docked in Sydney.

18. Passengers from the Ruby Princess had disembarked into Sydney on the morning of 19 March 2020[18] and had been allowed to disperse, greatly compounding the task of contact tracing and infection control. The outbreak from the Ruby Princess was linked to more than 800 COVID-19 cases.[19]

4.2 The basis of the decision to quarantine rather than continue or expand self-isolation for all returning travellers

Increasing COVID-19 cases and community transmission

19. When announcing the National Cabinet decision to enforce quarantine at a designated facility, the Prime Minister noted that 'substantial numbers of returned travellers and small community outbreaks associated with travellers continue to contribute most of the significant further growth in COVID-19 cases in Australia'.[20]

20. The Premier, similarly, noted that:

> While Victoria has seen some community transmission of this virus, most cases have been the result of travellers returning from overseas who then pass it onto their close contacts. To ensure this no longer happens, National Cabinet has agreed that all states and territories will put in place enforced quarantine measures.[21]

21. It is, therefore, reasonable to conclude that the increase in COVID-19 cases, and community transmission linked to returned travellers, influenced the National Cabinet's decision to review the effectiveness of self-quarantine and to elect to enforce a mandatory quarantine program on all returned travellers.[22]

Advice from the AHPPC

22. The decision of National Cabinet was announced by the Prime Minister as being based on the advice of medical experts.[23] As outlined in Chapter 1, the Australian Health Protection Principal Committee (AHPPC), led by the Commonwealth's Chief Medical Officer and comprising the chief health and medical officers from each jurisdiction, was the key medical advisory body to the National Cabinet.[24]

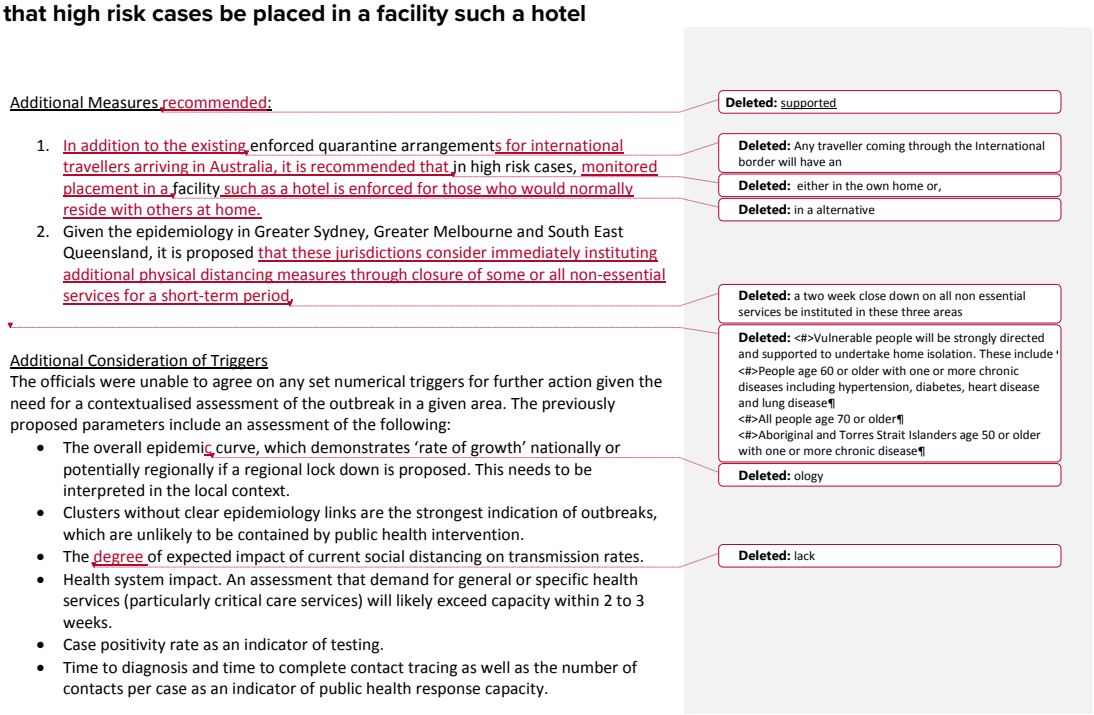
23. Professor Brett Sutton, Victoria's CHO and a member of the AHPPC, gave evidence that the AHPPC had not endorsed a hotel quarantine program for all returned travellers either prior to, or in the wake of, the Prime Minister's announcement on 27 March 2020.[25]

24. In his evidence, Prof. Sutton stated that 'on 26 March 2020, the AHPPC recommended to governments that the single most important thing that could be done was to stop the capacity for any returning traveller transmitting the virus'.[26] However, the AHPPC 'did not endorse the idea of quarantining travellers at hotels (or other designated facilities)'.[27]

25. The evidence of the Premier was that the AHPPC's advice to National Cabinet recommended that only so-called 'high-risk' cases, where those people would normally reside with others at home, should be placed in an enforced quarantine in facilities such as hotels.[28] This evidence is consistent with versions of a draft advice passing from Prof. Sutton to Kym Peake, then Secretary to DHHS, on the evening of 26 March and the early morning of 27 March 2020.[29]

26. In his witness statement, the Premier said that the 'National Cabinet considered the measure recommended by the AHPPC, but in respect to all returned travellers … That extended measure was ultimately agreed by National Cabinet'.[30]

Figure 4.1: Draft AHPPC advice regarding quarantine arrangements for returned travellers noting that high risk cases be placed in a facility such a hotel



Additional Measures recommended:

1. In addition to the existing enforced quarantine arrangements for international travellers arriving in Australia, it is recommended that in high risk cases, monitored placement in a facility such as a hotel is enforced for those who would normally reside with others at home.
2. Given the epidemiology in Greater Sydney, Greater Melbourne and South East Queensland, it is proposed that these jurisdictions consider immediately instituting additional physical distancing measures through closure of some or all non-essential services for a short-term period.

Additional Consideration of Triggers

The officials were unable to agree on any set numerical triggers for further action given the need for a contextualised assessment of the outbreak in a given area. The previously proposed parameters include an assessment of the following:

- The overall epidemic curve, which demonstrates 'rate of growth' nationally or potentially regionally if a regional lock down is proposed. This needs to be interpreted in the local context.
- Clusters without clear epidemiology links are the strongest indication of outbreaks, which are unlikely to be contained by public health intervention.
- The degree of expected impact of current social distancing on transmission rates.
- Health system impact. An assessment that demand for general or specific health services (particularly critical care services) will likely exceed capacity within 2 to 3 weeks.
- Case positivity rate as an indicator of testing.
- Time to diagnosis and time to complete contact tracing as well as the number of contacts per case as an indicator of public health response capacity.

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<#>People age 60 or older with one or more chronic diseases including hypertension, diabetes, heart disease and lung disease¶
<#>All people age 70 or older¶
<#>Aboriginal and Torres Strait Islanders age 50 or older with one or more chronic disease¶

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Source: Exhibit HQ10192_RP, draft advice to National Cabinet.

27. It, therefore, appears that, as at 27 March 2020, while the AHPPC recommended enforced quarantine for 'high-risk' cases, the AHPPC did not recommend or advise on an enforced quarantine program for all returned travellers as a way to minimise the growth or spread of COVID-19 cases.

28. This position changed in the months following the implementation of hotel quarantine programs across Australia. On 26 June 2020, the AHPPC published a statement noting that, on the advice of the Communicable Diseases Network Australia (CDNA), the AHPPC considered two options for addressing what it described as, at that time, an increasing risk of COVID-19 in returning travellers:[31]

    A. reducing the time of quarantine in a hotel for international travellers. This included most spending part of the time in home quarantine

    B. continuing the current model of 14-day quarantine in a hotel.

29. The statement noted that, having considered these options, the AHPPC:

    A. considered that there was not enough data to justify reducing the need for hotel quarantine

    B. recommended that all international travellers continue to undertake 14 days' quarantine in a supervised hotel.

30. Notwithstanding the AHPPC position as at 27 March 2020, Prof. Sutton confirmed he supported the idea of a hotel quarantine facility for all returned travellers at that time.[32] His rationale for supporting this idea is discussed below at paragraph 36.

31. Similarly, Dr van Diemen was of the view that mass quarantining of returning travellers was warranted. This was necessarily so, as it was Dr van Diemen who had to consider whether or not to issue the Direction and Detention Notice that gave effect to the National Cabinet's announcement in Victoria.[33]

4.3 Factors that influenced support for an enforced quarantine program for all returned travellers in Victoria

32. The evidence of the Premier, Prof. Sutton and Dr van Diemen was that several key factors drove their support for reducing community transmission of COVID-19 via a program of mandatory, mass quarantine for returning travellers:

    A. the continued increase in COVID-19 cases and the associated rising community concern[34]

    B. some evidence of recent arrivals to Victoria who were not complying with requirements to self-isolate at home[35]

    C. concern about the rising number of COVID-19 cases internationally and the prospect of our hospitals becoming overwhelmed if returning travellers were permitted to self-quarantine.[36]

33. The Premier gave evidence regarding the factors that influenced his own agreement with the National Cabinet decision:

    A. Firstly, it would make compliance and enforcement an easier task from a policy perspective.[37] The Premier's understanding was that there had been instances of non-compliance with the home quarantine direction for returned travellers in place at that time. The Premier considered that the honesty-based system of home quarantine that had existed to that point was too risky, and he had come to a view that quarantining people in a designated facility would reduce the risk.[38]

    B. Secondly, the Premier stated that it was not certain, at that time, how many Victorians who had not been overseas might contract the virus. The Government was trying to buy time to prepare the health system and expecting that the situation would unfold as it had in other parts of the world.[39] This evidence accords with remarks made by the Premier at a press conference on 28 March 2020, where he stated that the decision was 'appropriate' and that it was more likely to reduce cases in Victoria and flatten the curve.[40]

    C. Thirdly, the Premier was aware of a decision of the Expenditure Review Committee (ERC) on 20 March 2020 to allocate $80 million dollars for procuring hotel rooms. This was for an accommodation package to support key workers and provide emergency accommodation to people in need, including what became known as the Hotels for Heroes program.[41] The Premier agreed, in evidence, that his knowledge of this work was key to his view that it would be feasible for Victoria to implement a mandatory quarantine program.[42]

Continued increase in COVID-19 cases

34. As noted at paragraph 12, the rapid rate of COVID-19 transmission was concerning.

35. Dr van Diemen's evidence was that she had observed, primarily through international experience, that the disease spread rapidly with very high fatality rates.[43] Further, with no vaccine and no treatment to mitigate the effects of COVID-19, the virus was observed as being an 'exceedingly significant risk to public health'.[44]

36. It is clear that the concern over rising COVID-19 case numbers had played a significant role in Victoria supporting the idea of an enforced quarantine program.

37. Indeed, in his evidence, Prof. Sutton stated that he, personally, supported the idea of all returned travellers being quarantined in a hotel.[45] He discussed this view with Dr van Diemen, where the constraints on individual liberties and individual rights of a mandatory quarantine program were balanced against a 'recognition that countries like Italy were going through thousands of cases and were facing a catastrophic epidemic that ultimately killed tens-of-thousands of people in that country …'[46]

38. The Premier, by way of explaining why he considered, by late March, that the Airport Arrival Direction of 18 March 2020 was insufficient to mitigate the risks to Victorians, stated 'it was apparent that, if the virus seeded in a Victorian city, there would be no containing it without the imposition of unprecedented measures'.[47]

39. This was in the context of international borders being closed to non-Australian citizens and residents, and anticipation of a significant number of Australians, returning home in light of the pandemic.[48] The Premier stated that:

> In those circumstances, it was anticipated that a significant proportion of returned travellers would already be infected with the virus. That had been shown to have occurred with at least one group of travellers returning to Melbourne from Aspen, in the United States, and in the large number of infected passengers who had disembarked from the Ruby Princess cruise ship in Sydney, on 19 March 2020, and dispersed from there, with the virus, to other parts of Australia.[49]

Evidence of non-compliance with the Self-Isolation Directions

40. The Inquiry heard evidence from Dr van Diemen, the Premier and former Chief Commissioner of Victoria Police, Graham Ashton, that, prior to 27 March 2020, some recent arrivals to Victoria were not strictly complying with the home quarantine requirements imposed on them.

41. As Dr van Diemen recalled, DHHS had observed, through identified cases and subsequent interviews and outbreaks, that people were not adhering to the home isolation requirements. Dr van Diemen noted that DHHS had a 'reasonable amount of evidence, albeit over a short period of time, that people were not adhering to the home quarantine requirements as strictly as we needed them to …'[50]

42. Mr Ashton also noted, in his evidence, that there were levels of non-compliance, though he did also note that, on many occasions, people were isolating but not at the place where the Australian Border Force thought they would be. Police accordingly adjusted records and data on peoples' actual location.[51]

43. Notwithstanding that some people had incorrect location details, there was a level of concern about people not adhering to self-quarantine requirements. Indeed, the Premier noted, in late March, that he was mindful of reports Victoria Police had 'expressed concerns about instances of non-compliance with the Chief Health Officer's direction, including people continuing to breach self-quarantine requirements'.[52]

44. In this context, it was the evidence of Dr van Diemen that Victoria had a small window to stop the number of virus importations into the community. It was her view that quick action was needed because for 'every introduction of the virus to the community, there was significant amounts of spread being seen'.[53]

45. Taking into account the continued increase in COVID-19 cases and the information as to recent arrivals to Victoria not complying with requirements to self-isolate at home, there was support for an enforced quarantine program by the Premier, Prof. Sutton and Dr van Diemen. As stated by the Premier:

> I went into the National Cabinet meeting on 27 March 2020 with the firm view that, as a policy for stopping large numbers of returned travellers from spreading the virus, self-quarantine posed an unacceptable risk to the Australian community and to Victoria, and it was therefore insufficient.[54]

46. As set out in Section 2 of the Interim Report, on examination during the Inquiry, the evidence of non-compliance with the existing Self-Isolation Directions was not extensive and was set in the context of poor dissemination of information to those who were subject to the Directions. Mr Ashton's media comments from 23 and 26 March 2020 were played in evidence.[55] They indicated a degree of non-compliance on 23 March 2020, which was observed by 26 March 2020 to be improving as returned travellers gained a better understanding of the requirements.[56] In his evidence, Mr Ashton said that some people who were, at first, thought to be breaching their Directions, were later found to be self-isolating at a different address.[57] However, the Premier's view remained that the risk posed by self-isolation at home was too high.[58]

47. Section 2.8 of the Inquiry's Interim Report discusses the evidence of non-compliance during self-quarantine at home. Noting that the evidence of non-compliance with the existing Self-Isolation Directions was not extensive, concerns about non-compliance remain proper and must be addressed. Recommendations 60–67 of the Interim Report, which are now adopted into this Final Report, provide a pathway for managing non-compliance in an optional home-based quarantine model through a thorough risk assessment, clear communication and understanding of the Home Quarantine Directions and consideration of a range of methods for monitoring compliance with home quarantine requirements.

Concern about the rising number of COVID-19 cases internationally and the prospect of hospitals becoming overwhelmed if returning travellers were permitted to self-quarantine

48. The then Secretary of DHHS, Ms Peake, shared the Premier's concern to 'buy time' to prevent Victoria's health system from being overwhelmed.[59] Ms Peake focused the concern thus:

> Our modelling showed that without intervention, at the peak of the pandemic we would have had 10,304 people in hospital and 5,118 ICU admissions. At the time we had 448 staffed ICU beds and the capacity to surge to 2,000 beds across private and public sectors.[60]

49. The State Controller — Health, Andrea Spiteri, expressed a similar sentiment about the prevailing thinking within DHHS at the start of the Hotel Quarantine Program:

> It was also at a time where health services themselves were gearing up for a potential influx of patients that might need intensive care. So at that time it was a very different environment, when the program started, to where we were a couple of months later, with the lifting of restrictions in Victoria, with the easing of the potential pressure on health services, and their ability to be able to potentially support into that environment.[61]

50. Given contemporary understanding of the situation facing Victoria as at 27 March 2020, such concerns were doubtless reasonably and sincerely held. The prospect that an influx of people needing hospitalisation could overwhelm the health system was unquestionably a legitimate consideration for health authorities and government at that time. Victoria chose to address those concerns with an appropriate response at that time.

51. That said, it leaves open the question of whether there were and currently are other options available either as an alternative to hotel quarantine, or in conjunction with hotel quarantine in some cases.

4.4 Alternatives to hotel quarantine

52. Addressing the option of a home-based quarantine model, as is contained in Section 2 of the Interim Report, is not to be seen as a criticism of the decision taken on 27 March 2020 to respond to the rapidly rising numbers of cases internationally and the risk of returning travellers spreading the virus into the Victorian community. Rather, the recommendations contained in Section 2 of the Interim Report come after having had the ability to examine the actual evidence as to non-compliance and the context in which that arose.

53. It also comes after consideration, not only of that evidence, but also with time to give consideration to the steps available to minimise the risk that those assessed as suitable to quarantine in residential premises will not comply with Directions to do so. Section 2 of the Interim Report discusses what is necessary to address the issues that arose in the evidence including ensuring that people are properly advised of what is required of them together with the penalties for failing to comply and addressing the need for both support and monitoring for compliance.

54. Further, the recommendations also come set in the evidence that the greatest risk has come from transmission events from returned travellers in hotel quarantine to those working at the hotels. This appears to have happened in other states, too.

55. As stated at the outset to this Chapter, this was done in the Interim Report not to criticise the decision that was made **at the time** to abandon the Self-Isolation Directions for quarantining at home but rather to more closely examine, now, what actually happened and to re-assess what can now be considered as a more nuanced and potentially safer approach to quarantining as recommended in the Interim Report.

56. Section 2.7 of the Interim Report contains a summary of the evidence as to the forms of communication that were being used to advise international arrivals by air of their obligations to self-quarantine at that time. As I concluded at paragraph 49 of Section 2.7, this fell 'well short' of what was needed to effectively communicate what each person's legal obligations were as they entered the country. The consequences of non-compliance (particularly in terms of the spread of infection, but also of penalty) required far more direct, personal and reliable communication than such a system provided.

57. Section 2 of the Interim Report and the attached recommendations as to a home quarantine model set out what I have concluded and recommended in this regard.

4.5 Conclusions

58. As at 15 March 2020, Victoria adopted the agreement reached at National Cabinet to make precautionary self-isolation directions to all international arrivals to reduce the risk of community transmission from those potentially carrying the virus in from international locations.

59. At that time, numbers of cases were starting to rise in Australia and in Victoria. By 15 March 2020, Australia had a total of 298 confirmed COVID-19 cases and Victoria had 57 of those cases.

60. The DCHO and other experts were noting that, without effective intervention, those numbers would continue to rise exponentially.

61. By 27 March 2020, there was a total of 3,162 cases in Australia and 574 of those cases were in Victoria. This represented a ten-fold increase in cases in Victoria. Moreover, during this period, there had been an outbreak on the Ruby Princess cruise ship, which had docked in Sydney, with infected passengers allowed to disperse across the nation. This event was linked to 800 cases in Australia.

62. The view of National Cabinet, echoed by the Victorian Premier, was that the majority of cases in the community at that time were linked to the virus coming in via international arrivals.

63. Together with the considerable concern raised in the wake of the Ruby Princess, there was evidence that some returned travellers were not adhering to the requirement to self-isolate at home.

64. Notwithstanding that, as at 27 March 2020, the AHPPC had only recommended enforced quarantine to the National Cabinet for 'high-risk' cases, both the National Cabinet and the Victorian Premier took the decision to direct the mandatory detention of all international arrivals into designated facilities which, in Victoria, were hotels. Both the CHO and the DCHO supported the decision based on the following:

    A. an exponential increase in COVID-19 cases

    B. a link between returned travellers and community transmission rates

    C. perceived rates of non-compliance with Self-Isolation Directions

    D. perceived inadequacy of the Self-Isolation Directions.

65. As at 27 March 2020, there was a proper and grave concern being expressed about the extent to which Victoria's health system might be overrun by COVID-19. The situation in many countries was already very grave, with substantial rates of infection and serious illness that had caused demand for hospital care to exceed existing medical services.

66. Recommendation 58 of the Interim Report states that, in conjunction with a facility-based model for international arrivals, the Victorian Government should develop the necessary functionality to implement a supported home-based model for those international arrivals assessed as suitable for such an option.

67. Given the physical limitations of hotels as quarantine facilities (as in, they are not designed as such), a major risk of the hotel model is the daily movement of personnel in and out of the facility and then into the communities in which they live. Even in a best practice model, which has dedicated personnel not moving between facilities, clinical and non-clinical personnel are, of necessity, coming in and out of a facility which, by definition, contains potentially infected people.

68. Minimising the number of people working in such environments, by only having those unable to quarantine safely at home, in the facility, reduces this risk of transmission to the broader community.

Endnotes

1 Prime Minister, 'Coronavirus Measures Endorsed by National Cabinet' (Media Release 16 March 2020), <https://www.pm.gov.au/media/coronavirus-measures-endorsed-national-cabinet>.
2 Exhibit HQI0142_RP Voluntary Submission from the Commonwealth of Australia, HQI.0001.0002.0050.
3 Exhibit HQI0155_RP Annexures to witness statement of Prof. Brett Sutton, DHS.6000.0066.3880-3882.
4 Ibid DHS.6000.0084.0648-0649.
5 From 1 July 2019 to 30 June 2020 a penalty unit in Victoria was $165.22, 120 penalty units were attached to this fine, <http://www.gazette.vic.gov.au/gazette/Gazettes2019/GG2019G014.pdf>.
6 Exhibit HQI00211_P First witness statement of the Hon. Jenny Mikakos, former MP, 9 [47]; Exhibit HQI0218_P Witness statement of the Hon. Daniel Andrews MP, 8 [39].
7 Transcript of day 18 hearing 16 September 2020, 1471-1472.
8 Exhibit HQI0157_P Transcript of Prime Minister's Press Conference 27 March 2020, 3.
9 Dr Annaliese van Diemen, 'Revocation of Airport Arrivals Direction and Cruise Ship Docking Direction' in Victoria, *Victoria Government Gazette*, No S 167, 30 March 2020, 1 <http://www.gazette.vic.gov.au/gazette/Gazettes2020/GG2020S167.pdf>.
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14 Prime Minister, Minister for Health, Chief Medical Officer, 'Advice on Coronavirus' (Media Release, 13 March 2020) <https://www.pm.gov.au/media/advice-coronavirus>.
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17 Department of Health 'COVID-19 current situation and case numbers: daily reported cases' (Web page) <https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-current-situation-and-case-numbers#daily-reported-cases>; Department of Health and Human Services 'Coronavirus update for Victoria' (Media Release 27 March 2020) <https://www.dhhs.vic.gov.au/coronavirus-update-victoria-27-march-2020>.
18 Special Commission of Inquiry into the Ruby Princess, 'Report of the Special Commission of Inquiry into the Ruby Princess' (Report, 14 August 2020) 265 [14.1] <https://www.dpc.nsw.gov.au/assets/dpc-nsw-gov-au/publications/The-Special-Commission-of-Inquiry-into-the-Ruby-Princess-Listing-1628/Report-of-the-Special-Commission-of-Inquiry-into-the-Ruby-Princess.pdf>.
19 Ibid 252-256 [13.21]-[13.43], 263 [13.64]–[13.65], 265 [14.2], 265 [14.4], 267 [14.10] <https://www.dpc.nsw.gov.au/assets/dpc-nsw-gov-au/publications/The-Special-Commission-of-Inquiry-into-the-Ruby-Princess-Listing-1628/Report-of-the-Special-Commission-of-Inquiry-into-the-Ruby-Princess.pdf>. The Ruby Princess Report notes that, of the 1,682 Australian passengers, there were 663 cases, and an additional 62 reported secondary and tertiary cases in Australia. Further, the Report notes of the Tasmanian outbreak, at the North West Regional Hospital, that the original source of the 138 cases (as at August 2020) was due to one or both of two inpatients who had acquired COVID-19 on the Ruby Princess.
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21 Premier of Victoria, 'Enforced Quarantine for Returned Travellers to Combat Coronavirus', (Media Statement 27 March 2020), <https://www.premier.vic.gov.au/sites/default/files/2020-04/200327-Enforced-Quarantine-For-Returned-Travellers-To-Combat-Coronavirus-1.pdf>.

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39 Ibid 2133.
40 Premier of Victoria, 'Victorian Premier Daniel Andrews Update on Cases' (Press Conference, 28 March 2020) <https://www.theage.com.au/national/victoria/victoria-records-biggest-jump-in-virus-cases-as-on-the-spot-fines-introduced-20200328-p54erz.html>.
41 Transcript of day 25 hearing 25 September 2020, 2122.
42 Ibid 2127.
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CHAPTER 5

'The day was measured in minutes'

5.1 The first 72 hours of the Hotel Quarantine Program from 27–29 March 2020

1. As a consequence of there being no plan for the large-scale detention of international arrivals into a mandatory quarantine program when the National Cabinet decision was announced, those who would have to implement the program in Victoria had to do so without warning and without any available blueprint for what was required. The situation was further complicated by the fact that the decision would come into effect just 36 hours later, at 11.59pm on 28 March 2020.

2. At the Prime Minister's press conference on 27 March 2020, it was made clear that the arrangements were to be implemented by the state and territory governments, with the cost to be borne by them. It was announced that there would be support from the Australian Border Force (ABF) and the Australian Defence Force (ADF), but that was said to be a matter being worked on between those agencies and the Department of Prime Minister and Cabinet (DPC) with the state and territory jurisdictions 'to ensure they can get the measures in place'.[1]

3. When asked about the scale and number of people who would require quarantine, the Prime Minister said there had been 7,120 arrivals at airports around the country the day before, and that '(t)he number of arrivals now are at a level which the states and territories believe means they are able to practically implement these types of arrangements'.[2]

4. In response to a question about the level of restrictions more generally, the Prime Minister said:

> The decisions that I communicate from this podium are the decisions of all Premiers, Chief Ministers and myself. This is not some personal view of mine; these are the decisions of the National Cabinet based on the medical expert advice that we receive in terms of the restrictions that are necessary to deal with the management of the outbreak of the virus in Australia.[3]

5. As a member of the National Cabinet, the Premier of Victoria, the Hon. Daniel Andrews MP, was a party to the decision and committed Victoria to its implementation. He agreed, in evidence, that he did so, on the basis of very limited information or pre-planning for such a program.[4] He was aware that there was no pre-existing plan for large-scale quarantine in Victoria.[5] There had been no discussion in the Victorian Cabinet about the prospect of such a wide-scale quarantine program being put in place.[6]

6. The Premier, had only had a short period of notice of the possibility a quarantine program would be established. Prior to the National Cabinet meeting, he had received a briefing from DPC.[7] It outlined the possibility of a recommendation that all travellers self-isolate in hotels, rather than at home, if the household had more than one person.[8]

7. The Premier had also been provided with a written advice from the Australian Health Protection Principal Committee (AHPPC),[9] which included a recommendation that consideration be given by National Cabinet to requiring people to quarantine away from home in high-risk cases where those people would normally reside with others at home.[10] This was the recommendation to which then Commonwealth Chief Medical Officer, Professor Brendan Murphy, referred in his press conference with the Prime Minister. The Premier stated, in evidence, that while he did not know what the AHPPC regarded as 'high-risk' cases, his own view was that high-risk cases would mean travellers returning from countries with little or no public health response.[11]

8. There was clear evidence that returned travellers posed a serious risk of carrying the virus into this State. It was proper for the Premier to have regard for the need to take all actions necessary to minimise the risk of community transmission as identified in Chapter 4.

9. On the question of the power to enforce quarantine, the Premier said in his evidence that he made an assumption at that time that the powers to be used were those in the *Public Health and Wellbeing Act 2008* (Vic) (PHW Act), which were already being used to issue directions to returned travellers to isolate at home. He did not consider who was going to monitor compliance with the directions. It was his evidence that this was not a matter to which he would ordinarily turn his mind.[12]

10. With nothing more known to him beyond the availability of hotel rooms and a sense of what the detention power would be, the Premier was of the view that it was feasible to set up the program in the time allowed:[13]

> … it seemed to me that a dedicated team of people at that very much operational level … would be able to do as they had done many times before, they could rise to a challenge like this and that they would be able to stand the system up within the timeframe.[14]

Assumption of risk

11. In committing Victoria to the implementation of the National Cabinet decision, the Premier had committed the Victorian Government to assuming responsibility for managing the COVID-19 risk posed by returned travellers and ensuring compliance with the mandatory detention orders. What had, until that time, been a system in which returned travellers were directed to self-isolate at home was now to be a system in which the government assumed responsibility for the quarantine of, and the prevention of transmission by, returned travellers.

12. The Department of Health and Human Services (DHHS) submitted that it was returning travellers potentially carrying the virus that created the risk and the Government had to make a decision about how best to manage that risk. DHHS submitted that the Chief Health Officer (CHO) and Deputy Chief Health Officer (DCHO) considered the competing risks of the continuing Self-Isolation Directions for returning travellers versus those involved in the hotel quarantine option and agreed on the latter.[15] As noted in Chapter 4, no criticism is made of that decision. However, by directing the mandatory detention of returning travellers into the Hotel Quarantine Program, the government became responsible for the proper functioning of the Program. That is, in deciding to compel people into facilities it had selected for that purpose, the government took on the management of the risk inherent in doing so. The Premier agreed in evidence that the government was responsible for such risk.[16] (This issue of risk is discussed further in chapters 6 and 7.)

13. This included an assumption of responsibility for identifying and planning for the following:
    A. ensuring that quarantine would be enforced by requiring people to stay in a particular place[17]
    B. managing the risk posed by infection in the quarantine setting[18]
    C. ensuring that people were at least as safe in the hotels as they would have been at home[19]
    D. ensuring that the community was at least as protected from infection risk as it would have been were returning travellers quarantining at home[20]
    E. the risk that the workers in the quarantine program might be exposed to infection.[21]
14. The Premier said that he thought he was aware of how large a task it would be to set up the Program when he agreed to it at National Cabinet and formed a view that it was an appropriate process for Victoria. However, while the Premier had a sense of how many travellers may return and that there was sufficient stock of hotel rooms, he could not say, in his evidence, whether he would have turned his mind to these risks that were, as a consequence, assumed by his government. The effect of his evidence was that he would have left the risk mitigations to those at an operational level.[22]
15. I accept this evidence. The decision to embark on the Hotel Quarantine Program in Victoria was made by the Premier without any detailed consideration of the risks that such a program would entail. The risk from the spread of COVID-19 to the community from returned travellers was the only risk considered, and the assessment that that risk was too high to be managed with home-based self-isolation was the only analysis done before the decision was made. No consideration was given to the risks that such a program would, itself, create. The evidence was that those risks were considerable.

Complex logistical arrangements made within 36 hours

16. The Premier agreed, in evidence, that it was a very substantial logistical undertaking to stand up such a complicated program within that timeframe. He rightly described it as 'an unprecedented set of circumstances'.[23]
17. No one who was subsequently involved in the initial decision-making or planning that took place during the first 36 hours questioned whether it could be done. Yet, throughout the course of the public hearings, various witnesses spoke about the challenges that arose from the fact that there was no 'off-the-shelf' plan or blueprint of any sort for mass quarantine, let alone in a hotel setting.[24]
18. The Program was a complex logistical operation. It was known from the beginning that it would have to cater for thousands of returned travellers. To do so, it would require a workforce of thousands of people because the Program needed to run 24 hours per day, seven days per week for an indeterminate amount of time and accommodate an indeterminate number of people.
19. This unprecedented and complex logistical operation was being designed to serve a primary purpose — preventing the further spread of a deadly virus into the Victorian community. It was, therefore, an operation designed to protect public health.
20. There was no question that many people worked extraordinarily hard to give effect to the National Cabinet decision by the deadline given to them. Their planning and design for the Program was necessarily developed in haste and from 'scratch'. Significant decisions were made between the time of the National Cabinet resolution and the first arrivals into the Program on 29 March 2020. They were made under pressure and with limited information. They were often made on the basis of assumptions about how the Program would work as there was no model or plan. In many cases, those early decisions set the course for the Program and, ultimately, its failure to prevent the spread of the virus from returned travellers to the community.

21. Understanding the reasons for those decisions and the ones made subsequently has been the core work of the Inquiry. If lessons are to be learned for the future, those decisions need to be understood and evaluated, and that process must commence with trying to account for what occurred in those 36 hours from the Premier's commitment to the National Cabinet decision up to midnight on 28 March 2020. Ultimately, it can be observed that the extraordinary pressure placed on individuals and the unprecedented nature of what they were trying to achieve explains some, but not all, of what occurred.

5.2 The initial set-up of the Hotel Quarantine Program

A dual purpose

22. Following the press conference by the Prime Minister on 27 March 2020, the Premier held his own press conference at 3.00pm that same day to address the National Cabinet decision.[25]

23. The remarks made by the Premier, and the corresponding media release, provide a contemporaneous account of the public position of the Victorian Government regarding the development of the Hotel Quarantine Program at that time, as well as its intended purpose. The media release was in the following terms:

> Following agreement by the National Cabinet, all travellers returning from overseas to Victoria will be placed in enforced quarantine for a self-isolation period of 14 days to slow the spread of coronavirus.
>
> While Victoria has seen some community transmission of this virus, most cases have been the result of travellers returning from overseas who then pass it onto their close contacts.
>
> To ensure this no longer happens, National Cabinet has agreed that all states and territories will put in place enforced quarantine measures.
>
> This will see returned travellers housed in hotels, motels, caravan parks, and student accommodation for their 14-day self-isolation period.
>
> These measures will not only help slow the spread of coronavirus, they will also support hospitality workers who are facing significant challenges during this time.
>
> The new measures will be operational from 11.59pm on Saturday 28 March, with the Victorian Government already securing 5000 hotel rooms.
>
> We will try to accommodate returned travellers close to their homes, but in some instances that may not be possible. Each person will also receive self-isolation care packages of food and other essentials.
>
> The costs of accommodation, public health and security will be covered by each individual jurisdiction, and there will be reciprocal arrangements in place to house the residents of other states and territories.
>
> It has also been agreed that the Australian Defence Force will be engaged to support the implementation of these arrangements.

> The Victorian Government is working closely with the Australian Hotels Association and other organisations so all returned travellers can be housed safely and securely.
>
> As we take this extra step to slow the spread of coronavirus, our message to every other Victorian remains the same: Stay at home, protect our health system, save lives.
>
> If you can stay home, you must stay home.
>
> If you don't, people will die.[26]

24. The Hotel Quarantine Program was regarded by the Victorian Government as a necessary and justified risk mitigation strategy in order to prevent spread in the transmission of COVID-19. The message of the Premier echoed the sentiments expressed by the Prime Minister — the purpose of the Program was to save lives.

25. However, the Hotel Quarantine Program also served a dual purpose. This was remarked upon by the Premier during his press conference when he stated that it was 'not just about an appropriate health response. It's also … about working for Victoria and re-purposing people who have perhaps had their hours cut …'[27] The dual purpose was again reiterated by the Premier at his press conference the following day, 28 March 2020.[28]

26. Contemporaneous submissions later made to the Crisis Council of Cabinet (CCC) also refer to these dual objectives of the Program, being the protection of public health and the need to support the viability of the tourism and accommodation industry.[29] I note the CCC was established on 3 April 2020 and tasked with determining 'all significant matters of policy, administration, budget and legislation required to respond to the COVID-19 pandemic crisis'.[30] The CCC is discussed further in Chapter 8.

27. The Premier agreed in his evidence that there was a perceived economic benefit from the Program that was in addition to the stated public health objective. Hotels were largely empty and this was a chance to use them. However, his evidence was that this was a secondary consideration to the public health objective,[31] which was the principal objective.[32]

28. I accept that the Hotel Quarantine Program was created in response to the perceived risk posed by returning travellers and not, in the first instance, as an economic stimulus package. I note that the Victorian Government had been intending to support the accommodation industry even before 27 March 2020, through the $80 million allocation to the Department of Jobs, Precincts and Regions (DJPR) for use in securing hotel rooms. The opportunity to support sectors that were profoundly affected by COVID-19-related restrictions was seen by government as a substantial benefit of a hotel-based model. As the Premier agreed in evidence, a home-based quarantine model would not have had those economic benefits.[33]

5.3 DJPR becomes the lead department

29. Chris Eccles AO, the then Secretary of DPC, was present with the Premier at the National Cabinet meeting on 27 March 2020. Just before 12.20pm, having become aware of the impending decision regarding mandatory quarantine, Mr Eccles stepped out to make a telephone call to Simon Phemister, the Secretary of DJPR.[34]

30. Mr Eccles told Mr Phemister about the National Cabinet decision. It was during this call that Mr Phemister first became aware of the plan to quarantine returning travellers. Mr Phemister had no prior warning that there was going to be a Hotel Quarantine Program or that his Department would be called upon to implement it.[35]

31. According to Mr Eccles, the purpose of the call was to discuss with Mr Phemister the need for hotels, and for people with deep logistical experience, for the Program.[36] According to Mr Eccles, he called Mr Phemister before anyone else because his most urgent concern was to ensure that accommodation arrangements were put in place.[37]

32. Mr Eccles gave evidence that he had no awareness, prior to 27 March 2020, of any plans for enforced quarantine measures but, like the Premier, he was aware that funding had been approved on 20 March 2020 for the COVID-19 Emergency Accommodation Assistance Program (CEA) Program, which included what became known as the Hotels for Heroes program.[38] The CEA Program was being designed, as part of the Victorian COVID-19 pandemic response, to provide support for the self-isolation of certain groups of individuals who could not self-isolate at home.[39] This was part of the $80 million program referred to at paragraph 28. Mr Eccles had no immediate recollection that, at the time, he knew of the services that had been procured for the CEA Program, but he did know that DJPR had been sourcing hotel rooms as part of it.[40]

33. Mr Eccles gave evidence that, at the time of this phone call, his focus was fixed on the imperative to source hotel rooms and he did not give any greater consideration to the architecture of the Program or how it would be implemented.[41] The message from him to Mr Phemister at this time was to 'get on with it',[42] but he also gave evidence that the purpose of the call to Mr Phemister was not to commission the whole Hotel Quarantine Program.[43]

34. Mr Phemister described the call as short.[44] Telephone records reveal it lasted for six minutes and one second.[45] Mr Phemister viewed its purpose as giving him a head start to check the number of hotel rooms available and whether it was 'doable' to have hotel stock available 36 hours later.[46] Mr Phemister told Mr Eccles that he was confident that around 5,000 rooms would be available. Mr Phemister knew this from the work of DJPR sourcing hotel rooms for the CEA Program.[47]

35. At odds with the evidence of Mr Eccles, by the end of that call Mr Phemister understood that he and his Department were in charge of the Program 'from end-to-end', meaning that DJPR was to lead the Hotel Quarantine Program.[48] Even if it was not intended by Mr Eccles, the effect of his phone call was that DJPR understood it was commissioned to plan and implement the Hotel Quarantine Program. The evidence demonstrates that Mr Phemister set to work in the immediate wake of that call, consistent with his understanding that he was responsible for the set-up of a significant governmental program.

36. After the discussion with Mr Eccles, Mr Phemister understood it was his role to immediately start planning for all contingencies. He planned to put together an end-to-end program of work to support the operation but said, in evidence, that he immediately acknowledged in his own mind that he would be deferring to experts on many matters.[49] As Secretary of DJPR, he was aware that, in many respects, his Department did not have the requisite expertise to plan and implement the Hotel Quarantine Program beyond some necessary logistical capability.[50]

37. The conversation between Mr Eccles and Mr Phemister was the beginning of a quarantine program in which only hotels were ever seriously considered as locations for the detainment of returned travellers.

38. When the National Cabinet decision was announced, the Prime Minister stated that it was a matter for each state and territory to decide the nature of the 'designated facilities' that were to be used to house returned travellers.[51] He did, however, use the specific example of a hotel at the press conference.[52] The option to use hotels had also formed part of the AHPPC advice to National Cabinet regarding the potential quarantine of 'high-risk' people.[53] Beyond that evidence, I can make no findings about what, if any, discussions took place at National Cabinet about the use of hotels specifically.

39. Suffice to say, hotels were certainly the option to which the Premier immediately turned his mind when deciding if it was feasible to implement quarantine for returned travellers by the deadline. This was not surprising in light of the Premier's awareness that there was a CEA Program being funded to source hotel rooms from 20 March 2020.[54] He agreed in his evidence that he made that assumption.[55]

40. The work done by DJPR was known to Mr Eccles and was one of the main reasons for his call to Mr Phemister.[56] By contacting Mr Phemister regarding the available hotel stock that had been sourced by DJPR and indicating to Mr Phemister that he should [or that DJPR should] get on with making the arrangements to engage hotels, the decision regarding the appropriate 'detention facilities' in Victoria was effectively made at the time of the phone call.

41. By the time of the Premier's press conference at around 3.00pm, only hotels were mentioned in association with the National Cabinet decision.[57] While the associated media release still mentioned the possibility of more varied accommodation being used[58] and the Premier gave evidence that, to his mind, the use of hotels was not finally settled until the time of his press conference the following day,[59] there was no evidence from the moment Mr Eccles spoke to Mr Phemister that any other option was considered for the 'designated facilities'.

42. It was logical, at the time, that the initial work that had been done by DJPR for the CEA Program would be used to implement the National Cabinet decision. However, the Hotel Quarantine Program was, in fact, a substantially different undertaking to the CEA Program. Most importantly, the enforced quarantine of travellers required the mandatory detention of returned travellers who would number in the thousands. This aspect of the Program, and the implications arising from it, was plainly not something that had formed part of the previous planning by DJPR. In fact, other than the bare sourcing of numbers of available hotel stock, DJPR had done little preparation that was of relevance to an enforced quarantine program. The capability and capacity of the hotels, in terms of the provision of security, cleaning and catering, had not been a factor at that time,[60] nor had the capacity of the hotels to accommodate large numbers of people in a manner that would prevent transmission of COVID-19 to the community.

43. From the time of that phone call between Mr Eccles and Mr Phemister, there was no indication in the evidence that the decision to use hotels as designated facilities was subsequently revisited by anyone during the initial planning stages or that any assessment was made to determine if the purpose of the Program could actually be met using a hotel setting, and on such a large scale.

44. The suitability of hotels and their contracting and set-up arrangements is dealt with at length in Chapter 7.

The early context of decisions made by DJPR and DHHS

45. At 12.35pm, immediately after the phone call with Mr Eccles, Mr Phemister held a meeting with team members from DJPR to draft the 'end-to-end' plan of the operation.[61] Mr Phemister envisaged the operation as encompassing a chain of custody of the passengers through the quarantine program from the time they returned to Australia to the time they left quarantine.[62]

46. Claire Febey, Executive Director, Priority Projects Unit, DJPR, was allocated to lead the end-to-end response and this was Ms Febey's understanding of her role from the outset.[63] Mr Phemister selected Ms Febey because he considered her to be a highly trusted leader with experience managing large operations through previous roles in the not-for-profit sector.[64] He described Ms Febey as an 'excellent systems thinker' and someone who could put together different phases of large-scale operations and solve large-scale problems.[65]

47. Ms Febey and her team started work immediately. The record of messages they exchanged throughout the day on 27 March 2020 demonstrates the range of tasks they identified and the connections they were making with other relevant departments in the first few hours of planning.[66]

48. Mr Phemister allocated the task of procuring hotels to Unni Menon, Executive Director, Aviation Strategy and Services, DJPR.[67] Mr Menon had already been working on the CEA Program, sourcing available hotel stock in consultation with the hotel accommodation sector.[68] Mr Menon set about adapting that work to the new DJPR hotel quarantine operation. The Crown Promenade and Crown Metropol were the initial hotels used on 29 March 2020 when the first returned travellers arrived.[69]

49. Later that night, and in circumstances that will be reviewed later in this Report in Chapter 6, the function of sourcing private security firms was tasked to Alex Kamenev, Deputy Secretary, DJPR, who delegated it to Mr Menon and other DJPR executives, who then further delegated the task to Katrina Currie, Executive Director, Employment Outcomes, DJPR.[70] Ms Currie was on secondment to Working for Victoria, a program that was established to support people who had been impacted by COVID-19 and who had lost their employment.[71] Ms Currie made contact by Saturday morning with two security companies and one of them, Unified Security Group (Australia) Pty Ltd (Unified), provided guards on the Sunday morning at the Crown hotels.[72]

50. Mr Phemister said, in evidence, that from the moment he understood his department to be leading the operation, 'the day was measured in minutes, not hours'.[73] Staffing appointments were made quickly and the various staff members gave evidence regarding the detail of their actions and decision-making, which will largely be dealt with in subsequent chapters (particularly chapters 6 and 7).

51. By midnight on 27 March 2020, Mr Phemister and his DJPR team had produced a *Journey Map and Action Plan* for the entirety of the Hotel Quarantine Program.[74] The plan designated who was responsible for anticipated actions within the Program.[75] There were many gaps, but the document richly demonstrates the complexity of the Program and the breadth of expertise required at different phases. It was more detailed than the first iteration of what became the Operation Soteria plan, produced the same day by the State Control Centre (SCC).[76]

52. At some stage during the afternoon, Mr Phemister informed the Minister for Jobs, Innovation and Trade, the Hon. Martin Pakula MP, about the decision and the role assumed by DJPR to lead the Program.[77]

53. Prior to 27 March 2020, Minister Pakula was not aware of any plan to quarantine international arrivals.[78] He said, in evidence, that he first became aware of the Hotel Quarantine Program during a phone call with Mr Phemister on the afternoon of 27 March 2020.[79] He did not believe he received any notification about the Program from the Premier or the Premier's office on that day.[80]

54. According to Minister Pakula, Mr Phemister told him that DJPR would be 'in charge' of the Program.[81] From the Minister's perspective, he thought the allocation was the logical consequence of DJPR already working to acquire hotel rooms.[82] He did not believe that it was unusual that he was receiving this information from his Secretary rather than from the Premier's office.[83]

55. The Minister for Police and Emergency Services, the Hon. Lisa Neville MP, had learned of the proposed program from the Premier's Chief of Staff in a telephone call at 1.39pm on 27 March 2020.[84] She was told that DJPR would be responsible for standing up the Program.[85]

56. Soon after learning of the Program and of what he understood to be his role in it, Mr Phemister spoke to Kym Peake, the then Secretary of DHHS.[86]

57. Mr Phemister said that he knew that DHHS would be relied upon across all phases of the operation for advice, if not direct control, because he regarded the quarantine operation as primarily a health operation. He stated it was for that reason he made early contact with Ms Peake. He said that, at the beginning of his involvement, he had not contemplated exactly what all the phases would look like.[87]

58. When Mr Phemister spoke to Ms Peake, she was already aware of the National Cabinet decision. Ms Peake was first told about the decision by Kate Houghton, a Deputy Secretary at DPC, after the National Cabinet meeting.[88] Ms Peake had no prior knowledge that there was going to be a Hotel Quarantine Program implemented in Victoria.[89]

59. Ms Peake's evidence was that she believed that Mr Phemister understood that DJPR had been commissioned to be the lead agency for the stand-up of hotel quarantine.[90] She said that she believed that Mr Phemister initially envisaged that the Program would be run by DJPR.[91] Ms Peake, as the head of DHHS, did not question that DJPR, a department with no medical or public health expertise, was leading a program of large-scale mandatory quarantine with the primary purpose of preventing transmission of COVID-19. At this stage, there is no evidence that Ms Peake raised any concern or view that her own department, DHHS, ought to be in charge.

60. According to the evidence of Mr Phemister, in all early planning by DJPR, DHHS was regarded as responsible for health and wellbeing, and for crafting the legal framework within which the mandatory quarantine of returned travellers would occur.[92] As a result, legal advice was being sought from within DHHS and from external counsel to facilitate the detention arrangements.[93] DHHS still played no role in the logistical planning and contracting efforts being undertaken by DJPR at that point, but it did commence making its own arrangements with private medical contractors, including General Practitioners (GPs) and nursing agency staff.[94]

Victorian Secretaries Board meeting — 27 March 2020

61. The Inquiry was told that formal debriefs by all department secretaries about National Cabinet decisions have occured on occasion at meetings of the Victorian Secretaries Board (VSB).[95] The VSB is a forum of all department secretaries, the Police Commissioner and the Victorian Public Sector Commissioner. It is a meeting convened about the 'stewardship' of the public service.[96] Decisions of the VSB are limited to that stewardship function and not matters that are either operational or policy orientated.[97]

62. A VSB meeting occurred at 4.00pm on 27 March 2020.[98] There was discussion during the meeting about the Hotel Quarantine Program, with all the departmental secretaries present, relevantly including Mr Eccles, Mr Phemister, Ms Peake, Secretary of the Department of Justice and Community Safety (DJCS) Rebecca Falkingham, and then Chief Commissioner of Police (CCP) Graham Ashton.

63. Mr Eccles gave evidence that the VSB made no decision at this meeting about where accountability or responsibility should sit as between departments for the Hotel Quarantine Program.[99] Mr Eccles also said that it was here that it was first conceptualised that the SCC would play the dominant role in the Program using the legislated Victorian emergency management framework.[100] It was also, he said, when he first turned his own mind to what the Program would be.

64. Notes from the VSB meeting on 27 March 2020 were tendered into evidence.[101] Indeed, as this meeting was occurring, a planning meeting was already taking place inside the SCC, convened by Emergency Management Commissioner (Commissioner) Andrew Crisp and attended by representatives of multiple departments.[102]

State Control Centre

65. The SCC is the Victorian operations centre for emergencies. It does not belong to a particular agency; it is a facility. The SCC may be used at the discretion of the control agency for 'Class 2 emergencies' to bring various agencies together.[103] The classification of, and response to, emergencies are matters that are dealt with in detail in Chapter 8.

66. The COVID-19 pandemic was a 'health emergency' and therefore a Class 2 emergency under the legislated Victorian emergency management framework.[104] Under that same framework, DHHS was the control agency for the health emergency.[105]

67. The SCC had been stood up in early March 2020 at the request of DHHS in relation to the pandemic.[106] It was through that framework that the Victorian Government's response to the COVID-19 pandemic more generally had been occurring. The emergency management framework, and the understanding of it by the various decision-makers involved in the Program, is also considered in detail in Chapter 8.

68. Ms Peake gave evidence that it was at the VSB meeting that it was agreed the SCC would be the architecture through which the detailed planning for the Hotel Quarantine Program would occur.[107] As noted, in fact, a planning meeting at the SCC was taking place even as the VSB discussed the Program. However, it does not seem that anyone at the VSB meeting thought that DHHS should be running the Program as part of its responsibility as the control agency for the COVID-19 health emergency.

69. Throughout the afternoon and evening of 27 March 2020, Mr Phemister remained of the understanding that DJPR was running the Program announced by the Premier.[108] He came to the VSB with that belief in place and that remained his understanding at the end of the meeting.[109] The content and tenor of the notes of the VSB meeting suggest that this would have been apparent to others who were at the meeting. Mr Eccles, although he had no memory of the meeting, agreed the notes suggested Mr Phemister understood or was speaking about being in charge of developing the Program at the time.[110] There was no suggestion that anyone challenged Mr Phemister's understanding or that Ms Peake or anyone else suggested that DHHS should take the lead under the emergency management framework or otherwise.

70. Ms Peake understood that, under the emergency management arrangements, DHHS was the control agency for any health emergency.[111] The VSB meeting confirmed that DHHS had the lead responsibility for developing legal directions in order to enforce mandatory quarantine of returned travellers.[112] At that point in time, Mr Phemister did not know what the source of power was going to be to detain people.[113] In his evidence, he stated that this caused some difficulties setting up the Program due to having to plan for a number of contingencies regarding an enforcement model.[114] I note that the Premier had assumed that the PHW Act would be used, but the details of how the powers in that Act would be used were not finalised until late the following day.[115]

71. Ms Peake said that the reason for the decision to use the SCC for the overarching structure of the Program was because it was a really critical intervention to deal with the threat of COVID-19; it had the characteristic of requiring a multiagency response and it needed to be stood up incredibly quickly because of the threat.[116] This was uncontroversial. The SCC was a resource that was available to the control agency that was responding to an emergency and, indeed, DHHS was already using the facility for its more general response to the pandemic.

72. When Mr Eccles first spoke to Mr Phemister and asked him to 'get on with' planning for mandatory quarantine using hotels, he had not turned his mind to the emergency management architecture or the nature of the Class 2 emergency.[117] Nor did he turn his mind to calling Ms Peake from DHHS. In his evidence, he stated that this was because his:

> … immediate interest was in activating an extensive external facing logistics process as opposed to activating a process internal to Government — which was the activation of the EM [emergency management] arrangements under which DHHS was the control agency.[118]

73. The meeting at the SCC was attended by representatives from DJPR, including Ms Febey. DHHS was also represented among the various department and agency representatives. A recording of the meeting was tendered in evidence.[119]

74. It was at this SCC meeting, on 27 March 2020, that Jason Helps, State Controller — Health (also referred to as a Class 2 Controller), first became aware that DJPR had been tasked by its Secretary to put together the 'end-to-end' Hotel Quarantine Program and considered itself the lead agency.[120] From his perspective, this had occurred despite discussion throughout the afternoon and leading up to the SCC meeting that was moving towards locating the Program under the auspices of the emergency management framework. Meanwhile, by 4.30pm, DJPR staff had already been working for several hours to establish the necessary logistical components for the Program and understood themselves to be in charge. They had no sense that the Program was anything other than their responsibility.

5.4 The emergency management framework: Operation Soteria

75. According to Commissioner Crisp, the Hotel Quarantine Program was conducted within the emergency management framework, partly for role clarity:

> It was important to put a control structure around this particular operation and, again, based on our experience of our running operations about having a control agency and then support agency, being really clear as to their role, it is really important and useful in terms of achieving a good outcome.[121]

76. Commissioner Crisp went on to say '[i]t is always very important to know who is in control, who is running a particular operation, and the distinction is which other agencies are providing support to the control agency'.[122]

77. The role played by the Emergency Management Commissioner did not involve direct operational control. In this emergency, Commissioner Crisp did not have a 'hands on' role. Rather, as will be discussed in Chapter 8, the Emergency Management Commissioner is responsible for ensuring the State's response to an emergency is coordinated and that effective control arrangements are in place. The actual operational response is led through the State Controller for any particular emergency.[123]

78. Commissioner Crisp gave evidence that it was upon being advised of the decision to quarantine returning travellers at the meeting at 2.00pm on 27 March 2020 with Minister Neville and other relevant stakeholders that he commenced planning for what became Operation Soteria.[124] In doing so, Commissioner Crisp spoke with Mr Helps and the State Consequence Manager to put together an operational plan.[125] This was then discussed at the first SCC inter-agency meeting on the afternoon of 27 March 2020 at 4.30pm.[126]

79. Mr Helps stated that he first learned of the Program on the afternoon of 27 March 2020.[127] His evidence was that he spoke with Commissioner Crisp and they arranged the SCC meeting on 27 March 2020 to bring together all the agencies to plan the Program. At that stage, Mr Helps believed that the coordination of the Program would fall under the purview of the DHHS State Controller — Health in accordance with the State emergency management arrangements.[128]

80. As part of those arrangements, due to the complexity and span of control that the State Controller — Health had in the overall COVID-19 response, it was ultimately agreed that a dedicated Deputy State Controller — Health would be appointed to coordinate Operation Soteria.[129] Chris Eagle and Scott Falconer were appointed to share that role by 29 March 2020.[130] Both had extensive experience in emergency management in their substantive roles with the Department of Environment, Land, Water and Planning (DELWP), the department from which they were seconded.[131]

81. Following the SCC meeting on 27 March 2020, the first draft Operational Plan (V 0.1) was released for review to DHHS, DJPR, DPC, the Department of Transport, the ADF and Victoria Police.[132] This first plan did not have DHHS as the control agency. This suggests that, whatever was in the minds of some DHHS officials, there was no formal decision yet that the Program would be under DHHS control. It was still unclear to Commissioner Crisp whether the operation would be run under the emergency management framework. However, it was his view that it should come into line with the emergency management structures already in place in order to provide clear control and command structures.[133] Commissioner Crisp stated this was a view shared with him by telephone on 27 March 2020 by the Secretary of the DJCS.[134] At this point, Mr Phemister and DJPR staff still regarded themselves as leading the operation.

82. At around 9.00am on 28 March 2020, Mr Phemister received a telephone call from Mr Eccles informing him that Commissioner Crisp had responsibility for coordinating the Program and that DHHS was the control agency.[135] From that point, Mr Phemister regarded his Department's new role as that of a support agency within the emergency management framework.[136]

83. At some stage on the same day, Commissioner Crisp had a telephone meeting with the secretaries of DHHS, DJPR, DPC and DJCS, at which Commissioner Crisp repeated his view that the Program should sit within the State emergency management arrangements with DHHS as the control agency. Commissioner Crisp understood the secretaries present agreed with that view.[137]

84. There were two further SCC meetings that day: at around 10.00am and 6.15pm respectively.[138] At the second meeting, following a request by Mr Helps to clarify control arrangements, Commissioner Crisp confirmed DHHS would be fulfilling that role, stating:[139]

> So everyone, well, most people will be well aware that we have a State Controller … Health, Department of Health and Human Services is the control agency. So, we want to fit this as a discrete operation into the overall state operation. So as of tomorrow morning, we will have a Deputy State Controller — Health; not a person from DHHS. So, Chris Eagle from DELWP is on the line at the moment. So, Chris will be the first of those to take on that Deputy State Controller role who will sit over this particular operation.
>
> And Jason touched on it before in terms of who's in charge. It is the Department of Health and Human Services for this operation because, as I said, it fits in with the State's structure and under the State Controller Health. However, as we've discussed, and it is evident by the number of people in the room and on the phones, there are various departments and agencies and organisations that will be playing a support role, as we used (sic) to under our emergency management arrangements, to the Department of Health and Human Services and supporting the Deputy State Controller.
>
> So, does anyone have any questions around that? I just wanted to be absolutely clear in relation to who is in charge of this operation.[140]

85. In accordance with these arrangements, on 29 March 2020, Mr Helps telephoned Ms Febey emphasising that DHHS was the control agency and needed to be in charge as it was accountable for the Program.[141] Ms Febey and Mr Helps agreed that DJPR would transition various roles and functions over to DHHS.[142]

86. Later in the day, Mr Helps sent an email to Ms Febey with the subject line *DJPR-DHHS role clarity*.[143] As was clear from that email, there was, understandably, still work to do in clarifying where responsibilities now lay under the control structure. This was confirmed by Mr Helps who gave evidence that, although Commissioner Crisp had made it clear that DHHS had taken responsibility as the control agency, Mr Helps 'would not say that practically it was resolved' so he needed to 'clarify some aspects of that and how we would work through it'.[144] The email relevantly provided:

> As you are aware the Department of Health and Human Services (DHHS) is the Control Agency for the COVID-19 Pandemic, and at this time I am the State Controller — Health appointed by the Control Agency under the Emergency Management Act. Prof Brett Sutton is the Chief Health Officer leading the Public Health response under the Public Health and Wellbeing Act. As the Control Agency, DHHS has overall responsibility for all activities undertaken in response to this emergency. The response to the direction for all passengers returning to Victoria after 11.59 p.m. 28/03/20 requiring to be quarantined in approved accommodation is being led by Dep State Controller Chris Eagle as 'Operation Soteria'.
>
> … I don't underestimate the complexity of this task in the current environment. It will be vital that DHHS make the operational decisions in regards to which hotels we utilise and when, along with other decisions which require a risk assessment by the Chief Health Officer or delegated Authorised Officer.[145]

87. Ms Febey understood this email to confirm what had been discussed in the SCC meeting on the evening of 28 March 2020 — that DHHS was in control and that DJPR would be playing a support agency role.[146]

88. The first returned travellers arrived on the morning of 29 March 2020. By this time, the Program was being run as Operation Soteria out of the SCC and apparently overseen by DHHS in its capacity as the control agency. Operational responsibility at the SCC was managed at this stage by the Emergency Management Commissioner, State Controller — Health, Deputy State Controller — Health, the DHHS Agency Commander and a team of DHHS emergency management staff.[147]

5.5 Change of lead agency

89. From the time of his 9.00am call with Mr Eccles on 28 March 2020 (see paragraph 82 above), Mr Phemister regarded his Department's new role as that of a support agency within the emergency management framework.[148]

90. While, as discussed in Chapter 8, this substantially changed the governance arrangements then in place, it appears to have made little practical difference to the work DJPR already had in train at that early stage. DJPR remained responsible for contracting and organising many of the key logistical aspects of the Program — selecting the hotels, organising private security, cleaning and catering services where necessary and coordinating the transfer of returned travellers from the airport to hotels.

91. To assist in the logistical role that DJPR took on, Mr Phemister called on the CEO of Global Victoria, Gönül Serbest. Global Victoria was an agency that sat within DJPR. Ordinarily, its function was to organise logistics for events such as trade fairs.[149] Mr Phemister requested its involvement for its logistical expertise with 'advancing' of large events.[150] It was intended that its main role would be to assist with the initial 'dry runs' of the Program that occurred on 28 March 2020. Its role quickly expanded when it became obvious that the Program would require substantially more resources.[151] Having regard to its ordinary business model, it was unsurprising that none of the staff of Global Victoria had any public health expertise or any experience that could sensibly be said to equate with managing a large-scale disaster with public health implications.[152]

92. From the perspective of Mr Phemister and Ms Peake, the logistical tasks undertaken by DJPR did not change with the shift to a model where DHHS was the control agency. What did change, and where dispute remains, was the division of responsibility for the operation and oversight of the entire Program. According to Mr Phemister, this was, by 28 March 2020, a DHHS-led activity in which DJPR participated as a support agency.[153] Ms Peake, on the other hand, was of the view that DHHS had 'overall responsibility for ensuring any operation through the State Control Centre was appropriately scoped, involved the right people and had appropriate operational governance within it'[154] but that the DHHS role within that operation was limited by what she understood to be a model of 'joint accountability' for the Program with DJPR.[155] From this early point, that lack of role clarity became symptomatic of some aspects of the Hotel Quarantine Program and caused some of the gaps, fault lines and problems that emerged.

93. The issue of who was in charge of the overall Program, whether there was shared or joint accountability and what that meant for the day-to-day operation of the Hotel Quarantine Program and the contracts that were put in place with private security companies, hotels and cleaning contractors is dealt with in detail in chapters 6, 7 and 8.

5.6 Legal enforcement powers to direct people into quarantine

94. There was no controversy over the source of the legal powers to direct returning travellers into the Hotel Quarantine Program. It was the powers exercised under the PHW Act that were used to legally enforce the detention of returned travellers in quarantine at the hotels, including whether or not there would be any exemption from quarantine. As the fundamental legal basis of the Program, they were crucial to the Program's existence, enforceability and legality.

95. Over the course of the weekend, DHHS received legal advice from in-house lawyers[156] and external counsel[157] regarding the nature of the powers necessary to detain returned travellers. The Detention Notices that compelled returned travellers into the Hotel Quarantine Program were drafted and approved that weekend, relying on the powers in the PHW Act to detain individuals in hotels for the purpose of a 14-day quarantine period.[158]

Enforcement of quarantine

96. Implicit in the decision to require all returned travellers to quarantine in designated facilities was the need for an enforcement mechanism — a means to keep travellers in their places of quarantine in accordance with the directions issued by the Deputy Chief Health Officer under the PHW Act.

97. As of 27 March 2020, the range of enforcement options that were potentially available included one or more of the following:

    A. Victoria Police

    B. ADF

    C. private security.

5.7 The use of private security companies

98. That three private security companies, MSS Security Pty Ltd (MSS), Wilson Security Pty Ltd (Wilson) and Unified were engaged to provide the services of security guards as part of the enforcement regime in the Hotel Quarantine Program was an uncontroversial fact.[159]

99. The contracts with these three companies, initially verbal and, later, confirmed in writing, were authorised by the Secretary of DJPR and entered into by the Secretary of DJPR as the contracting agency. Invoices rendered under those contracts were authorised for payment by DJPR.[160]

100. Private security guards engaged through the three lead contractors were present at all of the quarantine hotels until their removal in early July 2020 and replacement by staff engaged by DJCS.[161] I deal with the changes to the DJCS model in more detail in Chapter 11.

101. These were settled, uncontroversial facts. The process by which the firms were identified and contracted, the terms of those contracts and the ultimate suitability of private security guards for the roles they were asked to perform are all considered in Chapter 6.

Who decided to use private security as the 'first tier' of enforcement?

102. What proved to be controversial was how the decision was reached to use private security companies as the first tier of enforcement, rather than some other enforcement model using police or the ADF or a combination of any of the three options.

103. The first public mention made of private security guards being used in the Program was made by the Premier during his press conference at around 3.00pm on 27 March 2020:

> Police, private security, all of our health team will be able to monitor compliance … I'm very grateful to the Prime Minister for his agreeing to let this be a true partnership between Victoria Police, our health officials, as well as the Australian Defence Force, I think that will work very well. (The ADF) won't be exercising any statutory power. They will be working to assist those who beyond any doubt have the powers necessary to get this job done.[162]

104. This suggests that use of private security in the Program — in some form — was in contemplation by that time.

105. By 6.00pm on the same day, Mr Phemister and others understood that DJPR's role as the lead agency included the obligation to engage private security and, over the weekend, that was done by Ms Currie who, having sent emails late on 27 March 2020, verbally engaged Unified to be present on 28 and 29 March 2020 to prepare for, and then receive, the initial cohort of returned travellers.[163]

106. Subsequent formal contracts with Unified and with Wilson and MSS resulted in the use of thousands of guards and the expenditure of some $60 million on private security.

107. But no one was able to say who it was who committed Victoria to the enforcement model that placed such heavy reliance on private security; a commitment that was understood by all concerned to have been made by the evening of 27 March 2020.

108. Despite examination and cross-examination, evidence, submissions and counter-submissions, no person, agency, Minister or department has been willing or able to identify that the engagement of private security commenced as a result of some action, instruction, agreement or understanding on their own part.

109. No one denied that a decision was made but, equally, no one admitted being the one to have made the decision or knowing who did. The Inquiry has been offered accounts of what was said to be a, shared governance, and 'shared accountability' model for the Hotel Quarantine Program. I accept that, in this context, the decision was most likely contributed to by a number of people. But none of those people have accepted accountability or responsibility for, or acknowledged their role in, the decision-making process. Shared accountability in this context has amounted to no accountability in that no person has accepted they were involved in the decision making and this represents a failure in the very first stages of the governance model for this Program.

110. The Premier, when asked whether we should know who made the decision, was firm in his reply:[164]

> Ms Ellyard: Because we really should know, shouldn't we? We should be able to say who made the decision to not only spend that much money but to give such an important function in this infection control program?
>
> Premier: Yes, it's one of a number of very important questions, yes.
>
> Ms Ellyard: Mr Eccles in his evidence, when I asked him a similar question, suggested that this might be … I'm sure I'm not doing justice to his answer, but I understood him to say this might be an example of what he called collective governance or collective decision-making.

> Do you have a view about whether that's what happened here in relation to private security?
>
> Premier: Well, I would only be offering an opinion, if that would be useful to the Board.
>
> Ms Ellyard: Yes, if you think that what happened here was collective decision-making, we would be pleased –
>
> Premier: I think it's … Ms Ellyard, I want good and the best decision-making, and I think it's very difficult to make judgements about that unless you can point to who made it. I don't know that this … I don't … my understanding of collective decision-making does not remove accountability, it does not remove … for instance, as the Chair of the Cabinet, the Cabinet makes a collective decision, but I have made that decision because I am the Chair of that Cabinet. If a group of people meet and a decision is made, then a similar formality ought [to] be borne to those process … come to those processes as well. That's, at least, my practical experience from the many, many meetings and different forums that I'm the chair of. I don't think collective decision-making makes it harder to determine what body and which people made a judgement, made a decision. That's why those forums have a record of decisions and minutes and a degree … they are an authorising environment.
>
> Ms Ellyard: So, to pick up on your point, Premier, Cabinet is an obvious example of group decision-making but everyone who is there understands that that's what they are doing, they are participating in a group decision-making process. Is that fair?
>
> Premier: That is correct, yes. That's correct.
>
> Ms Ellyard: They are all able to say afterwards, 'Yes, I was part of that, I was part of that decision-making'.
>
> Premier: Yes and, furthermore, at a subsequent meeting, if the decisions were not recorded accurately, if you had a different view, if your participation was not recorded accurately, then you have opportunities to correct the record. There's a formality to that, even though it's collective.
>
> Ms Ellyard: So here, assuming that Mr Eccles's analysis is correct, and this was an instance of collective decision-making, one would expect those who were part of the collective to know that they were and to be able to identify themselves as part of that collective decision-making. Is that fair?
>
> Premier: I would certainly hope so.
>
> Ms Ellyard: Given that would be your hope, it's alarming here, isn't it, that, to the extent it was a collective decision, no one seems to have understood that they were part of it?
>
> Premier: Yes, it is very disappointing.

111. Many said they participated in discussions or meetings that were information gathering or sharing exercises and not decision-making forums. In some cases, however, it was clear that discussions and meetings presented opportunities for influence, particularly where one or more party to a conversation or meeting held a position of power and influence.

112. To come to a view about this question I have examined all of the relevant evidence and submissions to the Inquiry. After the close of the evidence, in the context of consideration of the submissions in reply, I sought more information, followed by further statements and submissions in light of that additional information.

113. Set out below is the detailed evidentiary trail upon which I have come to a conclusion by inferential reasoning as to how the 'decision' was made to use private security.

As of 27 March 2020, the use of private security was not considered problematic

114. In reviewing the discussions about private security on 27 March 2020, I bear in mind what those involved or potentially involved in any decision or approval of the use of private security would have understood the role private security was going to play. The significance of the decision to use private security turns very much on what, precisely, that workforce would be doing.

115. That private security guards would have some role in the Hotel Quarantine Program was not itself an unreasonable operational decision as of 27 March 2020. Private security had been used in hotel quarantine in other jurisdictions.[165] As the private security representatives said in their evidence and submissions, private security is a flexible and easily scalable resource that can be responsive to fluctuating demands. Indeed, a document entitled *Process Summary for Mandatory Quarantine*, apparently prepared by the ABF and circulated to Victoria Police on the evening of 27 March 2020, refers to the use of private security to enforce social distancing at hotels, suggesting that it was in the contemplation of Commonwealth agencies that private security would have some role in each State's mandatory quarantine program.[166] Accepting the limitations upon the Inquiry's access to evidence that was National Cabinet in Confidence, I infer that there was broad discussion of enforcement options that might be used by states and territories as part of the deliberations leading to the National Cabinet resolution.

116. From the evidence of those who made initial contact with security companies and from the evidence of those security companies, I am satisfied that the initial conception of the role private security contractors were to perform was the role of static guards or sentinels, in which they would have very limited contact with returned travellers.

117. The current Chief Commissioner of Police (CCP), Shane Patton, stated he had no grounds to form any reservations or concerns about the use of private security in the Hotel Quarantine Program.[167] He stated that, in the past, Victoria Police had worked successfully with private security in the context of major events and sporting events.[168] CCP Patton did not consider that the involvement of private security in the Program would be inappropriate, subject to adequate skills, training, advice and supervision being in place.[169] However, he did recognise the Program was outside the normal work of private security as it had the added overlay with respect to infection control.[170]

118. Similarly, former CCP Ashton's view was that the role of private security, as proposed, was appropriate. The guarding duties — that is, being present to ensure guests remained in their rooms — were suited to private security, with police as a backup if any person attempted to leave quarantine. Mr Ashton did not envisage that the guards would be used for other purposes and, in that context, he viewed the arrangement as appropriate. He noted that this type of arrangement was consistent with how Victoria Police had worked with private security at events.[171] At the time of his evidence, Mr Ashton's view had not changed in relation to the use of private security, provided they were well-trained.[172] He had since learned that security was being used to escort travellers, which was not what he envisaged when the plan was first put forward.[173]

119. Commissioner Crisp believed at the time that security would be a suitable workforce for use in the Program based on previous experience working with them. When well-trained and well-supervised, Commissioner Crisp believed private security would be effective in this type of role.[174]

120. Minister Neville said she did not turn her mind to the appropriateness of using private security when she was told about the proposal on 27 March 2020. Her evidence was that the use of private security alongside Victoria Police was not inconsistent with her experience of how arrangements for major events operated; for her, it did not 'jump out' as a major concern[175] as private security contractors are used widely in Victoria for security purposes, including at Parliament House, hospitals and police headquarters.[176]

121. I accept that it has become common practice for private security to work alongside police and Protective Services Officers in a range of situations, including in many government buildings such as courts and detention settings. There were important differences between those situations and the Hotel Quarantine Program with all of its complexities, including:

    A. those being detained were potentially carrying a highly infectious virus, meaning they posed a risk to each other and those working in the Program

    B. those being detained included a percentage with additional health or welfare needs that made them vulnerable and requiring additional assistance

    C. the nature of this environment required a workforce that was able to absorb changing written and verbal information and instructions in a complex health environment

    D. the need for specific and ongoing training not being well-suited to a highly casualised workforce.

122. In making these comments, I note that CCP Patton, Mr Ashton, Commissioner Crisp and Minister Neville are not public health experts. I also note the evidence given by Professor Brett Sutton, Chief Health Officer, who *is* a public health expert, about what his position would likely have been if consulted on the decision to engage private security in the Hotel Quarantine Program. Putting to one side the question of what he knew about the decision at the time, which is dealt with below at Paragraph 130, when asked whether he would have raised the same concerns he raised in June 2020 after the outbreaks occurred, Prof. Sutton said:

> I don't think so. I think the wisdom we have in hindsight is a key element here. I'm not sure anyone at the point in time of decision-making around hotel quarantine commencement might have been able to foreshadow some of the complexities of that workforce. I certainly wouldn't have had sufficient familiarity with it to have made some of the conclusions that I can make now by virtue of having seen some of those complexities play out. I would have obviously brought a public health view, but I certainly couldn't say that I would have had the same level of concerns or understood what those concerns to be back at that point in time, in late March.[177]

123. Having regard to this, I accept that it would not be reasonable to expect that CCP Patton, Mr Ashton, Commissioner Crisp or Minister Neville would have turned their minds to the specific public health issues that were ultimately generated by the use of private security guards in the Program.

124. I note the evidence of Professor Lindsay Grayson, Director of the Infectious Diseases Department at Austin Health, that security guards are used at Austin Health's COVID and SCOVID wards. His evidence was that security guards working in the hospital undergo specific additional training in terms of PPE, the same as nursing staff or doctors would do.[178]

125. In this regard, I note that CCP Patton, Mr Ashton and Commissioner Crisp — each of whom gave evidence that private security was appropriate for the Hotel Quarantine Program — qualified their answers about suitability with the proviso that they would be appropriately trained, with Mr Ashton adding the further qualification that their role would be limited to static guarding.[179] Given her experience, it was reasonable to infer that Minister Neville would have expected the same limitation in role.

126. As will be discussed in Chapter 6, the evidence established that the initial role of private security on hotel sites grew.[180] That is, the role of private security expanded beyond the pure static guarding role that may have been anticipated on 27 March 2020 when it was expected guests would not leave their hotel rooms. Security guards taking guests for smoking and fresh air breaks, and transporting luggage to guests' rooms, meant that they moved through potentially contaminated areas or had the potential to interact with COVID-positive guests.

127. Finally, I note that the 'small-scale security force' originally contemplated by DJPR on 27 and 28 March 2020[181] became hundreds of guards by the time of the first arrivals on 29 and 30 March 2020.[182]

128. I am satisfied these matters must also be taken into account when assessing the role played by others, including Mr Eccles and those present at the SCC meetings on 27 and 28 March 2020, in the decision to engage private security. Neither Mr Eccles nor those present at the SCC meeting professed to be public health experts. It was not reasonable to expect that they should have turned their minds to the full extent of the supervision and training issues, the role changes and the increase in private security numbers that occurred over time.

129. These issues arose and evolved without any proper revisiting of whether the private security workforce remained the appropriate cohort for the first-tier security role.

130. This was compounded by the lack of clarity over who was 'in control' or 'in charge' or had 'oversight' of the detention program as a whole. The compartmentalisation of roles and failure of leadership (discussed in Chapter 8) added to the failure to address the dangers associated with the matters listed in paragraphs 121–128. This was perhaps best exemplified by evidence showing that, in the days following the engagement of private security, Ms Febey continued to advocate for a 24/7 police presence at hotels.[183] By that time, DJPR had ceased being lead agency and the matter was appropriately raised with DHHS for actioning. Despite Ms Febey's efforts, clearly, nothing came of it.

131. It was further compounded by the limited engagement of public health experts in the Program. One of the issues that arose in this regard was the level of knowledge held by Prof. Sutton about the use of private security in the Program.[184] There was a chain of emails dated 27 March which emerged after the close of public hearings which, on its face, was contrary to the evidence Prof. Sutton had given as to his knowledge about the engagement of private security until after the outbreak at Rydges.[185] Prof Sutton was required to provide further evidence on oath answering questions about his state of knowledge in light of that series of emails. Prof Sutton responded with an affidavit on 4 November 2020. I accept the explanation provided by Prof. Sutton in his affidavit,[186] and the submissions made by Counsel Assisting in respect of that evidence.[187] That is, while the evidence revealed there were opportunities by way of email traffic for Prof. Sutton to become aware that private security had been engaged in the Hotel Quarantine Program prior to the outbreaks occurring in late May 2020, I am satisfied that Prof. Sutton did not 'register' this detail or have a practical awareness of security arrangements on-site consistent with his lack of operational awareness more generally within the Hotel Quarantine Program. I am also satisfied that Prof. Sutton and the Public Health Team at DHHS had no role in the decision to engage private security, that Prof. Sutton had no role in their management and oversight, and that the Public Health Team had little or no role in this regard.

132. I approach this issue conscious of the immense public interest in the process that sat behind the decision to engage private security contractors. That public interest was no doubt heightened in circumstances where key witnesses were unable to recall key events and those who might be expected to know who decided to engage private security denied having this information. It was no doubt heightened by the nature of the outbreaks and numbers of security guards across the two 'outbreak' hotels who contracted the virus. It was further heightened by the provision of relevant information after the close of evidence that would have assisted the Inquiry during hearings.

133. The Inquiry has heard that the day was measured in minutes, and this was how I forensically approached this question. In doing so, on the evidence to the Inquiry and the investigations conducted, I have concluded:

    A. the decision was not one made by an 'individual' but, rather, there were those with influence who contributed to an understanding being reached that private security would be used and this understanding then became the decision that was adopted and acted upon at the SCC meeting chaired by the Emergency Management Commissioner

    B. that understanding was reached by the conclusion of the SCC meeting on 27 March 2020

    C. there were several main factors that appeared to have led to the understanding that became a 'decision' that was acted upon by DJPR in the wake of the SCC meeting

    D. the timeline was not completely linear and there were overlapping and independent influences on the 'decision'

E. the use of private security was in contemplation from the earliest time after National Cabinet concluded and likely during the course of discussions in National Cabinet given the widespread use of private security in other jurisdictions (National Cabinet discussions were not available to the Inquiry due to Cabinet in Confidence restrictions)

F. the use of private security was not considered controversial at the time.

Before 1.00pm

134. At 12.17pm, Alex Kamenev, a Deputy Secretary who had been working exclusively on COVID-19 responses within DJPR,[188] sent an email to several DJPR officers including Ms Currie, with Mr Menon copied in. In her evidence, Ms Currie identified this email as the first time she learned of the Hotel Quarantine Program.[189] The email was titled *Cleaning workforce for isolation rooms in hotels* and was in the following terms:

> Unni is going to write to us shortly with potential requirements for a cleaning and security workforce to manage people who might be quarantined in hotel rooms.
>
> We might need to act quickly depending on govt policy choices in this space so would be good to think through options. It would be in metro and regions
>
> I need a point person who can work with Unni [190]

135. At 'around midday', in Mr Menon's recollection, he received a telephone call from Mr Phemister informing him that a hotel quarantine program was likely to be implemented and asking him to ascertain which hotels would be available to provide accommodation as part of the program (including their capacity to provide meals, security and cleaning services).[191]

136. At 12.20pm, Mr Eccles spoke to Mr Phemister.[192] Mr Phemister said the conversation was about contracting hotel rooms and 'a few other obvious phases of the operation, particularly transport from the airport to the hotels'.[193] Neither recalled the question of private security being discussed.[194]

137. At 12.35pm, Mr Phemister met with Ms Febey and others[195] to begin planning.[196] Ms Febey's notes include:

> I will be responsible for the whole process
>
> Everything
>
> Sanitation, food services, health care, security
>
> They need to be safe, but we need them to stay where they are
>
> Simon will call Graeme Ashton, need a regime that makes sure they adhere to their quarantine
>
> ...
>
> Police and security [197]

138. The notes taken by Charles Rankin, Director, Office of the Secretary of DJPR, in respect of the same meeting include:

> Claire will be responsible for DJPR process. hotels to provide sanitation, health, security, catering. Medical support, concierge support. They need to provide a full suite of service. They cannot go out and wander. SP to call Graham Ashton. Need to ensure they abide by quarantine.[198]

139. In its Further Written Submissions, Victoria Police submitted that this evidence supported a finding that a decision was made to engage private security in the Hotel Quarantine Program before the SCC meeting commenced at 4.30pm or that there was a settled consensus in favour of private security (unaided by Victoria Police's view) prior to that meeting. In so doing, Victoria Police also referred to text messages exchanged by DJPR staff between 4.12pm and 4.30pm on 27 March 2020.[199]

140. I do not accept this submission for the following reasons.

141. First, the 12.17pm email from Mr Kamenov was preceded by an email sent at 12.06pm from Michael Lemieszek, Assistant Director, International Engagement, DPC, to DJPR staff, including Mr Menon. The 12.06pm email stated:

> We are seeking your assistance to respond to an urgent request from the Premier on the number of hotel rooms and other commercial accommodation available in Victoria. This is part of the broader work on COVID19 preparedness. Unni Menon, who is working on another element of this issue, is aware of the request and suggested we speak directly with you.
>
> Could you please provide any data you have on the number of:
>
> - Hotel/motel rooms
> - AirBNB listings
> - Other accommodation such as caravan parks, cabins, holiday camps (with buildings, not tents (sic) sites), guest houses, B&Bs.
> - Unused student accommodation.
> - Anything else you can think of.
>
> If possible, we'd like the data by region. We are primarily seeking the total number, but welcome any data on current availability if it was on hand.
>
> We need to get this to the Premier's Office by the end of the day. Please send through the best data you have available by the end of the day, earlier if you can.
>
> I'll give you a call shortly to discuss.[200]

142. Although not expressly stated, it was evident from the content and timing of the 12.06pm email that:

A. work was being done to ascertain what accommodation would be available for the quarantining of returned travellers (for example, a matter that was being considered by National Cabinet at that time)

B. work that had already done by DJPR in relation to the separate CEA Program was being leveraged as part of that work.

143. There was no mention of security in the 12.06pm email. However, as part of the separate CEA plan then in place,[201] there was a plan for hotels to provide 'general additional services' including 'general security'. It appeared far more likely that it was these matters, rather than some decision that had been made at this early stage of the day within DJPR to engage private security for the Hotel Quarantine Program, that gave rise to the 12.17pm email from Mr Kamenev.[202]

144. Second, Mr Menon's evidence was that he first learned of the Hotel Quarantine Program from Mr Phemister. [203] I accept this evidence and Mr Phemister's evidence that he first heard about the Hotel Quarantine Program from Mr Eccles at 12.20pm.[204] I therefore infer that Mr Menon did not speak with Mr Phemister about the Program until after receiving the 12.06pm and 12.17pm emails.

145. Third, even putting aside these matters, the language used in the emails at 12.06pm and 12.17pm did not support a finding that a decision was made to engage private security in the Program before the SCC meeting commenced at 4.30pm or that there was a settled consensus in favour of private security (unaided by Victoria Police's view) prior to that SCC meeting, including for the following reasons:

    A. In the 12.17pm email, Mr Kamenev refers to 'potential requirements for a … security workforce'.[205] The reference to 'potential' represents clear and contemporaneous evidence that a decision was yet to be made.

    B. In her notes, Ms Febey refers to 'security' but says that 'Simon will call Graeme [sic] Ashton, need a regime that makes sure they adhere to their quarantine'. [206] This reference to Simon (whom I take to be Simon Phemister) contacting, Graeme Ashton, (clearly a reference to the then CCP Graham Ashton) strongly indicates that a decision was not only yet to be made about the security regime, but that it would not be made until Mr Ashton's views had been sought. This finds further support in the evidence of Ms Febey, who stated that the decision to engage private security was communicated to her at the SCC meeting and that she understood this to be a directive to engage private security.[207]

    C. Mr Rankin's notes also stated 'SP to contact Graham Ashton'.[208] This provides support for the accuracy of the notes and recollection of Ms Febey that DJPR was waiting for the opportunity to consult with Mr Ashton before a decision was made about the security option. Both sets of notes represent contemporaneous evidence that a decision was yet to be made and would not be made until Mr Ashton had been contacted by Mr Phemister.

    D. Mr Menon's statement[209] and Mr Rankin's notes[210] referred to hotels providing security. These references were consistent with the arrangement contemplated as part of the CEA Program at that time, not the arrangement that was ultimately reached in the Hotel Quarantine Program, where private security companies were directly engaged by the State of Victoria (State). These references therefore provided further support for the conclusion, drawn above, that these early communications between DJPR staff were made in the context of initial plans leveraging off work already done in the CEA Program, rather than a decision that had already been made to engage private security in the Program at that time.

    E. The text messages exchanged by DJPR staff between 4.12pm and 4.30pm were sent following several important developments, discussed in more detail below, including the 1.17pm telephone call between Mr Ashton and Mr Eccles, the 2.00pm meeting between Minister Neville, Mr Ashton and Commissioner Crisp, the debriefing by DPC that appeared to have occurred before 2.48pm, the Premier's press conference at around 3.00pm and the commencement of the VSB meeting at 4.00pm. I accept Ms Febey's evidence that these text messages reflected a 'working assumption' held by DJPR at that time, rather than a decision that had been made.[211]

    F. The submission made by Victoria Police was also at odds with evidence establishing that DJPR did not begin contacting private security companies to ascertain their availability for work in the Program until well after the SCC meeting.[212]

146. Having regard to this evidence, I find that, while the *potential* engagement of private security in the Program may have been in the minds of DJPR staff prior to the SCC meeting, no decision had been made and no decision was being actioned by DJPR staff in the hours prior to that SCC meeting.

1.00–2.30pm

147. Sometime before 1.16pm, Mr Ashton received what he described as a 'heads up' from his Australian Federal Police (AFP) colleagues that the Hotel Quarantine Program would be announced later that day.[213] In his affidavit, dated 19 October 2020, Mr Ashton identified a call made to him at 1.03pm from AFP Commissioner, Mr Reece Kershaw, as the most likely source of this 'heads up' and his understanding about the potential use of police as the enforcement mechanism in the Program.[214]

148. 13 minutes later, at 1.16pm, Mr Ashton sent the following text message to Mr Eccles:

> Chris I am getting word from Canberra for a plan whereby arrivals from overseas are to be subjected to enforced isolation from tomorrow. The suggestion is Victorian arrivals are conveyed to a hotel somewhere where they are guarded by police for 14 days. Are you aware of anything in this regard?? Graham.[215]

149. During his evidence before the Inquiry, Mr Eccles was shown this text message.[216] Mr Eccles stated that, at the time of the text message, he was not aware of any plan for police to be guards in the Program, as stated by Mr Ashton in the text to be his understanding of the plan from Canberra:[217]

> Ms Ellyard: … So you may feel I've asked you these questions already but are you aware of any involvement by the DPC as at about 1.30pm in setting up what were going to be the details of the enforcement arrangements in Victoria?
>
> Mr Eccles: I'm not aware.
>
> Ms Ellyard: Is it possible that it could have been happening without you being aware?
>
> Mr Eccles: It's possible. But I would have thought extremely unlikely.
>
> Ms Ellyard: Likely that if it had been happening at the time without you being aware, you would since have become aware, I take it, if arrangements of that … if work of that kind had been being done?
>
> Mr Eccles: Both that and the simple fact that if National Cabinet was finishing at 1 o'clock and there was no … the relevant matter being considered by National Cabinet originated within National Cabinet itself and not in material going into National Cabinet, then to have developed a plan between the end of National Cabinet and this time seems … I'm unaware of how a plan could be developed within that timeframe.[218]

150. Mr Ashton did not receive any text message from Mr Eccles in response and could not recall if he spoke to Mr Eccles, or anyone else, on the phone at that time.[219] Mr Eccles said, in evidence, that he did not recall speaking with Mr Ashton, though it would be his usual practice to do so.[220] Mr Eccles's phone records, which were obtained by the Inquiry after evidence had closed, reveal that there was a call made by Mr Eccles to Mr Ashton at 1.17pm that lasted two minutes and 15 seconds.[221] Both Mr Ashton and Mr Eccles gave evidence that they could not recall the contents of any conversation.[222]

151. However, five minutes after that phone call, at 1.22pm, Mr Ashton sent a text message back to Commissioner Kershaw stating, 'Mate my advise [sic] is that ADF will do Passenger transfer and private security will be used'.[223]

152. At 1.32pm, Mr Ashton sent another message to Commissioner Kershaw, which stated: 'I think that's the deal set up by our DPC. I understand NSW will be a different arrangement. I spoke to Mick F',[224] Michael Fuller, who is the Commissioner of the NSW Police Force.

153. Mr Eccles was asked about Mr Ashton's texts to Commissioner Kershaw. Mr Eccles stated that he was not aware, as at about 1.30pm, of any involvement by DPC with regard to setting up the details of the enforcement arrangements in Victoria. As noted above, he thought it was extremely unlikely it was happening without him being aware.[225]

154. In his affidavit, made after his phone records were produced, Mr Eccles rejected any inference that Mr Ashton had learned of the proposed use of the ADF and private security from him, stating that he 'had no knowledge of these matters'.[226] He stated that it was not his role to have made operational decisions about the use of private security, nor would he have had the expertise to do so. He stated:

> [I]f I did call him [CCP Ashton] back [at 1.17pm], I would not have conveyed (and would not have been able to convey) any decision about the use of private security.[227]

155. Mr Eccles stated that he did not recall the content of the conversation with Mr Ashton,[228] and strenuously rejected any claim that he had misled the Inquiry, as his evidence under oath spoke to the fact that his normal practice made it likely that he would have called the then Chief Commissioner back.[229] Mr Ashton had no recollection of the contents of the conversation with Mr Eccles either.

156. The Premier was also taken to the message sent by Mr Ashton, which referred to the arrangement for private security as 'the deal set up by … DPC'. The Premier's evidence was that he was not personally aware of any such proposal made by his department.[230]

157. Based on the content of the text message sent to Mr Eccles from Mr Ashton, the call made by Mr Eccles one minute later to Mr Ashton lasting for two minutes and 15 seconds and then the text message to Commissioner Kershaw sent approximately 12 minutes after that call ended saying 'I think that is the deal set up by our DPC', I draw the inference that a discussion took place between Mr Ashton and Mr Eccles that caused Mr Ashton to 'think' there was a 'deal' set up by DPC whereby private security would be used for the Program.

158. This inference was further supported by the evidence given by Mr Ashton during cross-examination by Mr Attiwill QC for DPC:

> Mr Attiwill: And prior to that meeting [at 2.00pm], you were not aware of any request for Victoria Police to play any role in that quarantine program, were you?
>
> Mr Ashton: Ah … not that I have a recollection of, no.
>
> Mr Attiwill: Relating to private security, you had a belief that private security were to be used?
>
> Mr Ashton: An understanding, yes.[231]

159. In closing submissions, DPC submitted that neither Mr Eccles nor DPC were involved in the decision to use private security in the Program.[232]

160. While neither Mr Ashton nor Mr Eccles had any recollection of what was said in the 1.17pm telephone call, it would be fanciful to think that Mr Ashton sent the 1:22pm and 1.32pm text messages to Commissioner Kershaw based on no more than some inner speculation of his own when at 1.16pm he had been asking Mr Eccles for information about a proposal that police be used as security for the Program.

161. At 1.34pm, Mr Ashton received a text message from Commissioner Crisp, who forwarded a text received regarding the ADF:

> I just received this from [redacted] from ADF. I assume you would have it but just letting you know.
>
> Thanks Andrew, federal announcement very shortly regarding ADF support to state police for COVID19.[233]

162. Mr Ashton's telephone records reveal that he then rang Commissioner Crisp and that they spoke for nearly three minutes. Mr Ashton could not recall the details of that conversation.[234]

163. At 1.39pm, Minister Neville received a call from the Premier's Chief of Staff and spoke to her for just over five minutes.[235] In her evidence at the Inquiry's public hearings, Minister Neville could not recall who the call was from, but said she was told that there would be a Hotel Quarantine Program and that DJPR would be running it.[236] In her later affidavit evidence, Minister Neville said there was no discussion regarding enforcement options, including security at hotels, during that call.[237]

164. At 2.00pm, about 26 minutes after the text from Commissioner Crisp to Mr Ashton, both men attended an online meeting with Minister Neville[238] and other DJCS representatives. Such meetings had been taking place regularly since the pandemic started.[239] The evidence was that there was a discussion about the use of private security in that meeting but a divergence on the evidence about who said what to whom.

165. A few minutes after 2.00pm, and while in the meeting, Commissioner Crisp sent the following text message to Ms Houghton of DPC, who had texted Commissioner Crisp to update him on National Cabinet discussions about the use of the ADF:

> Think my Minister has some idea of ADF role and that's what we're discussing with Graham Ashton at the moment.[240]

166. The text message from Commissioner Crisp was contemporaneous evidence that the issue was being discussed in that meeting. Whatever was discussed, there did not appear to have been a settled position reached on the use of ADF or private security, as Mr Ashton contemplated in the VSB meeting later that afternoon that the ADF might be used at some point to assist with static presence over time.[241]

167. Minister Neville said that it was clear Commissioner Crisp and Mr Ashton already knew more than she did about the Program when they met. Her 'best recollection' was that Commissioner Crisp raised the issue of private security being used to guard those in mandatory quarantine and Mr Ashton discussed ADF involvement, however, she could not be sure.[242] Minister Neville said that the decision to use private security was provided at the meeting as a piece of 'factual information' and she did not know who made the decision.[243]

168. When asked whether she had had a view about the use of the ADF, Minister Neville said that her concern at the time would have been about the absence of any enforcement powers on the part of the ADF and whether Victoria Police would have been better suited for a role at the airport — a role she noted was ultimately filled by the AFP.[244]

169. Mr Ashton said that Commissioner Crisp was the one who said that private security would be used to guard hotels, that the Program would be coordinated by DJPR and that police would be used to help transfer travellers and provide back up to security.[245] His notes of the meeting refer to private security and hotels, but do not say by whom these matters were raised.[246]

170. Commissioner Crisp said that he first heard about the Program during that meeting with Minister Neville, prior to the Prime Minister's announcement.[247] He understood that, as Emergency Management Commissioner, his role in the Program would be overseeing coordination and ensuring effective control arrangements were in place.[248]

171. Commissioner Crisp said that he had no independent recollection of the meeting, apart from what was in his notes, which included the words 'ADF' and 'private security'.[249] He said that he had no recollection of making the comments ascribed to him by Mr Ashton and no recollection of having pre-existing knowledge at the time of the meeting that DJPR would be running the Program.[250]

172. Having regard to the contemporaneous notes made by Commissioner Crisp and Mr Ashton, it was clear that the ADF and private security were mentioned at the meeting. Each of Commissioner Crisp,[251] Mr Ashton[252] and Minister Neville[253] gave evidence that they were not aware who made the 'decision' to use private security in the hotels.

173. It was possible that Commissioner Crisp heard about the Program from Mr Ashton during their conversation prior to the online meeting, rather than at the meeting itself. Mr Ashton already knew about the National Cabinet decision and had been party to a discussion about potential private security involvement.

174. I am satisfied that, at the 2.00pm meeting between Minister Neville, Mr Ashton and Commissioner Crisp, the issue of the use of private security and ADF was discussed. There was no evidence that a settled position or decision was made at that meeting. Equally, neither was there evidence of objection, concern or disagreement among this group. Had Minister Neville, Commissioner Crisp or Mr Ashton disagreed with the proposal to use private security in any capacity, they would have said so, and it was reasonable to expect that their opposition would have carried substantial weight given their leadership positions and expertise in policing, security and emergency management. However, in saying this, I reiterate the matters discussed in paragraphs 121–129 above. While these senior justice-portfolio office holders are experts in policing and emergency management, they do not profess to be experts in public health or public health emergencies. Further, I do not consider that, on 27 March 2020, they should have reasonably foreseen the extent of the training and supervision issues that would arise, the changing role of security over time, the substantial increase in numbers of security engaged in the Program, the fragmentation of departmental responsibility and oversight or the limited involvement public health experts would have in the management of the Program. Without that foresight and, on the assumption that the role of security would be static or sentinel guarding, there was no reason for them to oppose the idea.

175. In addition to these matters, Minister Neville submitted that it was 'simply not her role' to disagree with the engagement of private security under the emergency management structures then in place, including because it would have been contrary to that framework and the legislation underpinning it.[254] While there was some force to this argument, and while I accept that any view expressed by Minister Neville would not have had legal force, it would naturally have been open to Minister Neville to express any view she may have had, as evidenced by Commissioner Crisp's text message referred to at paragraph 165 above, where Commissioner Crisp said he that thought Minister Neville had 'some idea' about the role of the ADF and that this was being discussed at the time. In saying this, I again reiterate the matters discussed in paragraphs 121–129 above.

176. It is important to note that there was no evidence that any formal request was made to Victoria Police to provide personnel for the Hotel Quarantine Program. As Minister Neville explained, she, as Minister, cannot direct the CCP as to how to deploy his personnel.[255] She did note that she would ordinarily be consulted if a request was to be made to deploy Victoria Police to perform a role and she was not so consulted.[256] There is no evidence that a formal request was so made to Victoria Police.

Other information disseminated by DPC

177. Around the same time as the 2.00pm meeting of DJCS officials, there appears to have been a debrief from DPC staff who had attended the National Cabinet meeting.

178. As a result of that debrief, an email sent by Nicole Lynch, Director, National Cabinet (Health and Public Health), DHHS, at 2.48pm stated 'keen for police not to babysit, but called in as needed (e.g. use private security)'.[257]

179. A subsequent email from Ms Lynch, on 31 March 2020, says the 2.48pm email reflected National Cabinet outcomes (based on verbal debrief from DPC) and further clarifications 'from Kym [Peake] via Chris Eccles'.

180. The Premier and Mr Eccles each gave affidavit evidence about the extract from Ms Lynch's 2.48pm email.

181. The Premier said that:

    A. it did not reflect the view he then held about the potential use of police and private security

    B. he did not understand this to be one of the outcomes of the National Cabinet meeting

    C. he was not aware of this view being held within his private office or within DPC.[258]

182. Mr Eccles also said that the extract did not reflect the view he held about the potential use of police and private security. He said that he had no view about such matters and that he was not aware that anyone else held the view expressed in the extract at that time.[259]

183. As discussed in paragraph 157 above, I have drawn the inference that the telephone call between Mr Eccles and Mr Ashton at 1.17pm caused Mr Ashton to have the impression that private security would be used and that there was a 'deal' set up by DPC whereby private security would be used for the Program. By extension, I draw the inference that Mr Eccles had some concept or idea of the potential for the use of private security at the time of that conversation and, therefore, at the time of Ms Lynch's 2.47pm email, but am unable to conclude on the evidence that that rose to the level of a 'view' held by either him or others in DPC at that time. I also note the possibility for the reference to 'keen for police not to babysit' to reflect Mr Eccles having discussed the issue of police versus private security with Mr Ashton and one or other of them having expressed that view, but the evidence did not provide the capacity to make a positive finding on the point.

1.00–4.00pm

184. There was evidence of those working in the Premier's office trying to gather information about what the enforcement model would be. This includes texts and telephone calls between the Premier's office and DPC.[260] The timing and content of these communications indicated that they were made for the purposes of the Premier's press conference.

185. At around 3.00pm, the Premier gave the press conference, during the course of which he said:

> ***Police, private security, all of our health team*** will be able to monitor compliance in a much easier way, in a static location, one hotel or a series of hotels, as the case may be. That'll mean, and this is the really important message, that will mean that more of those police that we have, those 500 police that are doing that work in terms of Coronavirus enforcement, they'll be able to get to even more homes where people are supposed to be quarantining. Those who've arrived prior to midnight tomorrow night. So, if you're doing the wrong thing, you will be caught (emphasis added).[261]

186. The Premier was asked during his evidence whether this announcement suggested that he had an assumption or understanding of what the enforcement model would be. He responded that, despite having given the matter 'quite some thought', he was not certain why he mentioned the above three groups of people during his press conference. He could not recall what was in his mind at the time about the enforcement model.[262] The Premier further stated that a matter such as security, which was a 'deeply operational matter', would not be determined by his office or his department, and that was what emergency management structures and agencies were for.[263]

187. In his further evidence by affidavit, the Premier stated that the press conference was given on short notice and in urgent circumstances. He stated that he always receives an oral briefing from a small number of advisers immediately before a press conference, and that he is usually provided with a written press release and sometimes a policy document to which he can have regard when answering questions. He produced two such documents — a press release and a document titled *Policy Q&A's* — and said that, while he had no present recollection of the briefing he received before the press conference, he had been informed that, before the press conference, he was very likely handed a copy of the press release but not the *Policy Q&A's*. Both documents refer to 'security', but neither contained the phrase 'private security' used by the Premier in his press conference. It may be that this additional detail was conveyed in the oral briefing he received before the press conference. The Premier's evidence was that, in preparing for an oral briefing of this kind, his staff would, as relevant, contact officers of DPC or one or more other line departments, to obtain operational and policy details concerning the subject of his announcement.[264]

188. The Premier said he did not know who made the decision to use private security as the first tier of enforcement.[265] He was not able to say when he became aware that private security would be used as frontline security, and did not remember having a specific view on the appropriateness of the decision to use private security at the time.[266]

189. Mr Eccles said that he was not aware that private security would be used when the Premier stated it during the press conference.[267] He was not aware of any information provided by him or DPC to the Premier to that effect.[268] Mr Eccles was unable to say who briefed the Premier regarding police, private security and the health team working together, or the use of private security freeing up police to do more community checks.[269] In his further evidence by affidavit, Mr Eccles maintained that he 'did not play any role in briefing or assisting the Premier with the remarks he made in his press conference'.[270]

190. Mr Phemister also gave evidence that he did not brief the Premier or his office at any time on 27 March 2020.[271] Phone records produced to the Inquiry reveal that members of the Premier's office did have contact with staff from DPC, who, in turn, were in contact with DJPR officers.[272]

191. Ms Febey was watching the Premier's press conference. At 3.26pm, she sent a message to members of her team that quoted the Premier's reference to police and security monitoring compliance.[273]

192. At 3.30pm, Mr Phemister sent a text message to Mr Ashton:

> Graeme, [sic] we're running the inbound passenger isolation system with Transport (just announced by Premier). Can I get a point person from your crew to liaise with pls. If anyone else sees a role for their crew pls let me know. Claire Febey DJPR is running this with support of Paul's team.[274]

193. At 3.34pm, Mr Ashton responded to Mr Phemister:

> Mate ask Claire to call dep commissioner Rick Nugent in the first instance. I will send you his number.[275]

194. Mr Phemister said that the reason for his making contact with Mr Ashton (which had been contemplated at about 12.30pm in his initial meeting with his staff)[276] was that, having segmented the end-to-end operation, the three most important partners for the delivery of the operation would be Health (primarily), Transport and Victoria Police. Victoria Police was one of the three because he knew, given the nature of the operation, there would be a security element and they held this expertise.[277]

195. At 4.12pm, in the context of continued messaging about different aspects of the Program she and her team were developing, Ms Febey sent the following message to her team:

> We need a security stream in our plan[278]

196. A few minutes later, at 4.18pm, she messaged her team:

> We will likely need:
>
> Private security on buses (TBC)
>
> Additional security at hotels (please raise with Unni that we require this as part of full service)
>
> Police on call to enforce where there is non compliance
>
> Authorized officers (health system) to direct security
>
> We will get more information on the scc call [279]

4.00–4.30pm: VSB meeting

197. As noted above, at the VSB meeting Mr Phemister remained of the view that DJPR would be running the Program.[280] Mr Ashton did not recall any discussion regarding the use of security at this meeting.[281] Mr Phemister did not recall having an understanding of Victoria Police's views about the enforcement arrangements as a result of the meeting either.[282]

198. However, the notes of the meeting suggest, and Mr Ashton and Mr Eccles agreed, that the question of the potential role for security and police and matters of that kind were, in fact, discussed.[283]

199. In the notes taken from the meeting, under a heading 'questions', Mr Ashton was recorded as posing the question:

> People coming in from OS … police wont [sic] guard but will be doing the checks? [284]

200. Later in the notes was the following exchange:

> GA [Graham Ashton] 'Challenge will be static presence over a long period of time - will end up with some private contractor or else the ADF ideally'. CE [Christopher Eccles] 'I assume a private contractor'.[285]

201. It might be thought that Mr Ashton had no need to pose this question if he knew from either Mr Eccles or Commissioner Crisp that a decision had been made to use private security. When asked about this in evidence, Mr Ashton said he asked this question to clarify that the arrangements he already understood to be in place were, in fact, now agreed. He had made notes for himself about the matters he intended to raise, including this question.[286]

202. Mr Eccles had no recollection of the remarks and would not speculate about what he understood at the time of the meeting.[287] When taken to the notes of the meeting, Mr Eccles did not agree it was an inevitable conclusion that he assumed, at the time, there was a role for private security in the enforcement arrangements for the Hotel Quarantine Program.[288] He said that, prior to this meeting, he had not turned his mind to how people would be kept in their rooms, and was not aware of anyone from DPC formulating plans or views about enforcement.[289] While I accept Mr Eccles was doing his best to recollect his state of knowledge and thought processes on this very busy day, as I set out above, I have drawn an inference that the issue of private security was discussed in the conversation he had with Mr Ashton at 1.17pm earlier that day.

4.30pm: SCC meeting

203. By the conclusion of the SCC meeting, following the numerous exchanges and discussions throughout the afternoon set out above and at the meeting set out below, there was a decision of that meeting that private security would play the first-tier role. That meeting was recorded and the recording was produced to the Inquiry.[290]

204. During the first phase of the meeting, while Commissioner Crisp was absent, the following exchange occurred:

> ADF Officer: Thanks. Just a question on, given that the security element probably overarches all of this, anybody got anything to say whether they can — on maintenance of security or the process?
>
> Ms Febey: Is anyone from Victoria Police on the call?
>
> AC Michael Grainger: Yeah, so you've got Mick Grainger monitoring, and [redacted] from our planning area. But, you know, just thinking through security, it is multi-layered, yeah, so we've got receipt of people at the airport, and someone who is working out a process flow will work their way through this, but then you've got the potential for people not to want to get on a bus, for example. My preference would be that if we were going to house these people anywhere, CBD makes sense, to keep it simple. I support, I think it was Claire's, comments on that. But then in terms of security, there would be private security, and then the police would have a role perhaps around that as well, but we'd have to work through what that looks like.
>
> Ms Febey: I'd be really keen to take this up with you. And I'm so sorry, I missed your name. Did you say, was it Rick?
>
> AC Grainger: No, Michael. Mick Grainger.
>
> Ms Febey: Michael Grainger. Sorry about that, Michael. I'd be really keen to work this through with you because, as you say, there are different steps in security and some of it should be, for example, increasing the provision of private security at hotels. Some of it will be around security either at the point of arrival or during transport. And then we'd like to understand from you where you see VicPol's role being predominantly, which I would have thought was around where things are not going as they should, and you need to be called in to assist with enforcement. So, could you and I take that up separately, and perhaps with you I could understand who else I need to bring to the table in that conversation?
>
> AC Grainger: Yep, so we'll have a planning and an operation cell in our State Police Operations Centre. I'll take the call from you —
>
> Ms Febey: Yep.
>
> AC Grainger: — and then we'll connect in with that group who are working afternoon and night.
>
> Ms Febey: Great, thank you.
>
> ADF Officer: And I'll talk with you on that, on the next steps, Mick, as well.

205. Later, Commissioner Crisp returned to the meeting after speaking with Mr Ashton. He gave evidence that, as he returned, he sent a text message to Assistant Commissioner (AC) Grainger at 5.20pm whom he knew to be on the SCC meeting call:

> I stepped out to speak to Graham and I let him know you're in this meeting as he's only just come out of VSB. He made it clear in VSB that private security is the first security option at hotels/motels and not police.[291]

206. On returning to the meeting Commissioner Crisp said:

> Commissioner Crisp: Sorry, [redacted] can we get … again, apology, I missed, I had to step out again … but in terms of security at accommodation, have we covered that? Is it private security, Victoria Police? I understand that the preference of Victoria Police or the Chief Commissioner is that private security be the first line of security and police to respond as required. Is that your understanding, Mick?
>
> AC Grainger: Yes. It's Mick Grainger here. Absolutely that's our preference.

207. At the end of the meeting, in response to a question from a DPC representative about the potential use of the ADF, Commissioner Crisp said:

> Commissioner Crisp here. Again, that's why we went through this particular process, to identify where there was a lack of capability or capacity to undertake any of the phases of this operation. I suggest that at this stage we can manage this. The ADF will be doing just exactly what they're doing at the moment, helping us to plan for this particular operation. So, at this stage, we don't see a need for boots on the ground, so to speak.

5.30pm onwards

208. From the time the SCC meeting concluded, the die was cast. Private security would be the first tier. Police would play a support role.

Evidence on the question

209. As I have noted, no one who gave evidence to the Inquiry thought they were the person who decided to engage private security in the Program or knew, with precision, who the 'decision-maker' was or even the point at which the decision was made. Indeed, there was heated resistance from almost every witness related to the issue that they were the decision-maker or involved in the decision.

210. Mr Phemister stated that DJPR did not execute any planning for the engagement of private security until such time as they felt they were either directed by an expert agency or commissioned to do so by a source of authority.[292] This only occurred, from the perspective of DJPR, at the 4.30pm SCC meeting.[293]

211. Mr Phemister understood from Ms Febey that it was during the SCC meeting on 27 March 2020 that DJPR was asked to commission private security to support the operation.[294] Not unreasonably, he regarded the Emergency Management Commissioner, ADF and Victoria Police as experts at the meeting with relevant authority to make judgements and decisions about enforcement.[295] The process to engage private security was only commenced by DJPR after Mr Phemister received a debrief of that meeting.[296] He made the observation that DJPR defers to the SCC for all engagement with 'uniforms' as standard practice and process.[297]

212. Mr Phemister explained, by way of example of the role played by Victoria Police and the deference given to its views, that Victoria Police was involved in the initial walk through on 28 March 2020 in order to identify how many guards were required, because it was the expert in security operation.[298]

213. Mr Phemister agreed in evidence that, from the time of the SCC meeting on 27 March 2020, it was the view of DJPR that there would be private security in hotels, and that police would assist with enforcement when things were not going well.[299] He did not agree that that was a model put forward by DJPR.[300]

214. Given the position of DJPR as the lead agency at 27 March 2020, it was understandable, and I accept Ms Peake's evidence, that she was not consulted about the suitability of using private security firms.[301]

215. Former Minister for Health, the Hon. Jenny Mikakos MP, stated that she did not know who made the decision to engage private security and that, to the best of her recollection, she only became aware of private security being used after the Rydges Hotel (Rydges) outbreak:

> I would have had no reason to turn my mind to issues around security guards until we had that first case and the first outbreak at the Rydges Hotel.
>
> … it was in fact DJPR that was the Department that had all the contracts with security contractors.[302]

216. Following public revelations that former Minister Mikakos had been present with Minister Pakula at a press conference on 29 March 2020, where the use of private security in the Program was discussed, former Minister Mikakos provided a second statement to the Inquiry.

217. Former Minister Mikakos stated that, since giving evidence to the Inquiry, media reports had suggested that there may have been opportunities for her to become aware of the use of security guards in the Program prior to the Rydges outbreak.[303] In particular, she referred to Minister Pakula's media conference on 29 March 2020 and a briefing note that she may have also received, which was sent to caucus by the Premier's office on or about 8 April 2020. Former Minister Mikakos maintained that she had no independent recollection of these matters. She further stated that she had no recollection of becoming aware of (and had no reason to turn her mind to) the use of security guards in the Program on these or any other occasions prior to the Rydges outbreak in late May 2020.[304]

218. I accept from former Minister Mikakos that, when giving evidence, she gave answers consistent with her best recollection of events. Former Minister Mikakos accepted that the legal powers to detain people in quarantine came from the PHW Act, which was within her portfolio. Despite that, she maintained that she had not turned her mind to how those legal powers were being enforced at the hotels for the first few months of the Program.[305] Former Minister Mikakos added that the decision to use private security, knowing what she now knows, was not a decision she would have supported.[306] Issues about the way in which DHHS and former Minister Mikakos saw their role operationally in the oversight of the Hotel Quarantine Program are dealt with in detail in Chapter 8.

219. Minister Pakula's evidence was that he had no recollection of how he became aware that private security was being used in the Program.[307]

220. The effect of this evidence was that each of the relevant secretaries, agency heads, Ministers, the former CCP and the Premier not only disavowed being the source of any decision to engage private security, but each could not or did not say how the decision came into being.

221. During the 4.30pm SCC meeting he chaired on 27 March 2020, Commissioner Crisp said that he understood it was the preference of Victoria Police or the CCP that private security be the first line and that police respond as required. I am satisfied that he said this having been informed by his telephone discussion with Mr Ashton at 5.15pm,[308] when he stepped out of the 4.30pm SCC meeting, as reflected in his text to AC Grainger at 5.20pm[309] and AC Grainger's subsequent statement in the SCC meeting, that private security was 'absolutely' Victoria Police's 'preference'.[310]

222. Commissioner Crisp said, in evidence, that he understood the decision to use security had already been made prior to the SCC meeting[311] (although he did not know by whom) and that, when he raised the issue at the SCC meeting, he was trying to confirm the arrangements were in place and confirm the position of Victoria Police, which was expressed by AC Grainger.[312] Of course, this must be seen in light of Commissioner Crisp having been the conveyer of the information from Mr Ashton to AC Grainger himself. The sequence of the phone conversation and text message followed by the invitation to AC Grainger to confirm Victoria Police's view in the meeting suggests that, in Commissioner Crisp's mind, the issue was not yet clearly settled and that he sought Mr Ashton's view and then ensured that that view was articulated to the meeting.

223. On the evening of 27 March 2020, the witness 'Police Superintendent', who had been in the SCC meeting, sent an email to various parties, which said 'CCP recommendation that private security is to be the first line of security'.[313] In her statement to the Board, the Police Superintendent said she was unable to recall why she described the use of private security as the 'recommendation' of the CCP, that she had not communicated directly with Mr Ashton in relation to Program and that the content of the email was based on her understanding of what had been discussed at the SCC meeting that afternoon.[314]

224. In his evidence, Mr Ashton denied making any 'recommendation' that private security be used and said he was unsure why this language was used by his colleagues.[315] Moreover, his evidence was he did not make any 'recommendation' regarding the enforcement model to be used in the Program. Mr Ashton's evidence was that he was not consulted about the use of private security by anyone and he made no comment or recommendation regarding its use.[316] I do not accept that he was not 'consulted' or made no comment during the multiple discussions to which he was party, including with Minister Neville and at the VSB meeting. In the context of Mr Ashton's imperfect memory of various exchanges during the afternoon of 27 March 2020, the far more reliable evidence was contained in the content of the text messages, notes (such as they were), recordings and emails taken and exchanged that day. The reference in the Police Superintendent's email to the CCP's 'recommendation', while conveying a stronger position than 'preference', was evidence of a position being taken that was consistent with the text message of Commissioner Crisp to AC Grainger and then the electronic recording of what was said between Commissioner Crisp and AC Grainger in the wake of AC Grainger receiving the text message from Commissioner Crisp.

225. As discussed above, in paragraphs 134–146, Victoria Police submitted that the decision to engage private security was made prior to the 4.30pm SCC meeting, and indeed before the 2.00pm meeting between Minister Neville, Commissioner Crisp and Mr Ashton. Alternatively, if no decision was made, Victoria Police submitted that an assumption or default consensus was reached prior to the SCC meeting without the input of any view expressed by Victoria Police.[317] This finding was said to be supported by the evidence before the Inquiry, including that there was no proposal or request made to Victoria Police, prior to or at the 4.30pm SCC meeting, for Victoria Police to guard returned travellers in the Program.[318] Having regard to the notes of, and evidence given about, the VSB meeting on 27 March 2020, Victoria Police submitted that the preferable finding was that Mr Ashton communicated his understanding arising from the VSB meeting that a decision had been made to engage private security as 'tier 1' enforcement, not that he told Commissioner Crisp of a preference that he had made clear in the VSB meeting.[319]

226. Notwithstanding these submissions, on all of the evidence, I find that Mr Ashton expressed a 'preference' in the VSB meeting and in conversation with Commissioner Crisp that Victoria Police not be the first tier of enforcement in the Program, consistent with Commissioner Crisp's text to AC Grainger at 5.20pm.[320] In circumstances where Victoria Police was present at the SCC meeting as the law enforcement agency for Victoria and where, under the *Victoria Police Act 2013* (Vic), only the CCP can make operational decisions about how police are deployed, I find that this 'preference' carried considerable weight at the SCC meeting. The weight attributed to this preference must be qualified by reference to the fact, as already stated, that there was no evidence of a formal request being made to Mr Ashton or the Minister for Police and Emergency Services for Victoria Police members to be deployed as the frontline of security in the Program. Victoria Police was not formally asked and, therefore, did not formally refuse, but its view was clearly articulated, and the likely outcome of any potential request clearly foreshadowed.

227. The Premier was asked to comment on the evidence from Minister Neville and Mr Ashton that they had not been consulted in relation to the decision to use private security or the enforcement model in general. The Premier said it would be very unusual or even unprecedented for a decision of this type to have been made without consulting the Minister and/or the CCP. He said that, ordinarily, he would expect the views of the CCP to be sought in relation to a decision about enforcement, and that he would expect the CCP's view to carry some weight.[321] His expectation accords with the conclusions I have reached based on the evidence set out above.

228. The effect on others at the SCC meeting when hearing of Victoria Police's view was significant. As soon as AC Grainger expressed the view and Commissioner Crisp asked who then would organise private security, Ms Febey said she understood it was for DJPR to take it up. The meeting moved on to other topics, with the decision now made, though those at the meeting do not appear to have been aware that such a significant decision had been taken.

5.8 The use of the ADF

229. The question of the availability of ADF personnel was also examined at length during the Inquiry. Whereas the examination of the private security workforce concerned the decision made to use that workforce, the issue regarding ADF personnel was whether they were, and should have been requested, to fill frontline enforcement roles in the Program.

Was the ADF available to fill frontline enforcement roles in the Program?

230. It was uncontroversial that ADF personnel were generally available to assist in respect of Victoria's COVID-19 response.

231. As of 27 March 2020, Victoria Police was already using ADF resources. ADF personnel were embedded in the SCC prior to the Hotel Quarantine Program, where they had been assisting the State response to the 2019–2020 summer bushfires.[322] The evidence also established that ADF personnel were present and involved in the initial planning meetings at the SCC for Operation Soteria on 27 and 28 March 2020.[323]

232. The question, in this context, was whether ADF personnel would have been available to perform the frontline enforcement role in hotels as part of the Program, if requested, from 27 March 2020 onwards.

233. On all the evidence, it was not possible to say that ADF personnel would have been available to fill that role from 27 March 2020 onwards.

234. While much has been said about media statements made by Commonwealth and Victorian leaders around this time,[324] the best available evidence comes from the terms of the National Cabinet decision reached on 27 March 2020. On that best available evidence, noting the Inquiry's limited ability to obtain evidence that was National Cabinet in Confidence, the terms of that decision included that:

    A. the requirement to quarantine in a designated facility such as a hotel will be implemented under state and territory legislation and will be enforced by state and territory governments, with the **support of** the ABF and the ADF **where necessary and according to need across Australia**

    B. ADF will begin assisting state and territory governments to undertake quarantine compliance checks of those who are required to be in mandatory isolation after returning from overseas, with enforcement remaining the responsibility of states and territories.[325]

235. These terms were open to multiple interpretations, including because:

    A. It was not certain whether the phrase 'with the support of' extended to front of house enforcement roles in hotels, as well as back of house support roles, such as the logistical support the ADF ultimately provided.

    B. It was not certain how the phrase 'where necessary and according to need across Australia' would have been applied. In this regard, I note that the Australian Government Disaster Response Plan (COMDISPLAN), which applied to requests for ADF assistance, and which was no doubt in contemplation by Commissioner Crisp and others at the time,[326] provides that before a request for ADF assistance was made under the COMDISPLAN 'a jurisdiction must have exhausted all government, community and commercial options to provide that effect'.[327]

    C. It was not certain whether the agreement that the ADF would 'begin assisting state and territory governments to undertake compliance checks …' extended beyond the 'door-knock' campaign known as Operation Sentinel, which focused on monitoring compliance with Directions in place before the Program commenced requiring returned travellers to self-quarantine at home. In this regard, there was no evidence of an express offer of assistance being made by the Commonwealth prior to 7 April 2020.[328]

    D. While ADF personnel were provided to fill frontline enforcement roles in NSW, this was done while NSW was responding to the Ruby Princess outbreak, meaning that such assistance was logically more likely to be deemed 'necessary and according to need' in that state.

    E. While a request for ADF personnel to fill frontline enforcement roles in Victorian hotels was granted by the ADF in June 2020,[329] this was amidst a very significant outbreak in this state that, again, meant that such assistance was logically more likely to be deemed 'necessary and according to need'.

    F. The Commonwealth Government declined the Inquiry's request to provide sworn evidence on these matters[330] and, to that extent, in the absence of powers enabling the Inquiry to compel the Commonwealth to provide such sworn evidence, the unsworn evidence of the Commonwealth remains untested.

236. Having considered this, on all the evidence, it was possible to say with sufficient certainty, and I find, that:

    A. had a request for ADF personnel to be present in the quarantine hotels been made on or around 27 March 2020, it would have been considered by the Commonwealth

B. ADF personnel were most likely available to assist in frontline enforcement roles at the quarantine hotels in Victoria from 8 April 2020, at the latest, although I am not able to say whether that would have removed the need for private security guards, given the number of guards involved. It seems most likely, having regard to the models adopted in NSW and Queensland, that if the ADF was available it would have only been available in numbers to supplement, rather than replace, the existing security workforce. This was further supported by recent media reports indicating that, while the ADF has made personnel available to assist in Victoria's revised hotel quarantine program, the ADF has not been willing to provide personnel for the purposes of patrolling the floors of 'hot hotels'.[331]

237. I have arrived at this conclusion on the basis that:

A. ADF personnel appear to have been provided to fill frontline enforcement roles in hotels in Queensland from 31 March 2020 following a request made on 27 March 2020.[332]

B. In evidence, Commissioner Crisp stated that, had a request for ADF personnel to fill frontline roles in hotels in Victoria been made, he would have expected it to be given proper consideration by the ADF.[333]

C. In the diary notes of CCP Patton, taken in respect of a conference call he attended with Mr Ashton and Deputy Commissioner (DC) Rick Nugent on the evening of 27 March 2020, reference was made to the ADF being 'available re static guarding of those sites'.[334] From the surrounding context of those notes, I infer that by 'sites', CCP Patton meant 'hotels'.

D. By email on 8 April 2020, the Secretary of the Commonwealth Department of Prime Minister and Cabinet, Phil Gaetjens, sent an email to Mr Eccles in response to an enquiry by Mr Eccles about the availability of financial assistance from the Commonwealth, stating:

> On the question of assistance with security, I am advised the only deal with NSW was in-kind provision of ADF personnel. I am sure the Commonwealth would be willing to assist Victoria if you wanted to reconsider your operating model.[335]

E. In evidence, Mr Eccles accepted it would be reasonable to infer from this email that, had Victoria wanted ADF personnel in hotels, the Commonwealth would have considered it. From the terms of the email, and Mr Gaetjens's senior position within the Commonwealth public service, I infer that the Commonwealth would have not only considered such a request, but would have considered it favourably.

238. When Mr Eccles was asked whether he had passed on Mr Gaetjens's email to those responsible for operational responsibility, he could not recall whether he did or did not.[336]

239. In his evidence, the Premier stated that he was not aware of the proposition that ADF personnel might have been available if Victoria elected to adopt a model that that required them in hotels and that he, in fact, had 'quite the opposite view'.[337]

240. There was nothing in Mr Eccles's response to Mr Gaetjens,[338] or anywhere else on the evidence, indicating that Mr Eccles communicated the terms of Mr Gaetjens's email to the Premier or anyone else with operational responsibility for the Hotel Quarantine Program. The Premier's evidence was that he would, ordinarily, have expected that the availability of a resource, such as the ADF, would be drawn to his attention and the attention of those who were making policy and operational decisions for the structure of the Hotel Quarantine Program.[339] The Premier said the proposition would have been 'very significant' to him and that he 'certainly would have wanted to know, because it would have presented us with options we otherwise didn't have …' in terms of the Premier's interpretation of what had been decided at National Cabinet.[340]

241. It was surprising and inexplicable that Mr Eccles did not communicate Mr Gaetjens's proposal when there was a possibility that the significant costs of private security might have been reduced through the introduction of an alternative workforce.

Why was a request for ADF personnel to fill frontline enforcement roles in the Program not made?

242. The evidence on this question follows a similar trajectory to the evidence on the question, discussed above, of who decided to engage private security in the frontline enforcement role in the Program.

243. The answers to these questions were clearly interlinked. The evidence demonstrated that there was no request for ADF personnel to fill frontline enforcement roles in the Program as of 27 March 2020 because it was not seen as necessary. The reason it was not seen as necessary was that the decision had been made to engage private security as the first tier of enforcement with Victoria Police to be called in as needed, so there was no 'need' that could then be identified for ADF to supplement that enforcement model.

244. The timeline of evidence that led to these related decisions being reached was largely the same and leads me to a similar conclusion. While there were, throughout the day of 27 March 2020, key events and players who influenced what became a decision not to request ADF assistance in frontline enforcement roles, that decision did not crystallise and was not made until the SCC meeting held at 4.30pm that day.

245. Rather than repeat matters already discussed in full, the evidence that has led me to this conclusion may be summarised as follows.

246. On the evidence, the first mention of the role that would be played by the ADF was the National Cabinet decision.

247. The next mention of the ADF's role appears in the text messages sent from Mr Ashton to Commissioner Kershaw at 1.22pm and 1.32pm, where Mr Ashton stated that the ADF would be doing 'passenger transfer'.[341] For the reasons discussed above, I infer from these text messages, and the communications between Mr Ashton and Mr Eccles immediately prior,[342] that Mr Ashton and Mr Eccles discussed the potential role that would be played by the ADF in the Program during their 1.17pm telephone call. It was not possible to say which of the two men raised this matter or that the conversation could be characterised as a 'decision' at that stage of the day. It was also not possible to say with certainty that the reference to the ADF doing 'passenger transfer' meant, by implication, that they would not be engaged to fill frontline enforcement roles, although I accept from the subsequent reference that 'private security will be used', and from Mr Eccles's comments at the 4.00pm VSB meeting, that this conclusion is open.

248. At 1.34pm, Commissioner Crisp sent a text message to Mr Ashton forwarding a message from the ADF stating that there would be a 'federal announcement very shortly regarding ADF support to state police for COVID19'.[343]

249. Commissioner Crisp's notes of the subsequent meeting at 2.00pm with Minister Neville, Mr Ashton and others included the words 'ADF' and 'private security'.[344] I am satisfied on the evidence that both matters were raised. During the meeting, Commissioner Crisp sent a text message to Ms Houghton of DPC advising 'I think my Minister has some idea of ADF role and that's what we're discussing with Graham Ashton at the moment'.[345] In her evidence, Minister Neville agreed that there was a discussion in which she participated about suitable roles for the ADF, but only in relation to the role they may play in escorting people at airports, and whether that role was appropriate noting the limits on the enforcement powers that could be exercised by ADF personnel.[346] It was not possible to say on the evidence that there was discussion of the ADF's role beyond that transport role. Further, whatever was discussed, there did not appear to have been a settled position reached at the meeting, since Mr Ashton appears to have contemplated at the VSB meeting later that afternoon that the ADF might be used at some point to assist by way of a static presence over time.[347]

250. At around 3.00pm, the Premier gave a press conference and spoke about ADF involvement in the Program, but gave no specific description of the role that it would play. In evidence, the Premier said he understood that ADF assistance was available where it was necessary, meaning where it was needed in the relevant state. He agreed that, when he spoke about the ADF being available according to need, that meant that it was a finite resource such that it would be apportioned according to who needed it most if there were multiple demands,[348] stating further:

> … leaving the National Cabinet meeting I had absolutely no expectation whatsoever that in the establishment and the running of hotel quarantine there would be significant, extensive ADF support. That was … that was not the case for every state. A case, I think, had been well made in relation to New South Wales. But I had no expectation at all that we would receive that type of support.[349]

251. At 4.00pm, the VSB met and discussed the Program. During that discussion, Mr Ashton was quoted as saying 'challenge will be static presence over a long period of time — will end up with some private contractor or else the ADF ideally'. Mr Eccles was then quoted as saying 'I assume a private contractor'.[350] While these comments from Mr Eccles cannot be characterised as a decision, they do reflect the ultimate outcome — private security was selected over Victoria Police and the ADF.

252. As the meeting at the SCC reached its conclusion, a DPC representative asked a direct question about the role the ADF would play in the Hotel Quarantine Program. Commissioner Crisp responded:

> Again, that's why we went through this particular process, to identify where there was a lack of capability or capacity to undertake any of the phases of this operation. I suggest at this stage we can manage this. The ADF will be doing just exactly what they're doing at the moment, helping us to plan for this particular operation. So, at this stage we don't see a need for boots on the ground, so to speak.[351]

253. The reference to a lack of capability or capacity was a reference to the criteria for requesting ADF assistance. It was for Commissioner Crisp to make the assessment that there was any relevant lack of capability or capacity that required ADF resources. He agreed in evidence that he was aware, on 27 March 2020, that he could request ADF assistance, if necessary, and that his assessment was that there was not a lack of capacity.

254. No one present at the SCC meeting spoke against that assessment. This view was reached by Commissioner Crisp after consideration of the requirements of each of the phases of the operation and in discussion with DHHS, the State Controller — Health and Victoria Police.[352] Mr Helps gave evidence consistent with Mr Crisp on this topic.[353]

255. This was Commissioner Crisp's assessment. Minister Neville said, in evidence, that she was not consulted by Commissioner Crisp prior to his statement at the SCC meeting that Victoria had sufficient capacity to meet all the requirements of the Program and, consequently, did not require 'boots on the ground' from the ADF.[354]

256. Mr Ashton initially provided a statement that he had no recollection of any discussion about the possible use of ADF as part of the Program.[355] He stated that he was aware of the suggestion that it would be used to help transfer passengers. Such assistance never eventuated because, on the afternoon of 27 March 2020, DJPR indicated that Skybus would be doing that job.[356]

257. The evidence of Mr Ashton was at odds with CCP Patton's diary note, detailed at paragraph 237.C above, which referred to the ADF assisting with 'back of house' checks and the ADF being available 're static guarding of those sites'.[357] CCP Patton did not have an independent memory of the conversation to which this note relates, and cannot add to what was in the diary note.[358] It clearly came to nothing.

258. CCP Patton, in his evidence to the Inquiry, stated that the ADF did not have any enforcement powers and ADF personnel were not trained in dealing with civilians.[359] He was clear that, while the ADF was assisting Victoria Police's enforcement response to the pandemic, it was not involved in enforcement *per se*. This corresponded with public statements made by the Prime Minister and the Premier that, to the extent the ADF was involved, or was to be involved, it would be in a role that assisted compliance and did not involve the exercise of any legal powers. Of course, private security guards have no enforcement powers either.

259. Victoria Police had a senior representative at the SCC meeting on 27 March 2020 and no concern was raised about the view provided by Commissioner Crisp regarding the ADF. This was unsurprising in light of the preference expressed at that meeting by Victoria Police that private security be used, and confirmation in the SCC meeting that DJPR was attending to those arrangements.[360] Frontline security was being addressed[361] and the assessment was that there was no gap.

260. Commissioner Crisp reiterated his position at another SCC meeting the following day, on 28 March 2020, stating that 'at this particular point in time, we certainly don't see the need for ADF boots on the ground in support of this operation'.[362] Once again, no one present, including Victoria Police, spoke against that assessment.

261. If there was any doubt about the decision announced on 27 March 2020 by Commissioner Crisp that the ADF would not have a frontline enforcement role in the Program, there could not have been any by the time of his remarks at the SCC meeting on 28 March 2020. Those remarks were accompanied by comments made by an ADF representative who, when asked if they wished to raise anything, responded 'no … just noting that the news tonight mentioned that ADF would be patrolling the corridors of hotels, ah, not in Victoria'.[363] It was a clear indication to all those at the meeting that ADF personnel would not be used inside the hotels in Victoria, albeit they were being used in other jurisdictions.

262. Mr Eccles could not recall the point in time that he became aware of the role that the ADF was to play. He was not aware why a DPC representative at the SCC meeting on 27 March 2020 sought clarification about what role was to be played by the ADF. He accepted that it was possible that DPC had a role to play in furnishing information to the Premier on that point, as it was a role played by DPC when requested, but he had no reason to conclude one way or the other. Mr Eccles was also shown an email sent shortly before 4.00pm from the Premier's office to someone at DPC regarding information the Premier required.[364] It asked *What role will the ADF play?* Mr Eccles agreed that DPC representatives at the SCC were likely asking about ADF at the SCC meeting because there had been a request from the Premier's office for information.[365] Mr Eccles, otherwise, had no recollection of being aware, on 27 March 2020, of any particular view or decision within government generally about the appropriateness or otherwise of using the ADF.[366]

263. As I have considered earlier in this Chapter, the use of private security as the first tier of enforcement was never the subject of analysis. At no time on 27 March 2020 did it appear there was any consideration of the respective merits of private security versus police versus ADF personnel in that first-tier role. Instead, an early mention of private security rather than police grew into a settled position, adopted by acquiescence at the SCC meeting. This means that there was no actual consideration of whether ADF personnel would have been a better option. That question never seems to have arisen in anyone's mind. The assessment that the ADF was not needed on the ground at the hotels was an assessment made without any proper consideration of the anterior question of what would be the best enforcement option.

264. Minds may differ about the benefits the ADF could have provided to the Program at that time. It is, in fact, a resource that could have been requested of the Commonwealth, at least in theory, and assuming a case could be made for its use.[367] I am satisfied that, as of 27 March 2020, the decision not to request the assistance of the ADF for a role in the quarantine hotels was made by Commissioner Crisp, on the basis of his assessment that the various agencies represented at the SCC meeting were appropriately resourced and did not require that form of ADF assistance. I am satisfied that no person or agency raised a concern about this assessment. It was an assessment that was open in the sense that, once it was agreed private security would be used at the hotels, there was no longer a 'need' for ADF.

5.9 Conclusions on initial decision-making

265. As a consequence of there being no pre-planning for the large-scale detention of international arrivals into a mandatory quarantine program, when the Premier committed Victoria to hotel quarantine, those who would have to implement the program in Victoria were required to do so with very little warning and without any available blueprint for what was required. The situation was further complicated by the fact that the decision would come into effect just 36 hours later, at 11.59pm on 28 March 2020.

266. To put the scale in context using information provided by the Prime Minister on 27 March 2020, 7,120 people had arrived at airports around the country on 26 March 2020, the day before the announcement of hotel quarantine.

267. The Premier was aware there was no pre-existing plan for large scale quarantine in Victoria and there had been no discussion in the State Cabinet about the National Cabinet decision. He considered it feasible to achieve, however, based on his knowledge of the availability of hotel rooms and the dedicated team of 'operational people' able to rise to this challenge.

268. The initial responsibility for setting up the Program was given to DJPR.

269. Other than the sourcing of numbers of available hotel stock, DJPR had no preparation for, or relevant expertise to operate, an enforced quarantine program. The capability and capacity of the hotels in terms of the provision of security, cleaning and catering had not been a factor at the time of allocating the lead to DJPR, nor had the capacity of the hotels to accommodate large numbers of people in a manner that would prevent transmission of COVID-19 to the community.

270. It was not appropriate to conceive of the Hotel Quarantine Program as an extension of, or substantially similar to, existing accommodation programs, such as the CEA Program. The logic of tasking DJPR to source hotels for quarantine purposes on the basis that it had previous awareness of hotels for the CEA Program, did not extend to DJPR sourcing hotels for quarantine purposes; the nature and purposes of the two programs were significantly different and involved different levels of risk.

271. DJPR understood from the outset that it would need the assistance of DHHS for crafting the legal framework for the Program and arrangements for the health and wellbeing of the people in quarantine.

272. Within a few hours of that call to the Secretary of DJPR, the Emergency Management Commissioner and the State Controller — Health at DHHS were setting up a meeting at the SCC on the understanding that this Program would be operated using the emergency management framework and would be named Operation Soteria.

273. By the afternoon of 28 March 2020, from a meeting at the SCC, the Emergency Management Commissioner, in conjunction with the DHHS State Controller — Health, made clear that DHHS was in charge of the operation as the control agency and that DJPR was a support agency, as were a number of other agencies attending the meeting.

274. DJPR continued to provide the contracting and organising of many logistical aspects of the program including hotels, security, cleaning contractors and general logistics, including transport and aspects of catering.

275. This appears to have been the genesis of the ongoing dispute as between DHHS and DJPR as to who was in charge of the overall operation of the Program. DJPR was clear that it was DHHS. DHHS was adamant that it was only responsible for parts of the Program and that DJPR was jointly responsible and accountable for the delivery of the Hotel Quarantine Program. This was the source of considerable and significant problems with the way in which the Program was operated.

276. I am satisfied that the decision to embark on a Hotel Quarantine Program in Victoria involved the State Government assuming the responsibility for managing the risk of COVID-19 transmission. But even though that risk was assumed by the Government, and as critical 'decisions' were made with respect to enforcement measures, there was no detailed consideration of the risks that would be involved in such a program. This was a failure in the establishment of the Program.

277. In committing Victoria to the mandatory quarantine of returned travellers, the Premier had committed the Victorian Government to responsibility for managing the COVID-19 risk posed by returned travellers and ensuring compliance with the mandatory detention orders. In so doing, the Government assumed responsibility for the safe quarantine of, and the prevention of transmission by, returned travellers and the maintenance of a safe system of work for those it brought onto quarantine sites.

278. This included an assumption of responsibility for identifying and planning for the following:

    A. ensuring that quarantine would be enforced, directing that people isolate in a particular place and monitoring compliance

    B. managing the infection risk posed by the quarantine setting

    C. ensuring that people were at least as safe in hotel quarantine as they would have been quarantining at home

    D. ensuring that the community was at least as protected from infection risk as it would have been were returning travellers quarantining at home

    E. managing the increased exposure risk for workers in the quarantine program.

279. It is beyond doubt that many people worked incredibly hard, in extraordinary timeframes, to deal with an unprecedented set of circumstances. But that is not a total justification for the deficiencies in some of the actions taken and decisions made in that first 36 hours, and it does not excuse the deficiencies I have found in the Program.

5.10 Conclusions on the enforcement model

280. I am satisfied that, while the evidence did not identify a single person who decided to engage private security in the Program, there were clearly people who influenced that outcome, which was the position adopted at the SCC meeting at 4.30pm on the afternoon of 27 March 2020.

281. I am satisfied that the first of those was Mr Eccles. The second was Mr Ashton.

282. Mr Eccles's oral and written evidence was that he did not make a decision or express any opinion.[368] I accept that Mr Eccles did not make the 'decision' within the strict meaning of that word as it relates to formalised government processes that would require documents to be produced and signed off. I also accept that Mr Eccles did not have the power to make any such decision on his own.

283. With the benefit of Mr Eccles's telephone records, I am satisfied that Mr Ashton first heard of the possibility of private security being used during the two minute and 15 second call they had at 1.17pm on 27 March 2020.[369] I cannot reach any firm conclusion about what was discussed but am satisfied that it was during that call that Mr Ashton gained the impression that private security could be used instead of police. Given that Mr Eccles had been present during National Cabinet discussions,[370] and given that all jurisdictions made some use of private security, I conclude that he was the one to mention private security as (at least) an option.

284. However, the mention of private security as an option did not equate to Mr Eccles having determined the precise role it would play. There was no evidence that the conversation between Mr Eccles and Mr Ashton was conveyed to anyone who was present in the SCC during the discussions about enforcement options. Further, there was no evidence that Mr Ashton, himself, referred to his conversation with Mr Eccles to anyone other than, by inference, Commissioner Kershaw in his text message outlining that DPC had made a 'deal' or established the private security role.

285. By the time Mr Ashton referred to 'a deal set up by our DPC, he had also spoken to his NSW counterpart, Commissioner Fuller.[371] Mr Ashton and Commissioner Crisp then spoke to each other before they met with Minister Neville at 2.00pm. I am not able to make any finding about what they discussed or about who first raised the question of private security in the 2.00pm meeting, but the evidence before me supports the view that Mr Ashton was the person who entered those discussions with some existing knowledge that private security would have a role to play, although he was not yet clear what that would be. He then raised the question at the VSB meeting and spoke to Commissioner Crisp while the SCC meeting was in progress.[372] Commissioner Crisp's text to AC Grainger about Mr Ashton's views appears to have prompted AC Grainger's comments about Victoria Police's preference,[373] which Ms Febey and others understood as having determinative force.[374]

286. It would be highly unusual if a final decision on an enforcement model was taken without consulting the CCP or taking into account their view. I am satisfied that Mr Ashton did have a view that the mention of private security by Mr Eccles was consistent with Mr Ashton's view, and that he promoted that view in subsequent meetings directly and by means of his conversation with Commissioner Crisp. As I have noted, it was after the view of Victoria Police was articulated in the meeting that DJPR's representatives understood that private security needed to be engaged.[375]

287. It was telling that it was not until after the SCC meeting that private security was engaged. Mr Phemister made the point in his evidence that, on 27 March 2020, it was DJPR that was responsible for the Program.[376] DJPR had no knowledge of any decision before the SCC meeting.[377] Had a decision already been made, one would expect DJPR to have begun the process of contacting security contractors much earlier in the day, noting the extreme urgency with which everything was being organised. In this regard, I am satisfied that Mr Eccles did not mention private security to Mr Phemister in their telephone conversations throughout the day.

288. The comments by AC Grainger in the SCC meeting clearly carried significant weight for Ms Febey from DJPR, who reasonably understood it to be a 'direction' that private security would be used.[378] Indeed, upon AC Grainger expressing that view, the discussion on security options ended because it was perceived that an agreement had been reached. DJPR then commenced its efforts that resulted in the informal engagement of Unified, Wilson and MSS to provide private security at the hotels.

289. I acknowledge the haste with which these decisions were being made. I note, too, the separate controversy that emerges with respect to the appropriateness of engaging private security for the various roles it ultimately performed, a matter I consider in Chapter 6. However, the fact remains that not one document was produced to the Inquiry that demonstrated a contemporaneous rationale for the decision to use private security as the first tier of enforcement, or an approval of that rationale in the upper levels of government. Such a finding is likely to shock the public. Unlike the formal application through the ERC process for the funding for the CEA Program, no such process has been uncovered for the use of private security in the Hotel Quarantine Program. It was a decision made in haste, without regard to its financial implications, and with no person made responsible for reviewing the decision as those financial implications became apparent.

290. The people of Victoria should understand, with clarity, how it was that millions of dollars of public money was ultimately spent, and we should be able to be satisfied that the action to proceed in this way was a considered one that addressed the benefits, risks and options available in arriving at such a decision. There was no evidence that any such considered process occurred on 27 March 2020 or in the days and weeks that followed.

291. The decision to engage private security was not a decision made at the Ministerial level. The Premier and former Minister Mikakos said they played no part in the decision. Similarly, Minister Neville and Minister Pakula stated they were not involved in the decision. Minister Neville was aware of the proposal but not responsible for it and Minister Pakula appears not to have been told until after private security had been engaged. Enforcement of quarantine was a crucial element of the Program that the Premier had committed Victoria to adopting, but neither he nor his Ministers had any active role in, or oversight of, the decision about how that enforcement would be achieved.

292. On its face, this was at odds with any normal application of the principles of the Westminster system of responsible government in that individual Ministers of the Crown are ultimately responsible to the Parliament (and thereby the people) for the actions of their departments. That a decision of such significance for a government program, which ultimately involved the expenditure of tens of millions of dollars and the employment of thousands of people, had neither an owner nor a transparent rationale for why that course was adopted, plainly did not accord with those principles. I have addressed this issue further in Chapter 8.

293. I issued Notices to Produce for documents relevant to the Inquiry's Terms of Reference to all government departments involved in the Program. The Inquiry received more than 70,000 documents in response, including Cabinet documents. No document was produced to the Inquiry that definitively revealed who made the decision to engage private security or how the initial decision-making process occurred. Likewise, no document produced to the Inquiry revealed that there was any consideration given to the ongoing expenditure associated with private security, the appropriateness of that expenditure or whether an alternative enforcement model should have been adopted, until late June 2020 following two significant outbreaks of infections among security guards.

294. This itself bespeaks of a failure of governance. This decision was a substantial part of an important public health initiative and it cost the Victorian community many millions of dollars. But it remained, as multiple submissions to the Inquiry noted, an orphan, with no person or department claiming responsibility.

295. In his evidence, the Premier agreed that the question of how this occurred should be capable of being answered.[379] As the head of the Victorian Public Service at the time, Mr Eccles acknowledged it was a fair point that, if no one knew who made the decision, there was an obvious risk that no one would understand that they have the responsibility for revisiting the decision if time and experience showed that it was not the correct one.[380] This was what occurred here. The decision was made without proper analysis or even a clear articulation that it was being made at all.

296. No one involved took issue with the use of private security at the time the arrangements were being made. This was despite an ongoing government-commissioned review that raised serious issues about the reliability and professionalism of some sectors of that industry.[381]

Endnotes

1 Exhibit HQI0142_RP Voluntary Submission from the Commonwealth of Australia, HQI.0001.0002.0059.
2 Ibid.
3 Ibid HQI.0001.0002.0065.
4 Transcript of day 25 hearing 25 September 2020, 2121.
5 Ibid.
6 Exhibit HQI0218_P Witness statement of the Hon. Daniel Andrews MP, 3 [11]; Transcript of day 25 hearing 25 September 2020, 2121.
7 Exhibit HQI0219_RP Annexures to witness statement of the Hon. Daniel Andrews MP, DPC.0001.0001.0230-0234.
8 Ibid DPC.0001.0001.0231; Transcript of day 25 hearing 25 September 2020, 2123–2124.
9 Exhibit HQI0219_RP Annexures to witness statement of the Hon. Daniel Andrews MP, DPC.0023.0001.0002; Exhibit HQI0218_P Witness statement of the Hon. Daniel Andrews MP, 3 [12]; Transcript of day 25 hearing 25 September 2020, 2124.
10 Exhibit HQI0218_P Witness statement of the Hon. Daniel Andrews MP, 3 [13].
11 Transcript of day 25 hearing 25 September 2020, 2124.
12 Ibid 2126.
13 Ibid 2127.
14 Ibid.
15 Submission 03 Department of Health and Human Services, 17 [91].
16 Transcript of day 25 hearing 25 September 2020, 2134.
17 Ibid 2133-2134.
18 Ibid 2134.
19 Ibid.
20 Ibid.
21 Ibid.
22 Ibid 2135.
23 Ibid 2127.
24 Transcript of day 22 hearing 22 September 2020, 1895; Transcript of day 18 hearing 16 September 2020, 1473.
25 Exhibit HQI0210_P Transcript of Press Conference of the Hon. Daniel Andrews MP on 27 March 2020.
26 Premier of Victoria, 'Enforced Quarantine for Returned Travellers to Combat Coronavirus' (Media Release, 27 March 2020) <https://www.premier.vic.gov.au/enforced-quarantine-returned-travellers-combat-coronavirus>.
27 Exhibit HQI0210_P Transcript of Press Conference of the Hon. Daniel Andrews MP on 27 March 2020, VPOL.0006.0002.0013-0020.
28 Premier of Victoria, 'Victorian Premier Daniel Andrews Update on Cases' (Press Conference, 28 March 2020) <https://www.theage.com.au/national/victoria/victoria-records-biggest-jump-in-virus-cases-as-on-the-spot-fines-introduced-20200328-p54erz.html>.
29 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0012.0001.0734; DPC.0001.0001.6565.
30 Exhibit HQI0193_P Letter from the Hon. Daniel Andrews MP to Ms Kym Peake, DHS.0001.0031.0004.
31 Transcript of day 25 hearing 25 September 2020, 2137.
32 Ibid.
33 Ibid.
34 Exhibit HQI0237_P Affidavit of Mr Christopher Eccles, 3-4 [14]-[16].
35 Transcript of day 22 hearing 22 September 2020, 1816; Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 6 [25]; Exhibit HQI0243_P Affidavit of Simon Phemister, 3 [11].
36 Exhibit HQI0177_RP First witness statement of Mr Christopher Eccles, 19-20 [77]-[78]; Transcript of day 21 hearing 21 September 2020, 1757.
37 Transcript of day 21 hearing 21 September 2020, 1757; Exhibit HQI0177_RP First witness statement of Mr Christopher Eccles, 20 [79].
38 Transcript of day 21 hearing 21 September 2020, 1755; Exhibit HQI0177_RP First witness statement of Mr Christopher Eccles, 20 [79].
39 Exhibit HQI0211_P Witness statement of the Hon. Jenny Mikakos, 3 [16].
40 Transcript of day 21 hearing 21 September 2020, 1755-1756; Exhibit HQI077_RP First witness statement of Mr Christopher Eccles, 20 [79].
41 Transcript of day 21 hearing 21 September 2020, 1758.
42 Ibid.

43 Ibid.
44 Transcript of day 22 hearing 22 September 2020, 1816.
45 Exhibit HQI0238_RP Further DPC documents, HQI.0001.0060.0001.
46 Transcript of day 22 hearing 22 September 2020, 1816.
47 Ibid 1813-1814.
48 Ibid 1816.
49 Ibid.
50 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 7 [27], 8 [42].
51 Prime Minister, 'Update on Coronavirus Measures' (Media Release, 27 March 2020) <https://www.pm.gov.au/media/update-coronavirus-measures-270320>.
52 Exhibit HQI0158_P Transcript of Prime Minister's press conference 27 March 2020, HQI.0001.0002.0003,
53 Exhibit HQI00218_P Witness statement of the Hon. Daniel Andrews MP, 3 [13].
54 Ibid 1-2 [4].
55 Transcript of day 25 hearing 25 September 2020, 2125.
56 Exhibit HQI0177_RP First witness statement of Mr Christopher Eccles, 20 [79]; Transcript of day 21 hearing 21 September 2020, 1757.
57 Exhibit HQI0210_P Transcript of Premier's press conference on 27 March 2020, 1.
58 Premier of Victoria, 'Enforced Quarantine for Returned Travellers to Combat Coronavirus' (Press Release, 27 March 2020) <https://www.premier.vic.gov.au/enforced-quarantine-returned-travellers-combat-coronavirus>.
59 Transcript of day 25 hearing 25 September 2020, 2125.
60 Transcript of day 10 hearing 31 August 2020, 634.
61 Exhibit HQI0185(1)_RP Annexures to witness statement of Mr Simon Phemister, DJP.202.002.0001; Transcript of day 22 hearing 22 September 2020, 1818.
62 Transcript of day 22 hearing 22 September 2020, 1818.
63 Transcript of day 22 hearing 22 September 2020, 1823-1824; Exhibit HQI0032_P Witness statement of Ms Claire Febey, 3 [11].
64 Transcript of day 22 hearing 22 September 2020, 1824.
65 Ibid.
66 Exhibit HQI1033_RP Annexures to witness statement of Ms Claire Febey, DJP.500.001.0001-DJP.500.001.0020.
67 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 10 [48].
68 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 7 [28]; Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 6 [19].
69 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 15 [77]; Exhibit HQI0185_RP Annexures to witness statement of Mr Simon Phemister, DJP.105.007.4370-DJP.105.007.4372.
70 Transcript of day 22 hearing 22 September 2020, 1829; Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 4 [14].
71 Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 4 [12].
72 Ibid 10 [34]-[35]; Exhibit HQI0037_RP Annexures to witness statement of Ms Katrina Currie, DJP.108.005.5135; Exhibit HQI0069_RP Witness statement of Mr David Millward adopted by Nigel Coppick, 7 [47], 8 [51]-[53].
73 Transcript of day 22 hearing 22 September 2020, 1825
74 Exhibit HQI0185_RP Annexures to witness statement of Mr Simon Phemister, DJP.101.002.6347, DJP.101.002.6348.
75 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 8-9 [43]; Transcript of day 22 hearing 22 September 2020, 1827.
76 Exhibit HQI0185_RP Annexures to witness statement of Mr Simon Phemister, DJP.113.008.5598; Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 17 [85(b)].
77 Exhibit HQI0195_RP Witness statement of the Hon. Martin Pakula MP, 1 [1], 2 [6].
78 Ibid [2].
79 Transcript of day 23 hearing 23 September 2020, 1924.
80 Ibid 1925.
81 Exhibit HQI0195_RP Witness statement of the Hon. Martin Pakula MP, 2 [6]; Transcript of day 23 hearing 23 September 2020, 1925.
82 Transcript of day 23 hearing 23 September 2020, 1925.
83 Ibid 1926.
84 Exhibit HQI0246_P Affidavit of the Hon. Lisa Neville MP, 1 [5]. Exhibit HQI0242_RP Premier's Private Office Documents, HQI.0001.0063.0001.
85 Exhibit HQI0246_P Affidavit of the Hon. Lisa Neville MP, 1 [20].
86 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 7 [28].
87 Transcript of day 22 hearing 22 September 2020, 1817.
88 Ibid 1902.

89 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 22 [105].
90 Transcript of day 22 hearing 22 September 2020, 1898.
91 Ibid 1907.
92 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 9 [43(f)]; Exhibit HQI0185(1)_RP Annexures to witness statement of Mr Simon Phemister, DJP.101.002.6353; Transcript of day 22 hearing 22 September 2020, 1827-1828; Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 15 [65].
93 Exhibit HQI0266_RP Bundle of notices and advices tendered by DHHS, DHS.0001.0004.1872, DHS.0001.0011.0658, DHS.0001.0103.0007.
94 Exhibit HQI0085_RP Witness statement of Ms Janette Curtain, 18 [118]; Exhibit HQI0095_RP Witness statement of Dr Nathan Pinskier, 2 [10]; Exhibit HQI0090_RP Witness statement of Mr Eric Smith, 2 [6.1].
95 Transcript of day 21 hearing 21 September 2020, 1761.
96 Ibid, 1761; Exhibit HQI0177_RP Witness statement of Mr Christopher Eccles, 14 [54].
97 Transcript of day 21 hearing 21 September 2020, 1761.
98 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0016.0001.0095, DPC.0013.0001.0001.
99 Transcript of day 21 hearing 21 September 2020, 1762.
100 Ibid 1763.
101 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0016.0001.0095, DPC.0013.0001.0001.
102 Exhibit HQI0033_RP Transcript of audio recording of SCC Operation Soteria meeting 27 March 2020.
103 Transcript of day 23 hearing 23 September 2020, 1946.
104 Exhibit HQI0145_RP Annexures to first witness statement of Commissioner Andrew Crisp, DOJ.600.001.0719.
105 Ibid.
106 Transcript of day 23 hearing 23 September 2020, 1946.
107 Transcript of day 22 hearing 22 September 2020, 1908.
108 Ibid 1862-1863.
109 Ibid 1822.
110 Transcript of day 21 hearing 21 September 2020, 1764.
111 Transcript of day 22 hearing 22 September 2020, 1891.
112 Transcript of day 22 hearing 22 September 2020, 1902; Exhibit HQI0186_RP Witness statement of Ms Kym Peake, 15 [65].
113 Transcript of day 22 hearing 22 September 2020, 1817.
114 Ibid.
115 Transcript of day 25 hearing 25 September 2020, 2126.
116 Transcript of day 22 hearing 22 September 2020, 1898.
117 Transcript of day 21 hearing 21 September 2020, 1757.
118 Ibid 1759.
119 Exhibit HQI0033(2)_RP Transcript and minutes of audio recording of SCC Operation Soteria meeting 27 March 2020.
120 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 12 [47].
121 Transcript of day 17 hearing 15 September 2020, 1373.
122 Ibid 1357.
123 Exhibit HQI0147_P Third witness statement of Commissioner Andrew Crisp, 3-4 [15]-[16].
124 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 16 [32]-[33]; Exhibit HQI0147 Third witness statement of Commissioner Andrew Crisp, 1 [5]; Exhibit HQI0196_P Witness statement of the Hon. Lisa Neville MP, 5 [35].
125 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 16 [34].
126 Ibid 16 [35].
127 Exhibit HQI00164_RP Witness statement of Mr Jason Helps, 11 [42].
128 Ibid 11 [43]-[44].
129 Ibid 11 [45].
130 Exhibit HQI0149_RP Witness statement of Mr Christopher Eagle, 3 [11]; Transcript of day 17 hearing 15 September 2020, 1433.
131 Transcript of day 17 hearing 15 September 2020, 1433.
132 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 16 [34]-[35].
133 Transcript of day 17 hearing 15 September 2020, 1372-1373.
134 Exhibit HQI0114_P First witness statement of Commissioner Andrew Crisp, 20 [45].
135 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 17 [84].
136 Ibid.
137 Exhibit HQI0114_P First witness statement of Commissioner Andrew Crisp, 20 [45]-[50].

138 Exhibit HQI0033(3)_RP Audio recording of SCC Operation Soteria meeting 10.00am 28 March 2020; Exhibit HQI0033(4)_RP Audio recording of SCC Operation Soteria meeting 6.00pm 28 March 2020.
139 Exhibit HQI0143(3)_RP Transcript of audio recording of Operation Soteria meeting 6.00pm 28 March 2020, 20.
140 Ibid.
141 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 15 [63].
142 Ibid.
143 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 12 [50].
144 Transcript of day 19 hearing 17 September 2020, 1614.
145 Exhibit HQI0033(1)_RP Annexures to witness statement of Ms Claire Febey, DJP.101.004.4571; Transcript of day 19 hearing 17 September 2020, 1614.
146 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 16-17 [65]; Transcript of day 8 hearing 27 August 2020, 411-412.
147 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 12-13 [51]-[52].
148 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 17 [84].
149 Transcript of day 8 hearing 27 August 2020, 484.
150 Transcript of day 22 hearing 22 September 2020, 1834-1835.
151 Ibid 1835.
152 Exhibit HQI0038_RP Witness statement of Ms Gonul Serbest 5 [16].
153 Transcript of day 22 hearing 22 September 2020, 1857.
154 Ibid 1905.
155 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 62 [332].
156 Exhibit HQI0226_RP Bundle of notices and advices tendered by DHHS, DHS.0001.0004.1702, DHS.0001.0004.1872 and DHS.0001.0011.0658.
157 Ibid DHS.0001.0103.0008 and DHS.001.0104. 0094.
158 Ibid DHS.0001.0004.1692 and DHS.0001.0004.1702.
159 Exhibit HQI0185_RP Annexures to witness statement of Mr Simon Phemister, DJP.105.003.1020, DJP.105.003.1296, DJP.105.003.0817.
160 Ibid.
161 Exhibit HQI0211_P Witness statement of the Hon. Jenny Mikakos MP, 15 [76]; Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 39 [198].
162 Exhibit HQI0210_P Transcript of press conference by the Hon. Daniel Andrews MP 27 March 2020, 2 [15]-3 [14].
163 Exhibit HQI0032_RP Witness statement of Ms Claire Febey, 2 [8]; Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 6-7 [29]; Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 4 [13], 7 [23]; Transcript of day 8 hearing 27 August 2020, 446-447.
164 Transcript of day 25 hearing 25 September 2020, 2156-2157.
165 Transcript of day 12 hearing 3 September 2020, 845.
166 Exhibit HQI0079_RP Annexures to witness statement of Commander Timothy Tully, VPOL.0002.0005.0124.
167 Exhibit HQI0169_RP Witness statement of Chief Commissioner Shane Patton APM, 11 [6.2].
168 Ibid [6.4].
169 Ibid.
170 Ibid; Transcript of day 19 hearing 17 September 2020, 1649.
171 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 6 [3.3-3.6].
172 Ibid 9 [6.1].
173 Ibid 9 [6.2].
174 Transcript of day 17 hearing 15 September 2020, 1380.
175 Transcript of day 23 hearing 23 September 2020, 1954; Exhibit HQI0196_R Witness statement of the Hon. Lisa Neville MP, 8 [65].
176 Exhibit HQI0196_R Witness statement of the Hon. Lisa Neville MP, 8 [65].
177 Transcript of day 18 hearing 15 September 2020, 1504-1505.
178 Transcript of day 3 hearing 17 August 2020, 52-53.
179 Exhibit HQI0169_RP Witness statement of Chief Commissioner Shane Patton APM, 11 [6.4]; Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 6 [3.4].
180 Exhibit HQI0067_RP Witness statement of Mr Sam Krikelis, 5 [36].
181 Transcript of day 22 hearing 22 September 2020, 1820.
182 Transcript of day 12 hearing 3 September 2020, 850; Exhibit HQI0069_RP Witness statement of Mr David Millward adopted by Mr Nigel Coppick, 6 [40].
183 Exhibit HQI0033_RP Annexures to witness statement of Ms Claire Febey, DJP.102.007.6152; Exhibit HQI0150_RP Annexures to witness statement of Christopher Eagle, DELW.0001.0020.1969.

184 See, e.g. Exhibit HQI0255_RP Affidavit of Mr Jason Helps; Exhibit HQI0256_RP Documents referred to in affidavit of Mr Jason Helps; HQI0257_RP Affidavit of Mr Braedon Hogan; and Exhibit HQI0258_RP Documents referred to in affidavit of Mr Braedon Hogan.
185 Exhibit HQI0230_RP DHHS emails re VIC Hotel Quarantine arrangements.
186 See, e.g. Exhibit HQI0249_RP First Affidavit of Prof. Brett Sutton.
187 Further Submission 01 – Counsel Assisting the Board of Inquiry, 5 [16]-[21].
188 Transcript of day 22 hearing 22 September 2020, 1829.
189 Transcript of day 8 hearing 27 August 2020, 440.
190 Exhibit HQI0037_RP Annexures to witness statements of Ms Katrina Currie, DJP.104.008.6765.
191 Exhibit HQI0049_RP Witness Statement of Mr Unni Menon, 3 [12].
192 Exhibit HQI0237_P Affidavit of Mr Christopher Eccles, 3 [Q4]; Exhibit HQI0243_P Affidavit of Mr Simon Phemister, 2 [11].
193 Transcript of day 22 hearing 22 September 2020, 1816.
194 Exhibit HQI0237_P Affidavit of Mr Christopher Eccles, 3 [18 Exhibit HQI0243_P Affidavit of Mr Simon Phemister, 4 [14]; Transcript of day 21 hearing 21 September 2020, 1757; Transcript of day 22 hearing 22 September 2020, 1816.
195 Rob Holland and Cameron Nolan, see Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 7 [31].
196 Exhibit HQI0032_RP Witness statement of Ms Claire Febey, 2 [8]; Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 7 [31]; Exhibit HQI0033_RP Annexures to witness statement of Ms Claire Febey, DJP.202.002.0001.
197 Exhibit HQI0033_RP Annexures to witness statement of Ms Claire Febey, DJP.202.002.0001.
198 Ibid.
199 Further Submission 02 – Chief Commissioner of Police, 1 [2], 2-4 [9]-[22].
200 DJP.102.007.8920.
201 DOJ.502.004.8832.
202 The 12.06pm email and EAP plan were not tendered in evidence, and were not available to Victoria Police for the purpose of submissions. Notwithstanding this, I consider that the above finding is open on the face of these documents, and that it is independently supported by the matters discussed at paragraphs 150.1-150.6.
203 Exhibit HQI0049_RP Witness Statement of Mr Unni Menon, 3 [12].
204 Exhibit HQI0184_RP Witness Statement of Simon Phemister, 6 [25]; Exhibit HQI0243_P Affidavit of Mr Simon Phemister, 3[11].
205 Exhibit HQI0037_RP Annexures to witness statement of Ms Katrina Currie, DJP.104.008.6765.
206 Exhibit HQI0033_RP Annexures to witness statement of Ms Claire Febey, DJP.202.002.0001.
207 Transcript of day 8 hearing 27 August 2020, 402.
208 Exhibit HQI0033_RP Annexures to witness statement of Ms Claire Febey, DJP.201.002.0001.
209 Exhibit HQI0049_RP Witness Statement of Mr Unni Menon, 3 [12].
210 Exhibit HQI0033_RP Annexures to witness statement of Ms Claire Febey, DJP.201.002.0001.
211 Transcript of day 8 hearing 27 August 2020, 397.
212 See Chapter 6.
213 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 2 [2.2].
214 Exhibit HQI0244_P Affidavit of former Chief Commissioner Graham Ashton AM APM, 3 [13].
215 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 9 [5.5].
216 Transcript of day 21 hearing 21 September 2020, 1767.
217 Ibid.
218 Ibid 1768.
219 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 9 [5.6].
220 Transcript of day 21 hearing 21 September 2020, 1795-1796.
221 Exhibit HQI0238_RP Further DPC documents, HQI.0001.0060.0001.
222 Exhibit HQI0237_P Affidavit of Mr Christopher Eccles, 1 [3]; Exhibit HQI0244_P Affidavit of former Chief Commissioner Graham Ashton AM APM, 2 [5].
223 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 8 [5.2]; Exhibit HQI0174_RP Annexures to first witness statement of former Chief Commissioner Graham Ashton AM APM, VPOL.0005.0001.0244.
224 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 8 [5.3]; Exhibit HQI0174_RP Annexures to first witness statement of former Chief Commissioner Graham Ashton AM APM, VPOL.0005.0001.0244.
225 Transcript of day 21 hearing 21 September 2020, 1768.
226 Exhibit HQI0237_P Affidavit of Mr Christopher Eccles, 3 [12].
227 Ibid 2 [5]–3 [9].
228 Exhibit HQI0237_P Affidavit of Mr Christopher Eccles, 1 [3].

229 Ibid 2 [5].
230 Transcript of day 25 hearing 25 September 2020, 2130-2131.
231 Transcript of day 19 hearing 17 September 2020, 1684.
232 Submission 05 the Department of Premier and Cabinet, [9].
233 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 9 [5.7].
234 Transcript of day 19 hearing 17 September 2020, 1665.
235 Exhibit HQI0242_RP Premier's Private Office Documents, HQI.0001.0063.0001.
236 Transcript of day 23 hearing 23 September 2020, 1948
237 Exhibit HQI0246_P Affidavit of the Hon. Lisa Neville MP, [7].
238 Exhibit HQI0196_P Witness statement of the Hon. Lisa Neville MP, 5 [35]-[36]; Transcript of day 17 hearing 15 September 2020, 1367.
239 Exhibit HQI0196_P Witness statement of the Hon. Lisa Neville MP, 5 [35].
240 Exhibit HQI0181_RP Texts between Commissioner Andrew Crisp and Ms Kate Houghton, DPC.9999.0001.0002.
241 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0013.0001.0003-0004.
242 Transcript of day 23 hearing 23 September 2020, 1951-1952.
243 Ibid 1953.
244 Transcript of day 23 hearing 23 September 2020, 1956.
245 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 3 [2.4].
246 Exhibit HQI0174 Attachments to First Witness Statement of Graham Ashton APM, VPOL.0005.0001.0064 .
247 Exhibit HQI0147_P Third witness statement of Commissioner Andrew Crisp, 1 [4]-[5].
248 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 16 [32]-[33].
249 Transcript of day 17 hearing 15 September 2020, 1368.
250 Ibid 1368-1369.
251 Ibid 1383.
252 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 7 [4.1].
253 Exhibit HQI0196_P Witness statement of the Hon. Lisa Neville MP, 5 [39]-[40].
254 Submission 04 the Hon. Lisa Neville MP, 2 [7] and 3 [9].
255 Transcript of day 23 hearing 23 September 2020, 1947.
256 Exhibit HQI0196_RP Witness statement of the Hon. Lisa Neville MP, 6 [46].
257 Submission 10 the Hon. Jenny Mikakos MP, 10 [39], referring to DHS.5000.0075.3961.
258 HQI0240 Affidavit of the Hon. Daniel Andrews MP, 3 [11]-[12].
259 Exhibit HQI0237_P Affidavit of Mr Christopher Eccles, 5 [26]– [27].
260 E.g. Exhibit HQI0238_RP Further DPC documents, HQI.0001.0061.0001, DPC.0028.0001.0001.
261 Exhibit HQI0210_P Transcript of press conference by the Hon. Daniel Andrews MP on 27 March 2020, 2 [15].
262 Transcript of day 25 hearing 25 September 2020, 2128.
263 Ibid 2129.
264 Exhibit HQI0239_RP Affidavit of the Hon. Daniel Andrews MP, 4-6 [16]-[27].
265 Transcript of day 25 hearing 25 September 2020, 2156.
266 Transcript of day 25 hearing 25 September 2020, 2145; Exhibit HQI0239_RP Affidavit of the Hon. Daniel Andrews MP, 2 [6].
267 Transcript of day 21 hearing 21 September 2020, 1768.
268 Ibid 1768–1769.
269 Ibid 1790.
270 Exhibit HQI0237_P Affidavit of Mr Christopher Eccles, 5 [25].
271 Transcript of day 22 hearing 22 September 2020, 1819.
272 Exhibit HQI0238_RP Further DPC documents, HQI.0001.0061.0001.
273 Exhibit HQI0033(1)_RP Annexures to witness statement of Ms Claire Febey, DJP.500.001.0002.
274 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 4 [2.8].
275 Ibid 5 [2.9].
276 Transcript of day 22 hearing 22 September 2020, 1818; Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 7 [31]; Exhibit HQI0185(1)_RP Annexures to witness statement of Mr Simon Phemister, DJP.202.002.0001.
277 Transcript of day 22 hearing 22 September 2020, 1818–1819; Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 7 [27].
278 Exhibit HQI0033_RP Annexures to witness statement of Ms Claire Febey, DJP.500.001.0005.
279 Ibid.
280 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 5 [2.11].
281 Ibid 6 [2.17].
282 Transcript of day 22 hearing 22 September 2020, 1822.
283 Transcript of day 21 hearing 21 September 2020, 1765.

284 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0013.0001.0003.
285 Ibid DPC.0013.0001.0004.
286 Exhibit HQI0174_RP Annexures to first witness statement of former Chief Commissioner Graham Ashton AM APM, VPOL.0005.0001.0065.
287 Transcript of day 21 hearing 21 September 2020, 1766.
288 Ibid.
289 Ibid.
290 Exhibit HQI0033(2)_RP Audio recording of SCC Operation Soteria meeting 27 March 2020.
291 Exhibit HQI0148_RP Annexures to third witness statement of Commissioner Andrew Crisp, DOJ.515.001.0014.
292 Transcript of day 22 hearing 22 September 2020, 1819.
293 Ibid 1825.
294 Ibid 1824.
295 Ibid 1825-1826.
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298 Ibid 1835.
299 Ibid 1866.
300 Ibid.
301 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 5 [121].
302 Transcript of day 24 hearing 24 September 2020, 2066.
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304 Ibid.
305 Transcript of day 24 hearing 24 September 2020, 2068.
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307 Transcript of day 23 hearing 23 September 2020, 1930.
308 Exhibit HQI0147_P Third witness statement of Commissioner Andrew Crisp, 2 [6]-[9].
309 Exhibit HQI0148_RP Annexures to third witness statement of Commissioner Andrew Crisp, DOJ.515.001.0014.
310 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 7-8 [4.6].
311 Exhibit HQI0144_RP First witness statement of Commissioner Andrew Crisp, 19 [47].
312 Transcript of day 17 hearing 15 September 2020, 1378-1380.
313 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 7 [4.5].
314 Exhibit HQI0172 Witness statement of a 'Victoria Police Superintendent', 3 [12]-[16].
315 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 7 [4.5] and [4.8]
316 Ibid 7 [4.1], 8 [4.8].
317 Submission 01 Chief Commissioner of Victoria Police, 1 [6]-[10], 4 [18].
318 Ibid 2 [8].
319 Ibid 17 [64].
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321 Transcript of day 25 hearing 25 September 2020, 2132.
322 E.g. Flight Lieutenant Marina Lysenko, 'ADF praised for rapid response to bushfire assistance', Defence News (Article, 20 February 2020) <https://news.defence.gov.au/capability/adf-praised-rapid-response-bushfire-assistance>.
323 Transcript of day 17 hearing 15 September 2020, 1385.
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325 Transcript of day 25 hearing 25 September 2020, 2124, referring to Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0001.0001.6123.
326 Transcript of day 17 hearing 15 September 2020, 1385.
327 Exhibit HQI0142_RP Voluntary Submission of the Commonwealth of Australia, 22.
328 Ibid 57.
329 Exhibit HQI0144_RP First witness statement of Commissioner Andrew Crisp, 29 [69]; Exhibit HQI0142 Voluntary Submission of the Commonwealth of Australia, 12 [56].
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331 'Victoria forced to cut ADF hotel quarantine request ahead of Monday start', The Age (Article, 4 December 2020) <https://www.theage.com.au/politics/victoria/victoria-forced-to-cut-adf-hotel-quarantine-request-ahead-of-monday-start-20201204-p56kr8.html>.
332 Exhibit HQI0142_RP Voluntary Submission of the Commonwealth of Australia, 8 [35].
333 Transcript of day 17 hearing 15 September 2020, 1387.
334 Exhibit HQI0169_RP Witness statement of Chief Commissioner Shane Patton APM, 5 [3.3].
335 Exhibit HQI0142_RP Voluntary Submission of the Commonwealth of Australia, 57.
336 Transcript of day 21 hearing 21 September 2020, 1774-1775.

337 Transcript of day 25 hearing 25 September 2020, 2151-2152.
338 Exhibit HQI0180_RP Annexures to Further Witness Statement of Christopher Eccles, DPC.0014.0001.0004.
339 Transcript of day 25 hearing 25 September 2020, 2151.
340 Ibid 2152.
341 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 8 [5.2]; Exhibit HQI0174_RP Annexures to first witness statement of former Chief Commissioner Graham Ashton AM APM, VPOL.0005.0001.0244.
342 Exhibit HQI0238_RP Further DPC documents, HQI.0001.0060.0001.
343 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 9 [5.7].
344 Exhibit HQI0148 Annexures to third witness statement of Commissioner Andrew Crisp, DOJ.514.001.0001.
345 Exhibit HQI0181_RP Texts between Commissioner Andrew Crisp and Ms Kate Houghton, DPC.9999.0001.0002.
346 Transcript of day 24 hearing 24 September 2020, 1954.
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351 Exhibit HQI0033(2) _RP Transcript of audio recording of SCC Operation Soteria meeting 27 March 2020, 25.
352 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 29 [74]-[75]; Transcript of day 17 hearing 15 September 2020, 1386-1387.
353 Exhibit HQI0164_RP Witness Statement of Mr Jason Helps, 26 [112].
354 Transcript of day 23 hearing 23 September 2020, 1956.
355 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 11 [12.6].
356 Ibid 10 [7.1].
357 Exhibit HQI0169_RP Witness statement of Chief Commissioner Shane Patton APM, 5 [3.3].
358 Ibid [3.4]; Transcript of day 19 hearing 17 September 2020, 1647.
359 Transcript of day 19 hearing 17 September 2020, 1650.
360 Ibid 1676-1678; Transcript of day 8 hearing 27 August 2020, 399-400.
361 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 10-11 [41].
362 Exhibit HQI0143(3)_RP Transcript of audio recording of Operation Soteria meeting 6.00pm 28 March 2020, 22; Transcript of day 17 hearing 15 September 2020, 1387-1388.
363 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 26 [110].
364 Transcript of day 21 hearing 21 September 2020, 1776,
365 Ibid.
366 Ibid 1771.
367 Transcript of day 17 hearing 15 September 2020, 1386-1387.
368 Transcript of day 21 hearing 21 September 2020, 1769; Exhibit HQI0179_RP Second witness statement of Mr Christopher Eccles, 5 [22].
369 Exhibit HQI0238_RP Further DPC documents, HQI.0001.0060.0001.
370 Transcript of day 21 hearing 21 September 2020, 1755.
371 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 8 [5.3].
372 Exhibit HQI0214_RP Texts between Assistant Commissioner Grainger and Commissioner Andrew Crisp 27 and 28 March 2020 VPOL.0005.0007.0006, Exhibit HQI0147_P Third witness statement of Commissioner Andrew Crisp, 2 [7]-[8].
373 Exhibit HQI0214_RP Texts between Assistant Commissioner Grainger and Commissioner Andrew Crisp 27 and 28 March 2020 VPOL.0005.0007.0006.
374 Transcript of day 8 hearing 27 August 2020, 432.
375 Exhibit HQI0148(2)_RP Transcripts and minutes of audio recording of SCC Operation Soteria meeting 27 March 2020, 12.
376 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 9 [45].
377 Ibid 8 [37].
378 Transcript of day 8 hearing 27 August 2020, 432.
379 Transcript of day 25 hearing 25 September 2020, 2156.
380 Transcript of day 21 hearing 21 September 2020, 1770.
381 In October 2018, the Premier announced that the Victorian Government would conduct a review into the private security industry. Submissions closed on 27 July 2020. The Final Report is due in December 2020. See Department of Justice and Community Safety, Review of Victoria's Private Security Industry, <https://engage.vic.gov.au/private-security-review-2020>.

CHAPTER 6

Private security

6.1 Introduction

1. In Chapter 5, I considered the evidence regarding the 'decision' on 27 March 2020 that private security guards would be the first and primary tier of enforcement at the quarantine hotels. I concluded that the 'decision' to use private security guards in that way was a position that was adopted during the State Control Centre (SCC) meeting at 4.30pm on 27 March 2020, following Assistant Commissioner Michael Grainger expressing Victoria Police's preference in the matter.
2. That 'decision' had profound impacts on the efficacy and operation of the Hotel Quarantine Program. How that 'decision' was implemented, from the identification of potential security firms to how they worked 'on the ground', is the subject to which I now turn.

6.2 The process of identifying security contractors

3. At the conclusion of the meeting at the SCC on the afternoon of Friday 27 March 2020, Claire Febey, Executive Director, Priority Projects Unit at the Department of Jobs, Precincts and Regions (DJPR), left the SCC with the engagement of private security as one of the items on her and DJPR's list of tasks.[1]
4. Late on Friday 27 March 2020, Katrina Currie, Executive Director, Employment Delivery, Working for Victoria at DJPR, was nominated as the person responsible for identifying private security firms for the purposes of the Hotel Quarantine Program.[2] Ms Currie was on secondment, with her substantive position being Executive Director, Employment, Inclusion Group at DJPR.[3] For context, Working for Victoria was a program established by the Victorian Government to assist people who had been dislocated from jobs by COVID-19.[4]
5. Although, on the evidence of Ms Febey and others, it was known from the time of the SCC meeting's conclusion around 6.00pm that private security needed to be engaged, and although Ms Currie had been forewarned earlier in the day of the potential need to find security suppliers,[5] Ms Currie was not actually asked to make contact with security companies until after 10.00pm that evening when she received an email from Alex Kamenev, Deputy Secretary, Precincts and Suburbs, DJPR.[6] She and her team were still at work at that time because of the imminent launch of the Working for Victoria scheme.[7]
6. The Secretary of DJPR, Simon Phemister, said, in evidence, that the reason no action was taken earlier in the day was because they were seeking clarity about what the role of private security would be.[8] It does not appear that any clarity was received, although the 'ideal' operating model for the Hotel Quarantine Program was suggested by Cameron Nolan, Executive Director, Priority Projects Unit, DJPR, as follows:

> Ideal model in my mind would be a supply of security staff … who work under the direction of an authorised officer in DHHS. This DHHS team would induct the security guards and provide on-call advice about what to do in certain situations and determine if any incidents should be escalated to the authorised officer and/or VicPol.[9]

It was in this context that Ms Currie set about engaging private security firms. She was informed, on the evening of 27 March 2020, of the requirement to have identified and engaged the relevant services by the evening of 28 March 2020.[10] Ms Currie had experience in the broader employment sector, but no particular experience with the security industry.[11] At this stage, there were no clear instructions about the exact nature of the work security would be performing or the companies that Ms Currie should approach.[12]

7. Although Ms Currie had been allocated the task of procuring security because she was seen as having pre-existing contacts with labour firms, she was, in fact, not sure who to approach (though had the idea of Wilson Security Pty Ltd and SECURECorp (Victoria) Pty Ltd being potentially suitable) and sought the assistance of her team within DJPR.[13] The Inquiry received evidence of a WhatsApp group chat between DJPR employees, where suitable companies were discussed.[14]

8. A theme in the Whatsapp messages was that the security companies needed to be reputable, and that there could be problems with some in the industry.[15]

9. From these WhatsApp messages, it does not appear that those involved in the group chat knew that there was a *State Purchase Contract: Agreement for the Provision of Security Services* (State Purchase Contract) and that there were publicly available details, including email and mobile numbers, on a website. Ms Currie gave evidence that she did not know about the State Purchase Contract.[16]

10. This was an early example of what was a recurring theme in the early days of the Hotel Quarantine Program, that is, people were working hard and in good faith but, unfortunately, without relevant knowledge and expertise to guide them. Ms Currie and her team were working towards midnight looking for the names and contact details of potential firms,[17] effectively reinventing the wheel when, all the time, the information they needed was readily available to them on a website, following a process that had vetted security companies for their suitability for government work.[18] When the Program was to be implemented in a matter of just hours, efficiency was of critical importance. That would have been better served by early engagement with those areas within DJPR, or even the Department of Treasury and Finance (DTF), with experience in procuring security services.

11. Those suggesting potential security providers had some general ideas about the security industry but did not have any knowledge of security contracting and, understandably, no knowledge of what their role in the Hotel Quarantine Program was going to look like. This reflected the absence of any proper discussion at the SCC about the role, and created the context in which the role of security remained unclear and liable to variation without any centralised oversight or consideration of whether those variations were appropriate.

Figure 6.1: Example of WhatsApp messages between DJPR employees discussing security firms

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Source: Exhibit HQI0182_RP Working with Vic messages re good security companies, p. 6

12. Following consultation with the Employer Engagement team, the recommendations Ms Currie received as potential providers were Unified Security Group (Australia) Pty Ltd (Unified), Wilson Security Pty Ltd (Wilson), MSS Security Pty Ltd (MSS) and Monjon Australia Pty Ltd.[19] Of those, it was Unified, Wilson and MSS that were engaged to provide security services.

13. Ms Currie explained, in her witness statement, that the basis for the Employer Engagement team recommending these three companies was positive feedback, previous working relationships and previous work on large-scale projects. She explained that:

> Unified was recommended because members of the Employer Engagement team had previously received positive feedback about Unified's performance in providing private security which was reflected in the fact that Unified had been awarded large-scale contracts, including a number with Metro Rail across various sites, and had a positive impression of Unified given their previous dealings with the firm;
>
> Wilson was recommended because DJPR had engaged Wilson on a number of occasions in the past and considered that Wilson would have the resources necessary to assist. Further, members of the Employer Engagement team had received positive feedback concerning Wilson's work in the non-government disability sector; and
>
> MSS was recommended because it was considered reputable based on feedback and opinions that had previously been expressed to members of the employer engagement team.[20]

14. I accept that those providing Ms Currie with suggestions did so to the best of their knowledge and with a desire to be useful, selecting companies that met their sense of a good employer. But they were not the ones who should have been making those assessments.

15. It so happened that MSS and Wilson were members of the panel of firms subject to the State Purchase Contract. Unified was not. Ms Currie did not know this.[21] Late on Friday 27 March 2020, contact details having been found, she sent an email to Unified and to Wilson asking about their availability to provide security services for the Program from the coming Sunday morning.[22]

16. The next morning, on 28 March 2020, David Millward, Chief Executive Officer of Unified, was the first to contact Ms Currie and, so, Unified became the company asked to provide security services at the first hotels being stood up in preparation for international arrivals. Mr Millward said that Unified could allocate 20 guards immediately and 100 over the coming day.[23]

17. Later the same morning, Greg Watson, General Manager of Wilson, made contact with Ms Currie, who also had discussions with Jamie Adams, General Manager — Victoria and Tasmania at MSS, on 29 March 2020.[24]

18. Ms Currie did not recall all of the discussions and largely accepted the recollections of Mr Watson, Mr Millward and Mr Adams about what was discussed.[25] With authority from her superiors, she engaged, over the weekend, Unified and Wilson on an informal basis.[26] She gave a verbal briefing, aided by work done by others in her Department, as to the nature of the security task.[27]

19. Nigel Coppick, National Operations Manager of Unified, attended a planning meeting in the early afternoon of 28 March 2020 and then was present at the 'dry run' at the Crown hotels. It was during this 'dry run' where the required number of guards was substantially increased after Victoria Police reviewed the number of points in the building requiring security cover.[28] The following morning, Mo Nagi, Victorian Operations Manager for Unified, who had been hired by Mr Coppick to work on Unified's operations in the Hotel Quarantine Program,[29] attended the Crown hotels along with Mr Coppick and a team of security guards (all subcontractors) to receive the first arrivals.[30]

6.3 Subsequent procurement decisions

20. By Monday 30 March 2020, Ms Currie was handing over longer-term responsibility for security contracting to the Principal Policy Officer at DJPR, whose role became one of receiving quotes and negotiating terms with each of the three selected suppliers.[31]

21. In the week commencing 30 March 2020, the Principal Policy Officer received quotes from the security companies and discussed them with Ms Currie. Unified was more expensive than Wilson.[32]

22. On 30 March 2020, the Principal Policy Officer received advice from procurement officers within DJPR and DTF that providers on the State Purchase Contract should be used.[33] When he forwarded that advice to Ms Currie, she responded that it was necessary to retain Unified as they were already on the ground and that an exemption (from engaging panel firms) should be sought.[34]

23. Ms Currie gave evidence that she spent 30 March 2020 seeking an exemption from the DJPR procurement policy to permit the engagement of Unified, but then came to understand that no exemption was needed because the COVID-19 pandemic met the definition of an emergency under DJPR's critical incident procurement protocols and policies.[35]

24. While it is true that there was scope within the policy for critical or emergency situations, Ms Currie and the Principal Policy Officer received specific counsel on 31 March 2020 from the procurement specialist who advised them:

> Need clarity on the rationale for going outside the SPC in this instance. I understand there was an urgency to get things up and running quickly over the weekend but to have a non-approved firm providing security and effectively enforcing government regulation at quarantine sites off the back of some emails and phone calls presents significant risk to individuals involved and the department/Government that is not easily mitigated.
>
> Need to be clear on why this provider was engaged instead of the other SPC providers (noting requests went to Wilson and MSS - who are on the SPC) and whether there is any reason to continue with them (as opposed to switching them out for an SPC provider, for example) in order to assist in determining next steps.[36]

25. This advice warned Ms Currie and the Principal Policy Officer about risks to individuals and the Government, and invited them to reflect on the suitability of continuing to retain Unified. In my view, that was sound advice. Although DJPR submitted to the contrary,[37] the State Purchase Contract represented pre-vetting and pre-approval of security companies that were competent and appropriate for government security work. Procurement guidelines are not to be lightly set aside and should have been followed. Though neither Ms Currie nor the Principal Policy Officer would have known it, Unified had, in fact, applied to join the State Purchase Contract but had been unsuccessful. They were also, as Ms Currie and others discovered, not 'preferred' by the Victorian Trades Hall Council (Trades Hall). Ms Currie gave evidence that she did not know at the time she liaised with Trades Hall, that Trades Hall did not 'prefer' Unified, and would not speculate as to Trades Hall's reasons why it did not 'prefer' Unified.[38]

26. Ms Currie's initial response was to advocate for a contract with Unified:

> I was tasked with standing up a security team on Friday night by the following Saturday morning.
>
> I sought advice from my employer engagement teams on security companies we have worked with through Jobs Victoria and asked for contact details of the firms concerned. I was provided with two options at that time — Wilson and Unified. I emailed Unified and Wilsons at 11.30pm Friday night. Unified replied to me at 6.52am on Saturday morning and I began discussions at 7.00am as to their capability and capacity to deliver servicing at the first two sites by mid-afternoon Saturday. I was advised by text of their capability and this was followed up in telephone conversations. They attended site at 3pm to assess risk and staffing needs; briefed and planned their rosters and secured personnel; and were onsite delivering as required from 5am on Sunday morning.
>
> Wilson replied to me by 8.00am on Saturday morning but by then I had already entered into discussions with Unified. I took up discussions with Wilsons for subsequent sites around 11am. They indicated they could also supply and so I spoke with them again around 4pm and asked them to consider how they could respond. They emailed me a series of questions on Sunday to which I responded by which time Unified had already been tasked with the first hotels. Wilson have been engaged for three subsequent hotels.
>
> Unified is an Aboriginal owned and controlled organisation and has worked with DJPR on related social procurement initiatives. They are accredited with Kinaway and Supply Nation. While they are not a panel provider for security services utilising their services is in keeping with the State Government's social procurement objectives of utilising Aboriginal businesses. A legal exemption should be sought but Unified are delivering and have been delivering services since Sunday. The rationale for the exemption is both immediate need and their responsiveness but also their status as an Aboriginal owned and controlled business under the Government's social procurement objectives.[39]

27. In her evidence, Ms Currie denied that Unified's status as an Aboriginal business had been a factor in her initial contact with Mr Millward.[40] I accept her evidence on that point, but this email does suggest a reason why those assisting her offered the name of Unified in the first place. Indeed, the WhatsApp messages confirm that Unified was known to members of the group through its work in inclusive employment.[41]

28. It appears that, for a period of time, DJPR did intend to confine Unified to its initial hotel allocations. Negotiations with Trades Hall proceeded on the basis that Unified would not be allocated additional hotels and the Principal Policy Officer, in receiving a formal handover from Ms Currie, confirmed that Unified would remain at the two Crown hotels but be allocated no others.[42]

29. In circumstances where Unified had been contacted outside ordinary procurement processes and without time for proper consideration of its suitability or capacity, honouring the informal contracts at the Crown hotels but distributing future work to suppliers who were part of the State Purchase Contract would have been the more prudent course for DJPR to adopt.

30. Instead, Unified appears to have won over those DJPR officers working on the frontline in hotels, and to have established itself as the preferred provider on the back of anecdotal reports about how well it was performing. Its elevated status in the minds of DJPR appears to have been set in place well before contracts were actually signed and before either of the other two providers had commenced work. On 30 March 2020, Unified was referred to as being 'a dream' while Wilson was said to have been 'difficult'.[43] Ms Currie initially gave evidence that this was linked to Wilson's refusal to undertake activities like bag searches, but she went on to clarify that answer as follows:[44]

> Ms Ellyard: So are you able, as you sit here now, to recall what, if anything, you were aware of that led you to have the view that that distinction could be drawn, between the way Unified had presented and the way Wilson had?
>
> Ms Currie: I think, no, I can't. It was to do with their responsiveness and issues to do with the range of different things that they wanted covered off beforehand.

31. On 3 April 2020, the Principal Policy Officer was told by Unified that it had 'significant additional capacity' and could 'mobilise at short notice at any required sites'.[45] As was conceded by Mr Coppick in his evidence, Unified was reliant on subcontractors for that capacity.[46] Mr Coppick explained that Unified had a small standing workforce of 89 permanent staff in Victoria.[47] As already noted, it was also willing to agree to any requests from DJPR for assistance that fell outside the usual scope of security duties, such as going toy shopping, organising and delivering Easter eggs, and undertaking other tasks, out of a desire to be as helpful as possible.[48]

32. On the same day, Gönül Serbest, Chief Executive Officer of Global Victoria, was making complaints about Wilson and consideration was being given to switching them out for Unified. Ms Currie said that Unified could be given additional sites, thus reversing the position agreed with Trades Hall at the beginning of the week.[49]

33. It appears that, on the back of those initial 'concerns' about Wilson being 'difficult' by raising what I find were valid safety concerns, a concluded view was reached that Wilson was not to be preferred. Its initial hotel allocation of two hotels was removed and allocated to Unified, and it was only ever given two further hotels for the remainder of the Program.[50]

34. Unified's position as the initial provider of security over the first weekend of the Program ended up giving it a substantial advantage over the other contractors. Unified was perceived by Global Victoria and DJPR staff to have been performing well in those early days, which led to it being allocated new hotels as they opened.[51]

35. Unified also met the expectations of DJPR regarding the kind of assistance that would be available from security. So, when Wilson expressed concern about luggage handling, Ms Serbest thought it was reasonable to expect Wilson to provide this service because it was being done at other hotels.[52] Unified's willingness to do anything asked of it made it an attractive partner in the work.

36. Of course, in allocating subsequent hotels among its contractors, DJPR was entitled to have regard to issues of past performance as well as issues of capacity. I do not suggest that perceptions and feedback about that past performance were irrelevant.

37. But a review of how hotels were ultimately allocated between the three contractors contained in Mr Phemister's statement reveals a disproportionate allocation to Unified that cannot be justified by anecdotal assessments from frontline DJPR staff. According to Mr Phemister:

    A. MSS was allocated a total of five hotels, one of which was a short-term engagement of two weeks

    B. Wilson was allocated a total of four hotels, with its initial two hotels being re-allocated to Unified by mid-April

    C. Unified was allocated 11 CBD hotels plus the one regional hotel used for ship workers in Portland. It was allocated eight hotels in a row between 6 and 26 April, two of which were re-allocations from Wilson.[53]

38. To take a snapshot of what this meant, in mid-May, Wilson was providing security at one hotel, MSS at four and Unified at eight or nine.[54] Yet, it was Unified that was not on the State Purchase Contract, not preferred by Trades Hall and who had a small footprint in Melbourne.

39. There also appears to have been different attitudes taken when inappropriate conduct by security guards came to light. While the decision to remove hotels from Wilson was predicated in part on allegations of misconduct by guards, when similar conduct was alleged against MSS and Unified subcontractors it was not deemed a basis for similar action.[55] Indeed, when significant allegations of bullying and harassment were made about security staff at Rydges on 11 May 2020,[56] Unified kept it and all its other hotels and was even allocated further work on 19 May and 24 May 2020.[57] This further suggests an underlying preference for Unified that, I infer, was based on its willingness to meet any requests made of it.

40. I am satisfied that the allocation of hotels to security companies was not based on any proper assessment of the respective companies' capacity and suitability to undertake the work. A substantial percentage of the work, in terms of hotels and money, went to a non-panel firm that, in turn, relied entirely on small subcontractors. DJPR took Unified at its own estimation and on the basis of the professional relationships it had formed.

41. Had there been consideration of such matters as training, infection control and direct supervision of subcontractors, Unified ought to have been compared less favourably with the other subcontractors, who had taken on responsibility for devising their own training and, in the case of Wilson, taking their own expert advice on infection prevention measures.[58]

42. Similarly, if regard were paid to size and experience and the nature of the work, Unified ought to have been ranked behind the other providers, who each had experience in areas more closely linked to the work in the hotels, such as work at courts, hospitals and detention centres.[59]

43. Further, if regard had been paid to costs, the allocation of work might also have been different. Unified was the most expensive,[60] although its subcontractors were not necessarily earning more than subcontractors for other providers.[61]

44. Any proper oversight of the benefits and risks to the Program by both DJPR and DHHS would likely have resulted in at least a different spread of work between the contractors.

45. As I consider below, the three security contractors were not all equal. Their differing sizes and competencies meant exposure to differing levels of risk, particulalry in circumstances where other aspects of the Program were not well managed. (See Chapter 8 regarding the role of on-site management by DHHS.)

46. The extent of the whole Hotel Quarantine Program's reliance on small subcontractors is best demonstrated by a review of how many hotels were being supplied with guards by one small subcontracting company. Sterling Services Group (Sterling), a company subcontracted by Unified, had held a private security business licence for less than a year and had never done government work before.[62] Its director, Sorav 'Sam' Aggarwal, said:

> Sterling … provided security staff to the government security contractor Unified Security for the following hotels and time periods in the Hotel Quarantine Program:
>
> (a) Novotel Collins: 26 June 2020–10 July 2020
> (b) Travelodge Southbank: 13 April 2020–14 May 2020
> (c) Crown Metropol: 29 March 2020–5 April 2020 (covered partly); 6 April 2020–11 July 2020 (covered fully)
> (d) Holiday Inn Melbourne: 21 May 2020–11 July 2020
> (e) Crowne Plaza: 19 April 2020–3 May 2020
> (f) Pan Pacific South Wharf: 26 April 2020–11 July 2020
> (g) Rydges on Swanston: 11 May 2020–30 May 2020; 14 June 2020–30 June 2020
> (h) Novotel South Wharf: 17 April 2020–1 May 2020; 9 May 2020–24 May 2020; 1 June 2020–17 June 2020
> (i) Crown Promenade: 3 April 2020–14 April 2020 (covered partly); 19 April 2020–11 July 2020 (covered fully)
> (j) Brady Hotel: 17 June 2020–23 June 2020
> (k) Comfort Inn Portland: 19 May 2020–21 May 2020; 20 June–27 June 2020
> (l) Marriott Hotel: 28 June 2020–11 July 2020
> (m) Hotel Grand Chancellor: 26 June 2020–3 July 2020.[63]

47. Sterling's capacity to source and provide high quality staff was attested to by Mr Coppick,[64] and I make no finding that either Mr Aggarwal or any of his colleagues did anything other than their best. But the allocation of so much work and responsibility to one small firm exposed the whole Program to risk. That risk was heightened because the role of subcontractors was not sufficiently visible to DJPR and, so, was not monitored. Mr Aggarwal gave uncontradicted evidence that he never saw Unified's head contract with DJPR and was unaware of its terms.[65] Yet it was his small company that was supplying the majority of the services the State was purchasing from Unified, including services at Rydges, the so-called 'hot hotel'.[66] Mr Aggarwal and Sterling took over at the Rydges on 11 May 2020 after another subcontractor,[67] Elite Services, was removed following complaints against it.[68]

6.4 The role initially envisaged for private security

48. As I have noted, at the time DJPR was tasked with engaging security contractors, there were no clear instructions regarding the nature of the work security guards would be required to undertake.[69]

49. Indeed, the precise role that private security and Victoria Police would play in the Hotel Quarantine Program was quite unclear at the initial meetings held when establishing the Program.[70] While it was Victoria Police's preference for private security companies to be the 'first line of security' at the hotels and police would be called in when required,[71] there was no more detailed discussion about what 'first line' or 'first tier' meant or what the actual duties of security would be. A summary by Mr Nolan of 'the ideal' model was Ms Currie's starting point and her discussions with security firms were on the assumption that security firms would:

A. support the Chief Health Officer (CHO), Authorised Officers and Victoria Police in the enforcement of isolation

B. ensure quarantined guests did not leave the hotel during their quarantine period without permission from the Authorised Officer

C. ensure disputes with quarantine guests were de-escalated without physical contact and, if this could not be done, escalate the matter to Victoria Police

D. provide advice to quarantine guests on which areas of the hotel they could enter.[72]

50. Evidence received from Wilson, Unified and MSS around the nature of services to be provided, in the first instance, largely reflected that security guards would provide 'on the ground' support to enforce isolation and ensure guests stayed in their rooms. The evidence before the Inquiry is that this limited role would have been consistent with the use of private security in many other contexts and, thus, would have been seen as uncontroversial, notwithstanding the limited understanding at that time of the complexities of the quarantine hotel sites.

51. Indeed, evidence provided by Wilson highlighted that it held an initial understanding that the role of security guards was to support the CHO in the enforcement of quarantine conditions by preventing people from leaving the hotel. It was understood that security guards would implement a 'hands off' approach and any non-compliance would be escalated to Victoria Police.[73] MSS also expected its guards' role to be 'reasonably simplistic' and primarily in relation to 'access control to each of the facilities, presence on each of the floors … and then providing generally a security presence on-site, with some infection control awareness'.[74]

52. According to Mr Coppick from Unified, between 28 March and 2 April 2020, his company received very little information and/or guidance from Victorian Government representatives in relation to the duties and responsibilities of its security guards.[75] I accept this evidence as consistent with the evolving understanding on the part of DJPR and others of the sheer logistical scale of the Hotel Quarantine Program and the speed with which it was set up. It is clear that the logistics were being worked out 'on the run'.

53. Wilson's Purchase Order Contract (POC) was finalised on 6 May 2020.[76] Prior to this, it was acting in accordance with the overarching contract already established by being on the panel of preferred contractors with the Victorian Government.[77] The POC included agreement about the rate of pay for guards and supervisors. The rate was inclusive of Wilson's costs, like supplying all of its own PPE.[78] Similarly, MSS commenced working at the hotels prior to its POC being finalised.[79] The duties, as set out in the contracts, appeared to reflect the uncertainty of what specific roles security would play in the Hotel Quarantine Program.[80]

54. With reference to MSS's POC, Schedule 3, Specifications (as of 23 April 2020) outlined general expectations of security guards when carrying out their roles as part of the Hotel Quarantine Program. It noted that MSS, the Service Provider, must provide services that included, but were not limited to:

A. before check-in: ensure there is an adequate number of personnel on the floors where guests are staying

B. during check-in: accompany guests in lifts to their rooms (no more than four people per lift), assist with arriving buses i.e. helping with bags, being present to manage onsite issues

C. once checked-in: maintain presence on the floors, lobby and front door, receive and check parcels, manage food deliveries, assist with outdoor breaks, only allow authorised persons to enter each location

D. during check-out: assist by escorting guests to the lobby and assist with luggage if require.

E. escalation of issues: guest health related requests/concerns must be communications to Authorised Officers/nurses, food complaints to hotel staff, onsite queries to designated location manager

F. at all times: respond to routine, emergency incidents, in case of emergency must call 000.[81]

55. These specifications were also outlined in Wilson's signed contract[82] and in Unified's Agreement for Professional Services.[83]

56. Wilson Security had an initial understanding that Victoria Police would have a permanent presence at each hotel site, however, it later became clear this would not be the case.[84]

6.5 The evolving role of private security

57. The specifications in the contracts mentioned above were, notably, included at a later stage. Mr Watson said that, when Wilson security guards were first deployed, they had a role to 'observe and report'. By early April 2020, the services that the Government had requested changed to include bag searches, food and care package deliveries and the facilitation of exercise breaks.[85]

58. This demonstrated how the role of security guards changed significantly over time. While, initially, there was an expectation that they would simply monitor guest activity and ensure guests stayed in their rooms for the 14-day quarantine period (static guarding), this later changed and security guards had the responsibility for facilitating fresh air breaks for guests and managing deliveries.[86]

59. Wilson raised concerns about the expanded roles guards were expected to play in relation to infection risks for its workers, legal powers of guards and their health and safety. Generally, the request for guards to engage in duties outside their initial remit was being communicated on the ground, without first being raised at a management level. This caused issues between Wilson and DJPR, as guards were refusing to do certain tasks without Wilson first approving it.[87] As set out above, I am satisfied that Wilson's concerns contributed to the perception that it was 'difficult' and to consequent decisions about how security guards should be allocated to hotels.

60. For example, in relation to handling luggage, there were infection control concerns around touching items, as well as general health and safety concerns because guards were not trained (as it was not part of normal guarding duties) to handle heavy items. Wilson was concerned the union would step in because luggage handling was not in the enterprise agreement.[88] Questions arose about the lawfulness of baggage searches; Wilson negotiated a limited form of search.[89] MSS appears to have been willing to undertake baggage searches:

> Ms Ellyard: Were you ever asked to do things like searching bags, for example?
>
> Sam Krikelis: Yes, we were. So, we were asked to search the care packages that would come from the guests' families and friends. We were looking for items that were, I guess, restricted; cigarettes, lighters, et cetera and for items that were prohibited, such as drugs. But we do that a lot at our events, so it was nothing different for our staff to undertake those tasks.[90]

61. It does not appear that those within DJPR who were pressing for security guards to take on additional duties were alive to potential industrial issues or that there was any thought given to the appropriateness of using private security guards as a workforce for performing non-security tasks. It may be that the presence of large numbers of security guards standing at entrances and on each floor gave the impression of an underused workforce that was available to fill in where no other personnel were available.

62. When Mr Nagi and Mr Coppick were asked about the further tasks that Unified staff and subcontractors were asked to do, such as the delivery of Easter eggs and Mother's Day presents and buying toys for children in the hotels, they agreed that these were not security-related tasks, but Unified took the view that they were there to provide support to the Government, in whatever capacity.[91] It is noteworthy that neither Wilson nor MSS was asked to go shopping for toys. I infer from the industrial safety issues, quite properly being raised by Wilson, that it was understood it would not have agreed to take on such tasks.

63. The most significant expansion of the role of private security guards came with the introduction of fresh air breaks. When initially contacted, all security companies were told that guests would not be leaving their hotel rooms.[92] It does appear that the initial conception of those establishing the Program was that guests would enter their rooms and not leave them until 14 days later.

64. It appears that slightly different arrangements were in place at each hotel depending on the available areas for fresh air breaks (for example, some hotels could use rooftop gardens whereas others relied on small spaces outside the building).[93]

65. The introduction of fresh air breaks had two implications for security guards:

    A. it increased the potential for direct contact between security guards and quarantined guests, some of whom were, or could be, infectious

    B. it meant that guests were not remaining in their rooms and were moving through common areas also used by security and hotel staff, increasing the risk of infection through the contamination of those common areas (particularly in circumstances where there was no agency responsible for infection control supervision on-site, a matter I deal with in Chapter 8).

66. Fresh air breaks, thus, fundamentally changed the role of private security from static guarding outside the areas where quarantined guests were located to a much more complex role that included the potential for direct contact with those guests and contact with surfaces and spaces that those guests had touched or passed through.

67. This is not to suggest that fresh air breaks should not have occurred; indeed, as set out in Chapter 11.3 (and recommended in the facility-based model, as per the Interim, and now Final, Report Recommendation 45), they were an appropriate part of a balanced and responsive quarantine program. However, the introduction of those breaks ought to have occurred in the context of a proper re-evaluation of the infection control measures in place in hotels and an assessment of the increased risks posed to security staff. For instance, the closer contact with guests heightened the significance of PPE and infection prevention training for security guards and made it even more important that there be a high level of understanding, compliance and expert supervision of security guards about their need for scrupulous attention to PPE usage. It raised the question whether, once it was no longer static guarding work with minimal contact with quarantined travellers or areas used by those travellers, the cohort of people comprising the private security workforce was the right cohort for the work. I deal with that issue later.

68. But no such re-evaluation or risk assessment occurred. Although Victoria Police did raise some concerns about fresh air breaks at the Pan Pacific and the potential for those in quarantine to mingle with members of the public,[94] there appears to have been no thought given to the deeper and more significant ramifications fresh air breaks held for the use of private security guards.

69. The same was true of the expanded role of security in luggage handling and parcel delivery. The use of security in that role began from the first day of the Program in response to the need for those services and in light of Unified's willingness to provide those services and to do anything asked of it by DJPR.[95] By the time the contracts were finalised, some reference to those activities had been included in the contracted scope of works,[96] but without any consideration of whether their inclusion altered the suitability of private security guards for the expanded role they would play. Like fresh air breaks, these activities increased the potential level of direct contact with quarantining travellers and also increased the extent to which private security would be handling items that were at risk of carrying the virus. Again, there was no analysis of the suitability of private security guards for those tasks and no assessment of how those tasks altered the workplaces of those undertaking them.

70. My view is that at least one reason this re-evaluation and risk assessment did not occur was because no person or agency regarded themselves as responsible for the initial decision to engage private security and no one had articulated the assumptions that underpinned this decision. The initial decision to use private security was, as I have found in Chapter 5, a decision made by acquiescence to a preferred position expressed by Victoria Police, but those party to the decision were not alert to their roles in the decision and none of them assumed accountability for it.

71. Furthermore, given there was no clear understanding or description, at that time, of what the role of private security guards would be, assumptions were made about the suitability of such a workforce based on previous experience of working with security guards at venues such as sporting events. This was compounded by there being no record of discussion about the suitability of such a workforce, even for the initial understanding of the role, and there being no person or agency accepting they had made the decision to use this workforce. This was further compounded by the positions taken by DJPR and DHHS about who was accountable for these contracted workers in circumstances where no one agency considered itself 'in charge' of the operation on-site.

72. Ms Serbest was not party to the initial decision to use security guards. Once she became involved in logistical arrangements for the Program, it appears she sought the support of security guards to deliver a range of additional services as she and her team required.[97]

> Chair: So that means that was communicated to you by the people that participated in the dry run? It was being articulated, 'This is what the role of private security is', rather than a document being provided to you so that you could understand that with clarity?
>
> Ms Serbest: Correct. There were times though, as things shifted and evolved, so it wasn't something that was fixed. It would … different policies would come onboard, and different requirements would need to be addressed, such as parcels being delivered to guests and things like that.
>
> Chair: And the understanding that you were, as I understand what you're saying, the understanding was an iterative process, in other words, bit by bit you were understanding what the role of private security guards was on the sites that you were familiar with?
>
> Ms Serbest: I would say it was quite clear from that first day what they would be doing, but as policies changed and as policies got introduced, whether they would be, as I mentioned, parcels from families coming into the hotels, Uber Eats policies for people with dietary requirements or fresh air breaks, the expectations on security changed.[98]

73. As already noted, Unified was willing to do what was being asked of it. Wilson raised concerns in some cases that it was being asked to do things beyond the scope of security guards' ordinary duties.

74. It was not for Ms Serbest to appreciate or analyse the implications of altering the role security guards were playing. She understood that the private security guards were a resource available to her and she used that resource. She appears to have drawn negative inferences when the help she sought was not forthcoming and to have been unaware that what she was asking security guards to do was materially different from what they would ordinarily do.[99]

75. In circumstances where it was DJPR that had contracted the three security providers and set the scope of their duties, responsibility for revisiting the scope of those duties lay with it. But because DJPR did not see itself as 'owning' the decision to engage private security, it appears not to have seen itself as responsible for monitoring the appropriateness of that decision.

76. The Principal Policy Officer, as set out below, was responsible for contract management. But his role did not extend to monitoring, as a matter of governance or principle, the continued suitability of private security for what had become a much more multi-faceted role than the one Ms Currie had contemplated when she spoke with Mr Millward on the morning of 28 March 2020.[100]

77. No-one thought about it other than — to some extent — the security companies that were being asked to perform duties in a high-risk environment and outside their areas of training.

78. This issue underscores, yet again, the need for a governance structure within a quarantine program that has clear lines of accountability and clarity of roles at each level within it, including on the hotel site, to ensure that a constant monitoring and supervision by the agency with the responsibility for the Program is watching every aspect of how the Program is or is not working and where potential risks are coming from and how to address those risks in a timely way (consistent with Recommendations 17 and 18).

6.6 The terms of the written contracts ultimately entered into, particularly as they related to infection prevention and training, and the deficiencies associated with those terms

79. As I have said above, the State — through DJPR — entered into three contracts with security services providers: MSS, Unified and Wilson.[101] Specifically:

    A. a Purchase Order Contract (POC) between DJPR and MSS was executed on 23 April 2020 (MSS Contract).[102] This was 17 days after MSS had started providing security services from 6 April 2020[103]

    B. a POC was also entered into between DJPR and Wilson for security services in relation to the Hotel Quarantine Program on 6 May 2020 (Wilson Contract),[104] covering the period from 30 March to 30 June 2020. Wilson did not have a prior POC under which it was providing services during the period from 30 March to 5 May 2020.[105] MSS and Wilson were engaged on terms set out in a POC as both firms were panel members of the State Purchase Contract. The terms were substantively the same, save for their respective fees and charges: Wilson had a higher rate of pay for its security guards but did not charge for the provision of its own PPE, whereas MSS had lower rates but charged cost plus 10 per cent for its PPE[106]

    C. the contract for services to be provided by Unified was entered into on 9 April 2020 (Unified Contract),[107] some 11 days after Unified had started providing security services across two quarantine hotels on 29 March 2020.[108] The Unified Contract was bespoke but based on the MSS and Wilson contracts[109]

80. Each of the three contracts contained the same or substantially similar terms. The key terms relevant to the Inquiry are set out below.

Key terms

WHAT AND HOW WERE THE SERVICES TO BE PROVIDED?

81. Each of the contracts described the services to be provided in the same way, that is:

> Service Provider must provide security services, including all ancillary services associated with the provision of security ('Services') at the Hotels notified by the Department (the Sites) which will include but not be limited to the following Services...[110]

82. I have described what those 'ancillary services' were above, at paragraph 54, noting that the role of security guards was 'iterative' as different policies were implemented and the functions the guards performed expanded.

83. Those expansions were reflected in directions given to security service providers, which were then included in the contracts over time. The main changes dealt with Department of Health and Human Services (DHHS) policies regarding exercise breaks and the provision of deliveries to guests.[111]

84. They were made as a result of DHHS having developed policies,[112] then having communicated those policies to the Principal Policy Officer, who then passed those policies on to the security service providers.[113] There was therefore an artificiality in DJPR's role as responsible for the terms of those contracts when it came to describing the role of security guards.

85. Each of the Wilson, MSS and Unified contracts required those providers to follow the direction of DJPR.[114] In practice, on the changing roles of security guards, DJPR acted at the direction of DHHS such that DJPR essentially passed on welfare-related directions to Wilson, MSS and Unified, including to support policy changes developed by DHHS.[115]

86. For example, at DHHS request, the Principal Policy Officer asked Unified for an additional three staff to be rostered for each shift between 8:00am and 8:00pm in order to implement and supervise fresh air and exercise breaks.[116]

87. By way of further example, when Ms Serbest was asked about what security would do when clarity was needed about those policies, she said that, where there were significant changes to a role, security services providers would seek guidance and direction from DHHS.[117]

88. The contracts set out the standard to which those services were to be performed. They each obliged Wilson, MSS and Unified to provide the services with, among other things, due care and skill.[118] Wilson and MSS were required to 'ensure the highest quality of work and the delivery of Security Services with the utmost efficiency'.[119] Similarly, Unified was required to ensure that the services were 'adequate and suitable for the purposes for which they are required',[120] and to use 'appropriately skilled and qualified Personnel to provide the Services'.[121]

CONTRACTORS WERE PERMITTED TO SUBCONTRACT

89. One of the main challenges for security contractors was meeting the need to deploy a large number of security personnel at very short notice.[122] Given the circumstances, the head contractors were dependent on subcontractors to fulfil a substantial portion of the number of security positions.

90. Each of the contracts between the State (through DJPR) and the contractors included provisions permitting the engagement of subcontractors. The requirements for doing so, however, were different.

91. Clause 26.1 of the Unified Contract provided that Unified 'must not engage subcontractors to conduct the whole or any part of the Services without the prior written approval of [DJPR]'.

92. That requirement was not as onerous as the one imposed on MSS and Wilson. Clauses 6(a) and 6(b) of the Wilson and MSS contracts stated as follows:

> (a) The Service Provider must not subcontract any of Its obligations under this POC to any third party unless the third party receives the prior written approval of the Purchaser in accordance with this clause 6. A breach of, or failure to comply with, this clause 6 by the Service Provider will constitute a material breach of this [Purchase Order Contract].
>
> (b) Prior to the engagement of any Subcontractor, the Service Provider must notify the Purchaser of its intention to subcontract particular obligations, and seek the Purchaser's written approval. Such notice must be provided within a reasonable time and contain the following information:
>
> ...
>
> (vii) acknowledgement from the Subcontractor that it will comply with all of the obligations arising under the POC;
>
> ...
>
> (x) a statement of compliance from the relevant Subcontractor(s) with this POC and all rights and obligations arising under it, including audit requirements.

93. Under its contract with DJPR, Unified was not required to inform the subcontractor of the head contractor's obligations under the contract with DJPR and provide an acknowledgment that Unified's subcontractors would comply with the same obligations as imposed on Unified (particularly with respect to training and infection prevention and control measures).

94. No reasons were given as to why the Unified Contract was drafted in this way, and the difference is perhaps surprising if there was an intention to promote substantive parity in terms between the three service providers. I infer that a reason for the difference may have been the lack of proper understanding by those preparing the terms of the Unified Contract as to the prevalence of subcontracting within the security services industry and the reliance that Unified would actually place on subcontractors.

95. The compliance or otherwise with these subcontracting requirements, and their consequences, is considered below.

RISK WAS ALLOCATED TO CONTRACTORS

96. The contracts explicitly recognised the risk of transmission of COVID-19 to security guards and the harm that it may cause. The contracts sought to transfer liability for that harm to the security companies, as follows:

> The Service Provider acknowledges and agrees that it and its Personnel, while delivering the Services, are likely to come into contact with people who have or may potentially have COVID-19.[123]
>
> The Service Provider releases and indemnifies...[the Department] against any loss, damages, cost or expense...incurred by the Department arising out of, or in any way connected with... personal injury, including sickness and death (including but not limited to in relation to exposure to or infection from COVID-19).[124]

97. Against that background, the contracts obliged Wilson, MSS and Unified to take certain steps towards protecting the safety and wellbeing of their security staff.

TRAINING AND INFECTION PREVENTION AND CONTROL OBLIGATIONS WERE IMPOSED

98. The contracts obliged MSS and Wilson to ensure that their security guards (that is, Service Provider Personnel) wore 'all necessary personal protective equipment (that complies with the relevant public health standards including but not limited to in relation to COVID-19) at all times while performing of the Security Services'.[125] The Unified Contract contained a provision in substantively the same terms.[126]

99. Wilson, MSS and Unified were each responsible for ensuring that, before their personnel performed the services, they:

    A. 'received adequate training in security, workplace health and safety, customer service and risk management as applicable for the provision of security services and, including but not limited to, in relation to COVID-19'[127]

    B. met 'all relevant safety induction requirements for the Designated Locations [i.e. quarantine hotels]'[128]

    C. 'have undertaken the Australian Government Department of Health COVID-19 infection control training module, or any and all other COVID-19 awareness training as directed [DJPR]'.[129]

CERTAIN TERMS ENTERED INTO WERE NOT SUITABLE FOR THE NATURE OF THE PROGRAM

100. These contracts with Wilson, MSS and Unified purported to structure their engagement in the Hotel Quarantine Program with the contractor carrying the entire responsibility to protect its workforce against the risk of transmission of COVID-19 and indemnify the State against any risk to which its workers may be exposed.

THE CONTRACTS DID NOT SUFFICIENTLY PROVIDE FOR DHHS TO GIVE DIRECTIONS

101. At the outset, it is important to note that the contracts were between the State of Victoria (through DJPR) and Wilson, MSS and Unified. There was no requirement in the contracts that security services personnel be subject to the direction of DHHS. It was a deficiency that these contracts did not explicitly subject security service providers to the direction of DHHS in the performance of their services. An assumption on the part of DJPR that security would work to Authorised Officers' directions was not reflected in the terms of the contracts or in the schedule of duties. The Principal Policy Officer did not, it would appear, receive any direction that the contracts specified the obligation to take directions from Authorised Officers.[130]

102. The Inquiry heard evidence that security guards considered they were working to assist Authorised Officers and some considered themselves to be subject to their direction.[131] Sam Krikelis, Business Manager for Events Services at MSS, gave evidence that security guards would raise issues with the Authorised Officer.[132] Mr Nagi said that Authorised Officers could give direction to, or make requests of, the security staff.[133]

103. On 30 March 2020, Mr Watson of Wilson was provided with a 'draft document', titled *Security Consultants — Roles and Responsibilities for Hotel Quarantine*, which stated that 'security personnel had been engaged to support authorised officers from [DHHS] and Victoria Police to uphold mandatory quarantine directions from CHO'.[134] That draft document was given to Wilson by DJPR. It was created by DJPR as a draft for DHHS, following discussions with DHHS on briefing security guards on how they should assist Authorised Officers to enforce the CHO's directions inside hotels.[135] DJPR understood that DHHS was to provide written material to security contractors so they could properly understand their role in enforcing those directions.[136] It suggested to DHHS that DHHS update the draft document and formally provide it to security managers at each site.[137] There was no suggestion from DJPR witnesses, Ms Febey or Mr Phemister, that this was actually done. The fact that DHHS submitted that Authorised Officers were not responsible for, or unable to direct, security guards,[138] leads me to infer that DHHS did not circulate that document to each of the contracted security services providers. This demonstrated a lack of agreement between DHHS and DJPR as to the role of security guards.

104. Explicit provision in the contracts would have provided greater clarity and certainty as to who was in charge of security services personnel, which may have led to a greater focus on the Government agencies supervising the work of security services personnel.

THE RESPONSIBILITY FOR PROTECTING AGAINST RISK SHOULD HAVE REMAINED WITH THE STATE

105. It was not appropriate that the contracts allocated the risk of COVID-19 transmission on to security service providers in the manner it did.

106. The contracts with security services providers effectively sought to impose the primary responsibilities relating to infection prevention and control on those private providers. This included obligations with respect to staff training and the supply of PPE. These were significant responsibilities to outsource, especially in the context of a government-led quarantine program, the primary aim of which was to contain the spread of a highly infectious disease.

107. Shifting a burden to those contractors who were not specialised in the areas of infection prevention and control was inappropriate and ought not have occurred.

108. By requiring all returned travellers to be detained in a hotel setting, the Government thereby concentrated, within the Program, a large number of potential carriers of the COVID-19 virus. This created risks of infection transmission as between those in quarantine and those working at quarantine hotels. The Government had a corresponding responsibility to take appropriate action to ensure appropriate systems were in place to address the risk that accompanies the creation of suspected or known hot spots.

109. DHHS submitted that the risks were not created or carried by the Hotel Quarantine Program but, rather, risks arose from COVID-19 itself and the entry into Victoria of travellers potentially infected with COVID-19.[139] What was required was a choice, it was submitted, as to how best to deal with the risk.[140]

110. The DHHS submission did not recognise that if the State mandates potentially infected people into the quarantine facility that it had created to avoid community transmission, it had then accepted the responsibility to take all necessary actions to keep the people in quarantine safe and minimise the risk of cross infection or community transmission from that quarantine facility (see also Chapter 11.1 for a discussion on the obligations of the State under the *Victorian Charter of Human Rights and Responsibilities Act 2006* (Vic)).

111. DHHS otherwise did not make submissions as to the contractual apportionment of responsibility for infection prevention and control measures in the context of security services; it did, however, consider that terms relating to PPE and training requirements on hotels were 'reasonable and prudent' and consistent with hotels' pre-existing legal obligations.[141] I infer that the same approach would be taken with respect to security guards.

112. DJPR did make submissions as to the contractual apportionment of responsibility for infection prevention and control measures.

113. DJPR submitted that security contractors were under a positive legal duty, themselves, to control risk.[142] It submitted that the contractors, as employers, had health and safety obligations under the *Occupational Health and Safety Act 2004* (Vic) at common law and as implied into employment contracts with their security services personnel.[143] It was reasonable and appropriate — so submitted DJPR — that contractors had responsibility for matters that were within their control.[144]

114. DJPR went further to submit that it would be inappropriate for the State to seek to assume contractors' own obligations with respect to their workforces because:

    A. obligations on contractors provide an extra layer of protection for workers

    B. the State and contractors exercise a different level of control over relevant workers and workplaces: here, DJPR submitted that contractors have particular roles with respect to on-site supervision arrangements, communication, disciplinary action and counselling

    C. it is appropriate for the State to limit its risk through contracts

    D. it was appropriate to require contractors to source their own PPE given the State's concern that it would be unable to source sufficient PPE.[145]

115. DJPR submitted that its contracts did not purport to transfer to contractors or diminish the State's infection prevention and control responsibilities, nor did the State seek to contract out of its obligations under the *Occupational Health and Safety Act 2004*.[146]

116. This Inquiry was not the proper venue for rulings and findings with respect to duties owed by these contractors at employment, contract or tort law. Suffice to say, as noted above in paragraphs 105 and 106, it was not appropriate for the State to seek to impose the risk of transmission of COVID-19 onto the security service providers in the way in which these contracts purported to do.

117. The Hotel Quarantine Program was not just a workplace or a private arrangement between employer and employee, or contractor and principal. It should not be seen solely through that lens. It was, fundamentally, a measure to protect the public from a significant public health threat.

118. There was simply too much at stake for the State to have conferred such responsibilities on private security service providers whose ordinary roles were so far removed from infection prevention and control measures.

119. Further, the state of specialist knowledge about COVID-19 was evolving over the months of the Hotel Quarantine Program. That knowledge was specialised and properly located within the ambit of DHHS.

120. For DJPR to determine that security service providers could or should have been making assessments about 'risk management' and what was 'adequate training' and 'relevant public health standards' for COVID-19 was inappropriate as a matter of public safety. Private security service providers simply could not have been expected to have had the specific expertise or experience in infection prevention control and use of personal protective equipment to be making such assessments and, certainly, not to the degree required to contain COVID-19, a new virus that was the subject of an evolving understanding in the medical and scientific communities.

RELIANCE ON THE OBLIGATION TO CONDUCT THE ONLINE TRAINING MODULE WAS NOT APPROPRIATE

121. Ms Currie gave the following evidence as to the inclusion, in each of the contracts, of the requirement for security services personnel to complete the Commonwealth Government Department of Health's COVID-19 online training module:

> I had become aware of the training program as part of my work for the 'Working for Victoria' scheme and I considered that, as a minimum, it would be beneficial if private security guards had completed this training before commencing the performance of their duties. I subsequently requested that this requirement be included in the written agreements with each private security company.[147]

122. I make no criticism of Ms Currie in purporting to include such a term into the contracts. Indeed, she is to be commended for being alive to the need for relevant training in those initial days. However, the training she nominated on 28 March 2020, and that was later specified in the contracts, was not sufficiently specific in the context of a quarantine program and was 'clearly misleading' for quarantine staff with respect to the use of masks.[148] It was a failure in preparing those contracts that the content of such training was not based on public health advice. Ms Currie did not have relevant expertise in public health, nor was any public health advice sought or given about the type of training that would be appropriate for non-health professionals working in close proximity to people potentially infected with COVID-19.

123. While it may be that the state of knowledge about COVID-19 was more limited in March 2020 than it was in June or July 2020, and accessible training modules were not in abundance at the time security companies were engaged, it remained fundamentally important that whatever training the State was requiring security companies undertake, such training would be fit for purpose.

124. Professor Lindsay Grayson, Director of the Infectious Disease Department at Austin Health, gave evidence before the Inquiry as to the utility of the Commonwealth Government Department of Health's COVID-19 online training module in the hotel quarantine context. He stated that this training module was not fit for purpose for those working in an environment where they were likely to be in contact with a potentially infectious patient.[149] He stated that:

> My assessment of this training module is that it is hard to know who their target audience is. Elements of it, indeed, the majority of it, is like a training module for the general public rather than someone who is going to come into direct contact, or indeed, be responsible for managing COVID patients … when I did the module some time back, I had assumed, just by the way it was structured, that this was really as a sort of a community education about infection control rather than a specific document related to staff of any sort who would be directly managing potential cases.[150]

125. Prof. Grayson concluded that the module was confused in its target audience, having regard to the level at which it pitched information and the detail with which the information was provided.[151]

126. In light of Prof. Grayson's evidence, a requirement to undertake COVID-19 related training should have been specifically tailored for non-health professionals working in a quarantine environment. That it was not, and that it was potentially confusing, meant that it was even more important that contractual requirements as to PPE and training were clear, specific and relevant.

127. Ms Currie also had a not unreasonable assumption, which she conveyed to security contractors in her initial discussions, that DHHS would provide on-site training and infection control. I consider the sufficiency of the steps taken by DHHS to provide that training and infection control in Chapter 8.

Requirements were vague and led to inconsistent PPE practices among security companies

128. Contractual terms for adequate training and PPE required security companies to work out, for themselves, what constituted adequate training and PPE that complied with 'relevant public health standards'. The contracts certainly did not define what those standards were or where they could be found. If, in fact, such standards existed, to ensure certainty and consistency, they should have been specifically referenced. And, if the drafters of the contracts did not know what those standards were, then it was unreasonable to expect that private security providers would know and almost impossible for DJPR to monitor and potentially enforce compliance with those requirements.

129. There was evidence that security companies were issued with a document — *Operation Soteria — PPE Advice for Hotel-Based Security Staff and AOs in Contact with Quarantined Clients* — that set out when PPE ought to be used.[152] That document was dated 5 May 2020.

130. To the extent that document constituted a relevant public health standard, it ought to have been given to the security companies much earlier than it was. It was not provided to Unified until 12 May 2020, some six weeks after Unified commenced its services;[153] MSS did not receive that guidance until 29 May 2020;[154] and Wilson received it on or around the same day.[155]

131. Each contractor had different ways of giving effect to its obligations with respect to infection control and PPE. The extent to which PPE and training obligations were discharged varied between the three contractors.

132. Mr Watson gave evidence that Wilson provided more than 30,000 masks, 81,000 pairs of gloves and 150 litres of hand sanitiser to its security guards.[156] It also provided safety goggles and surgical gowns to its guards.[157]

133. He gave evidence that Wilson took a range of different measures to manage risk. Those measures included having previously engaged an epidemiologist as a consultant to the company to provide advice on training staff, procedures, policies and guidance through the pandemic.[158] Mr Watson said that Wilson developed a process to continuously source PPE[159] and implemented guidelines and policies regarding the use of PPE, physical distancing, temperature checking and rostering requirements.[160]

134. Mr Adams gave evidence that MSS sourced, in sufficient quantities, its own disposable gloves, masks and sanitiser for its guards (including subcontractors).[161]

135. He said MSS developed its own infection control training module which all permanent employees were required to complete and was subsequently sent to contractors for completion by their guards.[162] Based on initial discussions with DJPR, MSS was of the view that DHHS staff would be on-site to provide guidance and assistance along the way.[163] The evidence of MSS was that it also provided COVID-19 information updates.[164]

136. Unlike for Unified, there was no explicit requirement in the MSS and Wilson contracts for MSS and Wilson to supply their personnel with PPE; only that they had to ensure their personnel *wore* all necessary (and compliant) PPE.[165] The evidence before the Inquiry was that it was an expectation that they do so and they, in fact, did so.[166]

137. With respect to Unified, in addition to the Commonwealth's module, Unified stated that its guards were inducted on-site, which included training on the use of PPE and some basic standard operating procedures.[167] Like MSS, Unified had an expectation that DHHS would offer training on-site, but its experience was that no guidance was received until late April or early May.[168]

138. This had consequences for the risk of transmission within hotels. Unified and its subcontractors were more reliant on DHHS training and guidance to reduce the risk of transmission and, so, were vulnerable if that training or guidance was not delivered (or not delivered in a timely way). In the case of other contractors, security guards may well have been better equipped to manage the risk of infection through more rigorous training, policies and practices implemented by the security contractor who had engaged them, whether directly or through a subcontractor.

139. Outbreaks occurred at a hotel staffed by Unified and a hotel staffed by MSS.[169] It is true that neither company had infection prevention measures in place that matched the standard that Wilson used at its hotels.[170] In the absence of evidence about the number of COVID-positive guests at hotels staffed by Wilson, I can draw no firm conclusions as to whether Wilson's heightened training and infection control measures, in fact, prevented or reduced the risk of outbreaks. The risk of an outbreak was much higher at the Rydges than at any other hotel because of its status as a 'hot hotel' and I accept that care needs to be taken in drawing inferences from the absence of outbreaks at hotels where the number of infected guests was likely to have been much lower.

140. The efficacy of the measures taken by each of the head contractors may be considered against evidence of how infection prevention and control measures were applied by security guards at the hotel.

141. In that context, evidence presented to the Inquiry highlighted varying levels of knowledge and support around infection control and appropriate use of PPE, depending on which guards were hired and where they were working, noting that this was but a small selection of examples:

    A. Witness Security Guard 1 said he 'went through use of [PPE], policies about keeping your distance from other people, and the processes for escalating incidents' on his first day working at Crowne Plaza.[171] His PPE training was about wearing masks and gloves, how to put the mask on, and he was told to use as much hand sanitiser as he wanted, to stay four metres away from guests with a maximum of three people in the lift. He stated he did not see any guards not wearing a mask properly.[172]

    B. Security Guard 1 said there were factsheets around the Crowne Plaza hotel that had information about wearing PPE and social distancing, and protocols for what to do if someone came out of their room. Security guards were not allowed to make any physical contact with the guests if this occurred; they would escalate the situation with the shift supervisor. There was no handbook or information distributed to the security guards.[173]

    C. By contrast, Kaan Ofli, a returned traveller who was quarantining with his partner, was told by a security guard at the Pan Pacific that he was overwhelmed as he did not have experience managing a team and he had not been properly trained.[174]

    D. Returned traveller Liliana Ratcliff stated she observed security guards not practising social distancing with each other, leaning on surfaces and not wearing gloves, which gave her a 'sense of panic' as she knew it was not safe.[175]

    E. Similarly, witness Michael Tait, who worked as a nurse in the hotel quarantine program, observed that security guards did not understand how to correctly handle PPE.[176] He explained that they became offended when nurses said they needed to wear their masks, and witnessed PPE constantly thrown on the floor instead of being disposed of correctly by security guards.[177]

142. This evidence of individual observations was, to some extent, contradicted by security contractors and subcontractors who said that there was training on PPE and that attention was paid to ensuring social distancing and hygiene. However, I am satisfied that, particularly at the Rydges and the Stamford Plaza hotels where outbreaks ultimately occurred, the practices of security guards fell short of necessary standards of infection prevention.

143. I base my conclusion largely on the evidence from the observations of the DHHS outbreak teams that attended both of these sites in the wake of the outbreaks at the Rydges and the Stamford. (The outbreaks are discussed in Chapter 9)

Figure 6.2: Narrative from Security Guard 4 about their experience with infection control training and PPE

'On my first day I got no instructions or training. I was told to just "sit there and do nothing". I was told that 'if any of the people came out of their rooms, tell them to go back into their room'.

I didn't have a mask or any PPE. They did have good hand sanitiser (alcohol based) at first, but after this we were just given hand wash, not proper sanitiser.

My friends who were also guards would help the travellers with their luggage and share lifts with them when they arrived from the airport. They didn't have a mask or any other PPE either. We didn't know if any of the travellers had the virus. Our subcontractor told us nothing'.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

6.7 The management of security services contracts

144. As a mechanism to ensure security services personnel were appropriately trained and performed their services to an acceptable standard, contract management became a critical component of the administration of the Hotel Quarantine Program.

145. There were deficiencies in the arrangements for managing contracts with security service providers Wilson, MSS and Unified (collectively, the head contracts), affecting the success of the Hotel Quarantine Program.

146. Before dealing with particular instances in which contract management led to deficiencies, a foundational question must first be answered; that is, was the contract management function properly located within DJPR in the first place?

147. It was accepted that DJPR was responsible for procuring security services and, also, managing the head contracts.[178] I have earlier referred to the head contracts requiring Wilson, MSS and Unified to comply with directions given by DJPR.

DHHS should have managed the head contracts

148. It does not necessarily follow that, if DJPR entered into the head contracts, it should also *manage* those contracts, including by way of giving directions to the security service providers.

149. A consistent theme arising from the evidence was that DJPR was responsible for 'logistics' whereas DHHS was responsible for returned travellers' health and wellbeing.[179] The distinction had some use in terms of differentiating between the set-up of the Program, on one hand, and the administration and operation of the Program on the other.

150. If that was the case, then the provision of security services, in order to enforce the quarantine regime imposed under legislation administered by DHHS, fell more appropriately into the latter category. Mr Krikelis, of MSS, aptly described the distinction between DJPR's and DHHS' responsibilities as follows: 'the role of DJPR appeared to me to be more directed at ensuring the operation was carried out, rather than *how* it was carried out'.[180] In terms of how the security operation was carried out, Mr Krikelis said that 'it was DHHS which provided guidance regarding the way in which security services were to be performed'.[181] Mr Nagi gave evidence that Authorised Officers could, in a practical sense, give directions and make requests of security staff.[182]

151. Mr Watson, on behalf of Wilson, expressed a similar sentiment when he said that, in practice, the Authorised Officer was in charge of a particular site.[183]

152. This view was both common and understandable. Given the entire Hotel Quarantine Program was about placing returned travellers into quarantine for public health reasons, and it was the powers of detention being exercised by Authorised Officers that kept those people in detention or allowed them to move around, it made sense, in the absence of any other person apparently 'in charge' on-site, to assume it was the Authorised Officers who were 'in charge'.[184]

153. As stated in Chapter 8, DHHS Authorised Officers were 'in charge' of people in quarantine at hotels, including because people were there as a result of their legislative powers of detention, and it was the security guards' function to assist Authorised Officers to enforce that detention. It is clear that all three security head contractors, themselves, understood that to be their function, and that they gained that impression from DJPR's initial work in drawing up the proposed scope of security guards' duties.[185]

154. DHHS was better placed than DJPR to manage the head contracts. Witnesses, including former DHHS Secretary, Kym Peake, and former Minister, Jenny Mikakos, gave evidence that there was no legal or practical preclusion from the management of service contracts being transferred to DHHS as Control Agency.[186] Indeed, the State of Victoria was the contracting agency. The ability to make that transfer as between government departments was further made apparent when the hotel accommodation contracts were transferred to DHHS on 1 July 2020[187] and again when the Department of Justice and Community Safety (DJCS), through Corrections Victoria, assumed responsibility for the supervision of returned travellers in the Hotel Quarantine Program by 11 July 2020.[188]

155. Fragmenting responsibilities between procurement and management of the security services providers led to deficiencies in the Hotel Quarantine Program. Mr Adams, of MSS, gave evidence that different reporting and accountability lines:

> … does create, and it did create, difficulties, in the sense that … our customer being a contracting department of the Government, with a number of other stakeholders who have not only responsibility but authority to make decisions at a site level. Those decisions … were not consistent. There was no clear demarcation of responsibility.[189]

156. A stark example of the confusion caused was the contradictory information given to security guards as to when PPE should have been worn. As stated above, the head contracts required security personnel to wear PPE 'at all times'.[190] That was also DJPR's position.[191] But DHHS took a different approach. Mr Nagi, of Unified, gave the following evidence in this regard:

> Unified Security also received PPE Advice documents from the DHHS which applied to security guards … these documents caused confusion as they contradicted the instructions that Unified was providing to guards, that is, to always wear PPE.[192]

157. As control agency of the services provided pursuant to the head contracts, DHHS should have been responsible for the management of the delivery of those services. To promote consistency and enable clear lines of accountability, responsibility and supervision of security service providers, DHHS and DJPR should have arranged, at the outset, for the transfer of responsibility for the administration of contracts to DHHS.

Complaints against security service providers were dealt with

158. Instead, DJPR managed the head contracts through the Principal Policy Officer, who was listed as the DJPR contact on each of the head contracts.[193] His duties included being the general point of contact for security providers regarding any contractual issues, relaying instructions to security providers and, at the direction of Rachaele May, Executive Director, Emergency Coordination and Resilience at DJPR, requesting responses from security providers to issues raised by DHHS, DJPR staff, hotel staff or returned travellers.[194]

159. Even though the Principal Policy Officer was the contract manager, he was never deployed to hotel sites; rather, he relied on receiving reports from DJPR or DHHS staff.[195] In contrast, DHHS maintained a constant presence at hotels through Authorised Officers and Team Leaders.[196]

160. Further, not only was the Principal Policy Officer absent from sites, he had no background or experience in public health or infection control[197] and, therefore, had no sense of the dangers that any of these complaints posed to the efficacy of the whole Program.

161. The Principal Policy Officer generally received complaints regarding the conduct of security guards and relayed those to the relevant security services provider for response.[198]

162. One returned traveller told the Inquiry Intake Team that she flirted with security guards in order to receive more fresh air breaks to support her mental health and wellbeing. This led to a guard asking to stay with her after she left quarantine:

> The extra fresh air breaks helped me feel much better emotionally, which was really important because my mental health was very poor at the time. I understand the guards broke rules in the way they interacted with me … After quarantine ended, the security guard asked if he could stay with me at my house. I told a white lie because I did not want him to stay with me.[199]

163. The Inquiry was provided with a statement from the Principal Policy Officer, who described 12 complaints about the conduct of security guards at hotels.[200] Those complaints were made variously against staff engaged by Wilson, MSS and Unified. The following is a sample of the complaints and outcomes identified by the Principal Policy Officer:

A. On 7 April 2020, a complaint was made against guards engaged by Wilson relating to misuse of equipment and poor customer service.[201] The matter was raised with Wilson and dealt with appropriately.

B. On 12 April 2020, a complaint was made against a guard engaged by Wilson alleging that the guard was 'overly friendly' with a guest.[202] Another complaint was made against a Wilson-engaged security guard on 14 April 2020, also alleging the guard was 'overly friendly' with a guest.[203] After the complaints were raised with Wilson, Wilson terminated the engagement of the relevant guards.[204]

C. On 28 April 2020, a complaint was received relating to the conduct of security guards engaged by Unified, including allegations that staff were consuming alcohol while working. After the complaints were raised with Unified, Unified stood down the crew working on the relevant evening amongst taking other steps.[205]

D. On 11 May 2020, a complaint was received about the conduct of guards engaged by one of Unified's subcontractors, which was investigated and resulted in the standing down of the entire team of guards that was working that evening.[206] The subcontracting arrangement was also terminated by Unified as a result.[207] Unified advised it would take additional steps, including a commitment to provide harassment and bullying training to its staff.[208]

E. On 14 June 2020, a complaint was made against MSS security guards regarding a lack of appropriate social distancing and misuse of PPE.[209] MSS agreed to provide further advice and guidance on the need to have smaller meetings and the role of PPE, amongst other things.[210]

164. The conduct of security guards, such as that described by the Principal Policy Officer, was unacceptable. Such behaviour affected the wellbeing of those subject to quarantine. It also risked the spread of COVID-19, particularly in instances of conduct related to misuse of PPE and failures to exercise proper physical distancing.

165. The evidence did not provide a basis for concluding that that inappropriate conduct by security guards was systemic or widespread, or that appropriate remedial action was not taken by DJPR or the security service providers. Rather, the evidence before the Inquiry was that Wilson, MSS and Unified took steps to resolve those complaints and reduce the risk of that conduct reoccurring.[211] That was so, even to the extent that, in one case, a subcontracting arrangement was terminated as a result of a complaint.[212]

166. The arrangements for subcontracting, however, posed their own significant challenges for the Hotel Quarantine Program.

6.8 Subcontracting terms were not appropriately managed

167. As set out above, each of the contracts permitted Wilson, MSS and Unified to engage subcontractors.[213] There was a process for giving effect to the subcontracting provisions under the standard POC used for Wilson and MSS, which involved the submission of a 'Notice of Intent' form, together with relevant documents.[214] That involved the contractor providing in the Notice of Intent, the details required by clause 6 of those contracts and copies of documents, including:

    A. an acknowledgment from the subcontractor that it will comply with all the obligations arising under the Purchase Order Contract

    B. a statement of compliance from the subcontractor with the contract and all rights and obligations arising under it.[215]

168. Such requirements were, on their face, intended to give the purchaser oversight of the suitability and capability of the proposed subcontractor to provide the services to DJPR's satisfaction. In the context of the Hotel Quarantine Program, they purported to give assurance to DJPR that the subcontractor had complied with the requirements for COVID-19-related training and PPE use (or that they would have complied with them before the services were provided).

169. Once those documents were provided and the material was considered, the purchaser (in this case, DJPR) may approve the engagement by countersigning the Notice of Intent. That Notice invited the purchaser to give reasons for the decision and specify any conditions or restrictions on the engagement.

170. In the Hotel Quarantine Program, each of Wilson, MSS and Unified used subcontractors.

WILSON

171. Wilson engaged 10 security services providers as subcontractors between 3 April and 5 July 2020 across four hotels.[216] That represented approximately 650 security guards under subcontracting arrangements, with the total 'peak' numbers being as follows:[217]

    A. 168 guards at Crowne Plaza

    B. 180 guards at the Pan Pacific Hotel

    C. 160 guards at the Mercure Hotel

    D. 145 guards at the Pullman Hotel.

172. In choosing which subcontractors to engage, Wilson prioritised those with whom it had previously worked, then would consider the availability of contractors that had served the aviation industry and, thereafter, those from the hospitality industry. It considered security guards from the aviation industry were known to be well trained with high service standards and those from the hospitality industry would have customer service skills appropriate for the Hotel Quarantine Program.[218]

173. Ultimately, Wilson hired a mix of subcontractors; some had pre-existing relationships with Wilson, while others had just started with Wilson in retail work, as there was a retail 'surge' prior to the Hotel Quarantine Program.[219]

MSS

174. Prior to hotel quarantine, in early 2019, MSS conducted a Request For Tender (RFT) process. MSS invited all existing subcontractors, along with other entities that had expressed an interest in working with MSS, to participate in the RFT process. MSS offered subcontract agreements to parties it believed were businesses with 'genuine employees' who were remunerated correctly, at least, in accordance with the applicable Security Services Industry Award, had the capacity to consistently deliver on the resources required and were able and reliable in delivering training requirements.[220]

175. MSS engaged four security services providers as subcontractors between 6 April and 10 July 2020 across four hotels.[221]

176. The Inquiry received evidence that MSS was asked, on 14 May 2020, to provide Notices of Intent for any subcontractors.[222] MSS had been providing security services to the Hotel Quarantine Program, including via subcontractors, since 6 April 2020.[223] On 14 May 2020, MSS provided Notices of Intent to DJPR, but did not provide signed acknowledgements, until 10 June 2020, that the proposed subcontractors would comply with the terms of the MSS Contract.[224]

177. The Principal Policy Officer approved the engagement of four subcontractors on 10 June 2020,[225] some two months after subcontractors commenced work.

UNIFIED

178. Unified also had pre-existing relationships with subcontractors, which it called 'service partners'. Unified worked with its service partners to fulfil the numbers of security guards needed at any one time.[226]

179. Between 29 March and 11 July 2020 and across 13 hotels, Unified engaged five security services providers as subcontractors.[227] Mr Coppick gave evidence of two instances of further (impermissible) subcontracting by those subcontractors.[228]

180. The Principal Policy Officer gave evidence of knowledge of only one Unified subcontractor. He said that Unified did not inform him that Unified had engaged Acost Security Services as a subcontractor.[229] It was only in June 2020, after a media enquiry, that the Principal Policy Officer became aware of its engagement.[230] The Principal Policy Officer did not give evidence about having approved the use of the subcontractors used by Unified. There was no evidence of Unified having formally notified DJPR of the use of its subcontractors or having complied with its contractual requirements to seek DJPR's prior approval for the use of those subcontractors.[231]

Non-compliance with requirement to obtain prior written approval

181. The evidence was that Wilson, MSS and Unified did not comply with their obligations to seek prior written approval to use subcontractors in accordance with the terms of their contracts.[232]

182. While the obligation was on Wilson, MSS and Unified to seek and obtain that prior written approval, that did not absolve DJPR from seeking to enforce the subcontracting terms (which it later did, certainly with respect to MSS).[233] DJPR should have been more vigilant and proactive in requiring Wilson, MSS and Unified to seek written prior approval, as per their respective contracts. That was particularly so when DJPR was on notice that subcontractors would be used,[234] regardless of the extent to which DJPR was aware of the prevalence of subcontracting within the security industry. Had the task of procuring security services providers been given to people with greater knowledge of the industry, it is reasonable to assume that those people would have had a greater awareness of the common practice of subcontracting in the security industry, in particular in circumstances where large 'surge' workforces are required.

183. In submissions, DJPR acknowledged that it 'could have done more to scrutinise and respond to the extent of subcontracting by the private security companies engaged by it … once that issue came to DJPR's attention'.[235] That concession is properly made. The issue of subcontracting first came to DJPR's attention during discussions between Ms Currie and Wilson on 28 March 2020.[236] The terms of the contracts DJPR initiated made it clear it was contemplated and understood that subcontracting may occur.

184. Mr Phemister gave evidence about 'post-incident reviews' that were undertaken for all subcontractors.[237] With respect to subcontractors that were not approved prior to their commencement in the Program, Mr Phemister said that '[t]hose post-incident reviews found that we would have, in all likelihood, permitted the subcontracting'.[238] That is, of course, a fortunate outcome, but it does not relieve DJPR of the need, prior to their engagement, to have considered the proposed subcontractors in order to satisfy themselves as to their competence and suitability. As set out elsewhere in this chapter, the heavy reliance on subcontracting posed a significant risk to the Hotel Quarantine Program.

185. The requirement for DJPR to give written prior approval to subcontractors,[239] having been satisfied of the subcontractors' agreement to comply with the terms of each relevant head contract, was an important one. It would have allowed DJPR to satisfy itself that those subcontracted to provide security services had, at the very least, 'adequate training' in relation to COVID-19 as designated by the head contracts and knew of, and were subject to, the requirement contained in the head contracts to wear PPE 'at all times'.[240]

186. These requirements were (at least) basic infection prevention and control measures. They were imposed as a way to protect the health and safety of security guards and returned travellers alike.

187. Non-compliance with the subcontracting provisions meant DJPR could not satisfy itself that, before they commenced work, subcontractors were being given basic training with respect to the risk of infection. It meant that DJPR did not implement a crucial contractual mechanism that was there to minimise risk of infection transmission.

188. In the context of Unified's services, it also meant that the overwhelming majority of its approximately 1,754 security staff[241] were subcontracted security staff engaged without DJPR having considered whether they were competent, suitable or sufficiently trained to perform those services safely. As set out earlier in this chapter, Unified was relying heavily on small subcontracting companies and DJPR was not even aware of that fact,[242] leading it to allocate more and more hotels to Unified without any proper assessment of its capacity to cover such a substantial percentage of the whole Hotel Quarantine Program's first tier of enforcement.

189. This was a failure of proper contract management on the part of DJPR. However, to an extent, this failure is shared with Wilson, MSS and Unified. There was evidence as to some subcontractors not being aware of their obligations under the head contracts until well into the delivery of service. In fact, Sterling Security Group, a subcontractor for Unified, never saw the Unified Contract.[243] Moreover, The Security Hub was first approached by Wilson and then MSS in early April to provide services but was only provided with the terms of the head contract by Wilson and MSS in May and June respectively.[244]

Vulnerabilities of the private security workforce

190. The issue arose before me as to whether security guards were the right cohort to provide the services they actually provided within hotels. To the extent that security guards were engaged in the Hotel Quarantine Program to provide static guarding services at points of exit and entry and stationed at points inside hotels to ensure people in quarantine stayed in their rooms,[245] it was not unreasonable to expect that private security guards were a suitable cohort. This assessment, by the former Chief Commissioner of Police, Emergency Services Commissioner and Minister for Police and Emergency Services, was made in that context and with the qualification that their performance was properly supervised and they were properly trained for this work.[246]

191. However, that was not the extent of the services provided by security guards, as I have set out above in Sections 6.4 and 6.5.

192. The evidence was that private security companies had the flexibility and capacity to scale up quickly and to provide the hundreds of guards that were required.[247] They did that through subcontracting and reliance on a workforce of casual and part-time workers, many of whom had lost previous work due to COVID-19-related shutdowns. That flexibility was necessary because arrival numbers changed every day. It is not difficult to see the rationale for using private security to meet such a fluctuating demand, and to do so using subcontractors who, themselves, could call on a readily available and flexible workforce.

193. But that 'flexibility' carried with it substantial potential vulnerabilities. The State Government was on notice of those vulnerabilities, including the risk of inadequately trained staff, underpayment of wages and poor working conditions, all of which had been identified as issues being considered in a review of licensing and regulatory arrangements in the private security industry[248] that commenced prior to the Hotel Quarantine Program. I turn to this review below, at paragraph 200.[249]

6.9 The security industry relies heavily on subcontracting

194. Subcontracting is common in the security industry.[250] Ms Currie, who identified the three security companies, gave evidence that she did not comprehend that subcontracting was the way the industry worked or that the companies would use subcontractors.[251] That evidence was challenged.[252] I am satisfied that DJPR was not aware of the extent to which the security services industry was reliant on subcontractors. That lack of awareness was reflected in DJPR's failure to properly manage the contracts with each of MSS, Wilson and Unified insofar as they placed obligations on the security companies with respect to subcontracting.

Subcontractors recruited security guards quickly and often informally

195. Each subcontractor had a limited number of staff on its books and relied on databases of guards, as well as word of mouth and online advertising, to recruit sufficient numbers. For example, Sterling primarily sourced guards from its database, however, due to the large number required, the company also received word of mouth recommendations, which would be followed by phone interviews.[253] About half of the United Risk Management (URM) guards who worked on the program were previous employees of URM. The remaining staff were recruited through word of mouth and advertising on Gumtree.[254]

196. There was evidence that some guards were hired through social media, including WhatsApp, LinkedIn and Facebook,[255] and recruitment websites such as Seek.[256]

197. Security 16, a guard who worked at the Rydges and Marriott hotels, gave evidence that he was recruited by subcontractor Silvans Security Services via WhatsApp:

> All of the arrangements were made using What's App and it was very casual. I was not asked to provide my visa or any hard-copy documents. I was not asked to undertake any extra training or read any other information about COVID-19 or infection control.[257]

198. Such recruitment processes were totally inappropriate in the context of a quarantine environment. The ad hoc, arms-length and impersonal nature of recruiting security staff reflected the need to satisfy the demands of the Hotel Quarantine Program (in terms of the number of security guards required) and to do so with very little notice. It also meant that there could not have been sufficient consideration as to whether the security guards being recruited by subcontractors actually had the training, experience, skills and competence to perform the services required and to perform them safely in such a dangerous environment.

199. As one subcontractor, who gave information to the Inquiry via the Intake Team, stated:

> I think the Hotel Quarantine Program was very rushed. To find 450 guards within a few days is a big task for a short amount of time. The Government put a lot of pressure on contractors, and the contractors put a lot of pressure on subcontractors.[258]

6.10 The security industry has inherent characteristics that make security guards a vulnerable cohort

200. The private security industry was the subject of an existing review by the Victorian Government at the time the Hotel Quarantine Program commenced.[259]

201. The Premier gave evidence that he was aware of concerns in sections of the community and the private security industry about how the industry operates.[260] The Premier was taken to a document, *Victoria's Private Security Industry — Issues Paper for Consultation* (Issues Paper), which invited comments and responses to the review into the industry.[261] The Issues Paper identified a number of characteristics of the private security industry that were concerns within the industry, generally, including:

    A. the industry attracted culturally and linguistically diverse people for whom English is a second language, as well as people with low levels of education.[262] The Issues Paper noted that '[poor] levels of language, literacy and numeracy skills … is a continuing concern …'[263]

    B. concerns as to job security and workplace rights, including concerns about 'sham contracting', insecure work and underpayment of wages and superannuation in the industry, and the extent to which workers can understand their rights and obligations.[264] The Issues Paper noted reports of 'widespread use of casual labour hire across the industry where permanent employment would be more appropriate'.[265]

202. The Government was already aware of the insecure nature of private security work, and the prevalence of subcontracting in a range of industries (including the private security industry), by reason of the *Victorian Inquiry into the Labour Hire Industry and Insecure Work*.[266]

203. In the specific context of the Hotel Quarantine Program, those concerns manifested and contributed to private security not being the appropriate cohort to provide security services in the Hotel Quarantine Program.

204. Dr Clare Looker, Senior Medical Advisor at DHHS, reflecting on the use of private security guards and DHHS's ability to contain the outbreaks in that cohort, identified social or health vulnerabilities in the security guard cohort, including in the following respects:

    A. in many cases, guards lived in crowded or dense housing, such that many of DHHS's usual outbreak control measures were harder to successfully implement[267]

    B. the age of the cohort was relevant; Dr Looker said that as a young, fit and socially-active cohort, they tended not to seek testing until it was required at Day 11, by which time there had been cases that had transmitted within their household[268]

    C. language and cultural issues and, at times, distrust or caution about government services.[269]

205. I accept Dr Looker's evidence that those factors may have each contributed to COVID-19 outbreaks and to some of the difficulties faced by contact tracing teams in the wake of the outbreaks.

206. Professor Brett Sutton, CHO, gave evidence in similar terms as to the characteristics of private security guards creating significant risks of COVID-19 transmission from the Hotel Quarantine Program into the community.[270] That evidence was consistent with some of the concerns identified in the Issues Paper referred to above.

207. That is, the language and cultural barriers, faced by many of those in the industry, may have impeded their understanding and acceptance of infection prevention and control measures.[271]

208. As to the nature of the workforce, Ishu Gupta, Managing Director of The Security Hub, said, 'because [security guards] are on casual employment, and as per fair work laws ... they are within their own rights to work with other contractors if they find work'.[272]

209. As Security Guard 2 told the Inquiry:

> My main concern about working at the hotels was the amount of movement of staff between locations — guards, DHHS staff and nurses. It seemed to me that they moved from hotel to hotel, and the nurses moved between hotels and hospitals. All this movement made me feel like something bad was bound to happen — which it did.[273]

210. The movement of staff created risks. To refer to Prof. Sutton's evidence:

> The casualised labour that was involved meant that a number of them had other work that they needed to do, which brought the risk of transmission to other workplaces and other individuals. The casualised nature of their work and the dependency they had on that work led to an incentive to stay at work, both in hotel quarantine work but in their other work, I would imagine, while potentially symptomatic, even potentially while diagnosed and aware of that diagnosis.[274]

211. Such concerns were borne out by the accounts of some guards, themselves, who contacted the Inquiry Intake Team and shared their experiences of being part of a casualised workforce and working in the Hotel Quarantine Program with the Inquiry.

Figure 6.3: Quotes from security guards regarding their experiences working in the Hotel Quarantine Program while being part of a casualised workforce

Security Guard 2: 'Some guards were very tired because they would finish their 12 hour shifts and then go to work at other jobs. I also was concerned that some of the subcontracted guards were poorly paid'.

Security Guard 5: 'Some guards did "back-to-back" 12 hour shifts at the same hotel and would fall asleep the next day. I would often try to wake them'.

Security Guard 6: 'Some guards would finish their shifts and then go and deliver Uber Eats or do cleaning jobs. I think they did this because they were not paid very well'.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

212. It follows that, where security guards were dependent on (low) wages, disclosing symptoms of COVID-19 to their employer would risk them losing work and income. Where security guards had no incentive to report those symptoms, it created a risk that potentially infected security guards would continue to work within hotels and increase the risk of transmission, particularly where embedded measures for infection prevention and control were insufficient.

213. Indeed, one guard told the Inquiry Intake Team that when he told his subcontractor he had been diagnosed with COVID-19, the subcontractor was not very supportive. The subcontractor told the guard that he would pay him for three weeks, for the shifts he was unable to do, but only paid him for two weeks and, since then, refused all his calls.[275]

214. Moreover, the unpredictability of work for security guards, understandably, would be likely to lead to guards wanting to accept work when it is offered to them. The impetus to accept and maintain work is strengthened during the COVID-19 pandemic when many security guards had their hours reduced or had no work at all.[276]

215. The need to maintain an income in the face of unpredictability and uncertainty would provide an incentive for security guards to do what was requested of them or risk not receiving work. That is so, even if it meant that security guards would be performing work beyond the scope of their capability or role as they understood it to be.

216. In that context, that no doubt contributed to security guards being willing to and performing tasks outside the security services they ordinarily provided. That involved exposure to a risk of COVID-19 transmission. That security guards did not refuse to perform those functions when they could and should have, on the basis that it posed a health risk to them, illustrated their vulnerability, particularly at that time. Job security, including through ongoing employment and associated entitlements, is likely to have alleviated such a willingness to accept the 'role creep' that ultimately created risks for the entire Program.

217. The risk inherent in security guards being willing to expose themselves to possible infection, in order to maintain their income, is exacerbated by the power imbalance between security guards, on one hand, and their employers, on the other. That is particularly so where there is a language barrier between employees and employers, or where workplace rights are not well known.

218. Security guards are relatively less organised in terms of industrial relations than the Victoria Police members who now perform security services at health hotels. Well-organised, unionised workforces would no doubt be more willing to assert their rights to safe workplaces and for there to be proper standards, protections and arrangements in respect of their members' health. It is noteworthy that the Crisis Council of Cabinet was briefed on the need to liaise with relevant unions in June and July 2020 when considering the use of government employees in the Program, since those unions would be alive to the occupational health and safety issues their members would face.[277]

219. There also exists, in the security industry, an inherent power imbalance between the head contractor and the subcontractor, regardless of whether or not a particular head contractor treats guards engaged through subcontracting in the same way as its own employees. The power imbalance reflects the reliance that subcontractors have on head contractors to provide them with work. That was evident through the statements given by representatives of subcontractors as to the small margins they received in providing security guards to head contractors.

220. The Inquiry heard evidence from a representative sample of three of the engaged subcontracting firms. As to the rates of pay charged to the head contractors, Mr Gupta, of The Security Hub, said that they operated at a margin of four to five per cent.[278] Rob Paciocco, Director, Black Tie Security, said that they 'made three per cent' on top of the casual award rates[279] and Mr Aggarwal, Director of Sterling, said that their margin was 'a bare minimum margin'.[280] Mr Paciocco explained the reason for the margin as follows:

> We were probably going to record a record month since we have been open, since 2014, in March, to within 72 hours having no work at all. So, reaching out to Wilson initially, it really was about survival and about holding onto, you know, a number of good people who it had taken years to recruit, so I don't lose them to other companies when things eventually do pick up.[281]

221. Similar sentiments were expressed by Mr Gupta and Mina Attalah, Managing Director at United.[282] Mr Gupta went further to say that 'head contractors enjoy the position of subcontractors in this space and that's how it has always been'.[283]

222. MSS submitted that there was no evidence that any consideration was given to the vulnerability of security guards, the density of their private living arrangements or any other cultural, educational, linguistic or socio-economic factor.[284] Counsel Assisting the Inquiry similarly submitted that there was no evidence that the factors referred to above were considered when the role of security guards was discussed or as the role expanded, despite the existence of the Issues Paper.[285]

223. MSS submitted that the Government was 'clearly well aware' that private security guards, as a cohort, were vulnerable in a range of respects, which meant that the risks posed by the Program and its lack of a proper structure were necessarily increased.[286] It is clear that those tasked with procuring private security services did not and were not instructed to do anything other than procure those services.

224. Wilson, on the other hand, submitted that security guards as a cohort did not pose a risk to infection simply because they were a casualised or unskilled workforce[287] and referred to its own employee and subcontractor management practices.[288] Wilson contended that Counsel Assisting's submissions as to the systemic issues faced by security guards as a cohort were broadly stated, made without evidence, were not put to witnesses and, in some cases, were wrong.[289]

225. On the basis of Dr Looker's and Prof. Sutton's evidence, the issues raised in the Issues Paper and the evidence that emerged more generally during the Inquiry, I conclude that there were aspects of the private security industry as referred to here that made this cohort vulnerable to the risks that eventuated.

226. But I do not impute onto those DJPR officers clear awareness of these vulnerabilities in circumstances where there was no policy analysis as to the merits of procuring private security guards to provide those services. Had proper consideration been given in the usual policy development process, with the benefit of proper reflection as to whether security guards were the appropriate cohort to provide security services, then the issues raised in the Issues Paper ought to have been raised and considered.

227. On the evidence given by representatives of the sample of subcontractors called before the Inquiry, as a cohort, there remains a general imbalance of power between head contractors and subcontractors; subcontractors would not want to risk a steady stream of work from head contractors.

228. A theme arising from those within the private security industry who gave evidence or provided information to the Inquiry was that they would (if given the opportunity) be willing to participate in a future Hotel Quarantine Program.

229. I have considered whether such future engagement might be appropriate and, if so, on what conditions. I have given weight to the evidence of Prof. Grayson as to the need for people to be appropriately and continuously trained, resourced with correct PPE and for any such quarantine structure to have in place clear oversight from those with infection control expertise.[290]

230. Private security guards were not the appropriate cohort for the Hotel Quarantine Program in the circumstances that unfolded. Nor would they be the appropriate cohort in any future program without addressing the issues that I identified in the Interim Report, and which I consider further below, being:[291]

    A. personnel working at multiple sites

    B. the nature and level of training and understanding about infection prevention and control requirements, including the use of personal protective equipment, social distancing and hand sanitising

    C. on-site supervision

    D. role clarity as to the work to be performed by on-site security

    E. the challenges of having personnel, in a highly complex and dangerous environment, who are engaged on a casual basis and not engaged directly by the management of the facility to enable support and instruction as to requirements in the event of a positive transmission.

231. To that end, I have recommended in the Interim Report — and do so again in this Final Report — that a future model of hotel quarantine should use a security cohort that, at least:

    A. makes every effort to ensure that on-site personnel do not work in other environments[292]

    B. is engaged on a salaried basis and is appropriately remunerated[293]

    C. is appropriately trained in infection control requirements and should understand personal protective equipment usage, physical distancing and hand hygiene[294]

    D. is subject to ongoing monitoring and supervision by personnel with expertise in infection prevention and control, including with respect to individual behaviour, use of personal protective equipment and cleaning practices[295]

    E. has been given role clarity by the Quarantine Governing Body,[296] and that the Site Manager ensures that they understand their roles and responsibilities.[297]

232. Unless a future Hotel Quarantine Program incorporates those measures into its design, security guards are not an appropriate cohort to be on the frontline in compliance and enforcement at quarantine hotels. In fact, it seems the State Government had, itself, already formed this view in June and July 2020 when it established the alternative model of hotel quarantine using Residential Services Officers.[298]

6.11 The potential use of Victoria Police

233. If private security guards were not the appropriate cohort to provide security services because they were inherently vulnerable, then the question that follows is, what cohort would be?

234. Victoria Police would be an obvious contender.

235. Prof. Sutton made two formal requests for police assistance as part of the pandemic response; the first was on 16 March, and the second on 29 March 2020.[299] The requests were for police to support, to the extent that it was feasible, Authorised Officers in the exercise of their functions.[300] The precise nature of the support was left for those running the operation to determine but, according to Prof. Sutton, the purpose was to ensure compliance with quarantine orders.[301]

236. The Inquiry heard evidence that there was, at times, advocacy for a 24/7 police presence to support the private security guards, from as early as the first weekend.[302] In evidence, Ms Febey expressed the view that a police presence was required and that she pressed for DHHS to take up this issue in its capacity as the control agency.[303] The evidence of Chief Commissioner of Police, Shane Patton, was that Victoria Police had not received an official request to maintain a constant presence at each hotel.[304] That evidence was not challenged and is accepted. It appears that, whatever the views of some inside the Program, those views did not find their way into a formal request.

237. The evidence of Commander Tim Tully of Victoria Police was that, given the number of police call outs, it would not, in any event, have been an efficient use of police resources to have police at the hotels at all times.[305] I accept that the number of those call outs was relatively low and that some of the risks of poor behaviour anticipated by those setting up the program did not eventuate.

238. This meant that Victoria Police responded, when requested, to a limited number of call outs to the hotels and, essentially, assisted in the operation in ad hoc ways,[306] consistent with the plan that came to be understood from the SCC meeting on 27 March 2020. In mid-April 2020, it convened a security forum after concerns were raised about fresh air breaks. The purpose was not to take control of security but to understand procedures in place to keep the public away.[307] I note here that Victoria Police had powers to manage cordons, and could have done so, had a request been made.[308]

239. There was no evidence that consideration was given, at the time, to the benefits that Victoria Police may have provided to the Program by virtue of its characteristics as a workforce, rather than simply its ability to enforce compliance with quarantine directions.

240. It was likely that a constant police presence would have ensured an increased focus on health and safety on-site. The documentation the Inquiry received from Chief Commissioner Patton regarding arrangements at the 'Health Hotels' in Operation Soteria 2 shows the attention that has been paid to ensuring a safe workplace for those police members working there.[309]

241. As I described in the Interim Report, Chief Commissioner Patton said that a full risk assessment had been conducted for his members to work on the sites, which had led to the creation of detailed procedures to ensure member safety.[310] These procedures included a Senior Sergeant of Police taking the role of Safety Officer, briefings for all members, written instructions for different roles, the delineation of 'green' and 'red' zones on-site, and training for contamination events and specific locations for decontamination.

242. As a cohort, police would also have been a stable and disciplined workforce. In the event of an outbreak, they would not have had the types of vulnerabilities that plagued contact tracing efforts among the security guard cohort as set out in Chapter 9.

243. It is worth noting here that there was evidence of the considerable tensions that arose from time to time in the hotel quarantine sites and, at times, aggressive and threatening behaviour of some quarantined travellers towards staff and personnel working in the facilities.[311] While the number of actual call outs to police seemed relatively low,[312] it is not difficult to conclude that the presence of Victoria Police on-site at the quarantine facilities would have provided considerable comfort and reassurance to the personnel working there and have likely acted as a deterrent to the more aggressive types of behaviour that were reported to the Inquiry.

244. The reality is that these issues were not considered at the time. I can make no finding about whether a proper, accountable decision-making process for enforcement arrangements might have avoided the outbreaks at the Rydges and the Stamford. However, given all of the vulnerabilities of the nature of private security generally discussed above, I am satisfied that the features of a fully salaried, highly structured workforce with a strong industrial focus on workplace safety, such as Victoria Police, would have minimised the risk of such outbreaks occurring and made contact tracing an easier job in the wake of any outbreaks. It is on that basis I made recommendation 20, that the Chief Commissioner of Police be requested to provide a 24/7 police presence on-site at each quarantine facility.[313]

6.12 Conclusions

245. I have already recommended, in the Interim Report, a different model of enforcement in any future facility-based quarantine program. I do so again here. I made that recommendation because the evidence was that, ultimately, the frontline of enforcement in a quarantine program was not a static guarding function and therefore not a function for private security to perform.

246. There was not a basis to conclude anything other than the overwhelming majority of security guards who worked in the Hotel Quarantine Program did so honestly and with goodwill. No doubt, none of those workers went to work to get infected with COVID-19. As Mr Gupta said, they were frontline workers and they were performing an essential service and putting themselves at risk in doing so.

247. The problems I have identified in this chapter are systemic governmental failings. They are not criticisms of individuals and should not be taken as such.

Decisions were not made at the right levels and with the right information

248. It likely would have come as a considerable surprise to many that public money of this magnitude and contracts of this size and significance did not appear to have had the direct oversight of the Minister. It ought to have had direct input and oversight from Mr Phemister[314] and Minister Pakula. Mr Phemister said that he briefed Minister Pakula very rarely.[315] Minister Pakula said that it was not 'typical for ministers to be necessarily apprised of the details or even the fact of contracts that are being entered into' for an operation.[316]

249. Putting to one side the issue as to proper public governance models generally, to accept that senior levels of government would not need to be involved in such operational matters is to view the Hotel Quarantine Program as an ordinary operation, when it was anything but ordinary.

250. Although it was not known in early April 2020 how long the Hotel Quarantine Program would run, it ought to have been apparent that the costs of security would be extensive and that the importance of security to the success of the Program was critical.

251. Outsourcing such a critical function warranted closer scrutiny from senior public servants and the Minister. Those who negotiated the terms of the contracts and those who supervised them were doing so without any clear understanding of how security fit into the broader Hotel Quarantine Program and had no expertise in security issues. They had no access to advice from those who had been party to the decision to use security and limited visibility over the services being performed.

252. The Minister should have been informed of security arrangements (See: Ministerial Briefing: Chapter 8).

253. It was not appreciated by the DJPR staff involved in the informal engagement of the security contractors that the workforce they were engaging would be a frontline service exposed to, and expected to manage, the risks posed by returned travellers who had contracted COVID-19. DJPR did not have any requisite experience or knowledge to make that assessment. Having regard to the role of DJPR, the role of Working for Victoria and the deadline involved, the main focus in the recruitment of the security companies was clearly availability and job creation, particularly if it could serve broader policy objectives.

Failings in the procurement process

254. The process by which the security guards were selected was not appropriate or sufficiently rigorous. It was made in haste and without any risk assessment, led by staff that did not have the requisite experience and knowledge needed, and without any public health oversight or input. The speed with which security had to be contracted is some explanation, though not a sufficient explanation, for why the initial contact was made in the way it was.

255. While I do not make a finding that the procurement decisions set out above can be directly causally linked to the problems that emerged at the Rydges and Stamford Plaza hotels, I do find that there were failures of proper procurement practice on the part of DJPR.

256. The first such failure was not using the State Purchase Contract when making initial arrangements for security over the weekend of 28 to 29 March 2020. Those involved in the WhatsApp chat were not aware of the State Purchase Contract arrangements for security services or the existence of publicly available details of security services providers that were regularly used by the Government by way of the State Purchase Contract arrangements. Those involved were also unaware of the applicable critical incident procurement policy and protocols and that an exemption from the State Purchase Contract was not needed.

257. At the time Ms Currie first made contact with Unified and Wilson she had no knowledge of how long the need for security would last or what it would cost. She is not to be criticised for making the quick decision to engage Unified in circumstances where time was of the essence. But the processes used by DJPR do warrant criticism. Ms Currie ought to have been furnished with details of the State Purchase Contract so that she could approach representatives of companies that had been assessed as competent and suitable for government work.

258. Procurement policies are there for a reason. The existence of procurement policies, in general, and the State Purchase Contract, specifically, reflect principles of value for money, as well as accountability, suitability and capacity to properly provide services, transparency and probity.[317] These contracts for security services represented tens of millions of dollars; it stands to reason that decisions made to spend public money on these providers should have been consistent with practices that are based on general procurement principles. That should have involved reliance on existing State Purchase Contract arrangements, as far as possible.

259. While it is true that there was a critical incident procurement policy that provided DJPR with the flexibility to source services outside of the State Purchasing Contract Panel, it does not follow that proper procurement practices and decision-making are irrelevant. Indeed, I note here that Hayley Baxter, from DTF, provided evidence that the Victorian Government Purchasing Board's communication to departmental procurement teams was that, wherever possible, state purchase contracts should continue to be used during the pandemic.[318]

260. The second failure was in contracting longer term with Unified despite advice that it was preferable to use those who were part of the State Purchase Contract.

261. Those tasked with procuring security services for the Hotel Quarantine Program should have heeded the specific procurement advice they were given as to the risks imposed by informally engaging a non-panel firm to provide quarantine security. They should have considered whether Unified was suitable to remain a service provider in light of their knowledge of the State Purchase Contract arrangement.

262. The third failure was in not making evidence-based decisions about the allocation of work between the three contractors with which contracts were signed.

263. Even allowing for the use of Unified in the short term, it was a failure of government decision-making to contract for what became very significant sums of money with a firm that had previously been refused admission to the State Purchase Contract panel and, then, to allocate so much work to that company.

264. There was a preference within DJPR for Unified. The preference appears to have been based on what was seen as a willingness for Unified to do the work asked of it.

The role of private security

265. The role played by security was ill-defined from the beginning and was, ultimately, a role not suited to the cohort of guards who were engaged without close monitoring and extensive and continued training.

266. The role of security guards changed over time, from 'static guarding' at the outset, to facilitating fresh air breaks later on. The expanded roles increased the risk of security guards being infected through contact with potentially infected guests and through contact with possibly contaminated surfaces.

267. The introduction of those additional functions should have occurred following a proper re-evaluation of the infection control measures in place and an assessment of the increased risks to staff that they posed. No such assessment occurred, because (at least) no person or agency regarded themselves as responsible and accountable for the decision. Responsibility for revisiting the scope of the duties to be performed by security guards lay with DJPR as the contract manager. DJPR did not see that to be the case.

268. The situation was compounded by the positions taken by DJPR and DHHS about who was accountable for these contracted workers in circumstances where neither agency considered itself 'in charge' of the Program on-site.

Contract development and management

269. DJPR should not have been responsible for contract management throughout the Hotel Quarantine Program. DHHS was the appropriate body to manage those contracts and should have done so when it assumed the role of control agency and overall responsibility for the Hotel Quarantine Program.

270. The contracts should have clearly stated that security guards were subject to the direction of DHHS in supporting their enforcement functions.

271. Explicit provision in the contracts would have provided greater clarity and certainty as to who was in charge of security services personnel, which may have led to a greater focus on the Government supervising the work of security services personnel.

272. It was not appropriate that the contracts placed responsibility for training and supervision in relation to PPE and infection prevention and control on the contractors in the manner they did. That should have been a responsibility that remained with the Victorian Government, as architect of the Hotel Quarantine Program.

273. The contractual requirement for security services personnel to complete the Commonwealth Government Department of Health's COVID-19 online training module was an inappropriate mechanism to properly mitigate the risk of COVID-19 transmission in a hotel quarantine context. Commendable as it was to require training to be undertaken as a precondition to engagement in the Program, it was a failure in preparing those contracts that the content of such training was not based on advice specific as to the risks at hotel quarantine sites. COVID-19-related training should have been specifically tailored for non-health professionals working in a quarantine requirement. That it was not, and that it was potentially confusing, meant that it was even more important that contractual requirements as to PPE and training were clear, specific and relevant.

274. Not having clear and consistent training and PPE requirements among the contractors led to each having different levels of knowledge and sophistication when it came to the use of PPE; at one end of the spectrum, Wilson had a significant suite of policies, practices and supports to mitigate the risk of virus transmission, at the other, Unified was particularly reliant on DHHS to provide training and information.

Subcontracting security services

275. The heavy reliance on subcontracting posed a significant risk to the success of the Hotel Quarantine Program in terms of the quality and competence of security guards actually recruited. Nevertheless, DJPR did not have adequate oversight of the use of subcontractors in the Hotel Quarantine Program. That was due, in part, to DJPR not being aware of the extent to which the head contractors would rely on subcontracting.

276. DJPR should have been more vigilant and proactive in requiring the security service providers to seek written prior approval, as per their respective contracts. But so, too, should the security services providers have complied with their subcontracting obligations at the required time. The consequence of this was that DJPR did not give proper oversight to those performing security services.

277. It was a significant deficiency that DJPR was not in a position to know the extent to which Wilson, MSS and Unified actually engaged in subcontracting throughout the duration of the Hotel Quarantine Program, let alone be confident as to who was providing the services and whether they were properly equipped to do so.

Private security guards should not have been engaged in the circumstances

278. Security guards were not the appropriate cohort to provide security services in the Hotel Quarantine Program without close monitoring and extensive and continued training by those with the requisite expertise. That level of monitoring and training did not occur.

279. Consideration was not given to the appropriateness or implications of using a largely casualised workforce in an environment where staff had a high likelihood of being exposed to the highly infectious COVID-19. This, of course, had flow on impacts in terms of the spread of the virus.

280. That is not to say that staff, whether those who contracted security providers or the security staff themselves, acted in bad faith. However, greater consideration ought to have been given to the environment in which staff were working and to prior infection control knowledge and training.

281. As an industry, casually employed security guards were particularly vulnerable on the basis of a lack of job security, lack of appropriate training and knowledge in safety and workplace rights, and susceptible to imbalance of power resulting from the need to source and maintain work. These vulnerabilities had previously been identified by the Government; with that knowledge, they should not have been selected to provide the services they did without having addressed those vulnerabilities.

282. A fully salaried, highly structured workforce with a strong industrial focus on workplace safety, such as Victoria Police, would have been a more appropriate cohort, which would have minimised the risk of such outbreaks occurring and made contact tracing an easier job in the wake of any outbreaks.

283. As highlighted in the Interim Report, a future model of hotel quarantine should use a security cohort that, at least:

    A. makes every effort to ensure that on-site personnel does not work in other environments[319]

    B. so far as possible, is engaged on a salaried basis and appropriately remunerated[320]

    C. is appropriately trained in infection control requirements and should understand personal protective equipment usage, physical distancing and hand hygiene[321]

    D. is subject to ongoing monitoring and supervision by personnel with expertise in infection prevention and control, including with respect to individual behaviour, use of personal protective equipment and cleaning practices[322]

    E. has been given role clarity by the Quarantine Governing Body,[323] and that the Site Manager ensures that they understand their roles and responsibilities.[324]

6.13 Recommendations

Recommendations 17, 18, 22, 23 and 25–29 of the Interim Report, adopted in this Final Report, apply directly to this chapter:

On-site role clarity

17. The Site Manager ensures that all personnel working in the quarantine facility understand their role and responsibilities.

18. The Site Manager ensures that all personnel on-site understand to whom they report and all lines of reporting and accountability on-site.

Dedicated personnel

22. Accepting the need to bring in expertise, every effort must be made to ensure that all personnel working at the facility are not working across multiple quarantine sites and not working in other forms of employment.

23. To achieve the aims of Recommendation 20 (that the Chief Commissioner of Police be requested to provide a 24/7 police presence on-site at each quarantine facility), every effort should be made to have personnel working at quarantine facilities salaried employees with terms and conditions that address the possible need to self-isolate in the event of an infection or possible infection, or close contact exposure, together with all necessary supports, including the need to relocate if necessary and have a managed return to work.

Training and workplace culture

25. The Site Manager be responsible for ensuring that all personnel working on-site are inducted into a culture of safety, focussed on infection prevention and control provided by those with the expertise to deliver such training.
26. The culture of safety to be fostered by the Site Manager should encourage collaboration, open discussion as to mistakes and oversights and speaking up about concerns and potential health and safety risks.
27. The Site Manager be responsible for ensuring that all personnel working on-site are engaged in ongoing training in infection prevention and control provided by those with the expertise to deliver such training tailored to the specific roles to be performed on-site.
28. The Site Manager ensures that the personnel on-site who have the expertise in infection prevention and control are engaged in ongoing monitoring and supervision of all of the requirements in place for infection prevention and control, which includes matters such as individual behaviour, the use of personal protective equipment (PPE) and cleaning practices.

Acquisition and use of PPE

29. The Site Manager ensures that the infection prevention and control experts direct the acquisition, distribution and use of PPE with specific, clear and accessible directions to all personnel on-site (acknowledging that such instructions may vary according to role).

Endnotes

1 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 10 [39]; Transcript of day 9 hearing 27 August 2020, 401–402.
2 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 14 [69].
3 Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 1 [3].
4 Transcript of day 8 hearing 27 August 2020, 439.
5 Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 3 [11]; Exhibit HQI0037_RP Annexures to witness statement of Ms Katrina Currie, DJP.104.008.6765.
6 Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 4 [13]; Exhibit HQI0037_RP Annexures to witness statement of Ms Katrina Currie, DJP.105.003.6258.
7 Transcript of day 8 hearing 27 August 2020, 440.
8 Transcript of day 22 hearing 22 September 2020, 1829.
9 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 14 [71]; Exhibit HQI0185_RP Annexures to witness statement of Mr Simon Phemister, DJP.101.002.1076.
10 Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 4–5 [14].
11 Ibid 2 [8]–[9]; Transcript of day 8 hearing 27 August 2020, 439.
12 Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 4 [14].
13 Ibid 7–8 [26].
14 Exhibit HQI0182_RP Working for Vic messages re good security companies.
15 Ibid DJP.361.002.0003, DJP.361.002.0006.
16 Transcript of day 8 hearing 27 August 2020, 442.
17 See Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 8 [27].
18 Exhibit HQI0183_P Buying for Victoria webpage re security services; Transcript of day 22 hearing 22 September 2020, 1833–1844.
19 Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 7–8 [26]–[27].
20 Ibid 8–9 [28].
21 Ibid 9 [29]–[30]; Transcript of day 8 hearing 27 August 2020, 442.
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50 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 23–25 [115].
51 Exhibit HQI00059_RP Witness statement of Principal Policy Officer, 5 [19]; Transcript of day 22 hearing 22 September 2020, 1837–38, 1845; Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 16 [80].
52 Transcript of day 8 hearing 27 August 2020, 497.
53 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 23–25 [115]
54 Ibid.
55 See Exhibit HQI0071_RP Witness statement of Mr Mo Nagi, 14–15 [116]; Exhibit HQI0072_RP Annexures to witness statement of Mr Mo Nagi, USG.0001.0001.2192; Exhibit HQI0067_RP Witness statement of Mr Sam Krikelis, 15–17 [128]–[146].
56 Exhibit HQI0072_RP Annexures to witness statement of Mr Mo Nagi, USG.0001.0001.3407.
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66 Exhibit HQI0069_RP Witness statement of Mr David Millward adopted by Mr Nigel Coppick, 13–14 [79].
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69 Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 4 [14].
70 Exhibit HQI0032_RP Witness statement of Ms Claire Febey, 11 [43]–[44].
71 Exhibit HQI0148_RP Transcript of audio recording of SCC Operation Soteria meeting 27 March 2020, 22.
72 Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 5–6 [18]
73 Transcript of day 11 hearing 2 September 2020, 786.
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76 Exhibit HQI0062_RP Annexures to witness statement of Mr Gregory Watson, WILS.0001.0001.8812; Exhibit HQI0061_RP Witness statement of Mr Gregory Watson, 21 [93].
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78 Ibid 791–792.
79 Exhibit HQI0065_RP Witness statement of Mr Jamie Adams, 11 [91]–[92].
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81 Exhibit HQI0185_RP Annexures to witness statement of Mr Simon Phemister, DJP.105.003.1082–1083.
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105 Exhibit HQI0061_RP- Witness statement Greg Watson, 21 [93].
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108 Exhibit HQI0069_RP Witness statement of Mr David Millward adopted by Mr Nigel Coppick, 5 [32].
109 Exhibit HQI0059_RP Witness statement of 'Principal Policy Officer', 6 [23].
110 Unified Contract, Annexure A; MSS Contract, Sch 3, Part 2; Wilson Contract, Sch 3, Part 2.
111 Exhibit HQI0059_RP Witness statement of 'Principal Policy Officer', 8 [31].
112 Wilson Contract, Sch 3, Part 2.1; MSS Contract, Sch 3, Part 2.1; Unified Contract, cl 2.1.
113 Exhibit HQI0059_RP Witness statement of 'Principal Policy Officer', 8 [31].
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116 Exhibit HQI0060(1)_RP Annexures to witness statement of 'Principal Policy Officer', DJP.110.002.8419.
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135 Exhibit HQI0033(1)_RP Annexures to Witness Statement of Ms Claire Febey, DJP.102.001.3600.
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138 Submission 03 Department of Health and Human Services, 27–29 [149]–[155].
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161 Exhibit HQI0065_RP Witness Statement of Mr Jamie Adams, 18 [131]–[132].
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170 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 12 [36].
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183 Exhibit HQI0061_RP Witness statement of Mr Greg Watson, 37 [140].
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190 Exhibit HQI0185_RP Annexures to witness statement Mr Simon Phemister, DJP.105.003.1296.

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216 Exhibit HQI0061_RP Witness Statement of Mr Greg Watson, 29 [116].
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CHAPTER 7

Use of hotels and cleaners

Section 1 — The decision to use hotels and the terms of their contracts

7.1 Decision to 'stand up' hotels for the Hotel Quarantine Program

1. Following the National Cabinet meeting on 27 March 2020, Prime Minister, the Hon. Scott Morrison MP, held a press conference to announce the decision that had been made. He stated that all international arrivals were to be quarantined in 'designated facilities'.[1] This generic description — designated facilities — was accompanied by an express example, namely 'such as a hotel'.[2]
2. The evidence of the Premier was that, after the decision of National Cabinet, he thought it most likely the designated facilities in Victoria would be hotels.[3] In his view, and as he described it, hotels were the most logical facilities to use for the Program.[4]
3. However, the Premier explained, in his evidence, that he did not consider the matter of hotels to have been settled at that early stage (namely, on 27 March 2020).[5] His evidence was that, in his view, the issue was not settled until the following day.[6]

The Secretary to the Department of Premier and Cabinet set the hotel procurement process in motion

4. I have described in Chapter 5, at paragraphs 29 to 37, the telephone call from Chris Eccles AO, Secretary to the Department of Premier and Cabinet (DPC), to Simon Phemister, Secretary to the Department of Jobs, Precincts and Regions (DJPR), tasking his Department to source hotels to implement the National Cabinet decision.
5. That call, particularly following the discussion I set out below, set in motion a significant logistical and procurement process that resulted in DJPR entering into formal agreements with 29 hotels in respect of the Program.[7]
6. To get a sense of whether it was achievable to have hotel stock available for the commencement of the Hotel Quarantine Program, Mr Phemister and Mr Eccles had discussed how far advanced DJPR was with respect to contracting hotels.[8]

7. Mr Phemister was confident that around 5,000 rooms would be available 36 hours after the call.[9] As a result of that call, Mr Phemister understood that he would start to put together an 'end-to-end' program of work to support the operation;[10] that is, from the moment someone was seated on an aeroplane to exiting the hotel after their two-week stay, and everything in between,[11] although I note Mr Eccles did not purport to commission DJPR to undertake the whole Program.[12]

8. Mr Phemister saw this call as 'effectively a head-start' for DJPR to commence work on the Program, including acquiring hotel stock.[13] Mr Eccles stated that it was likely that he advised the Premier and the Premier's Chief of Staff, Lissie Ratcliff, of what he was doing when stepping out of the National Cabinet meeting to telephone Mr Phemister.[14] However, there was nothing in the evidence to suggest that Mr Eccles was instructed or directed to place that call. In fact, it was the evidence of Mr Eccles that it was he who decided to place this call to Mr Phemister.[15] During the course of his press conference at about 3.00pm that afternoon, on 27 March 2020,[16] the Premier stated that returning travellers would be quarantined at hotels and that '5,000 rooms [were] basically on standby now'.[17]

9. Ultimately, only 20 of those hotels were actually used as part of the Hotel Quarantine Program.[18] However, it was that call as between these two departmental heads that commenced the hotel procurement process.

10. Although it was the evidence of Mr Eccles that it was his decision to call Mr Phemister and get the hotel procurement going, and that he was not directed by the Premier to do this, equally, by the following day, the Premier had embraced the proposal to use hotels.

7.2 Procurement of hotels

11. Following his call with Mr Eccles on the afternoon of 27 March 2020, Mr Phemister spoke with Unni Menon, Executive Director, Aviation Strategy and Services, at DJPR.[19] Mr Phemister requested that Mr Menon begin work immediately so as to ascertain the availability of hotels for use in the Hotel Quarantine Program. This included determining the capacity of hotels to provide meals, security services and cleaning services.[20]

12. Since around 22 March 2020, Mr Menon had been leading DJPR's efforts to assist DHHS in identifying and securing hotel stock for vulnerable persons requiring accommodation in order to self-isolate.[21] As part of these efforts, Mr Menon had run an 'expression of interest' processes through the Victorian Tourism Industry Council, the Australian Hotel Association and the Accommodation Association of Australia.[22] Consequently, by 27 March 2020, Mr Menon had a significant amount of information about which hotels across Victoria were available and willing to participate in the Program.

13. In order to identify appropriate accommodation for the purposes of the Hotel Quarantine Program, Mr Menon and his team speedily commenced work to review the information obtained through the earlier expression of interest processes.[23] Mr Menon's team sought feedback from the State Control Centre (SCC) team as to their preference from a mandatory quarantine perspective; he said SCC feedback was a preference for hotels to be located within the CBD.[24] Mr Menon understood the reason given for hotels in the Melbourne CBD was their proximity to major testing centres, major hospitals and to be confined in a geographical area for security and safety.[25]

14. Mr Menon and his team began by contacting various hotels in the Melbourne CBD in order to ascertain the security, cleaning and catering capacity of each.[26]

15. Meanwhile, having already spoken to Mr Menon, Mr Phemister convened a meeting with Rob Holland, Director, Office of the Secretary; Cameron Nolan, Executive Director, Priority Projects Unit; and Claire Febey, Executive Director, Priority Projects Unit at DJPR.[27] Ms Febey was made project lead.[28] At that stage, based on his understanding of the discussion with Mr Eccles, Mr Phemister believed that DJPR had lead responsibility for delivering the Hotel Quarantine Program. He believed, at the time, that other departments would hold responsibility for components of the Program within their areas of expertise, but that DJPR would 'bring it all together'.[29]

16. Early in the morning on 28 March 2020, Mr Menon circulated the spreadsheet he had created the day before, setting out the hotels that were available in the short term, as well as their cleaning, catering and security arrangements.[30] Around that time, the template for the contractual agreement for the provision of accommodation was drafted and provided to Mr Menon for completion.[31]

17. It appears that Mr Menon then sent an email to Mr Phemister requesting authorisation to execute the contracts with hotels.[32] Mr Phemister replied that afternoon to convey his approval.[33] Mr Menon was, thereby, able to execute the formal agreements with hotels on behalf of DJPR, which he did.[34]

18. Thus, it was that DJPR made the initial decisions about which hotel sites to use. According to Mr Menon, these decisions were informed by feedback from the team within the SCC, the views of key personnel within DJPR and discussions with the various hotels.[35] It was by this process the first hotels were selected and implemented within the Program.[36] It does not appear on the evidence that DHHS was specifically engaged in hotel selection at that stage. Notwithstanding the evidence of Mr Phemister that DHHS was consulted, Mr Menon did not identify any DHHS consultation at that point. State Controller — Health at the Department of Health and Human Services (DHHS), Jason Helps, in outlining to Ms Febey that a transition to DHHS must happen, stated that it would be 'now be vital' that DHHS made the operational decisions about which hotels to use and when.[37]

Change of 'lead agency'

19. On the morning of 28 March 2020, Mr Eccles informed Mr Phemister that Emergency Management Commissioner Andrew Crisp would have the responsibility for coordinating the Hotel Quarantine Program and that DHHS would be the control agency in respect of the program.[38] It was agreed that DJPR should transition various roles and functions over to DHHS.[39] (See chapters 5 and 8 for more detail).

20. DJPR's position was that, upon DHHS becoming control agency, its role was as support agency effectively working under the direction of, and managing contracts to assist, DHHS as the department in control of the Program. DHHS maintained that it was not in charge of the overall Program and had responsibility only for those parts of the Program that related to the health and wellbeing of those in detention. Throughout the Inquiry and in closing submissions, DHHS, through its witnesses up to and including the former Minister Jenny Mikakos, maintained a description of its role as one of 'shared accountability'. The impact of this is discussed at length in Chapter 8.

21. By Sunday 29 March 2020, Mr Helps emailed Ms Febey of DJPR to confirm his desire that DJPR 'continue to provide the valuable work in procurement of hotels', but went on to confirm that DHHS was the **control agency** (emphasis added).[40]

22. Mr Menon and his team, thereafter, sought and relied upon the specific requirements and preferences expressed by DHHS representatives, as well as any feedback that had been received from the relevant DJPR personnel.[41] According to Mr Menon, the views of DHHS on this matter were critical.[42] He stated that DHHS had the ultimate call regarding the selection or renewal of hotels for use in the Program.[43]

23. Some witnesses for DHHS appeared to have taken a different view as to its role in the selection of hotels. Merrin Bamert, the then Deputy Commander — Hotels at DHHS, gave evidence that, following her initial concerns about suitability of hotels, DHHS was able to have 'more input' regarding future contractual engagements, including by providing a checklist of 'must-haves' for contractual engagements and 'trying to encourage the selection of hotels with fresh air options where possible'.[44] While Ms Bamert's evidence indicated that DHHS had input into these decisions, it did not indicate that DHHS had ultimate responsibility. Indeed, DHHS submitted that selection of hotels was a matter for DJPR 'as the entity with responsibility and knowledge of the relevant hotels and their suitability'.[45]

24. The one exception to this was the Brady Hotel, which was selected to replace Rydges and to accommodate COVID-positive guests. DHHS selected and contracted the Brady Hotel, without the involvement of DJPR,[46] with it ultimately being stood up on 17 June 2020.[47]

25. Mr Menon explained his understanding of the criteria applied by DHHS in determining whether a hotel was appropriate for use in the Program. This included room types and configurations, access to natural ventilation (windows or balconies), whether there were controlled areas for recreation, layout for check-in/out and access to lifts.[48]

26. Mr Menon also gave evidence that he was not aware of any specific documentation from DHHS concerning assessment of prospective hotels from an infection control point of view prior to giving approval to engage them.[49]

Hotels as quarantine facilities

27. The starting point on the issue of the selection of hotels was that there were no specific quarantine facilities able to be identified in Victoria at the time of the National Cabinet decision. The evidence of Pam Williams, DHHS COVID-19 Accommodation Commander, was that there were no apparent viable alternatives to the use of hotels for the purposes of the Hotel Quarantine Program. Ms Williams explained that 'there are no specific quarantine facilities that we could have accessed'.[50] According to Ms Williams, while the Commonwealth had some designated quarantine facilities, Victoria did not have any such purpose-built facilities.[51]

28. Hotels provided the necessary capacity and availability given the then expected scale of the Program. While precise numbers of returning travellers were not known at that early stage, the evidence of the Premier was that he had been informed that thousands of rooms would be required.[52]

29. As a result of the limitations that had been placed on travel and tourism due to the COVID-19 pandemic, the Premier knew that there were many hotel rooms available at that time,[53] thus, they would be generally available for occupation by those to be quarantined pursuant to the Program.

30. The use of hotels was also seen by the Premier as providing a significant financial and employment boost to the State's pandemic-affected economy; specifically, a direct injection of work into the hotel and tourism sectors. As the Premier stated, in his press conference on 27 March 2020, and is described more fully in Chapter 5, the Hotel Quarantine Program was, in addition to being an appropriate health response, 'also … about working for Victoria and re-purposing people who have perhaps had their hours cut'.[54]

31. It appeared that the suitability of hotels as quarantine facilities was considered mainly from a point of view of expediency, rather than their capability to minimise against the risk of infection transmission.

32. Hotels, it was said, could contain returned travellers within specific hotel rooms with access to their own bathroom, which could provide a measure against cross-contamination and the proliferation of infection.[55]

33. But, as the Program unfolded, there were aspects of hotel facilities that provided challenges for infection prevention and control:

    A. the carpets and soft furnishings that made people in quarantine more comfortable may also have made it more difficult to clean surfaces[56]

    B. structurally, hotels were not designed for infection prevention and control; they do not typically have features, such as wide corridors and oversized lifts, that allow for physical distancing[57]

    C. handwashing stations and clinical waste disposal facilities were not readily available in a hotel environment[58]

    D. ventilation and air flow within hotels were not designed with a focus on infection prevention and control.[59]

34. Despite efforts being made to source hotels with natural ventilation (windows/balconies), controlled areas for recreation and an appropriate layout for check-in/out and access to lifts, many of the hotels used in the Hotel Quarantine Program did not present as having suitable areas for access to fresh air without guests coming into contact with others. As Ms Williams observed, '[t]he fresh air breaks were difficult to implement safely and without transmission risk due to the limitations of many of the hotels (many did not have balconies, rooftops, or open areas that could be sectioned off from the public to reduce flight and transmission risk)'.[60]

35. Ms Williams described what adaptations were made to ameliorate some of the challenges presented by the hotel environment in order to reduce transmission risks and support specific infection-control measures:

> [M]odifications were made to the physical set up of the hotels to reduce transmission risk. Hotel lobbies were cordoned off to encourage swift movement through the spaces. Hotels were encouraged to remove or limit soft furnishings. Lifts were assigned to 'clean' and 'dirty' purposes to reduce cross-infection. Staff on-site were separated into specific zones to prevent cross-infection.[61]

36. While such measures were conducive to reducing the risk of transmission, the physical features of hotels presented corresponding difficulties for the ability of staff to meet the health and wellbeing needs of those who were in quarantine. Hotels are set up so as to give guests privacy, and when those facilities are also used to ensure that potentially contaminated people do not come into contact with others, many guests may spend much, if not all, of their quarantine period without ever being seen by another person. The impact of this aspect of hotel quarantine on people's health and wellbeing is discussed in Chapter 12.2.

7.3 Contracts with hotels

37. As explained above, contracts were executed by DJPR with each participating hotel. Pursuant to those contracts (which were in substantially the same terms), the primary service that hotels were contracted to provide was the supply of rooms and meals to accommodate returned travellers.

38. The precise number of rooms to be supplied for the purposes of the Program varied between different hotels and at different times. Contractual arrangements were made with some hotels to supply the entire hotel for the Program, while others only agreed to supply a certain number of rooms or floors.[62]

39. The decision as to whether a hotel would be contracted to provide the entire property or whether only certain floors or rooms depended on a number of factors, including the hotel's availability, the incoming demographics of returning travellers and the projected or anticipated demand in terms of hotel stock.[63]

40. In addition to accommodation, the hotels were vested with other responsibilities under the terms of the contracts. These responsibilities included catering, certain cleaning, the provision of PPE for staff and general training in the use of PPE. Aspects of the contractual responsibilities of hotels were problematic and became the subject of some attention during the Inquiry. The hotels' contractual responsibilities are discussed below in this chapter.

Catering

41. With respect to catering, under clause 2.1(o), hotels were required to:

> Provide three reasonable meals a day to each of the Department's Nominees. The preparation and service of food must be done in accordance with recommended health standards including in relation to COVID-19.[64]

42. The evidence before the Inquiry was that there were a range of complaints from those in quarantine about the food provided by some of the hotels. These complaints included food quality, accommodation of dietary and religious requirements or preferences, religious requirements, quantity, the nutritional value of meals and a lack of variation in the food provided.[65]

43. Witness Liliana Ratcliff noted that '[W]e were given the same breakfast each day. The other meals were mostly curries and pies. Once, we were given a salad, but otherwise there were very few vegetables only mushroom or pumpkin soup'. She further commented that '[I]t was possible to order Uber Eats. I started ordering food for me and my kids, because it was a way that we could have some control over a small part of our lives while we were in quarantine. From a mental health perspective, it was good for us to have that autonomy — to eat when we were hungry and to choose what we wanted to have'.[66]

44. In some instances, the frustration expressed by witnesses was that, despite being asked about dietary requirements and giving this information on several occasions, the hotel catering was not apparently responsive to the information provided.[67]

45. In response to this evidence, the hoteliers who gave evidence explained that they were mostly in circumstances where they were receiving large groups of people at very short notice with little or no information about dietary requirements being provided to them and, consequently, had little time to make the necessary arrangements for the incoming group.[68] According to some witnesses before the Inquiry, this issue of catering was a matter that had an impact on people's sense of wellbeing.[69] This matter is discussed further in Chapter 12.2 on psycho-social impacts of quarantine.

Figure 7.1: Quotes from returned travellers about their experience with food and dietary requirements in the Hotel Quarantine Program

Returned Traveller 3: 'The food at the [hotel] lacked nutrition and meals were mostly very unhealthy. One lunch consisted of a meat pie and a very greasy potato cake. Breakfasts were particularly calorie laden and unhealthy, an unwise choice given that 'detainees' had no opportunity to exercise it off. After a few days, having found that the majority of meals to be inedible, I called the kitchen, and it was suggested that I purchase off the in-house dining menu — for me it seemed so wrong that and indeed deliberate that the hotel would serve inadequate and unhealthy meals, in the hope of forcing 'detainees' to order from their alternative menu at inflated prices'.

Returned Traveller 6: 'We were very tired after a long flight home. There was no food or drink in our hotel room. I was unable to order any food from room service and no one was answering my calls. I asked the security guards for help, but they said they couldn't help. I kept ringing hotel staff. Eventually a hotel staff member came and gave us food and drink. He told me they were too busy to respond to all calls quickly'.

Returned Traveller 11: 'I have no medical proof of my eating disorder so could not get an exemption to serve quarantine at home. So, I was very hungry and stuck. I resorted to having one meal a day by ordering my own Uber Eats or other delivery service meal. This was expensive so I could only do this once a day'.

Returned Traveller 12: 'I have issues with certain foods due to medical complaints. By the look of the meals they would not have cost more than $5 and were visually not appetising. I felt annoyed that some guests got the option to order meals and get reimbursed while the rest of us had to eat slops. One lunch was 3/4 tray of cold boiled rice and 1/3 cup if that of mushrooms in curry. Surely a fresh sandwich would be better. We were given bananas that were old and black'.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

7.4 Contractual responsibility for risk management, worker safety and PPE

46. It was not contentious at any time during the Inquiry that training in how to work safely in the quarantine environment, including the provision and proper use of PPE, was a key element of infection prevention and control. What was contentious was who should provide that training, who did provide that training, what that training was, what that training should have been and the sufficiency of 'episodic' training sessions without the on-site embedded supervision and oversight of those with infection control expertise.

47. The form of contract prepared by DJPR made the hotel operators generally responsible for their staff training in workplace health and safety, risk management and the provision of PPE. The presence of such provisions was an acknowledgment of the central importance of infection prevention and control inside the quarantine hotels, and that worker safety on-site was an issue that needed to be addressed with training and the provision of PPE.

48. Specifically, a standard clause (usually clause 2.1(h)) provided that hotels must:

> … be responsible for, ensuring that before its officers, employees, agents, contractors and sub-contractors perform the Services, they receive:
>
> I. adequate training in security, workplace health and safety, customer service and risk management; and
>
> II. are provided with personal protective equipment in accordance with the relevant public health standards, including but not limited to in relation to COVID-19.[70]

49. Managers from a sample of hotels from the Program did not take issue with the contractual provisions contained in 2.1(h). Each of the hotel managers who gave evidence stated that they largely sourced their own information and support around specialist infection-control training and provision, and the use of PPE.[71] The evidence established that each hotel, prior to its participation in the Program, had prepared for operating in a COVID-19 environment. Several hotels had quite detailed and structured policies and procedures in place around COVID-19 safe practices, which they used to train staff for the purposes of this Program.[72]

50. For example, Stephen Ferrigno, General Manager at the Four Points by Sheraton Melbourne Docklands, gave evidence that its staff were required to do online training courses, including with respect to social distancing, hand sanitising, the use of PPE, public space cleanliness and cleaning, and what to do with a presumed or confirmed COVID-19 case on the property.[73] They were also tasked to complete the Australian Government Infection Control online training course.[74] Ram Mandyam, General Manager at the Travelodge Docklands, gave evidence of policies that covered self-isolation, sanitisation, use of PPE and signage.[75] Shaun D'Cruz, Executive Manager of Crown Melbourne Hotels, gave evidence of its staff being trained around social distancing and the use of PPE.[76]

51. The PPE that each hotel provided to its staff varied. The evidence from the sample of hotels that gave evidence was that, generally, each supplied its own PPE to staff as per the hotel's contractual obligations. Each of the hoteliers who gave evidence said that different levels of PPE were provided to hotel staff depending on the nature of contact that staff might have with guests.[77] At Travelodge, for example, the evidence was that the hotel provided staff with gloves, masks (N-95 and surgical), hairnets, sanitiser and PPE training.[78]

52. At Crown, 'standard PPE' was supplied by DJPR to Crown staff, while all other PPE was supplied by Crown.[79] PPE was stationed throughout the hotel at various locations.[80] Staff were directed by Crown to wear standard PPE when working in designated areas.[81] This changed to wearing masks at all times after the Victorian Government announced additional restrictions.[82] All training on the use of PPE was provided by hotel management rather than people with expertise in infection prevention and control.[83]

53. At the Four Points by Sheraton, the hotel initially provided staff with masks, gloves and safety glasses.[84] About 4–6 weeks into the Program, DHHS made PPE available for the Sheraton staff.[85] The hotel provided online and in-person training by managers and supervisors in relation to the use of PPE to staff. At some time after the Program commenced, the hotel was provided with documents from DHHS and DJPR in relation to the use of PPE. Again, the application of the training was supervised by hotel management and not by people who had expertise in infection prevention and control.[86]

54. Understandably, the hotels that agreed to participate in the Hotel Quarantine Program were keen to have the business when the pandemic had such drastic impacts on the tourism industry. It was unsurprising they accepted obligations under their contracts to provide 'adequate training', 'workplace health and safety', 'risk management' and 'personal protective equipment in accordance with the relevant public health standard, including but not limited to COVID-19'. Given the consequences of any failure to discharge these obligations, it was an entirely different matter as to whether it was prudent for the Government to allocate this obligation to hoteliers in the first place.

Infection prevention and control in hotels: the ever-present risk of cross-infection

55. Self-evidently, the risk of infectious outbreaks as between those in quarantine, and to those working in the quarantine hotels, was an ever-present one on-site. Consequently, infection prevention and control (IPC) for those in quarantine and those working on the sites was an essential component of what the Hotel Quarantine Program was required to deliver.

56. IPC encompasses a wide range of issues in the context of hotels as quarantine facilities, including:

    A. training for hotel workers, including in how to work safely by understanding the risks of infection and how to mitigate against those risks by engaging in practices such as maintaining safe distances, hand sanitising, understanding high-touch area risks and coughing and sneezing requirements

    B. provision and use of PPE

    C. cleaning requirements including methods and standards.

What expertise was available to hotels for IPC?

57. It was uncontentious that IPC was a recognised area of expertise. In the context of the COVID-19 pandemic, even those with such expertise have explained that understanding the nature and transmission of the virus was, and remains, a constantly evolving process.

58. DHHS accepted that it was its responsibility to provide guidance and advice on IPC issues, and asserted that it did do so.[87]

59. More particularly, it was the position of DHHS that it was its role to provide the advice and guidance to DJPR and that DJPR was then responsible for passing it on and managing or overseeing compliance. DHHS took the position that it did not hold or manage the contracts with hotels and did not see it as its role to implement that advice and guidance and ensure it was done to the requisite standard.

60. DJPR's position was that although it held the contracts with the hotels, DJPR looked to DHHS for the necessary expertise and guidance in this area. This impasse made its contribution to what became a Gordian knot that developed in the early days of the Hotel Quarantine Program (See Chapter 8 for more detail).

61. At the time the Hotel Quarantine Program was set up, DHHS had one infection and prevention control consultant (IPC Consultant) at its disposal for the State of Victoria. That IPC Consultant stated that she had no formal role in the Hotel Quarantine Program.[88] The IPC Consultant's evidence was that she was not engaged with the Program,[89] had no knowledge of what PPE was provided to people working in hotel quarantine[90] and did not provide training at hotels about PPE, cleaning or other aspects of IPC other than providing guidance or advice or reviewing training materials from time to time.[91]

62. By early April 2020, the need for staff with IPC expertise was identified by DHHS as requests for assistance grew across the State.[92] In early April 2020, the IPC Cell commenced with the IPC Consultant, two additional part-time consultants and an administrative assistant.[93] By mid-April 2020, the team had expanded to include an IPC Cell Strategy, Policy & Planning Lead and two more part-time IPC practitioners.[94] The number of IPC staff in the DHHS IPC Cell fluctuated thereafter.[95]

63. Suffice to say, the evidence was that this very small team was handling general COVID-19 enquiries from across the State, rather than specifically focusing on the Hotel Quarantine Program. This would account for the slow and non-specific response that the Public Health Team inside DHHS was able to provide as the Hotel Quarantine Program commenced and developed.

64. The IPC Consultant explained that she answered questions from those working in the Hotel Quarantine Program from time to time in response to requests: 'Often this advice was also provided as state-wide advice, that was then available to those managing the Hotel Quarantine Program'.[96]

65. Her evidence was to the effect that various instances of 'one-off' training in the use of PPE were delivered at hotel sites for security staff in June.[97]

66. On the suggestion of the IPC Consultant, DHHS engaged an outside consultant to provide IPC advice. As a result, Infection Prevention Australia was engaged in early April 2020.[98]

67. There was no evidence before the Inquiry to suggest DHHS played a role in training hotel staff in infection prevention and control in any uniform, systematic or coordinated way. There were some examples of ad hoc training, like a short tutorial on infection prevention for all hotel staff at the Rydges on 11 April 2020, organised by DHHS.[99] No doubt, having such an inadequate capacity to provide that infection prevention control expertise from inside DHHS made its contribution to the lack of any cohesive approach to infection prevention and control in hotels.

Section 2 — Hotel cleaning contracts, oversight and vulnerabilities

7.5 The cleaning of quarantine hotels

The importance of cleaning

68. Cleaning was a critical element of infection prevention and control within the Hotel Quarantine Program and an important means of achieving the Program's key objective: to contain the further spread of COVID-19 among the people in quarantine and those working in and at the hotels.

What was understood by 29 March 2020 about modes of transmission of the virus?

69. Cleaning requirements in the Hotel Quarantine Program needed to be informed by what was understood about modes of COVID-19 transmission. I have dealt with the evidence as to what is currently known about how the COVID-19 virus is transmitted in Chapter 2, but in the context of cleaning, the evidence about fomites was particularly relevant and worthy of briefly revisiting here.

70. As noted in Chapter 2, Professor Lindsay Grayson, Professor of Infectious Diseases at Austin Health, explained that the SARS-CoV-2 virus 'can be transmitted through droplets, aerosols and fomites'.[100] Prof. Grayson provided the following explanation of fomite transmission:

> Fomites are surfaces or objects (including hands) which may become contaminated and serve as an intermediary vehicle for transmission. There are studies demonstrating that SARS-CoV-2 may survive on certain surfaces outside of the body (such as plastic, cardboard and stainless steel) for up to 72 hours. Were a person to come into contact with a surface containing droplets or aerosol which contain the virus, those particles and the virus could subsequently be transmitted to that person's body by exposure to their mucous membranes. For example, an infected person may cough on a door handle, which is then touched by another person. Should that second person then touch their mouth, there is transmission from the infected person to the second person.[101]

71. In respect of the possibility of fomite transmission, as of 1 May 2020, Dr Simon Crouch, Senior Medical Advisor, Communicable Diseases Section at DHHS and Deputy Public Health Commander for Case, Contact and Outbreak Management, held the view that:

> … while fomite transmission from surfaces (as opposed to people's hands or objects) was possible, there was not significant evidence of it happening in outbreak settings in Victoria prior to that date and I did not consider it a significant source of transmission for local outbreaks.[102]

72. Indeed, it was only when considering the Rydges outbreak, in late May 2020, that Dr Crouch first considered fomite transmission as a likely source of transmission.[103] He acknowledged, in light of the growing experience of the outbreaks that have since been managed, 'it does appear that fomite transmission plays a larger role than I would have given it credit at that point'.[104]

73. It appeared, however, that others within DHHS were of a different view at an earlier stage as to the risk posed by fomite transmission. When asked as to her knowledge of the ways in which COVID-19 could be transmitted as of 1 May 2020, Dr Sarah McGuinness, an academic infectious diseases physician who was, at the time, Outbreaks Lead at DHHS, stated that her understanding would have reflected the World Health Organization (WHO) material current at the time.[105] In particular, Dr McGuinness made reference to the WHO guidance titled *Modes of transmission of virus causing COVID-19: implications for IPC precaution recommendations: scientific brief, 29 March 2020*.[106]

74. That guidance provides as follows:

> According to current evidence, the COVID-19 virus is primarily transmitted between people through respiratory droplets and contact routes. Transmission may also occur through fomites in the immediate environment around the infected person. Therefore transmission of the COVID-19 virus can occur by direct contact with infected people and indirect contact with surfaces in the immediate environment or with objects used on the infected person.[107]

75. That same document also emphasised:

> The utmost importance of environmental cleaning and disinfection, among other infection prevention measures.[108]

76. Dr McGuinness was involved in drafting and updating DHHS's publication *Coronavirus disease 2019 (COVID-19), Case and contact management guidelines for health services and general practitioners*.[109] The version of this document that was available on 1 May 2020 (version 20, dated 25 April 2020) contained the following explanation about the mode of transmission for COVID-19:

> The mode or modes of transmission of COVID-19 are not yet fully understood, although based on the nature of other coronavirus infections, transmission is likely through droplet and contact. There were cases with a strong history of exposure to the Hua Nan Seafood Wholesale Market in Wuhan City, China where live animals are sold. However, the mechanism by which transmission occurred in these cases, whether through respiratory secretions after coughing or sneezing, or direct physical contact with the patient or via fomites after contamination of the environment by the patient, is unknown.

> Person to person transmission has now occurred worldwide and the WHO declared a pandemic on 11 March 2020. As a result, droplet and contact precautions are recommended.[110]

77. While the above section does not refer to airborne transmission, another section of that document states that '[a]irborne and contact precautions are now recommended in specific circumstances when undertaking aerosol generating procedures'.[111]

78. Dr McGuinness stated that the document was consistent with the WHO position and, together, these documents reflected her understanding of the modes of transmission as of 1 May 2020.[112] As noted above, Dr McGuinness confirmed that the WHO guidance from late March 2020 was her source material as of 1 May 2020, among others.[113]

7.6 Contracts for cleaning of quarantine hotels

79. When, on behalf of DJPR, Mr Menon initially emailed hotels to gauge their interest in providing accommodation services as part of the Hotel Quarantine Program, he indicated that responsibility for cleaning of rooms would vary, depending on whether a particular room had been occupied by a person who was known to have tested positive for COVID-19:

> Please note while we expect that cleaning of the rooms will be the responsibility of the hotel (in accordance with the Agreement), if there is a confirmed case of COVID-19 in any of the guests nominated by the department, the department will organise for cleaners to provide an industrial clean of the relevant rooms upon the departure of that guest.[114]

80. This responsibility was borne out in the contractual arrangements. Under the contracts entered into between the State (through DJPR) and hotels, primary responsibility for cleaning rooms fell to hotels participating in the program. As per clause 2.1(d), hotels were generally required to:

> … ensure that each Room is thoroughly cleaned and disinfected at minimum:
>
> i. prior to the commencement of each Department's Nominee's stay; and
>
> ii. as soon as practicable following the conclusion of each Department Nominee's stay, to a standard consistent with the most recent recommended public health standards in respect of COVID-19.[115]

81. As noted above, that general requirement was subject to an exception in respect of rooms that had been used to accommodate a person in quarantine who was known to have tested positive for COVID-19. A further part of clause 2.1 (usually 2.1(e)) provided that hotels must:

> … if there is a confirmed case of COVID-19 in any of the Department's Nominees, allow the Department's representatives to enter the Supplier's premises in order to undertake specialised cleaning of the relevant Room. For the avoidance of doubt, these specialised cleaning services will be at the cost of the Department.[116]

82. In these instances, rooms that had accommodated COVID-positive guests were dealt with by commercial cleaning providers. Those cleaners performed what was variously referred to as an 'industrial', 'commercial' or 'specialised' clean.[117]

83. Each hotel used its own contracted cleaners/housekeepers (as per their regular operation) for the cleaning of rooms and common areas around the hotel. Evidence to the Inquiry was that some hotels provided training to their staff in relation to social distancing, the use of PPE and sanitisation.[118] Mr Ferrigno of the Four Points by Sheraton Melbourne Docklands, noted that staff were required to undertake specific COVID-19 cleaning training, including training on public space cleanliness and high touch cleaning, and touchless transactions.[119]

84. The regular hotel cleaners only cleaned rooms after the guests had departed (that is, there was no cleaning during the 14-day quarantine period).[120] During the quarantine period, essential cleaning items were required to be provided to guest rooms upon request (noting that no cleaning services were otherwise provided during this time).[121]

85. However, one returned traveller told the Intake and Assessment Team that he asked for a toilet brush and toilet cleaner during his stay. After three failed responses (he was offered dishwashing liquid, antiseptic wipes and then hair conditioner), he was advised that they had run out of cleaning equipment.[122]

86. Representatives of the hotels who gave evidence at the hearings said they used subcontractors for their regular cleaning services. There was no evidence that these sub-contracted hotel cleaners were trained in any specific infection control procedures.[123]

7.7 Procurement of commercial cleaning companies for 'specialised cleaning'

87. DJPR was responsible for procuring and contracting the specialised commercial cleaning providers to perform COVID-positive cleans at quarantine hotels.[124]

88. Rachaele May, Executive Director of Emergency Coordination and Resilience at DJPR, began substantively performing the procurement role after taking over from Ms Febey in mid-April.[125]

89. Ms May was provided with the relevant quotes and sought to progress procurement.[126] As a preliminary step, she liaised with DHHS in an effort to understand its requirements in relation to the provision of commercial cleaning services.[127]

90. Ms May gave evidence that she understood that DHHS did not have specific requirements about which cleaning contractor(s) were to be engaged.[128] As to methods and standards for cleaning, DJPR was advised by DHHS to direct the commercial cleaning contractors engaged to the relevant cleaning protocol,[129] which, at that time, was *Cleaning and disinfecting to reduce COVID-19 transmission, Tips for non-healthcare settings* (Cleaning Protocol).[130]

91. One of the cleaning services that had provided a quote to DJPR was IKON Services Australia Pty Ltd (IKON), a commercial company that provides infectious cleaning services to a range of clients.[131] In his evidence to the Inquiry, Michael Girgis, General Manager of IKON, said that he first became aware on 11 April 2020 that IKON had been requested to provide a quote for infectious cleaning services in respect of the Hotel Quarantine Program. It was Mr Girgis' understanding that DJPR had initiated this contact and requested a quote.[132]

92. On 13 April 2020, Ms May had a discussion with Mr Helps to express the view that IKON satisfied the requirements of the Cleaning Protocol and explained that rooms at the Crown hotels needed to be cleaned urgently so that further arrivals could be allocated later in the week. Mr Helps agreed with her assessment and advised Ms May to proceed and engage IKON.[133]

93. Ms May approved the engagement of IKON and instructed that a contract be drafted for IKON's consideration.[134] Due to the urgency of the engagement, IKON commenced providing commercial cleaning services in the Program before having seen a contract. DJPR did, however, provide IKON with a copy of the Cleaning Protocol, in accordance with the direction from DHHS.[135]

94. IKON was the only actual provider of commercial cleaning services to the Program prior to the outbreak at Rydges Hotel.[136]

95. Mr Girgis gave evidence that his company provided specialised cleaning services including sanitising and disinfecting of rooms, and the use of a 'fogging' machine to ensure surfaces were free of bacteria and germs.[137] IKON used chlorine-based chemical (that is, bleach) to fog the rooms and a bleach and disinfectant to clean hard surfaces.[138] Rubbish and cutlery were removed in bio-waste bags. As requested, and on an ad hoc basis, IKON would also remove and bag linen from within those rooms.[139]

96. Ms May understood that commercial cleaning service providers were in high demand at the time due to the COVID-19 pandemic. Of the five cleaning companies that were subsequently contacted by DJPR, only AHS Hospitality Pty Ltd (AHS) and AMC Commercial Cleaning (AMC) were available. After satisfying herself that the cleaning proposals of AHS and AMC met the requirements of the Cleaning Protocol, Ms May engaged both companies.[140]

97. Ms May explained that IKON, AHS and AMC were each selected for the provision of commercial cleaning at the hotel quarantine sites because they satisfied the requirements prescribed by DHHS and they were available.[141]

98. The cleaning standards with which commercial cleaning contractors were required to comply also changed over time,[142] as did the contractual terms addressing cleaning methods and standards, each of which varied between contractors, depending on the time of their engagement by DJPR.[143]

Auditing of 'specialised cleaning'

99. The relevant commercial cleaning contracts imposed reporting obligations on the cleaners, but the form of those obligations also varied between different contractors. IKON was required to keep a record of the commercial cleaning it undertook, while AHS and AMC were required to provide DJPR with a report at the completion of each clean, attaching a cleaning certificate.[144]

100. Mr Girgis described that, when other infectious cleans are undertaken by IKON, their client would (in every case) engage a separate organisation to conduct 'swab tests'. He explained that this is done as a form of auditing or checking to ensure the clean had been effective in eliminating pathogens. Mr Girgis did not believe such a 'swabbing' process occurred in respect of IKON's work in the Hotel Quarantine Program.[145]

7.8 Cleaning standards and expert advice

101. As is clear, DJPR entered into the contracts with the hotels and the specialised commercial cleaning contractors. However, DJPR possessed no special expertise in infection control sufficient for it to direct or supervise the general hotel cleaners or the commercial cleaning contractors or assess the quality of their work.[146] Rather, DJPR asked DHHS to provide advice and guidance regarding infection prevention and control and appropriate cleaning methods so that DJPR could relay that information to the hotels and commercial cleaning contractors.

102. DHHS considered that DJPR was responsible for procuring commercial cleaning services.[147] Ms Williams saw DHHS's role as providing advice to cleaning contractors, but through DJPR as a conduit, on the basis that DJPR was the contract manager.[148]

103. DHHS submitted that it provided the following by way of cleaning advice:

    A. First, its consultant prepared cleaning advice, *Cleaning and disinfecting to reduce COVID-19 transmission: Tips for non-healthcare settings* (March Cleaning Advice), which was publicly available on 20 March 2020.[149] (This advice was not specifically for hotels nor people working in a quarantine facility but, rather, a general advice that had been prepared for state-wide use. It was amended on 22 March 2020.)

    B. Second, on 8 April 2020, DHHS emailed DJPR about cleaning requirements for rooms; specifically, those rooms that had been occupied by COVID-19 cases.[150] That email also provided the March Cleaning Advice and a document apparently directed to medical practitioners and those operating in a medical setting entitled, *COVID-19 Case and Contact Management Guidelines for Health Services and General Practitioners* (CCOM Guidelines).

    C. Third, in response to requests for advice from DJPR, DHHS advised DJPR to refer cleaners to the March Cleaning Advice.[151]

    D. Fourth, on 16 June 2020, DHHS issued a document, *Hotel Quarantine Response—Advice for cleaning requirements for hotels who are accommodating quarantined, close contacts and confirmed COVID-19 guests—Updated* (June Cleaning Advice).[152]

104. The June Cleaning Advice was the first comprehensive, situation-specific cleaning advice tailored to the Hotel Quarantine Program environment. It was provided to DJPR on 17 June 2020 and DJPR directed it be provided to the cleaning contractors.[153] It is unclear whether the June Cleaning Advice was also provided to the hotel cleaners.

105. Ms May gave evidence that she considered DHHS was ultimately responsible for the cleaning function.[154] She did so on the basis that DHHS was the control agency, the only department with expertise in infection control and the only Department with a consistent site presence at hotels within the Program. Ms May saw DJPR's practical role to be responsible for procuring commercial cleaning contracts 'in accordance with the directions of DHHS', managing issues that were drawn to her attention directly with contractors, liaising with DHHS and commercial cleaning contractors and escalating issues for DHHS for resolution.[155]

106. DJPR submitted that it had difficulties in getting DHHS to provide cleaning protocols tailored to the Hotel Quarantine Program environment and to respond to multiple and repeated escalations seeking tailored information and responses to specific questions about cleaning.[156]

107. DHHS submitted that the June Cleaning Advice, provided to DJPR in mid-June, was essentially and substantially the same as that contained in the March Cleaning Advice.[157]

108. In early April 2020, DJPR requested detailed advice from DHHS in relation to the general standard of cleaning for the hotels. Apart from a link to the generically available information referred to in paragraph 103, no further information was provided at that stage.[158] By mid-April, DJPR confirmed with DHHS that the Cleaning Protocol for the commercial contractors represented the standards expected of the cleaners in relation to cleaning COVID-19 positive rooms.[159]

109. As set out at paragraph 104, on 17 June 2020, Ms May directed that the June Cleaning Advice be sent to the three commercial cleaning companies that DJPR had engaged at that time. IKON, AHS and AMC and the contractors were instructed that it must be followed.[160] On 28 June 2020, after the outbreaks at Rydges and the Stamford, DHHS reissued this second cleaning protocol, responding to comments and feedback from the hotels and others.[161] Two days later, DHHS assumed control of all service contracts under the Program.[162]

110. At the time of the outbreak at the Rydges Hotel in Carlton, there was no cleaning protocol specific for the Hotel Quarantine Program. DHHS was still relying on the generic cleaning advice issued on 20 March 2020 in relation to non-healthcare settings. The Program-specific cleaning protocol issued by DHHS on 16 June 2020, following agitation for such by DJPR, was released on the day the outbreak at the Stamford was identified.[163]

111. The evidence demonstrates that DJPR was frustrated that DHHS did not provide tailored cleaning advice and protocols for the Hotel Quarantine Program in the initial phase of the operation. DJPR saw this as a concern and a problem that needed to be addressed.[164] In contrast, DHHS submitted that the March Cleaning Advice was applicable to the hotel environment and was sufficient and appropriate for the purposes of the program. DHHS did not share the same concern as DJPR. It should have.[165]

112. DHHS submitted that it provided advice to DJPR about the standard of cleaning required, based on public health advice, and expected DJPR to be responsible for passing on that information to the hotels and cleaners.[166]

113. As a result of the ad hoc nature of the information DJPR had received from DHHS around cleaning protocols, DJPR sought to consolidate all the information into one document for DHHS to consider. DHHS asked the Infection Control Consultant to review the document and also asked Ms May to approve the document. On 13 June 2020, Ms May declined, as DHHS was the control agency with responsibility for infection control and she did not consider herself to have the relevant expertise in infection control.[167]

114. Given the scarcity of IPC expertise inside DHHS, it did not have the necessary capacity to provide advice tailored to the needs of quarantine hotels. I note here that the provision of expert advice and guidance is a separate issue to on site supervision and oversight which is discussed in more detail in Chapter 8.

Protocol for cleaning of common areas

115. Initially, those doing general cleaning in the quarantine hotels were responsible for the cleaning of common areas, including lobbies, corridors and lifts. However, after the outbreak at the Rydges, and at the direction of DHHS, a different cleaning protocol was introduced. As a result, commercial cleaning contractors took over common areas and high touchpoint cleaning.[168] From that time, those doing general cleaning in the quarantine hotels were responsible for cleaning only 'back of house' common areas.[169]

Oversight of specialised cleaning in quarantine hotels — cleaning as an infection control measure

116. DJPR, as the contracting agency, performed the role of arranging and scheduling the attendance of commercial cleaning contractors at the various hotel sites. It also provided directions as to the expected cleaning standards (as determined by DHHS). The DJPR site manager at each hotel would take requests from hotels for cleaning of vacated COVID-positive rooms, except in respect of Rydges (where there was no DJPR site presence). The DJPR site manager, or a member of the DJPR support team, would then arrange cleans directly with a representative of the commercial cleaning contractor.[170]

117. There was evidence from DHHS witnesses that it did not accept its department as having responsibility in respect of the management and direction of cleaning contractors.[171] However, other evidence indicated that DHHS did play a role in the management and direction of commercial cleaning contractors, not only in relation to the creation of the policy documents as to the cleaning standards required but also, at least in the case of the Rydges Hotel on 12 April 2020, in the provision of training on cleaning standards.[172]

118. DHHS's evidence was that it was not responsible for supervising cleaning as part of IPC measures. Kym Peake, the then Secretary to DHHS, gave evidence that public health advice, including with respect to cleaning, would be translated into policies and guidelines by those at the Emergency Operations Centre.[173] Dr Annaliese van Diemen, Public Health Commander (and therefore having a formal position within Operation Soteria), gave evidence that, although her team had responsibility for the availability of IPC advice and guidance in hotels, it was not accountable for determining whether it was appropriately implemented.[174]

119. That DHHS did not proactively take an oversight and implementation role in respect of appropriate IPC cleaning was especially significant. DHHS took the view that its role was to provide policies to DJPR as the contractors with hotels and cleaning companies and that it was for DJPR to oversee the implementation of those contracts. DHHS accepted that it was the department vested with specific public health expertise and knowledge, including, critically, in relation to the ways in which the virus could be transmitted.[175] Given the centrality of appropriate cleaning to any effective system of infection control, this created vulnerabilities within the program. Chapter 9 provides further details as to how inappropriate cleaning practices at the Rydges likely contributed to the outbreak.

Infection prevention and control and on-site supervision

120. In Chapter 2 of this Report, a number of conclusions drawn from the scientific evidence presented to the Inquiry were set out in relation to the fundamental safety features required to underpin any efficacious quarantine program. One of those fundamental safety features is expert advice, input and ongoing supervision and oversight of IPC.

121. Consistent with the evidence to the Inquiry, it was uncontroversial that IPC, including cleaning services, was a crucial aspect of a successful quarantine program.

122. Prof. Grayson described quarantine environments as 'self-evidently dangerous spaces' and emphasised that 'the rigour and processes in place need to reflect and reinforce this'.[176] Prof. Grayson highlighted the importance of on-site supervision of IPC measures. He was discussing the use of PPE but noted it was applicable to any safety training for infection control:

> Inherent in PPE training (or indeed any safety training) is a regular objective system of monitoring to ensure adherence, resolve any practice questions and to provide constructive feedback to users. Thus, an ongoing 'system of supervision' should be established for infection control regimens to regularly reinforce the importance of adherence to the appropriate procedures and standards, and to ensure that adequate protections are maintained, even when one may be tired or distracted. People must understand the potential danger of infection in order to appreciate the importance of adhering to the training.[177]

123. The evidence demonstrated that this type of rigorous monitoring and training was not occurring within the hotels. DHHS, through consultants, provided mostly policy advice and some ad hoc training and site visits; not the rigorous supervision recommended by Prof. Grayson.

124. DHHS submitted that it employed an IPC consultant to conduct on-site reviews and report on IPC and PPE issues.[178] Further, it was submitted DHHS developed written guidance in relation to the use of PPE at quarantine hotels (which was provided to nursing staff, security guards and Authorised Officers on site at quarantine hotels).[179] Infection prevention measures were reinforced by the use of posters at hotels about infection prevention and PPE use (including donning and doffing of PPE).[180] The IPC consultant for DHHS gave evidence that she was involved in developing documents, upon request, that were used in the program, but was not involved in the implementation of the procedures and was unable to comment on their effectiveness.[181]

125. This approach demonstrates that IPC measures were not sufficiently monitored within the hotels. As Prof. Grayson stated:

> Infection control regimens in the hospital are regularly reinforced to staff through weekly CEO-led webinar presentations with the Infectious Diseases Department about COVID-19 infection control measures, direct monitoring of adherence by the Nurse Unit Manager on each clinical area, regular visits to wards by infection control staff to observe behaviour, widely displayed infection control signage throughout the hospital and biannual re-credentialing in hand hygiene. **As has been well published, educational signage alone has only limited value in reinforcing behaviour, unless they are updated frequently, since they quickly become ignored. In addition, if the signs are only in English, they may not be fully understood by people where English is not their first language**.[182] (emphasis added)

126. There were no IPC stationed at the hotel sites to give guidance, oversight or supervision on the range of risks to which hotel staff would be exposed and what they needed to do to mitigate those risks. That was a deficiency in the model.

127. Putting to one side the efficacy of the policies that were provided, the lack of an on-site presence with expertise in IPC, supervising, monitoring and overseeing the implementation of those policies was a demonstrable systemic flaw given the highly infectious nature of this virus and its risks of transmission, including by indirect surface (fomite) contact. This issue has been addressed in recommendations in Section 1 of the Interim Report and adopted as part of this Final Report at pages 38–49.

7.9 Vulnerabilities were created by the arrangements with hotels and commercial cleaning companies

128. While many within DHHS saw DJPR's support role as being of great assistance,[183] the allocation of the contracting function to DJPR had the unintended effect of reducing the access of contractors to direct, timely and authoritative guidance and advice on cleaning practices.

129. Perhaps of more significance, DHHS held the view that as DJPR was the contracting department, it (DHHS) did not have any obligations in relation to the direction and management of contractors, even in respect of infection prevention and control.[184] That was so, despite the fact that DHHS had health and infection control responsibility in Operation Soteria, and that the cleaning (whether it was undertaken by hotels or commercial cleaners) was a clear component of any proper system of infection control.[185]

130. DHHS submitted that Operation Soteria, and specifically the COVID-19 Accommodation Commander (a role held within DJPR), was responsible for 'operationalizing [sic] the public health policies in each hotel'.[186] DHHS also submitted that 'contracts between DJPR and hotels allocated responsibilities between them with respect to standard cleaning and for the commercial cleaning of COVID positive guest rooms'.[187] The difficulty with the first part of that submission rests on the use of the word 'operationalising'. Its ordinary usage seems to be 'putting into effect', which carries an implication beyond sending through a piece of advice or a policy.

131. The requirements referred to in paragraph 130 were set out in clause 2.1 of the agreements with hotels. Under clause 2.1(d), the responsibility was on hotels to identify the most recent recommended public health standards in respect of COVID-19 for the cleaning of rooms used to accommodate people who were not known to have tested positive for COVID-19.[188] The onus was clearly on the hotels to identify those standards, for themselves, without guidance from DJPR or DHHS. The onus was clearly — and was clearly intended to be — on contractors to determine the standards. As Mr Menon said, '… first and foremost, it was the responsibility of the supplier to actually avail themselves of that relevant information'.[189]

132. Similarly the agreements provided, at clause 2.1(h), that hotels:

> … will be responsible for, ensuring that before its officers, employees, agents, contractors and sub-contractors perform the Services [which included cleaning] they receive:
>
> i. adequate training in security, workplace health and safety, customer service and risk management; and
>
> ii. are provided with personal protective equipment in accordance with the relevant public health standards, including but not limited to in relation to COVID-19.[190]

133. As such, in respect of staff training, PPE supply and the cleaning of non-COVID guest rooms, hotel providers were largely left to determine these issues without guidance.

134. In respect of the training requirements within the commercial cleaning contracts, Ms May said that she asked for an approach to be taken in the commercial cleaning contracts similar to that adopted in the agreements for security services,[191] that is, commercial cleaners would agree to provide their own training. [192]

135. While the evidence shows, overwhelmingly, that all those working within the program acted in good faith and with good intentions, these providers simply did not have the expertise to adequately fulfil these obligations. That was evidenced and known to DHHS, certainly, following the outbreaks at the Rydges and Stamford Plaza hotels, where reviews found evidence of poor cleaning practices as well as poor training and education among some on-site personnel.[193]

136. That most unsatisfactory situation led to DJPR with contract management responsibility but no expertise in IPC. DHHS led Operation Soteria. DHHS promulgated the relevant cleaning standards, which meant that DJPR was effectively acting as a conduit between DHHS and the cleaning providers as far as cleaning standards were concerned.[194] Like the situation that arose with the hotels, and indeed with security services providers discussed in Chapter 6, that made the administration of those contracts unwieldy and unnecessarily complicated, and not a safe system of IPC.

137. Consistent with DJPR's contractual arrangements with security services providers, so, too, did the contracts with hotels and cleaning companies effectively impose the primary responsibilities for infection prevention and control on those private providers. That included obligations with respect to cleaning, staff training and the supply of PPE.[195] These were significant responsibilities to outsource, especially in the context of a government-led quarantine program.[196]

138. By requiring all returned passengers to be detained in a hotel setting, the Government thereby concentrated, within the Program, a large number of potential carriers of the virus. The Government had a corresponding responsibility to take appropriate action to ensure the safest systems were in place to address the risk that accompanies the creation of suspected or known hot spots.

139. The Premier explained that he was, by the time he gave evidence, aware that the contracts signed by the hotels and cleaning companies sought to put the onus on those private operators to be responsible for IPC training and implementation. When it was put by Counsel Assisting, Ms Ellyard, that 'issues of infection control were too important to be left entirely to private contractors' the Premier answered: '... given what's at stake, given the seriousness and the infectivity of this virus ... I think that is a fair statement'.[197]

140. This is, perhaps, an unsurprising concession. Given the focus of the Program and the engagement of contractors who were not specialised in the areas of IPC, shifting of a burden created, in part, by the Government to the contractors was inappropriate and ought not have occurred.

141. At odds with this concession from the Premier, DHHS submitted that the risks were not created or carried by the Hotel Quarantine Program but, rather, risks arose from COVID-19 itself and the entry into Victoria of travellers potentially infected with COVID-19.[198] What was required was a choice, it was submitted, as to how best to deal with the risk.[199]

142. DHHS otherwise did not make submissions as to the contractual apportionment of responsibility for infection prevention and control measures, save to say that it considered the PPE and training requirements in the hotel contracts were 'reasonable and prudent' and consistent with hotels' pre-existing legal obligations.[200]

143. The DHHS submission did not recognise that if the Government mandates potentially infected people into the quarantine facility that it has created to avoid community transmission, it had then accepted the responsibility to take all necessary actions to keep the people in quarantine safe and minimise the risk of cross infection or community transmission out of the quarantine facility. Neither did the submission grapple with a reasonable and legitimate expectation of the Victorian community that its government, when faced with the threat of a highly contagious virus, would take whatever action it considered necessary to address it and then accept responsibility for the actions it took.

144. It was not unreasonable to impose a range of contractual obligations on a private contractor but, in circumstances where the Government is compelling people into a facility that carries such obvious risks, whatever other obligations exist, it too retained an obligation to maintain the highest standards of safety in that facility. Whatever the reason for those contractual provisions, it did not absolve the Government of its duty to ensure that appropriate safeguards were in place.

7.10 Conclusions

Decision to 'stand up' hotels for the Hotel Quarantine Program

145. Once the decision had been taken to adopt a universal quarantine program for all international arrivals, within some 36 hours the decision to use hotels as the designated facilities for the purpose of Victoria's quarantine program was an obvious enough choice. Hotels were stood up because they were available, could be stood up quickly, would accommodate large numbers of returned travellers and would provide economic benefits. Even if afforded careful prior contemplation, hotels presented as the only readily available option in the absence of a purpose-built quarantine facility.

146. But that is not to make a virtue of necessity. Hotels were not designed as 'quarantine facilities'. The physical limitations of hotels, together with the highly infectious nature of the virus and the state of knowledge about transmission, meant that constant attention on all of the necessary IPC measures was needed to run the Program with a minimum of risk to both the people in quarantine and those working in the Program.

Procurement of hotels; contracting of hotels

147. It was beyond doubt that the organisation of the hotels and the cleaning companies involved a significant logistical undertaking. DJPR entered formal agreements with 29 hotels (only 20 hotels were ultimately used for the Program).[201] It engaged three professional cleaning companies for specialised cleaning, initially only for those rooms that had been used by people who were known to be COVID-positive.[202]

148. There is no controversy that those contracts between the State and the hotels and cleaning companies were prepared and executed, on behalf of the State, by DJPR.[203] DJPR maintained the obligation of contract management throughout the period from March 2020 until July 2020, at which time primary control of the Hotel Quarantine Program transferred to the DJCS.[204]

149. Putting to one side the question of who had overall responsibility for the Program (which is discussed in detail at Chapter 8), while DJPR engaged the hotels and the contract cleaners (and established those contractual relationships between those services and the State), many aspects of the way in which those contracts were to be performed required substantive input from DHHS, specifically in the form of policies directed to IPC measures.[205]

150. In practical effect, this meant that, while DJPR had responsibility for management of the contracts, in a number of important respects, especially in relation to IPC measures, direction and management of those contractors was based on advice from DHHS. This resulted in a situation where those responsible for ensuring compliance with the contracts (DJPR) were not the ones with sufficient expertise to understand whether the contracts were being performed as they should. This was an unnecessarily complicated and unwieldy situation and not a safe system of infection prevention and control.

151. Important information directed to IPC — the cornerstone of this program — was merely transferred to the contractors via DJPR; as a result, its import may have been diluted or, even, lost.

152. Additionally, this contractual framework complicated and obscured what was the necessary and appropriate, albeit apparently lacking, 'ongoing supervision and oversight'[206] by DHHS of the operational aspects of the Hotel Quarantine Program.

153. Insofar as those aspects were being delivered, or at least were intended to be delivered, by the hotels and cleaners who had been engaged, it was apparent that the Public Health Team and the IPC expertise available to DHHS had little direct insight into how the Program was being administered and, indeed, no oversight.[207] At most, DHHS submitted that 'the Public Health Team had responsibility for the availability of IPC and PPE advice and guidance'.[208]

154. A number of witnesses (including Ms Peake and former Minister Mikakos) accepted that, while they were grateful to DJPR for establishing the contracts with hotels and cleaning providers that furnished the Program with the necessary facilities and ancillary – but no less necessary – cleaning professionals at an early stage, there was no legal or practical preclusion from the management of those contracts being transferred to DHHS after the establishment of those agreements and while the Program continued to run under the various iterations of Operation Soteria, with DHHS the designated control agency.[209]

155. The impact of fragmenting responsibilities in this way as between DJPR, DHHS and the private contractors added to or increased the vulnerabilities inherent within the Hotel Quarantine Program. The provision of policy advice and guidance on IPC measures, such as proper cleaning standards and methods, to DJPR, a department with no expertise in the area and, therefore, no ability to oversee the correct implementation of these requirements, was not a safe way to minimise the risk of infectious outbreaks in hotel quarantine sites.

156. Apparently, with a realisation as to the unwieldy nature of the Program, subsequently, from 3 July 2020, DHHS assumed responsibility for both the selection and contracting of all hotels in the Program.[210] Existing agreements with hotels were amended to reflect this transfer of responsibility from DJPR to DHHS on 3 July 2020.[211]

157. At a much earlier stage in the Program, DHHS and DJPR should have arranged for the transfer of responsibility for the administration of contracts to DHHS. This would have brought the department with public health expertise into a direct role in administering essential components of the Program and would have provided clear lines of accountability, responsibility and supervision of roles. It would also have meant those with the requisite public health expertise could be fully embedded in the operation of the Program, including the necessary on-site supervision. Importantly, given it was an unplanned and untested Program with high risks, one agency overseeing the Program would also have likely embedded a proper, ongoing review of the Program in its operation.

158. Decisions to contract with hotels were made with reliance on DHHS's requirements as to what hotels were suitable; despite this, DJPR (Mr Menon) did not receive any specific documents from DHHS regarding whether hotels were assessed from an infection control point of view. The key consideration for such an assessment should have been the extent to which infection control measures could be successfully implemented.

Infection prevention and control in hotels: the ever-present risk of cross-infection

159. IPC measures are essential to a quarantine program. It is necessary to have those with the expertise in IPC deliver that training. And nothing short of constant reinforcement, supervision and oversight from those with the necessary expertise is what is required in such a highly infectious environment.

160. There were no IPC experts stationed at the hotel sites to give guidance, oversight or supervision on the range of risks to which hotel staff would be exposed and what they needed to do to mitigate those risks.

161. DHHS witnesses have made clear that knowledge about the virus and its modes of transmission was evolving.[212] Dr Crouch gave evidence that:

> The understanding of COVID-19 continues to develop. As this has happened, so too has my understanding of the virus and its modes of transmission. I am not convinced that we yet fully understand how it is transmitted.

162. Given what Dr Crouch stated, it made it even more unsatisfactory that hoteliers were contracted to provide their own PPE, training and infection prevention and control. It was a wholly inadequate situation.

The importance of cleaning

163. There was inadequate focus in the design and implementation of the Hotel Quarantine Program on the need for specialised and rigorous cleaning to address the risk of virus transmission through environmental contact. Given that the guidance from the WHO in March 2020, specifically identified fomite transmission as a recognised method by which infection might occur, the Program should have been informed by the development of proper and authoritative guidance that dealt specifically with rigorous 'environmental cleaning and disinfection'.

164. This was especially so given the movement of people in and out of the hotels; those in quarantine and the workers and staff and personnel on-site.

Procurement of commercial cleaning companies for 'specialised cleaning'

165. The requirement that hotels undertake specialised cleans of COVID-positive rooms was flawed. It was based on a presumption that it would be known, upon rooms being vacated, which people in quarantine were COVID-positive and which people were not. Having regard to the symptomology of COVID-19 (see Chapter 2), because of the possibility that people infected with COVID-19 might be asymptomatic or might experience only mild symptoms that they may not recognise or may not report, and because testing was not initially universal nor ever compulsory, it was reasonably possible that a person's COVID-positive status might not have been discovered. In such a case, a room that had held a person, potentially, at least, with COVID-19, would be cleaned by hotel staff or subcontractors rather than specialised cleaners.

166. Irrespective of the contracting arrangements and who carried out the cleaning, it was imperative that proper auditing checks were conducted with due care, particularly given the known risk of environmental transmission.[213] There is no evidence this was done.

Figure 7.2: Quotes from returned travellers regarding the cleanliness of their hotel rooms

Returned Traveller 3: 'I opened the fridge and found a hair and a piece of left-over container or carton. I was immediately concerned that the room had not been deep cleaned. I became anxious at the cleanliness standards of the hotel'.

Returned Traveller 12: 'There were a lot of stains in the room … It made me wonder if any checks had been done on the cleanliness of the rooms to see they were up to standard'.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

Cleaning standards and quality control

167. There was no comprehensive, specific cleaning advice tailored to the Hotel Quarantine Program until the June Cleaning Advice was developed. Until then, DHHS relied on the March Cleaning Advice but, even then, it was only provided to DJPR some 12 days after the Hotel Quarantine Program was announced.

168. It was necessary for advice that dealt specifically with hotels in the quarantine environment to have been provided early. It could not have been expected that DJPR officials engaging cleaning contractors had sufficient IPC knowledge to know whether generic guidance was appropriate in that specific context. Where DJPR had made requests of DHHS for tailored hotel quarantine advice and policies, those requests were reasonable.

169. The consequences of the 'split' DHHS and DJPR arrangement included delays in providing proper cleaning advice and services, hampering the ability of those within hotels to deal quickly with issues as they arose.

Oversight of specialised cleaning in quarantine hotels

170. Putting to one side the efficacy of the policies that were provided, as has already been noted, the lack of on-site presence of those with expertise in IPC, supervising, monitoring and overseeing the implementation of those policies was a systemic flaw given the highly infectious nature of this virus and its risks of transmission, including by surface (fomite) contact.

171. DHHS took over the management of all cleaning contracts (other than in relation to the Brady) in quarantine hotels from 1 July 2020.[214] Had DHHS taken over that contracting function earlier, it would likely have been more proactive in directing and managing hotels and cleaners in relation to IPC practices. The demarcation of roles that existed resulted in a diffusion of responsibility and led to an absence of appropriate oversight and leadership within the Program in respect of this central tenet of IPC.

172. From the outset of the Program, there should have been a fuller implementation of processes that adequately identified the known risks of transmission. Whether this arose due to the contractual arrangements or the division of responsibilities between DHHS as control agency and DJPR as the contracting party, or for some other reason, it is clear that this was an aspect of the program that was inadequate.

173. Further, the expertise to ensure proper IPC standards were embedded in the Program and maintained did not lie with the contracting agency. This was a structural problem that permeated the Program. DHHS should have been responsible for ensuring implementation of its own standards.

Vulnerabilities were created by the arrangements with hotels and commercial cleaning companies

174. Chapter 6 sets out that it was not appropriate for the Government to place contractual responsibility for IPC on security services providers. I come to the same conclusion with respect to contracts with hotels and commercial cleaners, and I repeat those reasons here with respect to hotel and cleaning contracts.

175. That is, contracts entered into by DJPR on behalf of the State allocated to hotels and cleaners key responsibilities for worker safety, including the need to provide PPE and to manage IPC.

176. DJPR submitted that it was reasonable and appropriate for contractors to have responsibility for matters within their control, noting that under the *Occupational Health and Safety Act 2004* (Vic), contractors have a positive duty to control risks.[215] DJPR went further to submit that it would be inappropriate for the State to seek to assume contractors' own obligations with respect to their workforces because:

    A. obligations on contractors provide an extra layer of protection for workers[216]

    B. the State and contractors exercise a different level of control over relevant workers and workplaces: here, DJPR submits that contractors have particular roles with respect to on-site supervision arrangements, communication, disciplinary action and counselling[217]

    C. it is appropriate for the State to limit its risk through contracts[218]

    D. it was appropriate to require contractors to source their own PPE given the State's concern that it would be unable to source sufficient PPE.[219]

177. DJPR submitted that its contracts did not purport to transfer to contractors, or diminish the State's IPC responsibilities, nor did the State seek to contract out of its obligations under the *Occupational Health and Safety Act 2004* (Vic).[220]

178. As I have said, earlier in Chapter 6, in the context of private security, this Inquiry is not the proper venue for rulings and findings with respect to duties owed by these contractors at employment, contract or tort law. Suffice to say, it was not appropriate for the Government to seek to impose the risk of transmission of COVID-19 onto the hotel and cleaning providers in the way in which these contracts purported to do. The Hotel Quarantine Program was not just a workplace or a private arrangement between employer and employee, or contractor and principal. It should not be seen solely through that lens. It was, fundamentally, a measure to protect the public from a significant public health threat.

179. There was simply too much at stake for the Government to have conferred such responsibilities on private service providers, whose ordinary roles were so far removed from IPC measures.

180. I note here that Rydges Hotels Ltd supported a finding that the Government assumed responsibility for the infection risks associated with the Hotel Quarantine Program.[221] It submitted that it was a matter for the Government as to where the Government should have placed contractual liability for PPE and infection control education,[222] but noted that it was the Government's responsibility to ensure effective IPC.[223] I agree.

181. As I have said before, the weight of the expert evidence before the Inquiry from all of the health and medical witnesses is that the state of science and learning about the COVID-19 virus, its modes of transmission, its highly infectious nature, what forms of PPE should be used, and where and when, was changing, evolving and developing.[224] Further, that state of learning was held not just in public health generally, but in infection control, more particularly, as a recognised field of expertise.

182. For either government department, be it DJPR through its contract provisions with hotels and cleaners or DHHS through its reliance on the contracting agency, to assume that hotels could or should have been making assessments about 'risk management' and what was 'adequate training' and 'relevant public health standards' for COVID-19 was completely inappropriate. There was no basis to assume that hotels would have had the specific expertise or experience in IPC and use of PPE to be making such assessments and, certainly, not to the degree required to contain this highly infectious virus or to the degree necessary to administer an effective and safe quarantine program.

183. The express provisions of the contracts placed primary responsibility for infection prevention control training and PPE supply and use on the contractors.[225]

184. In this regard, I repeat that it was the evidence of the Premier that it would 'absolutely' be a concern if the relevant departments 'didn't take an active role in ensuring that there was proper infection control and prevention measures in place', in particular where the Government had assumed such risk by bringing members of the public into the hotels.[226]

7.11 Recommendations

185. The recommendations that emerge from the conclusions in this Chapter are in Section 1 of the Interim Report. Recommendations 1-39 in Section 1 of the Interim Report, and adopted into this Final Report, contain the features of the recommended model for a facility-based quarantine program.

186. Rather than replicating recommendations 1–39 here, these recommendations can be found at pages 38–49 of this Report.

Endnotes

1 Prime Minister of Australia (Cth) (Press Conference, 27 March 2020) <https://www.pm.gov.au/media/press-conference-australian-parliament-house-act-270320>.
2 Prime Minister of Australia (Cth) (Media Release, 27 March 2020) <https://www.pm.gov.au/media/update-coronavirus-measures-270320>.
3 Transcript of day 25 hearing 25 September 2020, 2125.
4 Ibid.
5 Ibid.
6 Ibid.
7 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 7 [21]–[22].
8 Transcript of day 22 hearing 22 September 2020, 1816.
9 Ibid.
10 Ibid.
11 Ibid 1816-1817.
12 Transcript of day 21 hearing 21 September 2020, 1758.
13 Transcript of day 22 hearing 22 September 2020, 1816.
14 Exhibit HQI0177_RP First witness statement of Mr Christopher Eccles, 21 [80].
15 Ibid 20 [79].
16 Exhibit HQI0210_P Transcript of press conference by the Hon. Daniel Andrews MP 27 March 2020, 2; Transcript of day 25 hearing 25 September 2020, 2126.
17 Exhibit HQI0210_P Transcript of press conference by the Hon. Daniel Andrews MP 27 March 2020, 2.
18 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 7 [23].
19 Ibid 3 [12]; Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 7 [27].
20 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 3 [12].
21 Ibid 3 [13].
22 Ibid 3–4 [14].
23 Ibid 7 [25].
24 Ibid; Transcript of day 10 hearing 31 August 2020, 634.
25 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 7 [25]; Transcript of day 10 hearing 31 August 2020, 634.
26 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 7–8 [26].
27 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 7 [31].
28 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 2 [8].
29 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 6–7 [26]–[27].
30 Ibid 10 [50]; Exhibit HQI0185(1)_RP Annexures to witness statement of Mr Simon Phemister, DJP.102.007.9895, DJP.102.007.9907.
31 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 8 [27]; Exhibit HQI0050_RP Annexures to witness statement of Mr Unni Menon, DJP.104.001.5070, DJP.104.001.5072, DJP.104.001.5077.
32 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, [28].
33 Ibid 8 [29]; Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 11 [52].
34 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 8 [29].
35 Ibid 7 [25], 12 [43]; Transcript day 10 hearing 31 August 2020, 634.
36 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 11 [55].
37 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 17-18 [89]; Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 12 [50]; Exhibit HQI0032_P Witness statement of Ms Claire Febey, 15-16 [63]–[64].
38 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 17 [84].
39 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 15–16 [63]–[64].
40 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 17–18 [89]; Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 12 [50]; Exhibit HQI0032_P Witness statement of Ms Claire Febey, 15–16 [63]–[64].
41 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 9 [32].
42 Ibid 9 [31].
43 Ibid 10 [35]; Transcript of day 10 hearing 31 August 2020, 634–635.
44 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 25 [87].
45 Submission 03 Department of Health and Human Services, 48 [262].
46 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 10 [37].
47 Transcript of day 14 hearing 8 September 2020, 1026.
48 Transcript of day 10 hearing 31 August 2020, 635.

49 Ibid 657.
50 Transcript of day 16 hearing 11 September 2020, 1270.
51 Ibid.
52 Transcript of day 25 hearing 25 September 2020, 2125.
53 Ibid.
54 Exhibit HQI0210_P Transcript of press conference by the Hon. Daniel Andrews MP on 27 March 2020, VPOL.0006.0002.0014; see also Transcript of day 25 hearing 25 September 2020, 2136–2137.
55 Transcript of day 4 hearing 18 August 2020, 55–56.
56 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 7 [21].
57 Ibid.
58 Ibid.
59 Transcript of day 3 hearing 17 August 2020, 40, 56–58.
60 Exhibit HQI0130a_RP Witness statement of Ms Pam Williams, 12 [22(c)].
61 Ibid 19 [41(d)].
62 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 11 [41].
63 Ibid 11 [42].
64 Transcript day 9 hearing 28 August 2020, 565; Exhibit HQI0046_RP Annexures to witness statement of Mr Rosswyn Menezes, RYD.0001.0010.0003; Exhibit HQI0048_RP Annexures to witness statement of Mr Karl Unterfrauner, STAM.0001.0001.0150; Exhibit HQI0050_RP Annexures to witness statement of Mr Unni Menon, DJP.104.004.8159; Exhibit HQI0185_RP Annexures to witness statement of Mr Simon Phemister, DJP.104.005.9140.
65 See eg Transcript day 7 hearing 24 August 2020, 313–318; Exhibit HQI0027_P Witness statement of Mr Kaan Ofli, 2 [10]–[15]; Transcript of day 5 hearing 20 August 2020, 154–156, 158, 178; Exhibit HQI0013_RP Witness statement of 'Returned Traveller 1', 2 [17]–[19]; Exhibit HQI0014_RP Witness statement of Mr Michael Tait, 7–8 [60]–[67].
66 Exhibit HQI0020_P Witness statement of Ms Liliana Ratcliff, 4 [33]–[34].
67 See eg Transcript day 7 hearing 24 August 2020, 313–318; Exhibit HQI0027_P Witness statement of Mr Kaan Ofli, 2 [10]–[15]; Exhibit HQI0014_RP Witness statement of Mr Michael Tait, 8 [62], 8 [64].
68 Transcript of day 9 hearing 28 August 2020, 516–7, 524–26, 571; Transcript of day 11 hearing 2 September 2020, 802.
69 See e.g. Transcript day 7 hearing 24 August 2020, 313–16; Exhibit HQI0027_P Witness statement of Mr Kaan Ofli, 2 [10], [13], [29]; Transcript of day 5 hearing 20 August 2020, 141; Exhibit HQI0014_RP Witness statement of Mr Michael Tait, 7–8 [62].
70 Transcript day 9 hearing 28 August 2020, 562-563; Exhibit HQI0046_RP Annexures to witness statement of Mr Rosswyn Menezes, RYD.0001.0001.0013, RYD.0001.0010.0003; Exhibit HQI0048_RP Annexures to witness statement of Mr Karl Unterfrauner, STAM.0001.0001.0150; Exhibit HQI0050_RP Annexures to witness statement of Mr Unni Menon, DJP.104.004.8159, DJP.104.001.5072, DJP.104.005.9142, DJP.101.001.7184; Exhibit HQI0185_RP Annexures to witness statement of Mr Simon Phemister, DJP.101.001.7184, DJP.104.004.8159, DJP.104.005.9142, DJP.105.003.0795, DJP.105.003.1082, DJP.105.003.1357; Exhibit HQI0066_RP Annexures to witness statement of Jamie Adams, MSSS.0001.0002.0050_0063.
71 Exhibit HQI0040_RP Witness statement of Mr Ram Mandyam 15 [99], 15 [101]; Exhibit HQI0041_RP Witness statement of Mr Shaun D'Cruz, 3 [12], 18-20 [89]-[101]; Exhibit HQI0042_RP Witness statement of Mr Stephen Ferrigno, 9 [34]–[35].
72 Exhibit HQI0040_RP Witness statement of Mr Ram Mandyam 13-14 [92]-[95]; Exhibit HQI0041_RP Witness statement of Mr Shaun D'Cruz, 19 [90]–20 [101]; Exhibit HQI0042_RP Witness statement of Mr Stephen Ferrigno, 9 [35].
73 Transcript of day 9 hearing 28 August 2020, 511.
74 Ibid.
75 Ibid.
76 Ibid 512. also Exhibit HQI0040_RP Witness statement of Mr Ram Mandyam, 13 [93], 15 [101].
77 Transcript of day 9 hearing 28 August 2020, 512–3.
78 Exhibit HQI0040_RP Witness statement of Mr Ram Mandyam, 14 [97], 15 [101].
79 Exhibit HQI0041_RP Witness statement of Mr Shaun D'Cruz, 22 [108].
80 Ibid 21 [105]–[107].
81 Ibid 22 [110].
82 Ibid 22 [111].
83 Ibid 23 [113].
84 Exhibit HQI0042_RP Witness statement of Mr Stephen Ferrigno, 9 [37].
85 Ibid 9 [38].

86 Ibid 9 [35], 10 [40]–[41].
87 Submission 03 Department of Health and Human Services, 31-32 [166]-[167].
88 Exhibit HQI0203_RP Witness statement of Infection Control Consultant DHHS, 6 [26].
89 See eg Ibid 15 [68].
90 Ibid 14 [61].
91 Ibid 16 [70].
92 Submission 03 Department of Health and Human Services, 31 [166].
93 Exhibit HQI0203_RP Witness statement of Infection Control Consultant DHHS, 5 [20].
94 Ibid 5 [21]–[22].
95 Ibid 5 [23].
96 Ibid 6 [27].
97 Ibid 16 [72].
98 Ibid 10 [44].
99 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 44 [229].
100 Exhibit HQI0001_P Witness statement of Professor Lindsay Grayson, 8 [38].
101 Ibid 9 [42].
102 Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, 8 [39].
103 Ibid. See also Transcript of day 14 hearing 8 September 2020, 1076–1077.
104 Transcript of day 14 hearing 8 September 2020, 1067.
105 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 7 [26].
106 Ibid 7 [27].
107 Ibid.
108 Transcript of day 26 hearing 28 September 2020, 2249.
109 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 8 [28].
110 Ibid 8 [29].
111 Ibid 9 [30].
112 Ibid 9 [31].
113 Transcript of day 14 hearing 8 September 2020, 1112.
114 Exhibit HQI0049_RP Witness statement or Mr Unni Menon 4–5 [16]; Exhibit HQI0050_RP Annexures to witness statement of Mr Unni Menon, DJP.104.004.8157.
115 Exhibit HQI0185_RP Annexures to witness statement of Mr Simon Phemister, DJP.101.0001.7184.
116 Ibid DJP.104.004.8159.
117 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 4 [16].
118 Transcript of day 9 hearing 28 August 2020, 511-512.
119 Ibid 511.
120 Exhibit HQI0040_RP Witness statement of Ram Mandyam, 11 [82]; Transcript of day 9 hearing 28 August 2020, 520, 522.
121 Exhibit HQI0040_RP Witness statement of Ram Mandyam, 11 [82]; Transcript of day 9 hearing 28 August 2020, 520, 522; Exhibit HQI0185_RP Annexures to witness statement of Mr Simon Phemister, DJP.104.004.8159, Clause 2.1(f).
122 'Returned Traveller 10', Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020.
123 See eg transcript of day 9 hearing 28 August 2020, 520–521.
124 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 19 [74].
125 Exhibit HQI0080_RP First witness statement of Ms Rachaele May, 2–3 [8].
126 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 2–3 [6], [14].
127 Ibid 2 [8].
128 Ibid 4 [20(a)].
129 Ibid 4 [18].
130 Exhibit HQI0083_RP Annexures to second witness statement of Ms Rachaele May, DJP.103.007.7332-7335.
131 Transcript of day 16 hearing 11 September 2020, 1245–1246.
132 Exhibit HQI0128_RP Witness statement of Mr Michael Girgis, 3 [15].
133 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 4 [19].
134 Ibid 4 [21].
135 Ibid 5 [22]; Transcript of day 13 hearing 4 September 2020, 970–972.
136 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 6 [28].
137 Exhibit HQI0128_RP Witness statement of Mr Michael Girgis, 3 [12].
138 Submission 06 IKON Services Australia Pty Ltd, 1 [3]; Transcript of Day 16 hearing 11 September 2020, 1247, 1249.
139 Submission 06 IKON Services Australia Pty Ltd, 1 [4]; Transcript of Day 16 hearing 11 September 2020, 1250.

140 Submission 06 IKON Services Australia Pty Ltd, 6 [29].
141 Ibid 7 [35].
142 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 9 [46].
143 For example, the agreement with IKON did not refer to the Second Cleaning Protocol because that was only introduced in June 2020, after the IKON contract had been finalised. Instead, the IKON contract referred, more broadly, to the latest recommended cleaning standards for COVID-19, as that was the direction from DHHS at the relevant time: Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 9 [45].
144 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 8–9 [43].
145 Transcript of day 16 hearing 11 September 2020, 1251–1253.
146 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 13–14 [62]–[66].
147 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 9 [19(a)], 11 [26(d)].
148 Ibid 11 [27]; Transcript of day 16 hearing 11 September 2020, 1298–1299.
149 Submission 03 Department of Health and Human Service, 37 [193]; Exhibit HQI0131_RP Annexures to witness statement of Ms Pam Williams, DHS.0001.0015.0323.
150 Submission 03 Department of Health and Human Service 37 [195]; Exhibit HQI0131_RP Annexures to witness statement of Ms Pam Williams, DHS.0001.0015.0287, DHS.0001.0095.0001.
151 Submission 03 Department of Health and Human Service 37 [196]; Exhibit HQI0131_RP Annexures to witness statement of Ms Pam Williams, DHS.5000.0001.8769.
152 Submission 03 Department of Health and Human Service 37–38 [197]; Exhibit HQI0131_RP Annexures to witness statement of Ms Pam Williams, DHS.5000.0001.8954.
153 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 15–16 [37], 16–17[40]; Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 10 [50].
154 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 12–13 [60], 13 [63].
155 Ibid 13 [61].
156 Submission 04 Department of Jobs, Precincts and Regions, 4–5 [18(c)(i)], [18(c)(iii)].
157 Submission 03 Department of Health and Human Services, 38 [198].
158 Transcript of day 10 hearing 31 August 2020, 665–668.
159 Transcript of day 13 hearing 4 September 2020, 971.
160 Transcript of day 13 hearing 4 September 2020, 973–975.
161 Ibid 978.
162 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 11 [55].
163 See paragraphs [111]–[118] of this chapter; Transcript of day 14 hearing 8 September 2020, 1118.
164 Exhibit HQI0080_RP First witness statement of Ms Rachaele May, 12 [66]; Exhibit HQI0032_P Witness statement of Ms Claire Febey, 25 [111]; Exhibit HQI0083_RP Annexures to second witness statement of Ms Rachaele May, DJP.103.008.1083, DJP.104.008.3703.
165 Submission 03 Department of Health and Human Services, 38 [201].
166 Ibid 36–37 [191].
167 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 10 [48]–[49]; Exhibit HQI0083(1)_RP Annexures to second witness statement of Ms Rachaele May, DJP.103.008.2404.
168 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 9–10 [47].
169 Transcript of day 9 hearing 28 August 2020, 585.
170 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 15 [73], 16 [76]. This is consistent with the evidence of Mr Girgis (General Manager – IKON) who was generally contacted by a DJPR representative to confirm the details of the next infectious clean required to be performed: Exhibit HQI0128_RP Witness statement of Mr Michael Girgis, 4 [17].
171 Transcript of day 22 hearing 22 September 2020, 1899; Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 6 [19(a)].
172 Exhibit HQI0045_RP Witness Statement of Mr Rosswyn Menezes, 10 [36(b)]; Exhibit HQI0046_RP Annexures to witness statement of Mr Rosswyn Menezes, RYD.0001.0001.0641.
173 Transcript of day 23 hearing 23 September 2020, 1974.
174 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 22 [103].
175 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 6–9 [24]–[31].
176 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 15 [65].
177 Ibid 15 [64].
178 Submission 03 Department of Health and Human Services, 30 [163] citing Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert 10 [28], 13 [40]; Exhibit HQI0136_RP Annexures to the witness statement of Ms Merrin Bamert, DHS.0001.0021.0020.
179 Submission 03 Department of Health and Human Services, 32 [168] citing Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 12 [35].

180 Submission 03 Department of Health and Human Services, 32 [168] citing Exhibit HQI0205_RP Witness statement of 'Senior Project Officer DHHS', 8 [36], [42]; Exhibit HQI0064_RP Witness statement of Ms Jan Curtain, 10 [60], 12 [74]; Exhibit HQI0047_RP Witness statement of Mr Karl Unterfrauner, 16 [41]; Exhibit HQI0024_RP Witness statement of 'Security 1', 2 [16].
181 Exhibit HQI0203_RP Witness statement of 'DHHS Infection Control Consultant', 6 [28].
182 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 19 [75].
183 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 17–18 [89]; Transcript of day 23 hearing 23 September 2020, 2002.
184 See eg Submission 03 Department of Health and Human Services, 41 [220].
185 Exhibit HQI0126_RP Annexures to witness statement of Ms Melissa Skilbeck, DHS.0001.0001.1532-1535 (version 2.0), DHS.0001.0001.2258-2261 (version 3.0).
186 Submission 03 Department of Health and Human Services, 32 [167].
187 Ibid 32 [169].
188 Transcript of day 10 hearing 31 August 2020, 640; Exhibit HQI0050_RP Annexures to witness statement of Mr Unni Menon, DJP.104.004.8159.
189 Transcript of day 10 hearing 31 August 2020, 640.
190 Exhibit HQI0050_RP Annexures to witness statement of Mr Unni Menon, DJP.104.004.8160.
191 Exhibit HQI0082 Second witness statement of Ms Rachaele May, 8 [39].
192 Ibid.
193 Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0156; Exhibit HQI0155_RP Annexures to witness statement of Prof. Brett Sutton, DHS.0001.00136.0205.
194 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 19 [74].
195 Exhibit HQI0050_RP Annexures to witness statement of Mr Unni Menon, DJP.104.004.8159–8160.
196 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 5 [14].
197 Transcript of day 25 hearing 25 September 2020, 2144.
198 Submission 03 Department of Health and Human Services, 17 [91], [93].
199 Ibid 17 [94].
200 Ibid 15 [80].
201 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 7 [23].
202 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 3 [15].
203 Ibid; Exhibit HQI00049 Witness statement of Mr Unni Menon, 7 [21]–[23].
204 Exhibit HQI00035_RP Operation Soteria Operations Plan, DOJ.504.010.8488 (version 1.0); Exhibit HQI0126_RP Annexures to witness statement of Ms Melissa Skilbeck, DHS.0001.0001.1527 (version 2.0); DHS.0001.0001.2254 (version 3.0); Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 49 [252]–[254].
205 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 19 [74].
206 Exhibit HQI0126_RP Annexures to witness statement of Ms Melissa Skilbeck, DHS.0001.0001.1525.
207 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 4–5 [24].
208 Submission 03 Department of Health and Human Services, 31 [166].
209 See eg Transcript of day 23 hearing 23 September 2020, 2011, 2012; Transcript of day 24 hearing 24 September 2020, 2081.
210 Exhibit HQI0049_RP Witness statement of Unni Menon, 10 [37].
211 Exhibit HQI0041_RP Witness statement of Mr Shaun D'Cruz, 4 [16].
212 Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, 7 [37].
213 See Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 9 [42].
214 Exhibit HQI0128_RP Witness statement of Mr Michael Girgis, 3 [13].
215 Submission 04 Department of Jobs Precincts and Regions, 31 [111]–[112].
216 Ibid 32 [116(a)].
217 Ibid 32-33 [116(b)].
218 Ibid 33 [116(c)].
219 Ibid 33 [118].
220 Ibid 34 [121]–[122].
221 Submission 08 Rydges Hotels Ltd, 9 [28].
222 Ibid 14 [45].
223 Ibid 14 [46.2].
224 See eg Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, 7 [37]; Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 13 [54].
225 Exhibit HQI0050_RP Annexures to witness statement of Mr Unni Menon, DJP.104.004.8159-816.
226 Transcript of day 25 hearing 25 September 2020, 2144.

CHAPTER 8

DHHS as control agency

Introduction

1. This pandemic hit Victoria at a time when it was just recovering from a terrible bushfire season. Without doubt, responding to COVID-19 placed extraordinary demands on a public service workforce that was already under strain. Those demands were well articulated by Pam Williams, Department of Health and Human Services (DHHS) Agency Commander, Operation Soteria, as follows:

> Operation Soteria required extraordinary effort from the leadership teams and staff across all the agencies involved. The expectations were high, and the pressure was intense, with long hours and difficult situations to address, with operational guidance being developed contemporaneously. Many staff had just finished working through the bushfire emergency and, without a break, had moved onto hotel quarantine. The majority of staff were not able to be backfilled in their usual roles, which added to the pressure. There was significant demand for staff across the whole COVID-19 response, with hotel quarantine being only one part of the response. Resources were stretched. While action was being taken to fill roles more long term, it was difficult to keep pace with the demand.[1]

2. As has been set out in Chapter 5, the Hotel Quarantine Program was set up over a weekend. Those with experience in developing complex health programs, such as Merrin Bamert, DHHS Agency Commander, Operation Soteria,[2] and Professor Euan Wallace, then Chief Executive Officer, Safer Care Victoria, stated that a program of this size and complexity would ordinarily have taken months to develop, with risk strategies in place.[3] Ms Bamert noted, '[i]n this case, we had less than 48 hours to get the program up and running and in the first week, we had five hotels activated and 1,550 returning passengers'.[4] In her evidence, Ms Williams quoted a higher number, stating that the number of returned travellers in the first week 'quickly reached over 2,000'.[5]

3. Given, as set out in Chapter 3, there was no pandemic plan for quarantining people in facilities, and the speed at which the Program was set up, operational policies and procedures for the Program were being finalised over the days and weeks following the commencement of the Program.[6]

4. Indeed, after the announcement at National Cabinet on 27 March 2020, all health agencies across the nation were having to grapple with contingency plans for the impact of COVID-19 on the healthcare sector while setting up their Hotel Quarantine Programs.

Structure of this Chapter

5. This Chapter examines the plans, structures, decision-making, management and governance of the Victorian Hotel Quarantine Program. It contains four sections:

    A. Section 1 sets out some basic concepts of the Victorian emergency management framework relevant to this Inquiry. This has been done to put the role of DHHS in the Hotel Quarantine Program into the operational context in which it commenced.

    B. Section 2 sets out how DHHS interpreted and performed its role and functions, and how it was structured in its work on the Hotel Quarantine Program relative to other Departments, the emergency management framework and internally.

    C. Section 3 analyses how those interpretations, decisions and structures impacted the operation of the Hotel Quarantine Program.

    D. Section 4 summarises my conclusions.

Section 8.1 — the emergency management framework

6. As set out in Chapter 5, while overall responsibility for the Program briefly lay with the Department of Jobs, Precincts and Regions (DJPR) on the first day of the Program, over the 24 hours that followed, governance structures for the Program were quickly reset to align with Victoria's emergency management framework. In order to examine how the Program unfolded, it is necessary to consider the foundational concepts of this emergency management framework, which informed the roles, actions and responsibilities constituting the Program.

7. Before doing so, it is relevant to note that parts of the emergency management framework discussed in this Chapter were replaced or superseded by the Victorian State Emergency Management Plan (SEMP) on 30 September 2020 and the *Emergency Management Legislation Amendment Act 2018* (Vic) (Amendment Act) on 1 December 2020. The changes, introduced by the SEMP and the Amendment Act, were not the subject of evidence to this Inquiry, noting that both the SEMP and Amendment Act commenced after the close of evidence. Accordingly, in what follows, I will address the emergency management framework, in the present tense, as it stood at the time of the Hotel Quarantine Program. Those engaged in emergency management reform should read the following and apply the findings and recommendations reached in this Chapter to the revised emergency management framework on this basis.

Foundational concepts

8. 'Emergency management' refers to the arrangements for, or in relation to, the mitigation of, response to and recovery from, emergencies.[7] The emergency management framework in Victoria contains an extensive array of documents, manuals and plans that endeavour to address the range of emergencies that could emerge, and the operational structures to be implemented when responding to those various types of emergencies. According to former Emergency Management Commissioner, Craig Lapsley PSM, the creation of Emergency Management Victoria, being the central agency responsible for emergency management in Victoria, was an outcome of two catastrophic emergencies — Black Saturday in 2009 and the Victorian floods in 2010.[8]

9. The emergency management framework has a statutory basis. In Victoria, it is established by two main statutes: the *Emergency Management Act 2013* (Vic) (EM Act) and the *Emergency Management Act 1986* (Vic) (1986 Act).

10. The EM Act has several objectives.[9] One of those objectives is of particular relevance to this Inquiry, being to establish efficient governance arrangements that, amongst other things, clarify the roles and responsibilities of agencies and facilitate cooperation between agencies.[10]

8.1.1 Functions of the Emergency Management Commissioner

11. One of the ways that the EM Act purports to achieve its aims is through establishing the office of the Emergency Management Commissioner.[11] The Emergency Management Commissioner has a number of functions, including:

    A. the coordination of the activities of agencies having roles or responsibilities in relation to the response to Class 1 emergencies or Class 2 emergencies[12]

    B. ensuring that control arrangements are in place during a Class 1 emergency or a Class 2 emergency and that the relevant agencies act in accordance with the state emergency response plan[13]

    C. ensuring that the Minister for Emergency Services is provided with timely and up to date information in relation to the response to major emergencies[14]

    D. being responsible for the preparation of the SEMP.[15]

8.1.2 Classes of emergencies

12. Emergencies are categorised as 'Class 1 emergencies', 'Class 2 emergencies' or 'Class 3 emergencies'.[16]

    A. a Class 1 emergency is a major fire or any other major emergency for which the Metropolitan Fire and Emergency Services Board, the Country Fire Authority or the Victoria State Emergency Services Authority is the control agency under the SEMP

    B. a Class 2 emergency is a major emergency other than a Class 1 emergency, a warlike act or act of terrorism (whether directed at Victoria or at any other State or Territory of the Commonwealth), hijack, siege or riot. A major public health emergency falls within this definition

    C. a Class 3 emergency is a major emergency that *is a* warlike act or act of terrorism, hijack, siege or riot. A Class 3 emergency is often referred to as a 'security emergency'.[17]

13. The COVID-19 pandemic, as a human disease emergency, was a Class 2 emergency under the emergency management framework.[18]

8.1.3 A number of plans are in place to 'operationalise' the emergency management framework

14. The EM Act provides the foundation for a range of plans to guide emergency activities.

15. The EM Act requires that the Emergency Management Commissioner arrange for the preparation of the State Emergency Response Plan (SERP).[19] The SERP puts 'meat on the bones' of the framework of the EM Act.[20]

THE STATE EMERGENCY RESPONSE PLAN

16. The SERP outlines the arrangements for a coordinated response to emergencies by all agencies with a role or responsibility in that emergency. The SERP contains provisions:

    A. identifying, in relation to each form of emergency specified, the agency primarily responsible for responding to the emergency (the control agency)[21]

    B. relating to the coordination of the activities of other agencies in support of a control agency in the event of the emergency (support agencies)[22]

    C. specifying the roles of the control and all support agencies in the event of an emergency[23]

    D. setting out provisions relating to consequence management[24]

    E. setting out the roles, responsibilities and process for appointing State Response Controller, Class 2 Emergency Controller and controllers under s. 39 of the EM Act.[25]

17. The Inquiry received into evidence the Emergency Management Manual Victoria (EMMV),[26] a compendium of the principal policy and planning documents that set out the emergency management arrangements for Victoria. The EMMV sets out the SERP at Parts 3, 7 and 8,[27] and provides details about the roles that different organisations play in the emergency management arrangements for different classes of emergencies.

THE STATE HEALTH EMERGENCY RESPONSE PLAN

18. The EM Act also provides for the preparation of sub-plans to the SERP. The State Health Emergency Response Plan (SHERP) is a such a sub-plan.[28]

19. When it comes to health emergencies, the SHERP is a critical document in the Victorian emergency management framework. The SHERP provides:

> ... an overview of the arrangements for the management of health emergencies in Victoria. This plan describes the integrated approach and shared responsibility for health emergency management between the Department of Health and Human Services (DHHS), the emergency management sector, the health system and the community.[29]

20. The emergency management framework encompasses plans at a high level, but also plans at different degrees of specificity, depending on the nature of the emergency. Aside from the SERP and the SHERP, there is a range of such plans that have been considered earlier in this Report at Chapter 3 (with respect to the state of emergency preparedness). I note them again here for completeness:

    A. The Victorian Health Management Plan for Pandemic Influenza.[30]

    B. The Victorian Action Plan for Pandemic Influenza.[31]

    C. The COVID-19 Pandemic Plan for the Victorian Health Sector.[32]

21. As set out in Chapter 3, none of these plans contemplate mass mandatory quarantine.

8.1.4 Control agency

22. A 'control agency' is defined, under the SERP, as the agency with the primary responsibility for responding to a specific form of emergency.[33]

23. The EMMV (Part 7) lists control agencies for specific emergencies.[34]

24. A control agency's responsibilities are set out in Part 3 of the EMMV.[35] Those responsibilities include:[36]

    A. planning to deliver their responsibilities according to their Part 7 roles, including planning to resource those responsibilities through agency resources, support agency resources or contract or supply arrangements with private industry

    B. preparing a sub-plan for the emergency when the arrangements for managing an emergency vary from the arrangements in the Response Plan

    C. confirming the arrangements for the appointment of controllers for the specific form of emergency for which the agency is the control agency

    D. responding to the form of emergency for which the agency is the control agency in accordance with the arrangements in the Response Plan or the relevant sub-plan

    E. notifying the Emergency Management Commissioner of major emergencies or situations that may affect the capability of the agency to perform its role or responsibilities.

25. The EMMV lists control agencies for specific emergencies. Not surprisingly, given public health is squarely the responsibility of DHHS (particularly preventing the spread of communicable diseases),[37] DHHS is designated as the control agency for human disease emergencies.[38] Such emergencies are Class 2 emergencies under the EMMV.[39]

Support agencies

26. A support agency is defined, under the SERP, as an agency that provides services, personnel or material support to the control agency.[40] The SERP details the roles and responsibilities of the support agency generally. In the context of Class 2 health emergencies, where DHHS is the control agency, the roles of key support agencies are also listed in the SHERP.[41]

Individual agencies perform specific tasks according to their role

27. The EMMV describes the activities and roles performed by the agencies involved in a response to an emergency. Part 3.2.1 of the EMMV distinguishes between the roles of coordinating, commanding or controlling functions in an emergency as set out below:

    A. **Coordination** means bringing together agencies and resources to ensure effective response to, and recovery from, emergencies.

    B. **Command** means the internal direction of personnel and resources, operating vertically within an agency.

    C. **Control** means the overall direction of response activities in an emergency, operating horizontally across agencies.[42]

Importance of control agency for emergency management

28. A control agency has the primary responsibility for responding to the specific emergency. This was explained by former Emergency Management Commissioner Lapsley to mean that the control agency is responsible for leading the response to the emergency, setting the strategic direction and developing and executing a management plan that involves all agencies supporting the response to the emergency.[43]

29. Mr Lapsley explained why having a single control agency is important in an emergency response. He said:

> It is a fundamental premise to have a single agency designated for the leadership and management of an emergency so that there is no ambiguity of who is accountable for the management of the emergency.[44]

30. Mr Lapsley went on to emphasise the need to have a clearly defined structure and accountability in an emergency as follows:

> [Clear lines of command and control are] of critical importance from an accountability perspective so that agency/organisational commanders have a clear understanding of who is in control of the major emergency and who is responsible for coordinating effort seamlessly ...[45]

Complex emergencies

31. In defining a 'control agency', the EMMV says:

> There are complex emergencies where a shared accountability across a number of agencies occurs. In these cases, there is a need for a single agency to be responsible for the collaborative response of all the agencies. For the purposes of consistency, the term control agency will be used to describe this lead agency role.[46]

32. There is no further definition in the EMMV as to what constitutes a 'complex emergency.' In the context of this pandemic, it was uncontroversial that this was a major or complex emergency that was having significant consequences across the state. Nevertheless, when there is a multi-agency response, where accountability is shared, there is still a need for a single agency to be responsible for that collaborative response. That responsibility falls to the control agency.[47] This issue took on considerable significance in this Inquiry and is dealt with in sections 2 and 3 of this Chapter.

The State Health Emergency Response Plan sets out key roles for DHHS

33. The SHERP — being a sub-plan of the SERP — sets out how DHHS is to operationalise its SERP responsibilities within the EM Act framework.[48]

34. Importantly, the SHERP sets out key roles where DHHS is the control agency for a health emergency, as follows:

Figure 8.1.1: Key roles for DHHS under the SHERP

State Controller (DHHS as control) / State Health Incident Management Team Lead (DHHS as support)	As agency lead, the Secretary to DHHS appoints the State Controller (by instrument of appointment) to enable appropriate focus on managing health consequences according to the nature of the emergency: • the Public Health Commander will be appointed State Controller for identified public health emergencies (most likely to occur in circumstances where a public health emergency is anticipated) • all other emergencies, including in the event of a rapid onset health emergency where the causation is unclear, the State Health Coordinator will be appointed as State Controller. The State Controller is responsible for the following initial decisions and actions, in consultation with the appropriate internal and external stakeholders: • verify the relevant response assessment (refer to Section 6.3.3) • determine the strategic objectives for response • determine the incident management model or activate pre-agreed plans for the initial response • establish incident management team(s) (as applicable) • ensure timely and appropriate public information and warnings are provided to the community • notify the EMC, support agencies and relevant health system service providers. The State Controller may appoint a Deputy Controller. The State Controller should delegate their function on the State Health Incident Management Team (that is, Public Health Commander or State Health Coordinator) to a deputy or equivalent.
State Health Emergency Management Coordinator (SHEMC)	The SHEMC is an executive-level public administration function performed by DHHS and appointed by the Secretary of the department. The SHEMC is responsible for ensuring that appropriate appointments are made to state tier functions (the State Health Commander, State Health Coordinator and the Public Health Commander), as well as providing executive administrative support to ensure these functions operate effectively. While an instrument of appointment will determine whether the Public Health Commander or State Health Coordinator performs the function of State Controller, the SHEMC may advise the Secretary to DHHS who should fulfil the function of State Controller (with advice from the State Health Incident Management Team) according to the nature of the emergency and response, and consistent with the instrument of appointment.

Public Health Commander (Public Health Command functional lead)	The Public Health Commander function is performed by the Chief Health Officer (or delegate). The Public Health Commander reports to the State Controller and is responsible for commanding the public health functions of a health emergency response (including investigating, eliminating or reducing a serious risk to public health). Performing the function of Public Health Commander does not alter in any way the management, control and emergency powers of the Chief Health Officer under the Public Health and Wellbeing Act 2008. In performing this function, the Public Health Commander will liaise directly with the State Health Commander and State Health Coordinator. For emergencies where the Public Health Commander is not appointed the State Controller, the Chief Health Officer's authority under the Public Health and Wellbeing Act 2008 remains unaffected, and their decisions on matters of public health should not be overridden by a State Controller.
State Health Coordinator (Health Coordination functional lead)	The State Health Coordinator function is performed by a senior DHHS officer appointed by the SHEMC. The State Health Coordinator reports to the State Controller and is responsible for coordinating DHHS' emergency response activities across the health system (including hospitals, primary health and other acute services) at the state tier. In performing this function, the State Health Coordinator liaises directly with the State Health Commander and Public Health Commander.
State Health Commander (Health Command functional lead)	The State Health Commander function is performed by the appointed Ambulance Victoria Emergency Management Director (unless otherwise appointed by the SHEMC). The State Health Commander reports to the State Controller and is responsible for commanding the pre-hospital and field response to an emergency (including ambulance services, first responder assistance, and spontaneous volunteers) at the state tier. In performing this function, the State Health Commander will liaise directly with the State Health Coordinator and Public Health Commander.

Source: Exhibit HQI0145_P Annexures to first witness statement of Emergency Management Commissioner Andrew Crisp.

8.1.5 Controllers and Commanders

35. The language of controllers and commanders, and deputy controllers and deputy commanders, is prominent throughout this Chapter, as it is the language of the emergency management framework. The roles set out above demonstrate this. As can be seen, the concepts reflect a distinction between 'Controller' and 'Commander'. That distinction reflects the difference between the concepts of 'control' and 'command' (as operating horizontally and vertically across agencies, respectively, in the emergency management structure) as set out in paragraph 27. That is, whereas a 'State *Controller'* is responsible for leading and managing the response to an emergency across agencies,[49] an 'Agency *Commander'* is at the top of a particular agency's internal response structure and supervises their own agency personnel and the work being done by that agency in response to the emergency.[50] This applies regardless of whether an agency is a control agency or a support agency for a particular emergency.

APPOINTMENT OF CONTROLLERS

36. The State Controller in any emergency sits above any particular incident and is responsible for the overall response to the emergency.[51]

37. As can be seen from the table above, in a Class 2 health emergency the SHERP provides for the Secretary to DHHS to appoint the State Controller (who, in the Hotel Quarantine Program, was referred to as the State Controller — Health) to enable appropriate focus on managing health consequences according to the nature of the health emergency.[52] According to the table, where there is an identified public health emergency, the Public Health Commander is appointed the State Controller — Health.[53] The Public Health Commander is the role performed by the Chief Health Officer (CHO) or delegate.

38. How this appointment process occurred in the Hotel Quarantine Program, and who was ultimately appointed to the State Controller — Health role, are questions I address in some detail below, in sections 2 and 3 of this Chapter.

39. Once appointed under the SHERP, the State Controller — Health's responsibilities include to:

    A. lead and manage the response to a Class 2 emergency

    B. establish a control structure for the Class 2 emergency as appropriate and monitor to ensure it suits the circumstances

    C. support the Emergency Management Commissioner to identify current and emerging risks, or threats in regard to the Class 2 emergency, and implement proactive response strategies

    D. support the Emergency Management Commissioner in the development of a state strategic plan for managing the Class 2 emergency.[54]

8.1.6 The declaration of a State of Emergency was part of the framework for the exercise of quarantine powers

40. The emergency management framework that I have outlined above (including the allocation of roles to the various offices) applies to a response to a major public health emergency, whether or not there is a declaration of a State of Emergency in place.[55]

41. As I have set out in Chapter 1, the Minister for Health declared a State of Emergency in respect of the COVID-19 pandemic on 16 March 2020. This enabled the conferral of emergency powers on Authorised Officers, including the power to detain people.[56]

42. This declaration, on 16 March 2020, was the first time that a State of Emergency had been declared under the *Public Health and Wellbeing Act 2008* (Vic) (PHW Act) with respect to a Class 2 emergency.[57] It formed part of the legal arrangements for how DHHS administered and enforced the Hotel Quarantine Program.

Section 8.2 — DHHS governance, decision-making and Operation Soteria

43. It is against this backdrop, having regard to the emergency management framework summarised above, that I now turn to the governance structures ultimately adopted, and the decisions made, by DHHS in its role as control agency within the Hotel Quarantine Program.

44. There was no controversy that the COVID-19 pandemic was a Class 2 health emergency or that this Class 2 health emergency meant that DHHS was the 'control' agency. How DHHS interpreted that role and its functions and responsibilities in the context of the Hotel Quarantine Program was, however, the subject of considerable dispute.

45. The purpose of this section is to set out, in detail, how that interpretation came to be applied in practice.

46. From the outset, I note that the roles, functions and responsibilities discussed in this section are often difficult to follow. This is perhaps to be expected since, as will be discussed in Section 3, the governance structures forming part of the Program were, themselves, often fragmented and confusing. In what follows, the governance structures are described by reference to the policies, roles and appointments that comprised them and according to the manner in which these matters evolved over time. I will then return, in Section 3, to analyse how these matters impacted the operation of the Hotel Quarantine Program.

8.2.1 Key relevant structures to the role of DHHS in the COVID-19 pandemic emergency

47. As discussed in Chapter 5, the Hotel Quarantine Program had two key objectives, albeit perhaps not clearly articulated, each of which was a health and human objective. The paramount purpose of the Hotel Quarantine Program, and the very reason for its existence, was to prevent the further spread of COVID-19 from returning overseas travellers into the Victorian community, thus protecting the health of all Victorians.[58] The secondary objective of the Program was to meet the health and other needs of those detained in quarantine.[59]

48. Infection control, outbreak management, healthcare, welfare and human services are core to the work of DHHS. Kym Peake, former Secretary of DHHS, stated that the purpose of the Department is to provide policy advice to government and to 'fund, regulate and deliver programs to enhance the safety, health and wellbeing of Victorians'.[60] Key responsibilities of the Department relate to public health and include preventing the spread of communicable diseases.[61]

49. In its ordinary operations, DHHS reports to five Ministers across the portfolios of Health, Ambulance Services, Housing, Disability, Ageing and Carers, Mental Health, Child Protection, and the Prevention of Family Violence.[62] To say that its remit is expansive is, perhaps, to understate the position. Victoria's CHO, Professor Brett Sutton, evocatively and aptly, described DHHS as a 'rather large beast'.[63]

50. In this regard, it is of note that, on 30 November 2020, the State Government announced a restructure of DHHS to separate the Department of Health (DoH) from the new Department of Families, Fairness and Housing (DFFH), effective as of 1 February 2021.[64]

CONCEPT OF OPERATIONS

51. In November 2019, Prof. Sutton and the Director of the DHHS Emergency Management Branch prepared a joint document, the *Concept of Operations, Department of Health and Human Services as a Control Agency and as a Support Agency in Emergencies* (the Concept of Operations), which was an overarching guidance document for staff working in DHHS in emergency-related roles.[65] The intended purpose of the document was to set out DHHS's operational functions, roles, key activities and deliverables at the state and regional tiers across all types of emergencies, including public health emergencies. It recognised DHHS's responsibilities in the PHW Act, the EM Act, the EMMV and the health-specific incident management and escalation arrangements identified in the SHERP.[66] Ms Peake explained that this document was relevant to a number of public health emergencies, including communicable disease emergencies.[67]

52. The Concept of Operations provided the following descriptions of state-level functions, leadership roles and key activities:

Table 8.2.1: Functions, leadership roles and key activities in a Class 2 health emergency

Function	Public Health Command	Departmental Command	Health Coordination	Relief & Recovery Coordination and Services	Control (Class 2)
Leadership Role	**Public Health Commander**	**State Departmental Commander**	**State Health Coordinator**	**State Departmental Commander**	**Controller**
Key Activities	Command the public health activities of an emergency response (including the investigation, management of public health risk, and communication of risk) Undertake actions to reduce pressure on the health system through control measures and advice Monitor the impacts of an emergency on public health Authorise public health communication to the public	Monitor the impacts of an emergency on the department's clients and funded services Undertake activities that support the safe deployment of DHHS personnel to acquit responsibilities of the department Coordinate activities to manage the consequence of these impacts on clients, funded services and DHHS staff Authorise public communications about impacts to departmental services	Monitor state-level impacts of an emergency across the health system Coordinate health sector emergency response activities to support the health system (including hospitals and primary health) Authorise health system impact communication to the public	Coordinate the provision of financial assistance to affected communities Coordinate the provision of emergency accommodation to affected communities Coordinate the provision of psychosocial support to affected communities Authorise relief and recovery public communications	Ensure implementation of control measures for the identified hazard(s) Manage the emergency consequences across government Authorise public information and warnings to the public Support the Emergency Management Commissioner and the sector
Decision-making	Chief Health Officer/ Public Health Commander	Department Incident Management Team (D-IMT)* leadership group Department Executive Board (BC/surge)	State Health Incident Management Team	D-IMT leadership group	State Control Team
State EM Committees	State Control Team State Coordination Team	N/A	State Control Team State Coordination Team State Emergency Management Team	State Relief & Recovery Team State Control Team State Coordination Team State Emergency Management Team	State Coordination Team State Emergency Management Team

Source: Exhibit HQI0126_RP Annexures to witness statement of Ms Melissa Skilbeck.

53. The Concept of Operations also provided for decision-making processes, as follows:

> During an emergency, whether in control, support or coordinating, the department will convene a single body to inform decision-making by leadership roles irrespective of the type of hazard that has precipitated the emergency. For the purpose of the SHERP, the departmental incident management team fulfils the function, and will operate as the State Health Incident Management Team under SHERP when required.
>
> The D-IMT [Department Incident Management Team] determines the strategic priorities for the department, and in some cases the health and human services and emergency management sectors, in responding to emergencies across all functions. The D-IMT provides guidance on required decision-making, across the span of strategic, tactical and operational decisions. The D-IMT provides direction for functional lead officers in the discharge of all key activities and activities for which the department is accountable.[68]

54. The Concept of Operations provided that membership of the Departmental Incident Management Team or State Health Incident Management Team under the SHERP should include:[69]

    - State Health Coordinator
    - State Health and Human Services (Departmental) Commander
    - Public Health Commander
    - State Health Commander (as required)
    - Regional Commanders (as required)
    - Functional lead officers.

55. The Concept of Operations also provided the roles for DHHS at the State Control Centre (SCC) when acting as a control agency, as follows:

> When the department is a control agency and the emergency is a public health emergency, an appropriate Class 2 controller will be recommended by the State Health Emergency Management Coordinator (Deputy Secretary Regulation Health Protection and Emergency Management) to the department's Secretary for appointment. In keeping with SHERP, the Chief Health Officer will normally be appointed the Class 2 Controller for identified public health emergencies, and when that occurs the Chief Health Officer will delegate the Public Health Commander role to the DCHO relevant to the main hazard or consequence. The Public Health Commander will then be the chair of the D-IMT.[70]

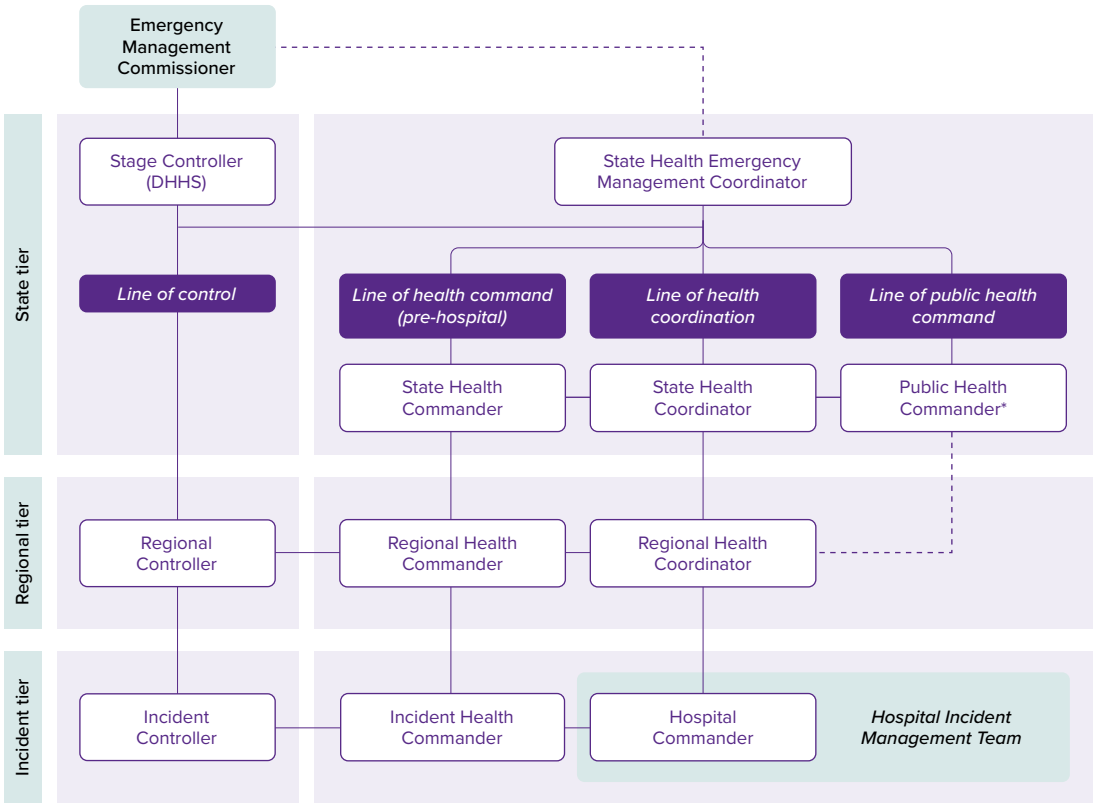
THE STATE HEALTH EMERGENCY RESPONSE PLAN

56. This is to be read in conjunction with the SHERP which, in the context of Class 2 health emergencies, outlines agency roles and responsibilities, and notes the capacity to use SCC facilities, in the following terms:

> Under the EMMV Part 7 – Emergency Management Agency Roles, DHHS is the nominated control agency for specified health emergencies in Victoria (refer to Section 1).
>
> DHHS is responsible for identifying unfolding or potential health emergencies, and escalating health emergency response arrangements outlined in this plan to ensure the health system can effectively respond and mitigate the adverse consequences for communities (refer to Section 6.3.3).
>
> DHHS may activate the State Emergency Management Centre (located at DHHS) when considered necessary for the effective management of an emergency. To ensure an effective response to adverse health consequences for communities DHHS may also, in consultation with the EMC, request activation of the State Control Centre (SCC) to provide support to the State Controller. The SCC provides a range of services to assist with the coordination and control of emergencies and has well-established protocols for working across all government agencies and for providing information and warnings to the community.[71]

57. The SHERP provides the following diagram of reporting relationships for Class 2 health emergencies, as reproduced in Figure 8.2.1.

Figure 8.2.1: Reporting relationship for Class 2 health emergencies



*Public Health Commander appointed State Controller for identifiable public health emergencies.

Source: Exhibit HQI0126_RP Annexures to witness statement of Ms Melissa Skilbeck.

8.2.2 DHHS's initial steps in its response to COVID-19 state-wide pandemic emergency

58. The recognition that the COVID-19 pandemic was a Class 2 emergency led to the use of the emergency management framework in order to respond to the serious risk posed to the Victorian community. However, as the arrangements under the SHERP apply on a continuous basis and did not require 'activation',[72] DHHS had already taken steps, from late January and into early February of 2020, to respond to the emerging COVID-19 pandemic emergency under the SHERP and in accordance with the Concept of Operations.

59. Ms Peake gave evidence that she and Melissa Skilbeck, Deputy Secretary Regulation, Health Protection and Emergency Management at DHHS (who also fulfilled the function of State Health Emergency Management Coordinator (SHEMC) under the SHERP),[73] met in late January 2020 to consider what action needed to be taken in respect to the COVID-19 pandemic.[74]

60. On 20 January 2020, DHHS established an Incident Management Team to coordinate the public health and sector response to the COVID-19 pandemic emergency.[75] This was the same day that the Australian Health Protection Principal Committee (AHPPC) first met to discuss the national response to the pandemic.[76]

61. Ms Peake stated that, on 1 February 2020, the same day that the AHPPC recommended that entry to Australia be limited for certain overseas arrivals due to the risk from COVID-19, she 'and others' were of the view that the COVID-19 outbreak met the definition of a 'major emergency' under the EM Act.[77] Not adopting the 'normal' course of appointing the CHO as the State Controller, Ms Peake appointed Andrea Spiteri as the Class 2 State Controller (later known as State Controller — Health) for the COVID-19 pandemic emergency.[78] Later, on 7 February 2020, Jason Helps was also appointed as State Controller — Health in response to the COVID-19 pandemic emergency.[79]

62. On 2 February 2020, DHHS established a State Health Incident Management Team for the COVID-19 pandemic emergency.[80] Dr Finn Romanes, Deputy Public Health Commander, gave evidence that he performed the role of the Public Health Commander on initial establishment of the State Health Incident Management Team in February 2020, however, that role transitioned to Dr Annaliese van Diemen, as Deputy Chief Health Officer (DCHO) and Public Health Commander, in March 2020.[81] Dr van Diemen also gave evidence that 'on the declaration of a state of emergency on 16 March 2020, [she] became the [Public Health Commander] for the purposes of the SHERP'.[82]

63. On 11 March 2020, the SCC was activated by the Emergency Management Commissioner, at the request of DHHS, to respond to the COVID-19 pandemic emergency.[83]

8.2.3 Hotel Quarantine Program is commenced

64. On 27 and 28 March 2020, those gathered at the SCC commenced implementing National Cabinet's decision that all international arrivals be required to quarantine in a designated facility for 14 days.[84] It was revealed in the course of those SCC meetings that DJPR had been engaged by the then Secretary to the Department of Premier and Cabinet (DPC) to run the Program.[85]

65. As of 27 March 2020, the two operating State Controllers — Health (Ms Spiteri and Mr Helps, both from DHHS) and the Deputy State Controllers (Christopher Eagle and Scott Falconer from the Department of Environment, Land, Water and Planning (DELWP)) were operating out of the SCC.[86]

66. On 3 April 2020, Pam Williams commenced in the role of COVID-19 Accommodation Commander.[87] The role was renamed Commander, Operation Soteria from 1 May 2020, though the titles continued to be used interchangeably.[88] As Commander, Operation Soteria, Ms Williams reported to the State Controller — Health (Ms Spiteri and Mr Helps).[89]

67. On 4 April 2020, DHHS established the Public Health Incident Management Team[90] — also referred to as 'Public Health Command'.[91] The structure was revised on about 8 April 2020 so as to better respond to the COVID-19 pandemic emergency.[92] The Public Health Commander and the DCHO (Dr van Diemen) led the Public Health Incident Management Team and reported to the CHO. In addition, also reporting to the Public Health Commander were four Deputy Public Health Commanders presiding over the following teams:[93]

    A. Pathology and Infection Prevention and Control (IPC)

    B. Case, Contact and Outbreak Management

    C. Strategy and Implementation

    D. Intelligence.

68. On 7 April 2020, due to the complexity of DHHS's contribution to the COVID-19 pandemic emergency, Ms Peake made a decision to divide functional responsibilities as follows:[94]

    A. the Regulation, Health Protection and Emergency Management Division, headed by Ms Skilbeck, was to be responsible for the emergency accommodation function (reporting through the Operation Soteria command structure) and enforcement and compliance functions. That division also retained responsibility for non-COVID-19 public health work

    B. the COVID-19 Public Health Command Division (COVID-19 PHC Division)[95] was to be responsible for managing the state-wide response to the critical public health risks arising from COVID-19, including the provision of public health advice to DHHS and other government agencies, IPC, case contact and outbreak management, physical distancing, public information and intelligence.

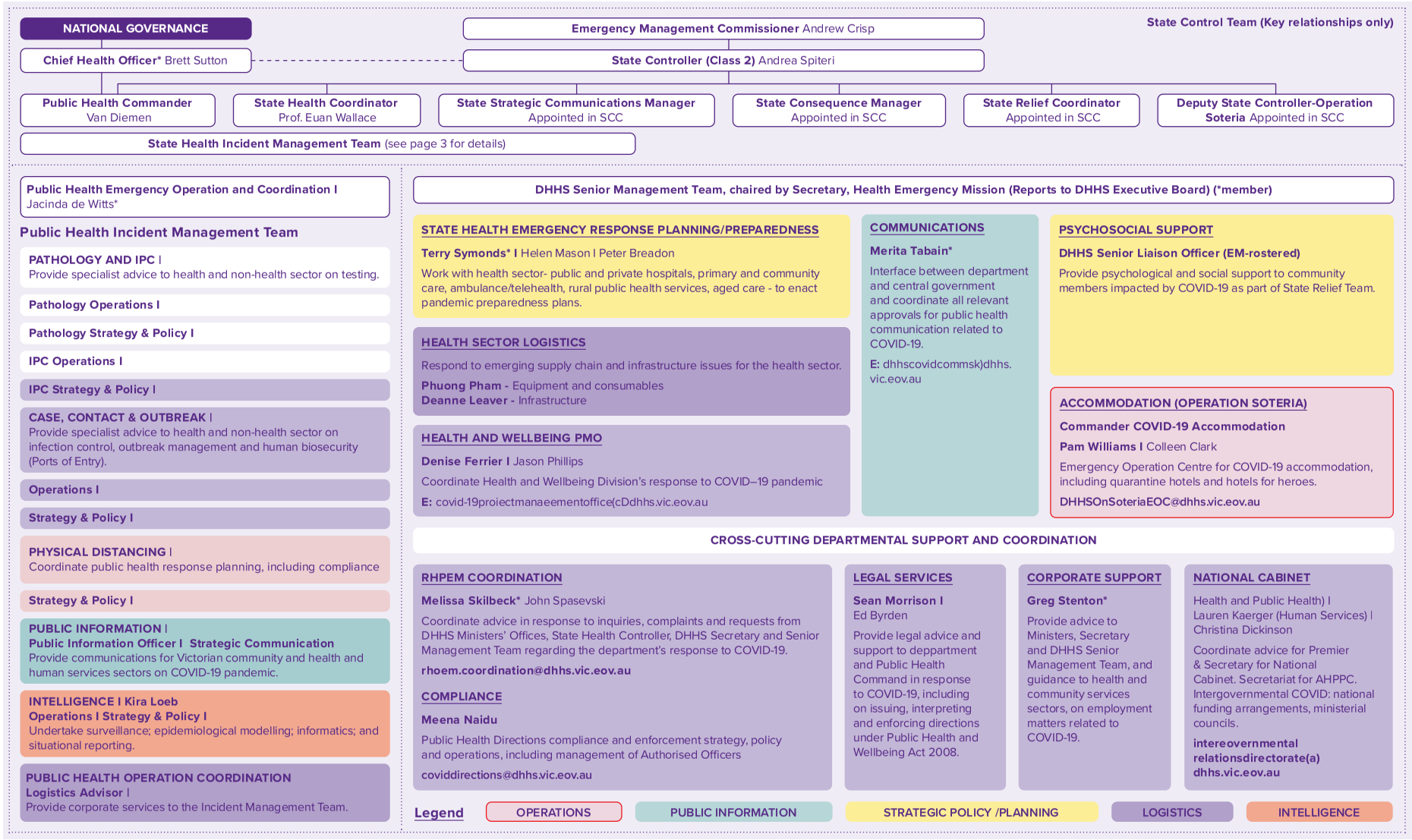
69. On 8 April 2020, Jacinda de Witts commenced in the role of Deputy Secretary, COVID-19 PHC Division.[96] Her usual role was Deputy Secretary, Legal and Executive Services Division.[97]

OPERATION SOTERIA MOVES OUT OF THE STATE CONTROL CENTRE

70. On 16 April 2020, Operation Soteria transitioned out of the SCC to a centre set up by DHHS in Fitzroy named the Emergency Operation Centre (EOC).[98] This move was a recognition that the Hotel Quarantine Program, known as Operation Soteria, needed to be run as a longer-term program rather than on an ongoing emergency footing. Ms Williams took on the role of leading Operation Soteria out of the EOC. This move was also in recognition of the realisation that Operation Soteria would be a significant and complex program and require specific attention.[99] It came to be the sole focus of Ms Williams's work.[100]

71. On about 30 April 2020, Merrin Bamert was also appointed Operation Soteria Commander, sharing the role with Ms Williams on a rostered basis.[101] Ms Bamert had previously held the role of Deputy Commander – Hotels.[102]

72. DHHS provided details of its organisational structure in response to both the COVID-19 pandemic emergency and the Hotel Quarantine Program, as of 18 April 2020, as part of a response to the Victorian Ombudsman.[103] The overall governance structure for the COVID-19 health emergency at that time is represented in Figure 8.2.2:



Source: Exhibit HQI0126(1)_RP Annexures to witness statement of Ms Melissa Skilbeck.

Figure 8.2.2: Governance structure for the COVID-19 health emergency April 2020

Relevant decision-making structures external to DHHS

73. Pursuant to the *Public Administration Act 2004* (Vic), as the then Secretary of DHHS and Department Head, Ms Peake was responsible to the relevant portfolio Ministers for the general conduct and the effective, efficient and economical management of the functions of her department and its administrative offices.[104]

74. As Secretary, Ms Peake described her 'key accountabilities' as being 'to provide strategic leadership and stewardship of the Department and associated service systems, to ensure compliance with our legislative and regulatory responsibilities, and to advise portfolio Ministers on policy and service improvements to raise health and wellbeing outcomes'.[105] She agreed that the responsibility to advise portfolio ministers included the responsibility to keep the relevant Ministers informed of 'significant issues' within their portfolios.[106]

CRISIS COUNCIL OF CABINET AND MISSION COORDINATION COMMITTEE

75. On 3 April 2020, DPC announced a new government and public service structure to respond to the COVID-19 pandemic emergency. This included the establishment of the Crisis Council of Cabinet (CCC) and the Mission Coordination Committee (MCC).[107] The CCC met for the first time on 6 April 2020.[108]

76. The CCC comprised seven ministers, each with a portfolio directed to the coordination of the COVID-19 response.[109] The CCC was tasked with determining 'all significant matters of policy, administration, budget and legislation required to respond to the COVID-19 pandemic crisis'.[110]

77. Departmental secretaries were given 'Mission Lead' roles and together formed the MCC.[111] Ms Peake was appointed to the role of Mission Lead Secretary — Health Emergency.[112] As such, she was to support the Minister for the Coordination of Health and Human Services, a role undertaken at the time by the Hon. Jenny Mikakos in addition to her role as Minister for Health.[113] The Mission was tasked with 'leadership of the health response to COVID-19'.[114]

78. Ms Peake was accountable directly to the Premier for delivery of that Mission.[115] As explained in her evidence, in the ordinary course of events, Ms Peake was accountable primarily to the five Ministers of DHHS, and not directly to the Premier.[116] Thus, her accountability as Mission Lead involved an extra line of reporting.

79. The Premier's letter to Ms Peake of 3 April 2020 outlined the new government structures that were being put in place, as follows:

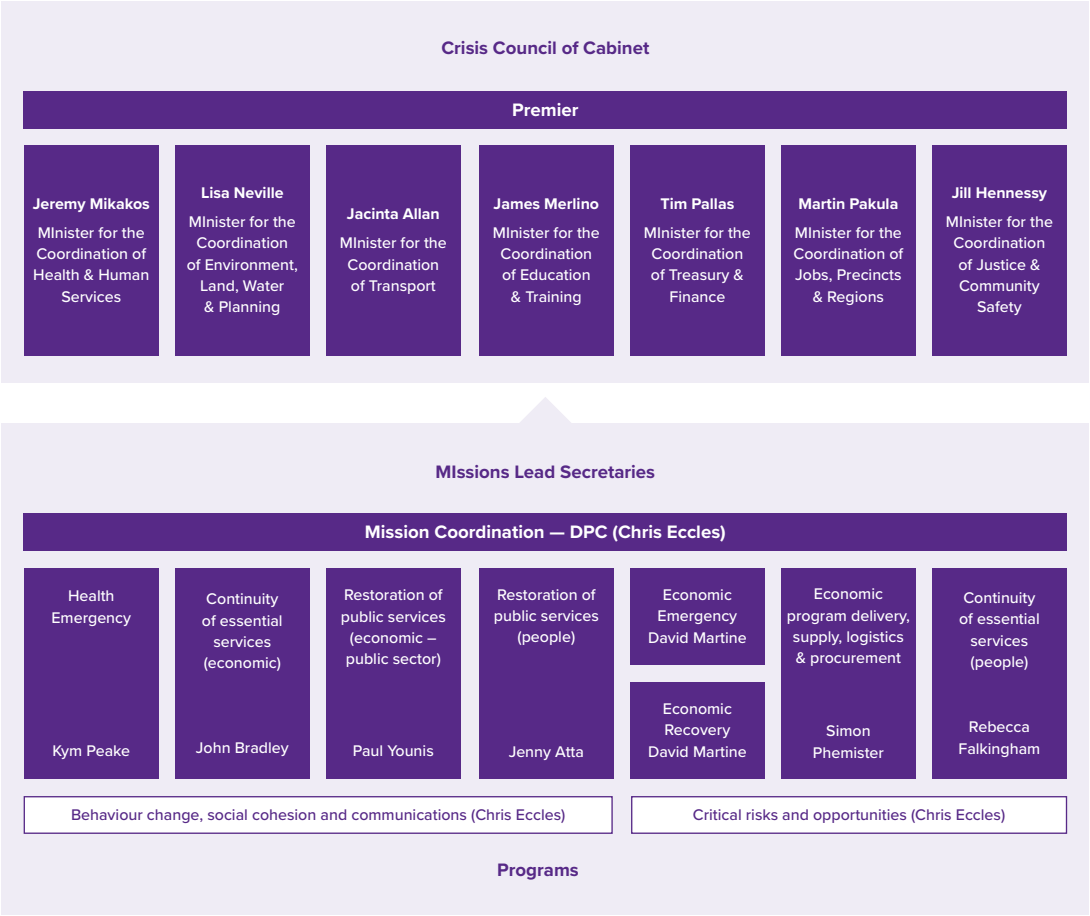
> In this role you are accountable to me for the delivery of the missions. You will assist the new Crisis Council of Cabinet (CCC) which I have convened and new portfolio Ministers appointed to act as 'Minister [sic] for the Coordination of the COVID-19 response. The CCC will determine all significant matters of policy, administration, budget and legislation required to respond to the COVID-19 pandemic crisis.
>
> The new portfolio Ministers will comprise the CCC and report to me in developing and implementing the Victorian Government response, which will be structured around the core missions outlined in Attachment A. I ask that you support the Minister for the Coordination of Health and Human Services - COVID-19 in this new portfolio.[117]

80. Ms Peake explained these changes as a 're-conceptualisation of the architecture of Government' to deal with the pandemic, which had been implemented due to the scale and complexity of the crisis.[118] She said:

> ... there were a whole series of risks, threats and consequences that did require a whole-of-Government policy and strategic set of decisions and did require decision-making about allocation of resources that go beyond the remit of the control agency and the control function, and that's precisely why our Government made the decision to establish, alongside the arrangements for the emergency management functions, the Crisis Council and the mission coordination structures.[119]

81. As of 3 April 2020, the structure of the CCC and Core Missions were as outlined at Figure 8.2.3.

Figure 8.2.3: Structure of Crisis Council of Cabinet and the Core Missions



Source: Exhibit HQI0193_P Letter from the Hon Daniel Andrews MP to Ms Kym Peake.

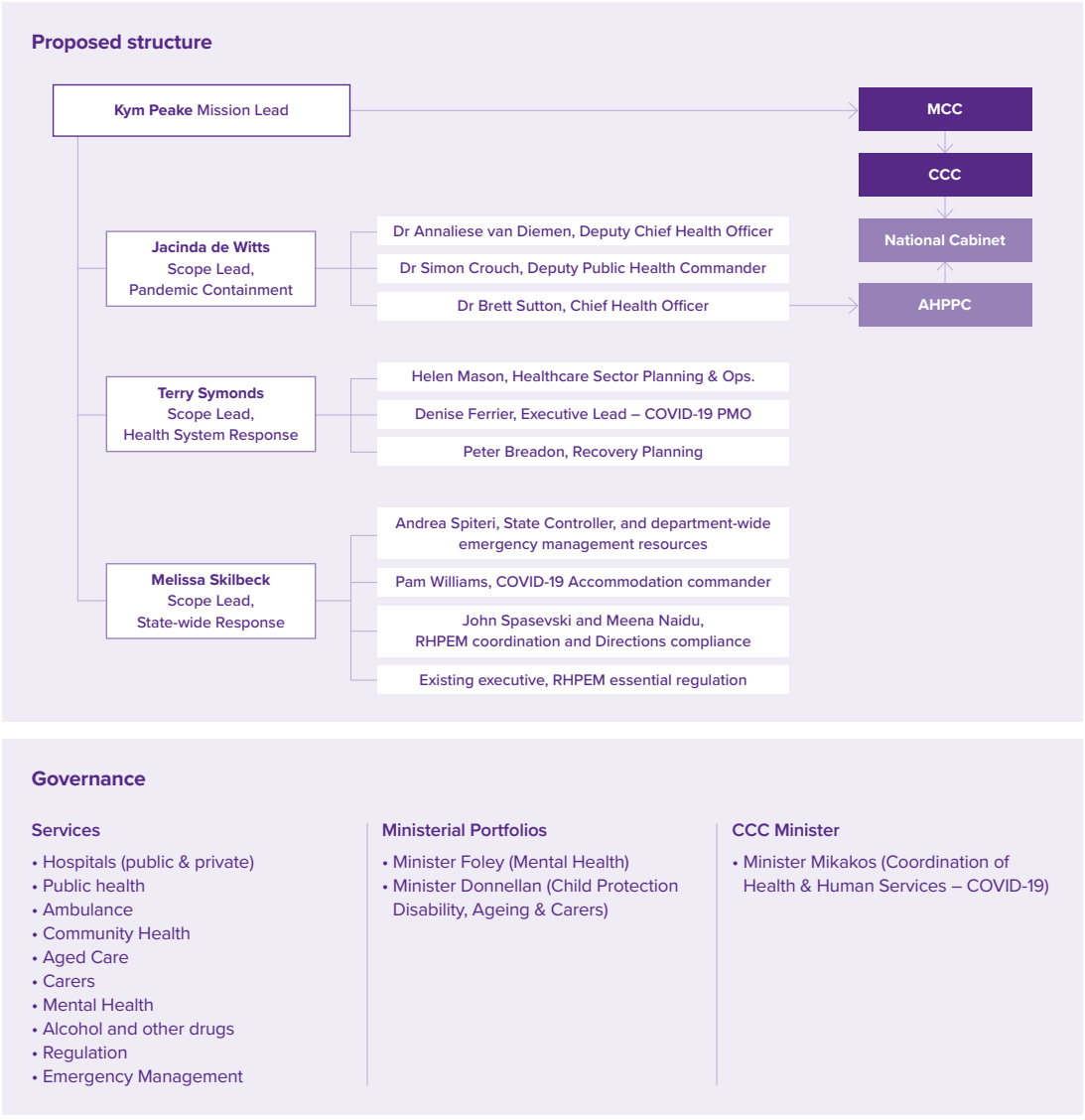
82. By his letter to Ms Peake, the Premier designated two immediate tasks to her: first, that she establishes an implementation plan for the Mission; second, that she nominates an Associate Secretary to be responsible for the day-to-day administration of her Department.[120]

83. Despite the direction from the Premier that she should divest herself of ongoing responsibilities as Secretary to DHHS, Ms Peake retained her day-to-day responsibilities for health[121] and appointed a Deputy Secretary only for responsibility of the day-to-day management of the human services aspect of her usual role.[122]

84. Even though this was a departure from what the Premier had requested of her expressly, and in writing, she did not raise it with the Premier directly.[123] Rather, Ms Peake explained that, following subsequent discussions at the Victorian Secretaries Board (VSB), she retained some of her day-to-day responsibilities because 'health and public health were so intrinsically tied to the mission responsibilities'.[124] As Ms Peake was aware, there were no minutes or records of that discussion available.[125] Nor has the Inquiry received any such minutes or records. Nevertheless, Ms Peake explained to the Inquiry that she was satisfied that she 'acquitted' the Premier's request by way of her discussions at the VSB meeting and with the then Secretary to DPC, Christopher Eccles.[126]

85. Ms Peake confirmed that the Mission Implementation Plan that was created following the Premier's request included a governance structure that was in place for some time prior to June 2020.[127] That structure was as outlined at Figure 8.2.4.

Figure 8.2.4: Mission structure and governance

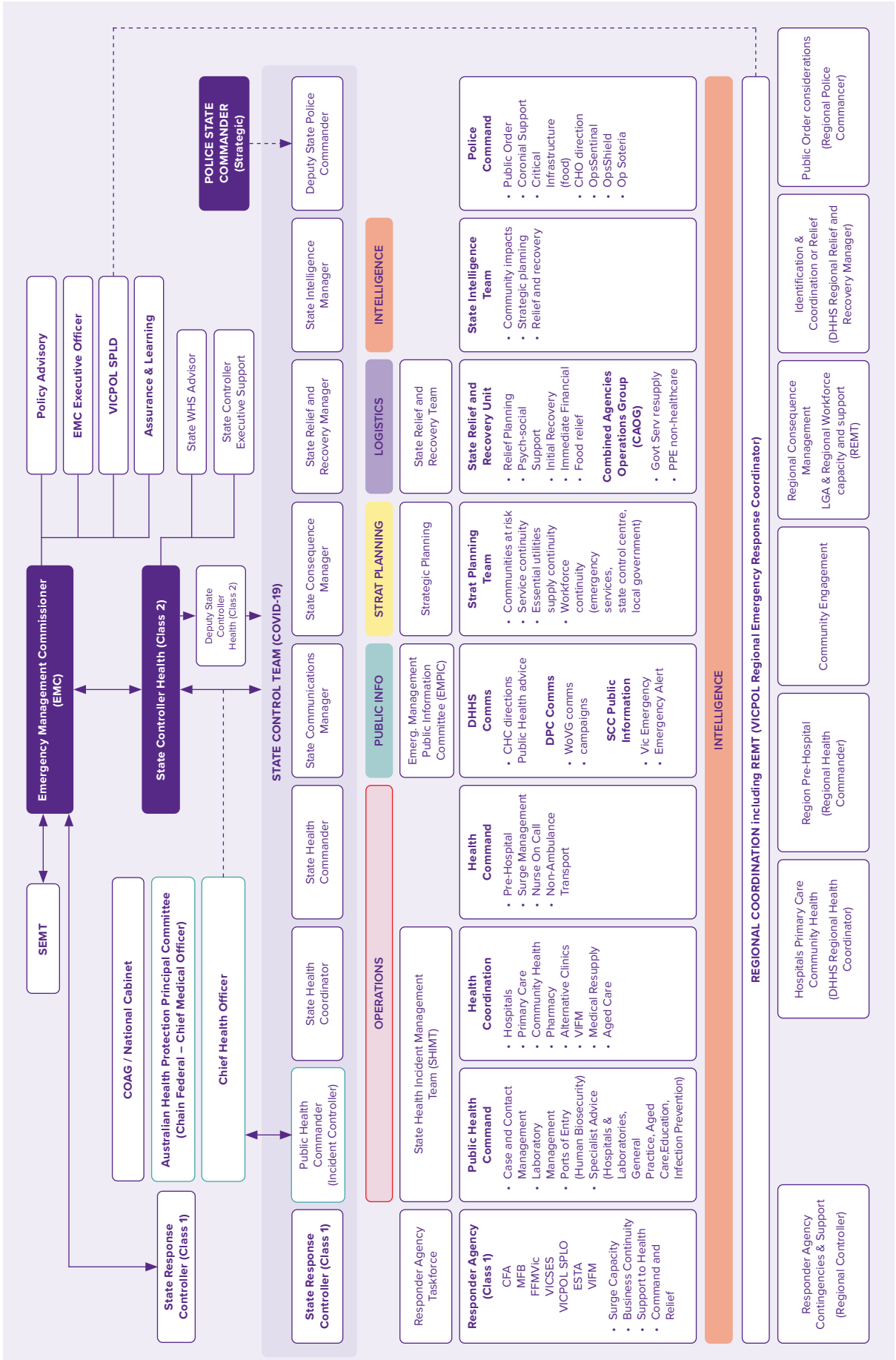


Source: Exhibit HQI0194_RP Mission Implementation Plan.

86. This structure showed, and Ms Peake agreed,[128] that there was a direct reporting line into the MCC and the CCC from the emergency management framework through Ms Skilbeck. Separately, there was a reporting line into the CCC through Public Health Command from Ms de Witts.

87. In evidence, Ms Peake was also shown the State Governance Structure for the COVID-19 pandemic emergency, as contained in the State Operations Arrangements document as of 22 May 2020, as outlined in Figure 8.2.5.[129]

Figure 8.2.5: State governance structure for the COVID-19 pandemic emergency



Source: Exhibit HQI0167_RP EMV State Operational Arrangements COVID-19.

88. Given the maze-like presentation of this document, when asked if people in charge understood the intersection of the CCC and MCC structures with the State Operational Arrangements, Ms Peake responded that, in the beginning of the pandemic, she did not think that, due to their emergency management background, staff would have expected there to be such an intersection between the emergency management frameworks and the whole-of-Government Cabinet structures. She explained that a lot of work was done to determine how that intersection would work but that, ultimately, and in her opinion, the arrangements were well defined and documented.[130]

89. It was suggested by Ms Peake that the State Operations Arrangements governance structure was 'an elaboration of the emergency management element [of the Mission Structure]'.[131] When it was put to Ms Peake that the two structures had differing reporting lines, that is, that the State Controller — Health reported to the Emergency Management Commissioner under the emergency management framework and to Ms Skilbeck under the Mission Structure, Ms Peake said:

> They're related to each other, but one is for the purpose of policy, resourcing, decision-making. And this [the operational arrangements] is for the command structure, for making sure that where we are operationalising a response, that we have the elements in place for that response.[132]

90. Later in her evidence, Ms Peake explained that there were different processes and structures for reporting to Cabinet than there were for operational functions on the ground. She said:

> So I think that it is appropriate, and it is really understood by members of my staff that the reporting lines for a Government decision-making process are one set of reporting lines, and the operational structures for either a program or an emergency management operation are acquitting a different purpose.[133]

91. It was Ms Peake's evidence that the structures and governance frameworks were, at least after some time, well understood. As will be discussed later in this chapter, there is evidence from other DHHS witnesses, including those involved in the operational elements of the Hotel Quarantine Program, that suggests the separation of decision-making from operations, a bifurcation that Ms Peake described as appropriate, was not well understood and, at times, served to fracture and confuse roles and responsibilities and lines of reporting and accountability as designated under the SHERP.

8.2.4 Establishment of separate roles for Regulation Health Protection and Emergency Management Division, and COVID-19 PHC Division (decision-making structures within DHHS)

92. Prior to the COVID-19 pandemic emergency, Prof. Sutton headed up the Health Protection Branch, which sat in the Regulation Health Protection and Emergency Management Division.[134] The Health Protection Branch consisted of two DCHOs; the DCHO (Communicable Diseases), a role fulfilled by Dr van Diemen, and DCHO (Environment), a role fulfilled by Dr Angela Bone.[135] The communicable diseases team within the Health Protection Branch formed the basis of what would become the Public Health Command and, later, the COVID-19 Public Health Division.[136]

93. As noted above, on 7 April 2020, Ms Peake divided functional responsibility for the COVID-19 pandemic response across two Divisions in DHHS. As a result, public health functions (in respect of the COVID-19 pandemic emergency) were taken out of the Regulation Health Protection and Emergency Management Division and formed the separate COVID-19 Public Health Command (PHC) Division, with a second reporting line from Ms de Witts to Ms Peake.[137] This was also reflected in the Mission Structure, where information regarding 'pandemic containment' came to the MCC through Ms de Witts and the COVID-19 PHC Division and information about the 'state-wide response' came to the MCC through Ms Skilbeck.[138] I discuss the DHHS COVID-19 PHC Division in more detail below, at Section 8.2.6.

94. Ordinarily, the CHO reported to Ms Skilbeck as Deputy Secretary, Regulation Health Protection and Emergency Management.[139] However, from about 8 April 2020, when Ms de Witts was seconded to assist the COVID-19 emergency response, the CHO had a dual reporting line to both her and to Ms Skilbeck.[140] Neither Ms Skilbeck nor Ms de Witts have a background in public health.[141]

95. During examination, Prof. Sutton explained that he continued to have a reporting line to Ms Skilbeck because his statutory obligations to protect the health and wellbeing of Victorians outside of the COVID-19 pandemic emergency continued and he remained accountable to Ms Skilbeck in respect of that work.[142]

96. Prof. Sutton also gave evidence that, although he reported to Ms de Witts, she did not have a role in approving public health advice.[143] Prof. Sutton did not accept that Ms de Witts's role was as a mere conduit for that advice but agreed that she was 'a point of liaison for that advice into the Department'. He explained her role:

> … as ensuring that the issues that arose that required executive awareness and action at the executive board level of DHHS or reporting through to the Secretary were facilitated … And so, it was to try and bring a more sustained, almost bureaucratic structure to that command-and-control structure …[144]

97. It is apparent that the DHHS leadership made a decision early in the COVID-19 pandemic emergency response (probably understandably, at the time, in consideration of the enormous volume of work being undertaken) to separate the Department's public health structures from the operational aspects of Operation Soteria and the wider COVID-19 pandemic emergency response.

98. This had ramifications for the operation of the Hotel Quarantine Program through Operation Soteria.

State Controllers — Health

99. As was noted above, Ms Peake, on the advice of Ms Skilbeck, did not adopt the 'normal' course of appointing the CHO, Prof. Sutton, as the State Controller — Health. Ms Peake appointed Ms Spiteri as State Controller — Health on 1 February 2020 and, on 7 February 2020, Mr Helps was also appointed as State Controller — Health.[145]

100. The functions of the State Controller — Health in a Class 2 emergency are set out in paragraphs 35 to 39 above. In a Class 2 emergency, the first-listed responsibility for the State Controller — Health is to 'lead and manage the response to a Class 2 emergency'.[146]

101. Mr Helps and Ms Spiteri gave evidence that the role of State Controller — Health did not operate in the Hotel Quarantine Program as would ordinarily be envisioned under the SERP and the SHERP. Mr Helps explained that critical decision-making for the emergency response was undertaken by National and/or State (Crisis) Cabinets.[147] He described these among the 'key control decision-makers' and said they, rightly, included decisions made by the CHO or the AHPPC, given their expertise in public health.[148]

102. Mr Helps explained:

> … the structure that we set up in Victoria meant that the Chief Health Officer and the Public Health Commander had absolute control of the public health emergency across the entire State, so they were the Incident Controllers for the emergency across the State.
>
> The State Controller — Health role was to complement the public health response by managing the consequences, the broader community consequence, of that emergency. So, my role wasn't to effectively lead the decision-making in regards to public health or national or State policy in regards to the significant restrictions on civil liberties, on international trade, et cetera.[149]

103. Mr Helps agreed in examination that, ordinarily, the EMMV envisaged a decision-making and leadership role for the State Controller. He stated that, in the context of Operation Soteria, the State Controller — Health could not fulfil that role. He added, however, that this was 'well known and well recognised'.[150]

104. Ms Spiteri agreed that, ordinarily, the State Controller — Health would be vested with significant decision-making power under the EM Act, particularly in the context of an emergency such as a bushfire, which is generally a more localised emergency. However, due to the far-reaching nature of the decisions made (in the context of a pandemic), that decision-making was occurring elsewhere, namely at National and State Cabinet levels. She added, however, that there was still a decision-making element to the role.[151]

105. Ms Spiteri accepted that the State Controller — Health's principal responsibility in Operation Soteria was to be operationally accountable for the quarantine of returned travellers.[152] In practice, this meant the State Controllers — Health were responsible for ensuring:[153]

A. there was an appropriate operations plan in place, with clear roles and responsibilities allocated for the Program

B. all necessary structures and governance arrangements were in place to manage the emergency, including the escalation and resolution of issues

C. environmental safety at the hotels. That meant ensuring public health guidance was provided to those in charge of the people on the ground, drawing on the expertise of the Public Health Command.

106. Ms Spiteri was at pains to emphasise that, while she and Mr Helps were in 'direct control' of ensuring that public health resources and advice, including PPE and relevant instructions, physical distancing guidance and behavioural expectations were provided to those working in the Program, it was a complex environment with many players:

> The accountability for the hotel environment was … it was a complex space. You had a hotel that was owned and managed by the hotel company. We were effectively … and I think Ms Williams went to this the other day in her statement … renting space in it, through the Department of Jobs, Precincts and Regions, DJPR. We had our own staff in that … the Department of Health and Human Services had their own staff in that environment, so did DJPR, so did Victoria Police and so did a number of contracted companies as well. So overall the contribution to the safety of the environment was to ensure that there was guidance and instructions provided specifically to this emergency.
>
> …
>
> **But every person working in that environment, from an occ. health and safety perspective, was responsible both for themselves and for complying with those instructions, and also their own organisations as a workplace were responsible as well** (emphasis added).[154]

107. Ms Spiteri explained that public health information was sought from the Public Health Commander and Deputy Public Health Commanders in the Public Health Incident Management Team, and agreed that the information was then 'provided to all parties that were involved in that environment'.[155] She explained that by 'all parties' she meant the employers of those contracted staff working in the Hotel Quarantine Program, as well as the DHHS staff deployed into the hotels.[156]

Deputy State Controllers

108. The role of Deputy State Controller — Health was created on 29 March 2020.[157] It was filled by Mr Eagle and Mr Falconer, both of DELWP.[158] The role ceased on 1 May 2020, when Operation Soteria moved from the SCC to the EOC.[159]

109. The Deputy State Controller — Health position was created specifically to enact the role of the Controller of Operation Soteria.[160] This position was in the 'control line', meaning that each agency with responsibilities designated under the *Operation Soteria Operations Plan* was thereby accountable to the Deputy State Controller — Health.[161] However, notwithstanding the description of his role, Mr Eagle saw it differently and described his role as 'a coordinator between the agencies and the State Controller — Health'.[162] He agreed that the model deployed had a line of command whereby each agency had an Agency Commander at its head and those Agency Commanders would then escalate information through to him as the Deputy State Controller — Health.[163] He would then coordinate and escalate those issues to the State Controller — Health.[164]

110. Mr Eagle explained that he did not make decisions in relation to public health matters.[165] He said that he reported to the State Controller — Health and escalated questions and issues from other agencies working in the Program, including a significant number of queries relating to public health issues, but had no interaction with the broader DHHS arrangements.[166] When it was put by Counsel Assisting, Mr Eagle agreed that his:

> … role as Deputy State Controller — Health had 'health' in the title but what [he was] really doing was coordinating the logistical arrangements of the program, rather than also coordinating in any hands-on sense the delivery of public health services or public health expertise.[167]

111. Mr Eagle said that the Deputy State Controller — Health role had no power delegated under any act, and all activities he undertook, or directions given, were on the direction of (and, thus, pursuant to the powers vested in) the State Controller — Health. No one reported to him and he was only there for information flow between Agency Commanders and the State Controller — Health.[168]

112. Mr Eagle gave evidence that, during the course of the operation, it was common practice for conversations to occur, and directions to be given, directly between the DHHS State Agency Commander and the State Controller — Health or from other Agency Commanders directly to the State Controller — Health (leaving out the Deputy State Controller — Health). When asked if this made his role more difficult, Mr Eagle said that it did not. He said that this process made passing on information more efficient, without it being filtered through him.[169] Mr Eagle's evidence demonstrated a disjunct between his title and the apparent intention of the role and any apparent role in the chain of command relating to a 'health' input beyond being a conduit for information to the State Controller — Health.

113. In any event, the role of Deputy State Controller — Health changed with the establishment of the EOC in mid-April. The Deputy State Controller — Health assisted in supporting the Commander, Operation Soteria (Ms Williams and Ms Bamert) in this transition, but Mr Eagle said he had little to do with the EOC because the position of Deputy State Controller — Health was discontinued once the transition to the EOC was completed.[170]

8.2.5 Establishment of Emergency Operation Centre (EOC)

114. From the early days in Operation Soteria it was recognised that the Hotel Quarantine Program would be in place for likely up to 12–18 months.[171] The emergency management response arrangements were not something designed to be maintained long-term, and it was determined that the Hotel Quarantine Program should transition from an emergency operation to a departmental program.[172] Over the following weeks, a plan was created to transition the Program to be led by the DHHS COVID-19 Accommodation Commander, Ms Williams.[173]

115. From 16–17 April 2020, the Hotel Quarantine Program operations team moved from the SCC to the DHHS office in Fitzroy, where the EOC was established for the purpose of running the Hotel Quarantine Program.[174]

116. Both Ms Williams and Ms Bamert described the COVID-19 Accommodation Commander role as one of responsibility for the chain of command ***within*** DHHS, as it related to the department's obligations to Operation Soteria.[175]

117. As the COVID-19 Accommodation Commander positions were within DHHS, they reported up the line to the Deputy Secretary, as did the State Controllers — Health (that is, they shared a common reporting line).[176] The COVID-19 Accommodation Commander was the State Controller — Health's avenue into the Hotel Quarantine Program.[177] Ms Spiteri stated, after Operation Soteria shifted to the EOC, that the State Controller — Health roles were still positioned at the SCC, overseeing the entire COVID-19 response.[178]

118. Ms Bamert said that, as Commander, Operation Soteria, she was:

> … responsible for the day-to-day management of Operation Soteria … providing strategic and operational direction and leadership to Operations in the fulfillment of the Department's command, relief and health coordination responsibilities … providing operational leadership for returning passengers from arrival at the airport, whilst quarantined in the hotels, until exit.[179]

119. Ms Bamert described this as including 'operationalising' the public health policy developed by the CHO and Public Health Command, as well as coordinating activities for which other agencies were responsible.[180]

120. Ms Williams described her role as Commander, Operation Soteria in the following terms:

> So our Department had responsibility for the broad, if you like, the broad policy environment in which Hotel Quarantine was operating, so we were working with our public health and wellbeing colleagues around the broader policy environment in which Hotel Quarantine was operating. So, we were then operationalising those policy requirements, and we had staff in all the hotels, and our staff in the hotels were essentially overseeing what was happening in the hotels and helping to support guests in all their needs and ensuring that the hotels were operating appropriately. They would feedback to me through the operations leads and the Deputy Commanders any issues that were occurring. So, we were essentially dealing with quite a complex environment that was changing quite rapidly. We developed a set of procedures and protocols, and the support agencies would refer to us for guidance and policy advice around the functions that they were performing.[181]

121. Ms Williams and Ms Bamert gave evidence that their roles included ensuring that relevant advice, guidance, policies and procedures from within DHHS were implemented in the hotels. It was also their evidence that, in some cases, it was the responsibility of others to undertake that same task and it was those others, therefore, who were vested with responsibility for ensuring adequate implementation. During examination, Ms Williams was asked, in the context of cleaning policies for the hotels, whether it was the responsibility of DHHS to bring those specific policies to the attention of the hotels. Ms Williams ultimately asserted that it was not DHHS's responsibility but, rather, the responsibility of DJPR or the hotel contractors themselves.[182]

122. Dr van Diemen was asked to comment on the responsibilities of the Commander, Operation Soteria as outlined in the *Operation Soteria Operational Plan* where it is said that the 'DHHS Commander COVID-19 Accommodation is responsible for … ensuring a safe detention at all times'.[183] In response, Dr van Diemen said:

> I think, looking at that point in retrospect, it could be interpreted that the DHHS Commander was responsible for the safe detention environment of individuals in hotel quarantine, or it could be interpreted that the Commander is responsible for the overarching hotel quarantine environment.[184]

123. This lack of clarity and consistency as to the nature of the roles, reflected both in the documentation guiding Operation Soteria and in the subjective understanding of those involved as to the limits of their accountability in the Hotel Quarantine Program, unfortunately, was a repeated theme, which I discuss further below in Section 3.

Role of the Chief Health Officer in the Hotel Quarantine Program

124. For the purposes of a response to a Class 2 emergency, the SHERP envisaged that public health expertise would be embedded in the command structure of the health emergency response by appointment of the CHO to the role of State Controller. The non-appointment of Prof. Sutton as State Controller — Health, his views about that and the impact of it are dealt with from paragraph 254 below.

125. As CHO, Prof. Sutton was responsible for the Public Health Command structure, including the Public Health Incident Management Team.[185] In that role, he was vested with capacity to raise issues directly with the Minister for Health and the Secretary to DHHS.[186] However, it was Prof. Sutton's evidence, emphasised particularly in two affidavits produced following the close of the evidentiary hearings, that, despite those accountabilities, he and Public Health Command 'were not in day-to-day decision-making roles'[187] and, as such, were somewhat disenfranchised in the running of the Program.

126. Prof. Sutton gave evidence that one of his key areas of focus in the COVID-19 pandemic emergency response was in relation to his membership on the AHPPC and attendance at almost daily meetings of the AHPPC since mid-February 2020. In this capacity, he contributed to the nationwide response to the pandemic, including through the preparation of briefings and recommendations.[188]

127. He described his other areas of responsibility in relation to the pandemic, more generally, as:[189]

    A. playing a leading role in public communications in relation to the government-controlled measures (the directions and the enforceable requirements)

    B. providing advice, taking into account AHPPC recommendations, on COVID-19 and appropriate mitigation measures and the matters they address in their public statements and in Victoria, by advising the Minister for Health, the Premier and the CCC on policy settings for key public health issues

    C. making decisions on critical matters, normally raised with him by the DCHOs, usually where something was of high consequence and/or importance, or otherwise contentious or sensitive and therefore escalated to him.

128. Dr van Diemen gave evidence that, because the emergency response to the pandemic required the exercise of powers contained in the PHW Act, under which the CHO is the 'primary person', she continued to report to the CHO in her capacity as Public Health Commander because, 'it was made clear that [the CHO], regardless of whether he was the State Controller, would retain control over and ultimate responsibility for the public health response'.[190]

8.2.6 Structure and function of Public Health Command (Public Health Incident Management Team and, later, COVID-19 PHC Division)

129. Prof. Sutton gave evidence that the size and structure of the DHHS Public Health Team evolved over time due to the COVID-19 response.[191]

130. Dr van Diemen explained that the Public Health Incident Management Team is an emergency management structure that was 'stood up' in response to an incident.[192] The Public Health Incident Management Team was stood up in respect of the COVID-19 pandemic emergency and as 'the incident' continued and multiplied, it became necessary for the structure of the Public Health Incident Management Team to develop into a more regular government structure.[193] That structure became the COVID-19 PHC Division.

131. Ms de Witts described the key functions of the COVID-19 PHC Division as follows:[194]

    A. Case, Contact and Outbreak Management, which was responsible for undertaking contact tracing and responding to outbreaks

    B. Intelligence, which was responsible for undertaking surveillance, epidemiological modelling, informatics and situational reporting

    C. Physical Distancing, which was responsible for formulating the public health directions required to manage the virus (but not for compliance with those directions, which was managed by the Enforcement and Compliance branch within the Regulation, Health Protection and Emergency Management Division)

    D. Pathology and IPC Policy, which was responsible for advising on testing issues, working with public and interstate laboratories and research institutions, setting overarching IPC policies for the State, providing cleaning and personal protective equipment (PPE) policies (available publicly on the department's website) and providing specific advice on complex settings

    E. Public Information, which was responsible for providing communications for the Victorian community and health and human services sectors on the COVID-19 pandemic (which included content input from the other teams as needed)

    F. Public Health Operation Coordination, which was responsible for providing corporate services (such as finance support, HR support, procurement and rostering) to the Division.

132. Each of the Deputy Public Health Commanders reported to the Public Health Commander who, in turn, reported to the CHO.[195]

Role of the Public Health Commander

133. Dr van Diemen's usual role was DCHO – Communicable Diseases. This role sits in the Health Protection Branch of DHHS.[196] In the context of the COVID-19 pandemic emergency, she was also the Public Health Commander (as described above). In each role, she was required to report to Prof. Sutton as CHO.[197]

134. Dr van Diemen also had functions under the PHW Act, separate from her role as Public Health Commander and as DCHO. She was delegated a number of the CHO's powers pursuant to instruments of delegation and was also an Authorised Officer under the PHW Act.[198] It was in that latter capacity that she issued detention directions under the PHW Act, which gave the legal bases for the Hotel Quarantine Program. While Dr van Diemen signed the directions identifying her role as the DCHO, she explained in her evidence:

> So all of the directions were issued as an authorised officer. The fact that I was Deputy Chief Health Officer was, I suppose, inconsequential to the issuing of directions, but as an authorised officer, yes, I did issue a large number of other directions both in terms of the primary issuing of the direction and in terms of re-issuing of directions as the State of Emergency was extended on a number of occasions.[199]

135. The SHERP describes the role of the Public Health Commander as follows:

> The Public Health Commander reports to the State Controller and is responsible for commanding the public health functions of a health emergency response (including investigating, eliminating or reducing a serious risk to public health).
>
> Performing the function of Public Health Commander does not alter in any way the management, control and emergency powers of the Chief Health Officer under the PHW Act.
>
> In performing this function, the Public Health Commander will liaise directly with the State Health Commander and State Health Coordinator.
>
> For emergencies where the Public Health Commander is not appointed the State Controller, the Chief Health Officer's authority under the PHW Act remains unaffected, and their decisions on matters of public health should not be overridden by a State Controller.[200]

136. In final submissions, DHHS contended that, as the Public Health Commander led the Public Health Incident Management Team, Dr van Diemen '[sat] between the emergency and the Public Health Teams and provided direct input into decision-making as a member of the State Control Team'.[201]

137. Somewhat at odds with that submission, Dr van Diemen gave evidence that, despite what is said in the SHERP, and despite the various governance structures placing the Public Health Commander in the State Control Team with a direct line of report to the State Controller — Health,[202] in practice she did not report to the State Controller — Health but reported to the CHO and, instead, fulfilled an advisory role to the State Controller — Health.[203] She described her role as Public Health Commander in respect of the Hotel Quarantine Program as:

> Under SHERP, where DHHS is the control/lead agency, as it is for the current emergency, the PHC is responsible for commanding the public health functions of a health emergency response (including investigating, eliminating or reducing a serious risk to public health). The hotel quarantine program was not a public health function but an emergency management function and response relating to a health emergency. As such, my functions as PHC in relation to the hotel quarantine program related to the issuing of directions as delegate of the CHO (although that role is not undertaken in the capacity of PHC); and as PHC, issuing guidance and advice relating to COVID-19, and setting policies and procedures to address the health and wellbeing of returned travellers. The State Controller has oversight for the implementation of that advice, guidance, policies and procedures.[204]

138. Prof. Sutton agreed in his evidence that there was no clear or direct reporting line from Public Health Command into Operation Soteria. Specifically, in respect of Dr Romanes, Prof. Sutton observed:

> The Deputy Public Health Commanders, all four of them, reported to the Public Health Commander, who reported to me. So, I wouldn't say that it's a report directly into the State Controller, but Dr Romanes, in particular, was engaged in advice on policy and other guidance matters to Operation Soteria more than most. But it was a … it was more in the liaison role than a direct line of command.[205]

139. However, in Prof. Sutton's later affidavit evidence he said:

> While Dr van Diemen as DCHO reported to me as CHO, she also reported to the State Controller in her role as Public Health Commander in Operation Soteria. In this way, the command roles for the Hotel Quarantine Program were not in the Public Health – Incident Management Team but were under the State Controllers within the emergency management framework.[206]

140. The role of the Public Health Commander as envisaged in the SERP and SHERP reflects the intention that there be a strong public health focus in the response to any health emergency. The actual role that Public Health Command did have, and the role that it should have had, is discussed in greater detail below in Section 8.3.

Infection Prevention and Control (IPC)

141. Dr Katherine Ong was the Deputy Public Health Commander Pathology and Infection, Prevention and Control. In early April 2020, Dr Ong established an Infection Prevention and Contol Cell (IPC Cell) at the request of Dr van Diemen (as Public Health Commander).[207] As I have described earlier, in Chapter 7, the IPC Cell was initially staffed by **one** DHHS IPC Consultant, along with two part-time IPC consultants. The IPC Cell expanded over time, with two additional part-time IPC consultants joining in mid-April 2020 and a further part-time consultant joining in mid-May 2020.[208]

142. However, Dr van Diemen gave evidence that, at the time of a request from Operation Soteria in early April 2020 to the 'infection control' team, that team consisted of one person.[209] Later in her evidence Dr van Diemen explained:

> At the beginning of the pandemic, there was a single person who was employed as an IPC consultant for public health matters specifically in my team in communicable diseases. That person, obviously when COVID started, was primarily working or entirely working on COVID, and we have since employed a number of other people into the Incident Management Team or into the public health operations for COVID. But at that time there was a single person. I believe there's one other person in the Department who is an IPC consultant who joined us, and I would have to check at what point she did, but she wasn't employed as such in her substantive role in the Department.[210]

143. The DHHS IPC Consultant gave evidence that she had no formal role in the Hotel Quarantine Program and the IPC Cell was only responsible for providing advice and guidance from time-to-time as queries from those working in the Hotel Quarantine Program were received.[211] Prof. Sutton's evidence echoed that of the Consultant. He explained that the IPC Cell, through the Public Health Incident Management Team, provided advice:

> … to innumerable settings across the State, from public transport settings to residential settings to various other settings, and so oversighting how that guidance or policy direction was implemented across the State in all of those settings was not part of our purview.[212]

144. DHHS, subsequently, engaged an external IPC consultant through Infection Prevention Australia to assist with providing IPC advice to the Hotel Quarantine Program.[213] The arrangement commenced around the time that the Rydges Hotel in Carlton was established as a 'hot hotel'.[214] Dr van Diemen gave evidence that the advice produced by Infection Prevention Australia was only looked over by DHHS's internal team but developed by the external person for the Hotel Quarantine Program.[215]

145. Further discussion of the IPC advice and training that was implemented in the Hotel Quarantine Program and, in particular, in relation to the hot hotels, is contained in Chapter 9.

Case, Contact and Outbreak Management

146. Dr Simon Crouch and Dr Clare Looker fulfilled the role of Deputy Public Health Commander Case, Contact and Outbreak Management (CCOM) within the Public Health Incident Management Team; a role that was shared on a rostered basis.[216]

> The Public Health Incident Management Team, led by the Public Health Commander, has responsibility for the public health management of COVID-19 cases and outbreaks. When an outbreak is identified, an Outbreak Management Team (OMT) will be constituted under the guidance of the Deputy Public Health Commander Case, Contact and Outbreak Management (DPHC CCOM).[217]

147. According to the Outbreak Management Plan, the core members of an OMT included the Outbreak Lead, who reports to the Deputy Public Health Commander, CCOM (Dr Crouch and Dr Looker), the Case and Contact Management Lead and the Epidemiology Lead, who both report to the Outbreak Lead, and the DHHS Agency Commander who represented the State Controller — Health and an Outbreak Squad Coordinator. [218]

148. Under the Outbreak Management Plan, an OMT is to be created in respect of each outbreak that occurs. Each OMT is led by an Outbreak Lead with responsibility for overseeing the outbreak response.[219] Dr Sarah McGuinness stated that she had the overall role of 'Outbreaks Lead', which is distinct from the role of Outbreak Lead for a specific outbreak, despite the near-identical title.[220]

149. Dr Crouch explained that Outbreak Squads were established by the Outbreak Squad Coordinator, if deemed necessary by the OMT.[221] The Outbreak Squad was the 'eyes and ears on the ground'.[222] It was required to report back to the OMT and provide advice on the ground, including in relation to IPC, PPE and cleaning.[223]

150. Dr Crouch stated that, while the Outbreak Lead for an OMT should be required to directly report to the Deputy Public Health Commander CCOM, it was decided that the Outbreak Squads would report directly to Ms de Witts, as Deputy Secretary, COVID-19 PHC Division and not via the Deputy Public Health Commander CCOM, who were also, separately, reporting at that time to Ms de Witts.[224]

151. A detailed discussion of the outbreaks that occurred at the Rydges and Stamford hotels is contained in Chapter 9.

Strategy and Implementation (Planning)

152. Dr Romanes was the Deputy Public Health Commander, Strategy and Implementation (also known as Deputy Public Health Commander – Planning).[225] The responsibilities of the Deputy Public Health Commander – Planning included responsibility for the Physical Distancing Cell. The functions and role of the cell were to advise the Public Health Commander and to provide evidence and an informed policy rationale for decisions. The cell also prepared and consulted on policy and procedures.[226]

153. While Dr Romanes, as Deputy Public Health Commander – Planning, was not directly involved in Operation Soteria, Prof. Sutton described him as being engaged in advice on policy and guidance matters to Operation Soteria 'more than most'.[227] Dr Romanes's statement includes a reference to this in his description of his role as Deputy Public Health Commander – Planning:

> As DPHC Planning, I took an active role in advocating on behalf of the PHC/DCHO and CHO for a central location for all plans that drive actions and an involvement by Public Health Command in the operational structure for the hotel quarantine program, including recommending clear governance, clear lead roles, and comprehensive operational plans to assist officers and detainees. In mid-April it was decided between the PHC/DCHO and the State Controller that the Public Health – Incident Management Team would be responsible for providing policy and procedures and the Emergency Operation Centre would be responsible for implementing those procedures.[228]

154. It seems that it was around this time (that is, mid-April 2020) when Dr Romanes's active involvement (as described) lessened.[229]

155. Dr Romanes stated that his team's role in the Hotel Quarantine Program was most active up until about 15 April 2020.[230] In this period, his team developed a range of policies and procedures, including the draft *COVID-19 DHHS Physical Distancing and Public Health Compliance and Enforcement Plan*[231] and the *COVID-19 Interim Healthcare and Welfare Mandatory Quarantine plan* — a single policy addressing the healthcare and welfare of people in mandatory quarantine.[232]

156. However, like other members of Public Health Command, it was Dr Romanes's evidence that he was not responsible for **implementing or overseeing** those procedures, and that work was to be carried out by the DHHS run EOC.[233]

8.2.7 On-site at Quarantine Hotels

157. There was a range of personnel on-site at any given time at each of the hotels engaged in the Hotel Quarantine Program, including hotel staff, cleaning contractors, nurses and doctors from various agencies, security guards contracted and subcontracted and some employed by hotels, specialised cleaning contractors, DJPR staff and DHHS staff including Authorised Officers and Team Leaders. A central question during the Inquiry was not only who was in charge of the operation of the Hotel Quarantine Program overall, but who was in charge at each of the sites. DHHS as the control agency and the department that held the legal powers to detain people in quarantine had an on-site presence reposed in two roles: Team Leaders and Authorised Officers.

DHHS TEAM LEADERS

158. The evidence of Ms Williams was that DHHS Team Leaders were on-site every day from early in the morning to late in the evening. She explained they had a roving person overnight and that there was an Authorised Officer on-site at all times.[234] Ms Bamert agreed that as Commander, Operation Soteria, part of her role was to provide leadership to the DHHS Team Leaders, and to enable them to report through the Operation Soteria command structure as required.[235]

159. Ms Williams gave evidence that many of the DHHS Team Leaders had worked in previous emergencies and, therefore, had some training.[236] This included staff from within DHHS as well as those from other government departments.[237] However, in her evidence, Ms Bamert conceded that Team Leaders were recruited from a range of backgrounds[238] and that she had concerns about DHHS's capacity to provide 'suitably skilled' personnel.[239]

160. Ms Williams gave evidence about how public health advice was 'operationalised' in the Hotel Quarantine Program, explaining that EOC operational staff attended on-site at the hotels and worked with DHHS Team Leaders on the ground.[240]

161. While Ms Williams described the role of DHHS Team Leaders as being to coordinate and problem solve,[241] she also noted that significant reliance was placed on contractors operating in the Hotel Quarantine Program. She explained:

> So there were a range of people who were operating according to their contractual obligations and their understanding of their responsibilities and they had managers. And our team leaders were there to coordinate the issues, to ensure that guest issues were dealt with promptly, and that the hotel was operating well. If there was a hotel issue, they would deal with the hotel manager on a day-to-day basis. If it was a significant issue, they would go to the DJPR site leader. Those site leaders, as I mention in my statement, were there initially quite a lot and then they were remote at other times. So as the program went on, they were more remote. They would deal, if there were security issues, they would deal with the security team leader. If there were bigger problems than they could deal with on-site, they would escalate either to DJPR or they would come through us in the Emergency Operation Centre.[242]

162. Ms Williams was asked whether she would, based on her explanation above, characterise the Team Leaders as being 'in charge' on-site, to which she responded that the term was 'somewhat loaded' in the context of the Inquiry.[243] She described the Team Leaders as being 'our representatives on-site'.[244] She went on to say:

> This was an environment where the usual things that you do to develop a team weren't possible. Sitting close to one another and sharing stories and being able to have team meetings were all more difficult. So it was a difficult environment but the team leader was our representative on the site. They worked closely with other people. The hotel managers were managing their hotel. Security companies had team leaders on-site who were managing their operation. DJPR was overseeing that side of it. We had our nurses and mental health nurses, et cetera, and the coordination came through our team leader.[245]

163. Ms Bamert described the role of the Team Leaders as being to:

> … coordinate people on the ground and to really support processes, to make sure that the nurses had anything they needed, to be a conduit back into the command structure, to, you know, provide us with any evidence of the risk or, you know, any concerns that they might have had that we could look for systematic failures. So, you might have an issue at one hotel, is that pre-empting other issues at other hotels? It was to work very closely with the DJPR site leader as well to look at implementing the policies that were written.[246]

164. Noel Cleaves, Senior Authorised Officer, gave evidence that, in some cases, the DHHS Team Leaders did dictate operations on the ground in hotels. For example, he said that operational decisions, such as the suspension of all fresh air breaks, were communicated to Authorised Officers (via emails or verbally) by the DHHS Team Leaders.[247] He went on to observe that 'the hotels, for the time I was involved in the program, did not run as a classic pyramid organisational structure … it wasn't as clear as there was one person who had ultimate authority for everything that happened inside that hotel'.[248] Mr Cleaves went on to explain, consistent with Ms Williams, that 'the DHHS team leaders had a coordination function and performed that well but they did not have operational control over authorised officers'.[249]

165. Murray Smith, who held the position Commander, COVID-19 Enforcement and Compliance, gave evidence that the DHHS Team Leaders were the 'port of call for services provided by DHHS' and that, for functions falling outside of those services, other Departments had site managers in the hotels.[250]

166. Jan Curtain of Your Nursing Agency said, in her evidence, that 'DHHS would appoint a Team Leader for each shift who would be in charge of each hotel during that shift'.[251] Likewise, Eric Smith of SwingShift Nurses gave evidence that the DHHS Team Leaders had the 'responsibility for ensuring health and safety risks were properly managed'.[252]

167. The evidence of Ms Williams and Ms Bamert was that DHHS Team Leaders performed a coordination function in the hotels but that should not be characterised as evidence that Team Leaders were 'in charge'. Despite this, the perception of some other witnesses, who were on the ground in hotels and who were not DHHS employees, was that DHHS Team Leaders were in charge of the Program at the hotel sites.

AUTHORISED OFFICERS

168. Authorised Officers are common across the Victorian Public Sector. Agencies with regulatory functions often appoint officers as Authorised Officers to exercise compliance and enforcement functions under the legislation administered by those agencies.

169. Authorised Officers, for the purposes of the PHW Act, may be appointed by the Secretary to DHHS under s. 30(1) of that Act. Only public servants (that is, those people employed under Part 3 of the *Public Administration Act 2004*) may be appointed as Authorised Officers under s. 30(1), with s. 106(i) of the *Public Administration Act 2004* (Vic) expressly precluding police officers employed pursuant to the *Victoria Police Act 2013* (Vic) from the Act's operation. Accordingly, members of Victoria Police are not eligible for appointment as Authorised Officers for the purposes of the PHW Act.[253]

170. Appointed Authorised Officers can exercise the general powers and functions conferred on them under Part 9 of the PHW Act. Those powers include entry, search and seizure powers that may be exercisable for certain limited purposes, including investigating whether there is a risk to public health or to manage or control a risk to public health,[254] or to monitor compliance with the PHW Act or its regulations, or to investigate a possible contravention of the PHW Act.[255]

171. Authorised Officers may be further authorised to exercise specific powers in the case of a risk to public health. Section 189(1) of the PHW Act provides that, if the CHO believes it is necessary to do so to investigate, eliminate or reduce a risk to public health, the CHO may authorise Authorised Officers appointed by the Secretary (or a class or classes of authorised officers appointed by a specified Council or Councils) to exercise any of the public health risk powers. Those powers are set out at s. 190(1) of the PHW Act.

172. Under s. 199(2) of the PHW Act, the CHO may, for the purpose of eliminating or reducing the serious risk to public health, also authorise Authorised Officers appointed by the Secretary (or a class or classes of authorised officers appointed by a specified Council or Councils) to exercise any of the public health risk powers and 'emergency powers'.

173. The 'emergency powers' are set out at s. 200(1) of the PHW Act. They are to:

> a. subject to this section, detain any person or group of persons in the emergency area for the period reasonably necessary to eliminate or reduce a serious risk to public health;
>
> b. restrict the movement of any person or group of persons within the emergency area;
>
> c. prevent any person or group of persons from entering the emergency area; and
>
> d. give any other direction that the authorised officer considers is reasonably necessary to protect public health.

174. Section 200(2)–(8) of the PHW Act sets out the requirements that must be satisfied by Authorised Officers when exercising the emergency powers under s. 200(1). One of those requirements relates to reviews of detentions under s. 200(1)(a).[256] Section 200(6) of the PHW Act provides:

> … an authorised officer must at least once every 24 hours during the period that a person is subject to detention under subsection (1)(a) review whether the continued detention of the person is reasonably necessary to eliminate or reduce a serious risk to public health.

175. Section 203 sets out heavy penalties for a person who refuses or fails to comply with a direction given to a person or a requirement made of the person, in the exercise of a public health risk power or an emergency power; a person subject to a direction to quarantine, for example, may be fined up to almost $20,000 for failing to comply with a direction.[257]

176. The fundamental role of the Authorised Officers in the Hotel Quarantine Program was to exercise those powers conferred on them by the PHW Act to give effect to the detention direction notice issued by the DCHO as an Authorised Officer. It was the detention direction notice issued by Dr van Dieman as an Authorised Officer that compelled people into detention in hotel quarantine, dealt with applications for temporary leave or exemption from quarantine and authorised the discharge of people at the end of their mandatory stay in quarantine.

177. Mr Cleaves described the role of the Authorised Officer as 'to manage the compliance aspects of the Hotel Quarantine Program, that is to ensure compliance with the detention direction notices that have been issued to all of the incoming international passengers'.[258] In his evidence, Mr Cleaves stated that the role of Authorised Officers was heavily focused on (amongst other things) understanding and interpreting detention direction notices, and making reasonable judgements about the appropriate ways to deal with instances of non-compliance.[259]

178. The roles of Authorised Officers, as described by Mr Smith and Mr Cleaves, were consistent with the role of Authorised Officers as described in DHHS policies issued to Authorised Officers. By 30 April 2020, around a month after Operation Soteria was established, the role of the Authorised Officer within hotels was set out in the *Annex 1 – COVID-19 Compliance Policy and Procedures–Detention and Authorisation* document (Annex 1).[260]

179. Annex 1 described the Authorised Officer's role in terms of monitoring compliance as to 'provide oversight and ensure compliance with the direction and detention notice'.[261] The specific roles and responsibilities in doing so included:[262]

    A. check that security are undertaking floor walks to encourage compliance and deter non-compliance

    B. oversee and provide advice on compliance related issues (including to respond to requests from security to address compliance and to seek assistance from security or Victoria Police to support compliance efforts)

    C. administer permission to leave and monitor compliance

    D. raise any exemption requests with the Authorised Officer Team Leader in the first instance.

180. Annex 1 also gave specific guidance as to the scope of the role of the Authorised Officer. It said that Authorised Officers 'should be aware that their role and scope is related to administration of, and compliance with, the direction and detention notice under the [PHW Act]'.[263]

COMMANDER COVID-19 ENFORCEMENT AND COMPLIANCE

181. Mr Smith stated that, in his role as Commander, COVID-19 Enforcement and Compliance, he was responsible for the entire enforcement and compliance command structure. This included supervision of all Authorised Officers, Authorised Officer Team Leaders and Senior Authorised Officers.[264] Mr Smith reported to the State Controller — Health throughout his involvement in the Hotel Quarantine Program,[265] rather than to the Accommodation Commanders of Operation Soteria.

182. In response to questions about the on-site role of Authorised Officers, Mr Smith gave evidence that his role was limited to exercising powers under s. 200(1) of the PHW Act, including serving detention notices on returning travellers, ensuring compliance with those notices, managing permissions and exemptions and, ultimately, approving people's release at the end of their detention.[266] Mr Smith said that Authorised Officers had no role in supervising any other staff at the hotel, including security staff or in overseeing IPC or the use of PPE at the hotels.[267] He advised that the person in charge of overseeing those functions generally was the Commander, Operation Soteria through the DHHS Team Leader,[268] a role distinct, and in a separate line of command and reporting, from the roles of the Authorised Officers and Authorised Officers' Team Leader and, indeed, himself.

183. Claire Febey, Executive Director, Priority Projects at DJPR gave evidence that she thought that the work of overseeing security should have been under the direction of Authorised Officers as representatives of DHHS.[269] Ms Febey explained that she held this view because the people in quarantine were being held on the legal authority of the Authorised Officers, as delegates under the PHW Act, with the role of security being to support those Authorised Officers in the exercise of the legal powers vested in them.[270]

184. Mr Smith's evidence was, however, that despite Authorised Officers operating as delegates of the DCHO, and despite what is set out in Annex 1 at paragraph 179, they played no part in the oversight of those people who were engaged in ensuring enforcement of that detention (namely, the security guards).[271] His evidence indicates that Authorised Officers played no part in ensuring the safety of the environment in which those people were detained, that is, ensuring compliance with IPC and PPE protocols.[272]

Section 8.3 — Analysis and conclusions: faults and shortcomings within the DHHS response

185. Having now discussed the manner in which DHHS interpreted, structured and performed its work in the Hotel Quarantine Program, this section focuses on how that approach ultimately impacted the operation of the Hotel Quarantine Program.

186. As noted in the introduction to this Chapter, there is no doubt that DHHS staff who worked within the Hotel Quarantine Program (whether in leadership positions or on the Program's frontlines or in providing advice and guidance) worked long hours, under enormous pressure, likely at a cost to their own wellbeing. I accept that individuals working within the Hotel Quarantine Program acted in good faith and with good intentions and performed their roles under immense pressure with stretched resources.

187. Notwithstanding this, there were significant systemic flaws and shortcomings within the DHHS response that affected the Program's capacity to achieve its objectives. These are the subject of this section.

8.3.1 The 'control agency' function and the Hotel Quarantine Program

188. As has been set out previously, within 24 hours of National Cabinet's decision to direct all international arrivals into quarantine for 14 days, the Hotel Quarantine Program was being developed to align with Victoria's emergency management framework. This decision was understandable at the time, given a public health emergency had been declared. As described in Section 8.1 of this Chapter, within Victoria's emergency management framework different types of emergencies are given classifications that are intended to then direct that the agency with the recognised expertise to deal with that class of emergency becomes the designated **control** agency.

189. There was no controversy as to the classification of this emergency as a Class 2 public health emergency. Further, there was no controversy over which agency therefore became the 'control agency'. It was DHHS as the agency responsible for public health in this State, as the name of that Department quite clearly contemplates, and the emergency management framework designates. Indeed, by the second iteration of the Operation Soteria Plan, developed on 28 March 2020, DHHS was designated as the control agency with operational command for each phase of the Program.[273] Where the controversy lay was in the interpretation of what it meant to be the '**control** agency'.

190. DHHS accepted that it was the control agency for the overall response to the COVID-19 pandemic. DHHS appeared to accept that its responsibilities included the control of the identified hazard, which, in the context of the pandemic response, was the virus.[274] However, the precise functions and responsibilities of DHHS as control agency in the context of the Hotel Quarantine Program were matters of deep disagreement before the Inquiry.

DHHS executive view of the meaning of 'control agency' was qualified by it being a 'complex emergency'

191. A theme of the evidence from DHHS witnesses (from the Minister through to the executive and into the frontlines of the Operation) that emerged throughout the Inquiry was that their Department was not 'in charge' or 'in control' of the Hotel Quarantine Program overall, as their interpretation of being a 'control agency' should be seen through the lens of the Hotel Quarantine Program being a 'complex' emergency within the meaning of the emergency management framework. This, it was said, meant the role of DHHS was a 'coordinator' or 'collaborator' and not a 'controller'. The senior executive, indeed, through to former Minister Mikakos, interpreted the concept of 'control agency' as meaning that DHHS had a 'shared accountability' with the range of other agencies participating in the delivery of the Hotel Quarantine Program. It had some responsibilities and accountabilities but was not in control of the Hotel Quarantine Program overall.[275]

192. The essence of the Departmental witnesses' evidence was that the 'control agency' role required coordination of the multi-agency approach, as conceived in the concept of a 'complex emergency' that resulted in all agencies involved having a shared accountability for the overall delivery of the Program.[276]

193. Ms Peake gave evidence that the role of DHHS,[277] as the control agency, was 'to provide operational control by ensuring appropriate governance was in place, to facilitate sharing of intelligence, enable escalation and resolution of operational issues'.[278] She said that DHHS's role was to bring together all departments and agencies with defined roles and responsibilities as part of the Hotel Quarantine Program.[279] She further stated that, as the control agency, DHHS worked to 'coordinate the input of all relevant departments and agencies'.[280]

194. Ms Peake gave evidence that, although DHHS was the control agency in emergency management terms, this was classified in emergency management terms as a 'complex emergency', stating:

> … the scale and complexity of this operation means that there have had to be capabilities and skills and legal powers and resources from every Department that have been brought to bear, some of which fit within the scope of [the EMMV] and an emergency management multi-agency response, some of which are just relevant to the normal functions of each department administered under the *Public Administration Act* and *Financial Management Act*, and for parts of the response, the role of the control agency has been to determine who should be the appropriate lead.[281]

195. When pressed on the EMMV language of the need, even in a complex emergency, for there to be a single agency responsible for the collaborative response, Ms Peake responded that DHHS 'As the control agency, was responsible for determining for each of the operations that it was clear, the scope was clear, the roles and responsibilities was clear and the governance was clear, yes, that is my evidence'.[282]

196. Ms Skilbeck gave evidence the effect of which was that the term 'control agency' caused confusion. She explained:

> The key role in the control agency in something as big as this particular emergency, 'control agency' becomes something of a misnomer where really most of the activity is coordinating across the array of agencies and departments that have come together to respond as fulsomely as the Victorian public sector can to this emergency. So, it is both control in a very specific sense of the word, the public health response to a novel coronavirus; and the coordination role … little c 'coordination', to make the distinction, because I think 'Coordination' is defined in the SERP as well … but coordination across the many agencies that have come to support the response.[283]

197. The understanding proffered by Ms Skilbeck was consistent with that of former Minister for Health Mikakos, who expressed a view that control agency was a 'highly misunderstood' term and the fact that DHHS was the control agency 'doesn't mean that DHHS had control as such'. Former Minister Mikakos said 'I think the best way to understand it is a coordination role. And the Hotel Quarantine Program was a multi-agency response with shared accountability. There were many Departments and agencies involve'.[284]

198. Former Minister Mikakos, consistent with Ms Peake's evidence, identified two roles for DHHS in the Hotel Quarantine Program, which were to (a) provide the legal framework for the detention notices that compelled people into quarantine and (b) to provide for the health and wellbeing of those people in quarantine.[285]

199. This view that DHHS did not have overall responsibility for the Hotel Quarantine Program was echoed by those Departmental employees working closer to the frontlines of the Program. As noted above, when Ms Williams was asked during her evidence who was 'in charge' of the hotel sites in the Program, her response was that the terminology 'in charge' was 'somewhat loaded' in the context of the Inquiry.[286]

200. The framing, interpretation and impact of the term 'multi-agency' response was consistent through the DHHS management witnesses. The two appointed State Controllers — Health, Mr Helps and Ms Spiteri, gave evidence about their understanding of the emergency management language of 'command', 'coordination' and 'control'. Mr Helps noted that 'there was a lot of coordination in the role'[287] as did Ms Spiteri, who stated, when describing her role as State Controller that it 'became one of overall co-ordination of the implementation of both Chief Health Officer and government decisions and directions across government agencies, through the operational arrangement for COVID-19, using the structures and resources of the State Control Centre'.[288]

201. At odds with this evidence and the position taken by DHHS throughout the Inquiry is the position taken by Mr Helps on the first weekend of the Program's commencement, when he made plain to Ms Febey from DJPR that he was the State Controller, and DHHS was the control agency for the Program.

202. In the context of Mr Helps learning that DJPR had been assigned the initial lead on 27 March 2020, Mr Helps was firm in clarifying with Ms Febey that DHHS should instead be the lead department. Ms Febey's evidence to the Inquiry was that, when she discussed DHHS's role as control agency with Mr Helps on 29 March 2020 at the SCC, he 'emphasised that DHHS was the control agency and needed to be in charge as it was accountable for the Program'.[289] In the below follow-up email from Mr Helps to Ms Febey on 29 March 2020 with the subject line 'DJPR-DHHS role clarity', Mr Helps stated that: '[a]s the Control Agency, DHHS has overall responsibility for all activities undertaken in response to this emergency'.[290]

> Dear Claire,
>
> As you are aware The Department of Health and Human Services (DHHS) is the Control Agency for the COVID-19 Pandemic, and at this time I am the State Controller — Health appointed by the Control Agency under the Emergency Management Act. Prof Brett Sutton is the Chief Health Officer leading the Public Health response under the Public Health and Wellbeing Act.
>
> As the Control Agency, DHHS has overall responsibility for all activities undertaken in response to this emergency. The response to the direction for all passengers returning to Victoria after 11.59 p.m. 28/03/20 requiring to be quarantined in approved accommodation is being led by Dep State Controller Chris Eagle as 'Operation Soteria'.
>
> As discussed today I am extremely grateful to the support DJPR have provided to date, your team have demonstrated flexibility, good planning and expertise which has contributed to making the first day as successful as it could be. I also look forward to your team continuing to support Operation Soteria.
>
> It is important however that we clarify some roles and responsibilities and work on a transition plan over the next day or so. Chris Eagle will work with you on this. Many of the roles DJPR provided in the planning, and operationally today will need to transition to the Deputy State Controller and DHHS as the Control Agency. I would like to clarify that, at a minimum, I would request DJPR continue to provide the valuable work in procurement of hotels and the services required to support people under the direction to detain, I don't underestimate the complexity of this task in the current environment. It will be vital that DHHS make the operational decisions in regard to which hotels we utilise and when, along with other decisions which require a risk assessment by the Chief Health Officer or delegated Authorised Officer.

> It was a pleasure to discuss this with you today and I sense the value of working closely on this for both agencies.
>
> Please contact me again if I can assist or if a resolution cannot be reached during the handover process.
>
> Regards
> Jason Helps
> Deputy Director Emergency Operation and Capability | Emergency Management Branch

203. When Ms Peake appeared before the Inquiry, Ms Peake speculated as to an explanation for Mr Helps's statement, '[a]s the Control Agency, DHHS has overall responsibility for all activities undertaken in response to this emergency'. She said that she thought that what Mr Helps meant by it was that DHHS had 'overall responsibility for ensuring any operation through the State Control Centre was appropriately scoped, involved the right people and had appropriate operational governance within it'.[291]

204. However, the plain meaning of Mr Helps's email, which was sent at the outset of the Hotel Quarantine Program, is consistent with the evidence of all of the other witnesses not aligned with DHHS, as set out below.

205. Notwithstanding the remainder of non-DHHS witnesses being at odds with this view, during the Inquiry and in closing submissions, DHHS sought to rely on the definition and acceptance of this situation as a 'complex emergency' to maintain its position that its role was to coordinate rather than be 'in charge' or 'in control' or the agency with the overall responsibility for the operation of the Hotel Quarantine Program.

206. In closing submissions, DHHS extracted the passage from Part 7.1 of the EMMV it relied on and referred to throughout the Inquiry, which I set out again as follows:

> There are complex emergencies where a shared accountability across a number of agencies occurs. In these cases, there is a need for a single agency to be responsible for the collaborative response of all the agencies. For the purposes of consistency, the term control agency will be used to describe this lead agency role.[292]

207. DHHS submitted that no one agency could respond alone to such a complex emergency and that this 'does not reflect the reality of emergency management'.[293]

208. A few observations are noteworthy with respect to this submission.

209. First, it appears from this submission, that DHHS is referring to its role in the response to the entire pandemic state-wide rather than the operation of the Hotel Quarantine Program. The submission refers in a broad and sweeping way to the crisis structures of government and whole-of-government leadership and decision-making on overall directions for the COVID-19 response.[294]

210. Second, the DHHS submission refers to the other agencies involved in the delivery of the Hotel Quarantine Program, pointing out that agencies such as DJPR and private contractors all held their own responsibilities and accountabilities, ostensibly in support of the position that DHHS was a coordinator, rather than a controller of the Program that was in charge of, or responsible for, the Hotel Quarantine Program. The problem with this position is that the two concepts are not mutually exclusive. That agencies such as DJPR engaged in responding to the emergency are properly accountable for their actions is not in question. But that concept of accountability does not obviate the need for the control agency to be more than a mere coordinator. Indeed, the language DHHS seeks to rely upon seems plain enough: 'There is a need for a single agency to be responsible for the collaborative response of all agencies'.[295]

211. Third, this submission was not consistent with the evidence of the Emergency Management Commissioner or, indeed, any other witness who gave evidence on this issue who was not an employee of DHHS. That is, DHHS was alone in holding this view. It appears to have been the only agency confused or unclear about its role — despite the State Controller initially being very clear with Ms Febey in this regard.

212. Emergency Management Commissioner Andrew Crisp and former Emergency Management Commissioner Lapsley both provided their opinions as to the interpretation of control agency and the importance of that role. Mr Lapsley, said:

> It is a fundamental premise to have a single agency designated for the leadership and management of an emergency so that there is no ambiguity of who is accountable for the management of the emergency.[296]

213. Mr Lapsley went on to emphasise the need to have clearly defined structure and accountability as follows:

> [Clear lines of command and control are] of critical importance from an accountability perspective so that agency/organisational commanders have a clear understanding of who is in control of the major emergency and who is responsible for coordinating effort seamlessly … There are numerous examples where emergencies have been poorly managed because of structures and accountabilities being poorly defined, understood and acted upon.[297]

214. Emergency Management Commissioner Crisp stated that one of the main reasons for placing Operation Soteria within the emergency management framework was for role clarity. He stated '[i]t was important to put a control structure around the particular operation and again based on our experience of our running operations about having a control agency and then support agency, being really clear as to their role. It is really important and useful in terms of achieving a good outcome'.[298]

215. Emergency Management Commissioner Crisp gave his view as to who was responsible for the Hotel Quarantine Program at the SCC meeting held in the afternoon of 28 March 2020. He said '[a]nd Jason [Helps] touched on it before in terms of who's in charge. It is the Department of Health and Human Services for this operation because, as I said, it fits in with the State's structure and under the State Controller — Health'.[299] In examination, Emergency Management Commissioner Crisp said that he made those remarks to make it 'absolutely clear who was running the operation'.[300]

216. The Premier, when asked for his view as to who he thought had responsibility for the Hotel Quarantine Program, gave evidence that DHHS 'as the designated control agency, was primarily responsible for the Program'[301] and that, from 8 April 2020, he 'regarded Minister Mikakos as accountable for the Program'.[302]

217. However, as noted above, former Minister Mikakos expressed a much narrower view of DHHS's role in respect of the Hotel Quarantine Program:

> [W]hilst the DHHS was designated as the control agency for the overall COVID-19 pandemic response in Victoria, this meant it had a coordinating role across numerous government departments and agencies in responding to the health emergency … The fact that the DHHS is designated as the control agency for the pandemic response as a whole did not mean that the DHHS was running Operation Soteria.[303]

218. Simon Phemister, the Secretary to DJPR, gave evidence that 'consistent with its role as a support agency as understood in the emergency management context', DJPR was 'subject to the control and direction of DHHS'.[304]

219. The Hon. Martin Pakula MP, Minister for Jobs, Precincts and Regions, gave evidence that, as control agency, DHHS was 'in charge, if you like, and had overall responsibility' and that it was the role of DJPR to assist DHHS.[305]

220. The Hon. Lisa Neville MP, Minister for Police and Emergency Services, said 'I'm very clear about how these arrangements work. It was a Class 2 pandemic. In this case it was a health emergency, therefore the control agency was DHHS'.[306]

221. Similarly, Chief Commissioner of Victoria Police, Shane Patton, stated that 'Victoria Police had only a supporting role in the HQP, which was in the control of DHHS'.[307]

222. The weight of the evidence is that, at all material times, DHHS had 'overall responsibility' for the Hotel Quarantine Program as (a) not only the government agency responsible for public health, but (b) also the government agency that had responsibility for the exercise of the statutory powers of detention that mandated the detention of people in quarantine and (c) the designated control agency in the emergency management framework in which the Program was set. The fact that it did not see itself as having this responsibility and did not accept this responsibility, either during its involvement in the Program or throughout this Inquiry, can be understood as being a progenitor of many problems that eventuated in the Hotel Quarantine Program.

'Shared accountability'

223. Separate, although related to the concept of multi-agency collaboration, is the concept of 'shared accountability' upon which DHHS sought to place much weight. It is plain that this language comes from the language of 'complex emergencies' from the EMMV.[308] In this 'shared accountability' model, DHHS sought to create a delineation between what it saw as its areas of responsibility, being (a) public health and wellbeing and (b) the statutory framework for the making of the detention orders. During the Inquiry, this position was particularly aimed at DJPR in the 'shared accountability' model but included the private contractors as well.

224. As has been stated several times already in this report, the evidence is uncontroversial that, in its first 24 hours, the Hotel Quarantine Program was initiated as a departmental operation run by DJPR.[309] As a result, a number of the initial operational decisions were, in effect, inherited by DHHS when it became control agency under the transition on 28 and 29 March 2020 into the emergency management framework.[310]

225. It is plain, as a matter of fact and practicality, in an emergency response such as the set up and operation of the Hotel Quarantine Program was, that no single agency will have all the resources, expertise and experience to respond alone. It is also plain that agencies that are given responsibilities to deliver aspects of the component parts of the Program, as was the case here, bear responsibility for that proper delivery.

226. The evidence of DHHS witnesses and former Minister Mikakos was that accountability was 'shared' between DHHS and other agencies.[311] They explained that this model of 'shared accountability' was expressly provided for by the emergency management framework. In her first statement to the Inquiry, Ms Peake offered the observation that emergency management has reflected a general trend in the public sector toward 'collaborative governance'.[312]

227. The concept of 'shared accountability' is, indeed, expressly identified in the EMMV. However, what many DHHS witnesses failed to acknowledge in their invocation of the concept of 'shared accountability' was the necessity for designation of overall responsibility and the expressly stated requirement for a single agency to be the lead agency.[313]

228. Senior figures within DHHS, including the former Minister, regarded the Department's function as a control agency for the operation of the Hotel Quarantine Program as an exercise in 'collaborative governance', where the role was one of coordination and facilitation but not one in which it was functioning as the single agency with overall responsibility for the Program.

This was a mischaracterisation of its role and function in the Hotel Quarantine Program and one that had significant ramifications throughout its operation, despite the individual hard-working efforts of many individuals working inside DHHS.

229. In the shared accountability model, DHHS sought to silo its responsibilities as related to the health and wellbeing of the people in quarantine. This created an artificial and unworkable notion that, somehow, the health and wellbeing of the people in quarantine could be separated out from the operation of the environment in which they were being detained.

8.3.2 Support agency role: DJPR

230. Once it became apparent over that first weekend to Ms Febey of DJPR that DHHS was the lead Department, she understood that DJPR would act as a *support agency* to DHHS.[314] As noted above, the SERP defines a support agency as an agency that provides services, personnel or material support to the control agency.[315]

231. Ms Febey gave evidence that it took a few days into the Program to clarify exactly what that supporting role meant in practice.[316] Ms Febey understood, in functional terms, that DJPR was:

    A. contracting hotels and other services

    B. meeting day-to-day needs of people in quarantine

    C. arranging food

    D. implementing a call centre function for people in quarantine

    E. providing logistical support on the ground; for example, around deliveries, Uber Eats, exercise, smoking, et cetera.[317]

232. From that point onwards, Ms Febey understood, correctly in my view, that DJPR was required to act as a support agency to DHHS and was to work under its direction.[318] That DJPR did a substantial amount of work towards the Program did not change Ms Febey's view that DHHS was, from that point, the control agency.[319]

233. When Ms May, of DJPR, took over from Ms Febey as DJPR Agency Commander, Ms May stated that she understood she was required to take direction from DHHS in relation to matters of policy and procedure and could only act on the directions of DHHS.[320] Ms May described her role as Agency Commander of DJPR as also having responsibility for supporting the directions of the State Controller — Health via the DHHS Commander. Her evidence was that she was also required to establish a DJPR command structure, lead DJPR resources and ensure a timely flow of information to the DHHS Commander.[321] Ms May gave evidence that she did establish a command structure within DJPR, as required by the EMMV framework, and all DJPR staff on the Hotel Quarantine Program ultimately reported to her.[322]

234. Ms May gave evidence that she understood that Operation Soteria was run by its DHHS Commander, Ms Williams, and that she understood that DJPR would work under the direction of the DHHS Commander.[323]

235. Ms Williams saw it differently, saying she had no control or authority to direct others within the Operation, for example, DJPR, Authorised Officers or on-site medical staff.[324] However, DHHS (through the former Secretary and Minister) accepted that it could have transferred conduct of the contracts for hotels, security guards and cleaning being held and managed by DJPR to itself at any time. To disavow its capacity to exercise all of the necessary powers to take control of the Program is an untenable position for this government agency to take in the face of such an important program.[325]

236. As Emergency Management Commissioner Crisp stated in his evidence when asked about the reason for drawing a distinction between a control agency and support agencies: '[i]t is always very important to know who is in control, who is running a particular operation'.[326]

237. In other words, in any emergency response, it is essential that there is clarity as to roles, chains of command and lines of control. The fact that there were conflicting views about what it meant for DHHS to be the 'control agency' is a matter of considerable concern. It is also of concern that it does not appear to have been identified and escalated as an issue by DHHS, through which it could have sought clarification as to its functions and role from the Emergency Management Commissioner, or through its Minister or the CCC.

238. It would not be hard to understand that DHHS staff may have felt exhausted and overwhelmed given the enormity and range of the Department's functions, tasks and responsibilities during the early months of the pandemic. However, as previously stated, the impact of DHHS not taking overall responsibility for the Hotel Quarantine Program, and endeavouring to reframe this responsibility as one in which it was but one part of a collaborative approach of all agencies, left the Program without a responsible, accountable supervisor. Coordination is one thing. Being accountable to ensure that the collaborative approach does not break down or that, by reason of the collaboration and involvement of multiple agencies, there are not governance or operational gaps in meeting the aims of an emergency response, is another.

239. In my view, the designation of DHHS as control agency vested it with clear responsibility to deliver that response with the collaboration of multiple support agencies responsible for the proper delivery of that support agency response, as was required, **and** to ensure that those agencies were working together so that the response fulfilled its aims. But that did not remove or vary the overall need and responsibility for the single agency, DHHS, to take control of the Program and exercise the necessary vigilance required to ensure its safe and proper operation shaped into a best practice model.

240. Accordingly, I do not accept the DHHS submission that it 'delivered on the appropriate role of the control agency in a complex emergency'.[327] At a minimum, as control agency, DHHS was responsible for ensuring that the plans for the Operation, including division of responsibilities, chains of command and overall accountability, were understood by all operating within it. Evidence of this clear leadership role is documented in several iterations of the Operation Soteria plan and further evidenced by the leadership hierarchy of the Program, where all key roles were either filled with DHHS staff or staff appointed by DHHS.

241. Notwithstanding the language contained in the EMMV, while DHHS accepted it was the control agency, it sought to re-define what 'control agency' meant in the emergency management context. The impact of this was multilayered.

242. By mischaracterising or misinterpreting its role as the control agency, it left the Hotel Quarantine Program without a manager, without a leader and without what was critically needed for such a high-risk program: an agency to be in charge and take responsibility to ensure, to the best of its ability, that the Program was being operated to minimise the risks inherent in it.

243. That such a misinterpretation or mischaracterisation of the role and function of this central aspect of the response to a public health emergency could become so embedded in the minds of the senior management of DHHS — all the way through to the Minister — points to the obvious need to clarify the meaning and role of control agency, whether it be a complex emergency or not.

244. To ensure that such a situation does not emerge again, I make the following recommendation:

Recommendation 74: That the Emergency Management Commissioner clarifies the language used in the Emergency Management Manual Victoria to ensure that there is no possibility of any ambiguity about the role and responsibility of the Control Agency, including a more fulsome definition of what constitutes a complex emergency and the role of the designated control agency in a complex emergency.

Not enough public health experts to go around? The breadth of DHHS's role in responding to the pandemic

245. As part of its ordinary operations, one of the key responsibilities of DHHS is in preventing the spread of communicable diseases.[328] Within the structure of Victoria's response to the pandemic, 'the department had responsibility for public health interventions to suppress the virus (including through investigation [and] management of public health risk'.[329] As noted above, Ms Peake stated that DHHS 'was also responsible for stewardship of health and human service sector responses to the pandemic, including overseeing delivery of services that support the health and wellbeing of Victorians'.[330]

246. It is well understood and accepted that, throughout the relevant period in which the Hotel Quarantine Program was implemented, DHHS had responsibility not only for the Program, but for numerous other aspects of Victoria's response to the pandemic.[331] DHHS continued to attend to its broader public health functions throughout the Hotel Quarantine Program. I have been cognisant of that fact when assessing the roles, responsibilities and accountabilities of personnel and DHHS within the Hotel Quarantine Program including the DHHS Public Health Team.

247. I accept the submission advanced on behalf of DHHS that 'the hotel quarantine program was one part of a State-wide emergency response to the pandemic'.[332] However, this changes nothing, other than to confirm that the resources of DHHS were severely stretched. Further, Ms Peake gave evidence of the 'understanding, in late March 2020, that the major form of transmission of COVID-19 in Australia at that time was from returned travellers'.[333]

248. Because the major form of transmission, as understood at that time, was from returned travellers, the Hotel Quarantine Program was the State's most critical bulwark against the further spread of disease and the devastation feared by its proliferation. The purpose of the Program — to contain the spread of the virus — and the magnitude of the decision to deprive citizens of their liberty to achieve that aim, means that it had to be given primary focus in relation to its conception, development, resourcing, oversight and operation. There is evidence that the ability to properly resource the Hotel Quarantine Program with the health and medical expertise needed was compromised by not enough public health experts either employed by DHHS or available to DHHS to fulfil the necessary functions and demands of the Hotel Quarantine Program.[334]

249. As an example, as at early April, the evidence is that DHHS had only one IPC expert, employed by the Microbiological Diagnostic Unit Public Health Laboratory in a 'shared capacity' with the Department[335] (noting that Dr van Diemen would later establish a new IPC Cell led by a public health physician and comprised of infection control consultants).[336] As stated above, that person initially provided advice across Victoria in response to the pandemic. When that DHHS consultant had no capacity to respond to Operation Soteria requests for further specialised advice regarding the Hotel Quarantine Program, including in the context of establishing the Rydges Hotel in Carlton as a designated COVID-19 hotel, it was recommended that Operation Soteria engaged an outside consultant for advice. DHHS engaged Infection Prevention Australia as a contractor on a number of occasions.[337] Similarly, DHHS engaged nursing agencies to provide nursing services and a newly created company to provide general medical practitioners.[338] It is no criticism at all of DHHS that it engaged this assistance, particularly in response to not only the unprecedented pandemic to which it was responding but the unpredictable numbers and limited information on the health needs of those coming into Hotel Quarantine. These factors made it very difficult to plan for, particularly given there had been no contingency plans in place at the time the Hotel Quarantine Program was announced.

250. A number of the public health officials had concurrent responsibilities in both their substantive and emergency management roles. Included in this was the DCHO, Dr van Diemen, who was also the Public Health Commander. Mr Helps referred to the entire Public Health Team as being very stretched at the time, with resourcing being an issue.[339] Dr van Diemen similarly expressed a view that:

> In an ideal world, we would have placed multiple public health positions in both the Emergency Operation Centre and the State Control Centre. But the reality was there weren't enough to go around and we needed to determine where people would sit and many … most of the public health positions in the response were covering more than one role at any given time.[340]

251. The limited number of employees with public health and infection control expertise posed practical difficulties to the Program meeting its objectives.

Engagement with medical experts outside DHHS

252. Dr Julian Rait, the President of the Australian Medical Association (AMA), gave evidence that there was insufficient engagement with stakeholders and experts outside DHHS in the establishment of the Program:

> We believe that there was no shortage of experts in Victoria who could have assisted the government with establishing hotel quarantine – but somewhere along the line, the government didn't view engagement with these types of experts as being necessary.
>
> Overall, there is not a culture within government and within the DHHS of meaningful engagement with stakeholders. There appears to be a lack of appropriate planning, collaboration and two-way communication between the DHHS and its external stakeholders. There need to be more genuine attempts to seek feedback, test assumptions and ideas, obtain input from experts, and collaborate in planning and understand the experience on the ground.[341]

253. This sentiment was expressed by others who made contact with the Inquiry. These were not issues that were tested during the Inquiry, although the statement made by Dr Rait formed part of the evidence. Suffice to say here that, given the position held by Dr Rait and the issues raised by him, in particular the issues that address the availability of experts to DHHS through the AMA, the Secretary to DHHS and the Minister for Health should engage with the President of the AMA to address and understand the issues raised by him.

Recommendation 75: That the Secretary of DHHS engages in discussions with the President of the Australian Medical Association to address the availability of medical expertise to meet current and future surge and planning demands for public health emergencies.

8.3.3 Not appointing Chief Health Officer as State Controller — Health

254. Related to the issue of 'not enough public health experts to go around' was the impact of the non-appointment of the CHO as State Controller — Health. As set out above, the default position in the SHERP for Victoria is that the CHO will be appointed as the State Controller — Health. As Secretary of DHHS, Ms Peake was aware of the presumption under the SHERP that the CHO is the presumed appointment.[342] As DHHS was the control agency for a Class 2 health emergency, Ms Peake had the authority to appoint a State Controller — Health and to depart from the normal course. She chose to depart from it. In February, Ms Peake was advised by Ms Skilbeck (an economist by training) to appoint someone other than the CHO, Prof. Sutton, as the State Controller — Health.[343]

255. Instead of the CHO, as previously stated, two executive members of DHHS were appointed to the role of State Controller — Health by the Secretary of DHHS in response to the COVID-19 pandemic.[344] The first, Ms Spiteri, Executive Director of Emergency Management, DHHS, was appointed on 1 February 2020. The second, Mr Helps, Deputy Director of Emergency Operation and Capability, DHHS, was appointed on 7 February 2020.[345] They performed the role of State Controller — Health according to a rostered arrangement.[346] Both were very experienced in emergency management.

256. Ms Peake gave evidence that, despite the presumption in the SHERP that the CHO would fulfil the function of State Controller, this was not always the case and her decision not to appoint the CHO was due to:

> [M]y understanding of the very significant operational responsibilities the CHO was already undertaking in response to the pandemic at both state and national level.[347]

257. In Ms Peake's view, given the other duties of the CHO in response to the overall public health emergency, it was not practicable for him to take on the role of State Controller — Health.

258. Ms Skilbeck spoke about her reasons for making that recommendation. Ms Skilbeck explained that she viewed the Hotel Quarantine Program primarily as a significant logistics program that required logistical expertise rather than public health knowledge.[348] She also referred to the other responsibilities falling to the CHO at the time.[349]

259. Shortly after Ms Spiteri's appointment, Ms Skilbeck provided Ms Peake with a brief that documented her reasons for recommending the appointment of Ms Spiteri rather than Prof. Sutton as State Controller. In her brief, Ms Skilbeck explained as follows:

> I recommended the State Health Coordinator as controller for the 2019-nCov outbreak to manage the growing social and economic impacts of the virus across government and provide access to the needed logistics and communications support, rather than hazard (virus) control. Specifically, through the State Co-ordination Team, departments are providing necessary planning, logistics and communications support to the public health response.[350]

260. In her reasons, Ms Skilbeck went on to note the key role the CHO played in developing advice through the AHPPC, that he held 'the central role in media and other interfaces' and the dearth of public health physicians in the Department.[351] Ms Skilbeck acknowledged that Prof. Sutton did not agree with the decision to appoint someone other than him as State Controller — Health.[352]

261. In reflecting on his not having been appointed State Controller — Health, Prof. Sutton said that the position of State Controller — Health would have given him a significant 'line of sight' perspective over operational elements for which he (as CHO) was accountable because it was his authority, pursuant to the PHW Act, which was the source of legal power for the Program. He said that it was important for him to have line of sight of the application of those controls and to have 'situational awareness of those operational activities'.[353] Moreover, in Prof. Sutton's view, it would have been preferable to appoint 'a public health physician with communicable disease experience and tropical medicine experience and [his] specific qualifications and experience'.[354]

262. In her evidence, Dr van Diemen (who was DCHO and Public Health Commander and the person who authorised the detention notices placing people in quarantine) stated that it would have been 'perhaps more ideal' to have someone who had a public health background and greater communicable disease focus as the State Controller.[355] However, she said that she could understand the reasoning that was advanced for the appointments that were made, given the enormous demands on everybody's time.[356]

263. As previously noted, Ms Skilbeck explained, in her evidence, that Ms Spiteri and Mr Helps were chosen, '[To] provide access to the needed state level logistics and communications support, rather than hazard (virus) control'.[357]

264. Emergency Management Commissioner Crisp was consulted by Ms Skilbeck about the proposed appointment. He stated that the rationale for the departure from the normal position was explained to him by Ms Skilbeck, and he agreed with that position. He did so on the basis that the CHO was too busy with other responsibilities.[358]

265. Both Ms Peake and Ms Skilbeck knew that Prof. Sutton did not agree that someone else should be appointed, and there was discussion between them about the disagreement.[359] Despite that conversation, Ms Peake remained of the view that it was just not feasible that the CHO could perform the role of State Controller — Health, and doing so would have compromised his other functions.[360]

266. Both Prof. Sutton and Dr Romanes expressed their concerns that those in the leadership roles in the Hotel Quarantine Program were people without significant public health experience. It was the view of Dr Romanes that those appointed to senior leadership positions 'did not have significant public health experience' and that this resulted in the Hotel Quarantine Program being 'characterised and managed predominantly as an accommodation or logistics program'.[361] In his evidence, Prof. Sutton agreed that he, too, had reservations about the lack of Public Health Command involvement in Operation Soteria.[362]

267. Ms Peake gave evidence that, by the time of her appearance before the Inquiry, she was aware of various statements made by DHHS staff, including the CHO, the DCHO/Public Health Commander and Dr Romanes, to the effect that if the CHO had been appointed State Controller, public health expertise may have been more embedded in the governance of the Hotel Quarantine Program.[363] Her view was that it was important to reflect on the practical realities of the 'bandwidth' of public health at the time of the appointments, having regard to other DHHS tasks.[364] She said that it had been, and remained, her view that it was not practicable for Prof. Sutton to execute his statutory obligations of CHO at the time and take on that facilitation of multiagency operations across government, and that the Public Health Command was established to ensure there was public health input into Operation Soteria and into other operations that were in train at the same time.[365]

268. Ms Spiteri stated that this was the first appointment of a State Controller for a Class 2 human disease pandemic in Victoria with 'a remit to coordinate whole of Victorian Government planning and responses to the broader impacts and consequences of the pandemic'.[366]

269. Ms Spiteri referred to the detail of what is contained in the SERP that includes to lead and manage the response to a Class 2 emergency, establish a control structure for the Class 2 emergency as appropriate and monitor to ensure it suits the circumstances, and give directions to other incident controllers, if applicable.[367]

270. Ms Spiteri stated that '[p]ractically, the Chief Health Officer was an 'incident controller', operating across the state, with powers under the *Public Health and Wellbeing Act 2008* to make directions to mitigate and control the spread of the virus.[368] I understand this aspect of Ms Spiteri's evidence to be that the CHO had delineated statutory powers under the PHW Act and, therefore, his role and functions were independent of the State Controllers and not affected by the roles performed by her or Mr Helps.

271. Ms Spiteri went on to state:

> This meant the role of State Controller — Health for this Class 2 emergency became one of overall coordination of the implementation of both Chief Health Officer and government decisions and directions across government and agencies, through the operational arrangements for COVID-19, utilising the structures and resources of the State Control Centre.[369]

272. Ironically, given the stated rationale for the non-appointment of Prof. Sutton as State Controller — Health, it was the evidence of Mr Helps that he was not able to effectively meet many of the role functions described, given the complex national and state arrangements and the role of the CHO and Public Health Commander. That is, it was his view that control decisions were made at national and state cabinet levels and that the CHO and the Public Health Commander had absolute control of the public health emergency across the entire state. [370] Mr Helps gave this evidence notwithstanding that the Public Health Commander role reported to him.

273. Mr Helps described the role of the State Controller as quite different in the COVID-19 pandemic compared with other emergency situations. Typically, the role of State Controller is one of decision-making and leading in an emergency response.[371] However, due to the complex nature of the emergency, and the tendency for the decisions to intersect with so many areas (human rights, economic, trade, industry, transport), Mr Helps considered that the regular emergency management arrangements were not appropriate as the predominant decision-making tools.[372]

274. Ms Spiteri, echoing the views of DHHS executives, saw her role as State Controller — Health as *co-ordinating* activities.[373] Ms Spiteri did state that she had operational accountability for the quarantine of people and a responsibility, under the guidance of the public health experts, to ensure that there was guidance and instruction provided and that there was a plan and arrangements and a governance structure. Ms Spiteri's evidence was that she was satisfied that she had the right structure in place to enable information to go to the people who needed it.[374]

275. In an odd and inexplicable side note, it appears from documents compelled under Notices to Produce, that, about six days after appointing Ms Spiteri as State Controller, by an instrument of appointment dated 7 February 2020 and approved by Ms Skilbeck, Ms Peake did in fact appoint Prof. Sutton to the role of State Controller — Health, together with Dr Bone and Mr Helps.[375] It would appear that Prof. Sutton was not advised of this appointment, given his evidence that he was unhappy that he was not so appointed.

276. The briefing memorandum that accompanied the other three appointments made by that same instrument made no reference to Prof. Sutton, nor did it suggest that he be appointed.[376]

277. The explanation proffered by Ms Peake as to her reasons for executing the instrument of appointment that included Prof. Sutton; namely, that he was appointed merely as an alternative, or backup, State Controller,[377] is at odds with the reasons that she (and Ms Skilbeck) gave for not appointing him only days earlier. It is also at odds with the fact, as I have found it to be, that Prof. Sutton was not advised of this appointment and made even more inexplicable in light of the evidence given by Ms Peake that she had discussed Prof. Sutton's views with him in the wake of Ms Spiteri's appointment. I found the explanation given by Ms Peake on this topic to be, at the very least, confounding.

278. The impact of this decision (apparently) not to appoint the CHO as State Controller — Health meant that the senior person in this State with the recognised public health expertise necessary to oversee such a Program did not have any active oversight role in the Program. This deprived the Program of that expertise and created another fragmented line of reporting, accountability and opportunity lost for oversight of the Hotel Quarantine Program. Further, given the CHO and DCHO were accountable for the exercise of the statutory powers under the PHW Act, both of them considered it important that they should have visibility over the activities undertaken in respect of the exercise of those powers. This is a position that, in my view, is unarguably correct.

279. Both Prof. Sutton and Dr van Diemen raised their concerns about this internally, for example, with Prof. Wallace as evidenced by Prof. Sutton's email to Prof. Wallace dated 13 April 2020, extracted at paragraph 318 below.[378] However, despite this concern, Prof. Sutton did not elevate the issue to the former Minister for Health with whom he met regularly.[379]

8.3.4 The Public Health Commander and Incident Management Team: state-wide role vs Hotel Quarantine Program

280. Adding to the apparent complexity of the governance of the Hotel Quarantine Program was another layer of either intersecting pathways or parallel lines, depending on the way it was viewed, created by the emergency management framework and the statutory role and powers of the CHO. It was said to emerge in this way.

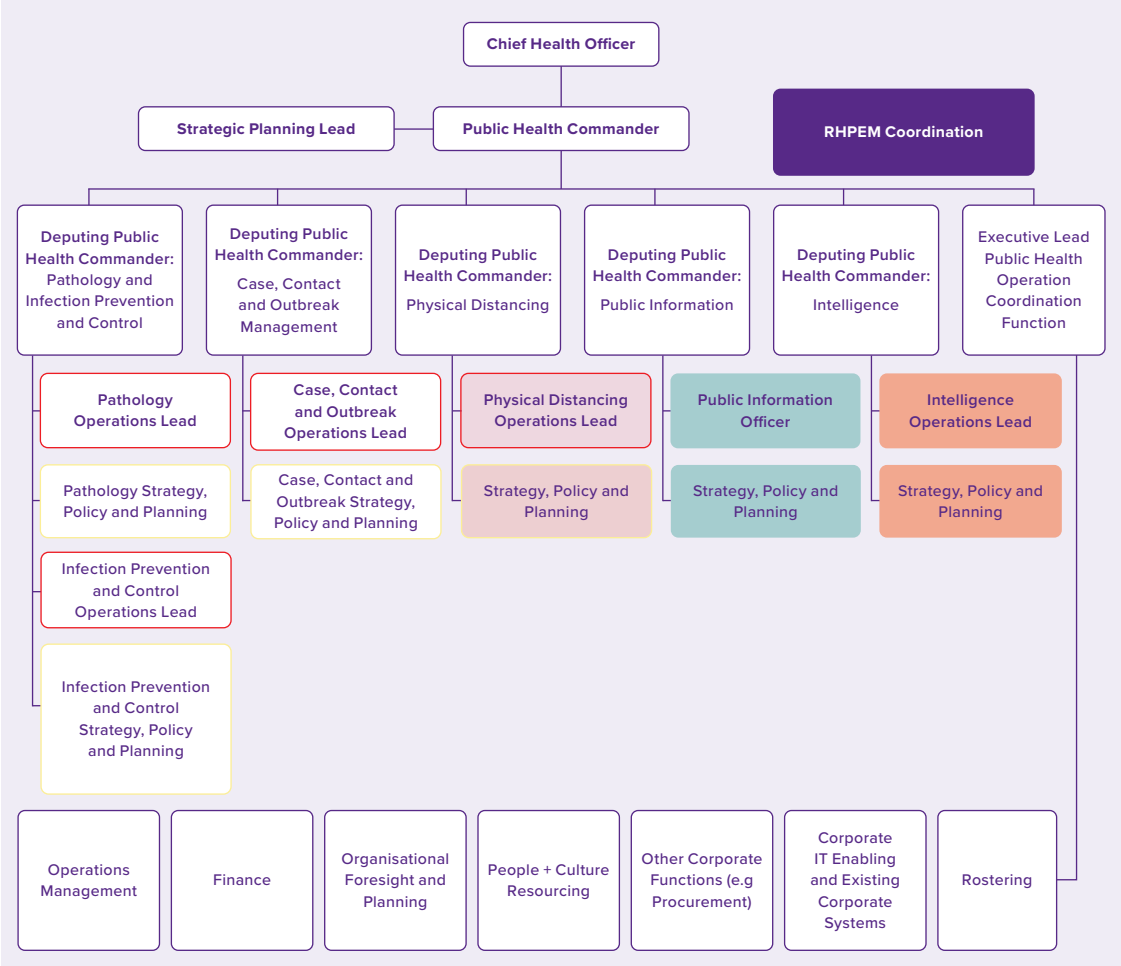
281. The common emergency experience (for example, bushfires or floods) is that incident control is exercised in response to a geographical incident (for example, a particular fire ground). If there are multiple incidents (such as several different bushfires), each Incident Control Team will be supported by the Regional and State Controllers. It is an hierarchical system.[380]

282. According to Mr Helps, the COVID-19 emergency differed from that norm because the 'incident' encompassed the entire State. In his view, the 'Incident Control' function lay with the CHO by reason of his statutory powers and with the Public Health Commander by reason of the appointment under the emergency management framework. In his view, this meant, in practice, the Incident Management had the same 'footprint' as the State Control and was not within a traditional hierarchy.[381] According to Mr Helps, this meant there was no hierarchy between Incident Management and State Control.[382] The State Operational Arrangements COVID-19 described Incident Management, as it was applied to this emergency, in this way:

> Incident Management for a state-wide Health Emergency will be managed by a single Incident Management Team (IMT) that brings together Public Health Command Operations (Case and Contact Management, Laboratories, Ports of Entry, Specialist Advice), Planning (Health Service, Public Health and other services), supported by Intelligence, Public Information. The incident footprint is the State of Victoria. The Incident Controller is the Public Health Commander.
>
> The Public Health Commander reports to the Chief Health Officer, Victoria's health response is working in conjunction with other States and National response, with Governance arrangements at a National level leading key National policy.

> The State Controller — Health, where appointed, will manage impacts of COVID-19 across the broader community that require the coordination of agencies in response to the consequences. It is difficult to predict precisely where or when specific COVID-19 impacts are going to occur, so it has been determined that a state level response is the best method to manage these emergencies.
>
> Management of the impacts and consequences of COVID-19 on the affected community will be undertaken by emergency management agencies and government departments. This management of consequences requires agencies and government to work together in a coordinated way, therefore, a coordination centre (remote or in a facility) may be established, to facilitate identification and manage the response to the consequences rather than to control the emergency.[383]

Figure 8.3.1: State Operational Arrangements – COVID-19 Version 3.0



Source: Exhibit HQI0167_RP EMV State Operational Arrangements COVID-1.

283. This diagram demonstrates the size and complexity of the Public Health Incident Management Team. Although the incident management team sat within the State Governance Structure (see above), in practice, because the incident encompassed the entire State, it was running parallel, rather than under, the emergency management leadership.

284. This parallel structure added to the complexity of the COVID-19 pandemic emergency response and hence the Hotel Quarantine Program. The Public Health Commander under the SHERP leads the Incident Management Team. The role is to have oversight of the public health response to the health emergency. In this particular emergency, there was an operations aspect to the role (contact tracing, outbreak management, et cetera), a planning aspect (implementing and easing of restrictions, health planning), an intelligence aspect (epidemiology, data, surveillance) and a logistics function (human and physical resources to response to emergency).[384]

285. The SHERP contemplates the Public Health Commander reporting to the State Controller — Health, as it is presumed under the SHERP that the CHO will be the State Controller. However, because the CHO was not (apparently) appointed the State Controller, the Public Health Commander reported directly to the CHO, as he had ultimate responsibility for the public health response, not the State Controller.[385] Although this was not in line with the emergency management arrangements, according to Dr van Diemen, this was 'an agreed approach by everybody'.[386]

286. The Public Health Incident Management Team is part of the emergency management structure and sits under the Public Health Commander. The Public Health Incident Management Team was initiated in response to the declaration of the COVID-19 pandemic. As the pandemic developed, the Public Health Incident Management Team became larger and more multi-layered as it adjusted for the scale and requirements of the emergency across the entire State. It seems to have developed into a more permanent structure.[387]

287. The Public Health Incident Management Team provided advice to the State Controller — Health in relation to the health aspects of the COVID-19 response across the entire State. This was both in an informal capacity and a more formal setting by creating policies and guidance around general IPC, among other things across many different settings. This guidance was provided to those running the Hotel Quarantine Program but, largely, was not tailored to the Hotel Quarantine Program and its very particular and unique requirements. Much of the advice was directed to the broader population, including various industries, as part of the COVID-19 response as a whole.[388] As such, the advice was often not particularly helpful as it was not engaged with the very particular circumstances in Hotel Quarantine.

288. Mr Helps's conclusion that there was no hierarchical relationship between incident management and State Control, as there would be in a more 'traditional' emergency such as a bushfire or a flood, raises the question as to how appropriate the emergency management framework was to operate the Hotel Quarantine Program. I return to this question at 8.3.12

8.3.5 Hotel Quarantine: logistics and compliance program vs public health program

MISCHARACTERISATION OF THE PROGRAM

289. While the decision not to (apparently) appoint the CHO as State Controller for the state-wide response to the pandemic may have some coherence if the response is conceived of as a complex logistics exercise, that coherence diminishes in the context of the operation of the Hotel Quarantine Program. This Program was much more than a logistical exercise of moving people in and out of accommodation, feeding them and keeping them detained under guard in their rooms. It required clinical oversight and governance with expert advice and oversight on IPC, which was always its greatest challenge and its greatest risk given what its objectives were and its very reason for being set up: to quarantine people in a government-run program for 14 days to minimise the risk of transmission of the virus into the community.

290. The views about its primary characterisation as a logistics or public health program largely split inside DHHS as between the emergency management division and the public health division. Dr Romanes saw Operation Soteria as 'characterised and managed predominantly as an accommodation logistics program' but that 'public health consideration needed to be concurrently addressed'.[389]

291. Ms Bamert saw a real need for someone who was part of the Operation Soteria management team to have IPC expertise at that management level.[390]

292. In evidence, Dr van Diemen agreed that she, Prof. Sutton and Dr Romanes all expressed concern that there was an absence of health focus in the governance of the Hotel Quarantine Program.[391]

293. Both Prof. Sutton and Dr Romanes expressed concerns that those in the leadership roles in the Hotel Quarantine Program were people without significant public health experience.[392] Dr Romanes offered the following view in his statement to the Inquiry:

> From what I could see, the program was characterised and managed predominantly as an accommodation or logistics program. I drew this view from observations of the appointment of senior leadership figures that did not have significant public health experience, and that the Operation Soteria governance meetings I attended did not involve the [Public Health Commander] initially and did seem to me to focus heavily on logistics considerations. While the program had significant logistical challenges attached to its implementation at that time, these were part of the challenge only and I felt that public health considerations needed to be concurrently addressed.[393]

294. Part of the evidence I relied upon in reaching a conclusion on this issue was based on the reality of the on-site presence at the hotels. DHHS Team Leaders appeared to be liaisons who were maintaining 'representation' of DHHS on-site for daily issues. The other DHHS presence on-site was the Authorised Officers, whose role was characterised as overseeing compliance with the detention directions.

295. The weight of the evidence was that the Program was characterised as a compliance and logistics exercise rather than a public health program. The conceptualisation of the Program in this way created tension within DHHS, and also meant that the necessary attention was not paid to the central risk of the Program and, ultimately, to the whole State, being the risk of outbreaks inside the hotels or into the community at large.

296. While the Hotel Quarantine Program was not in existence or even contemplated when the decision was made to (apparently) not appoint the CHO as State Controller — Health, the consequence for the Program was that, when it was brought under the control of the State Controllers — Health, it was also being brought under emergency management, rather than public health governance.

297. The essential rationale behind the designation of DHHS as the control agency in response to a health emergency was that public health expertise, rather than logistical support, was the unique function that was required at the helm in the SCC infrastructure. That was the purpose for which DHHS was designated as the control agency in the first place.

298. No system of IPC in the context of this pandemic was going to be perfect. It goes without saying that this virus can, and has, crossed over containment lines even in best-practice settings, such as hospitals and other healthcare settings. However, the starting point for a Program to minimise the risk of transmission events is one that sees itself as a public health program, not a logistics program, and therefore places those with the right expertise into lead positions.

8.3.6 Transfer of Operation Soteria to the Emergency Operation Centre

299. As noted above, at Section 8.2.5, in recognition that Operation Soteria needed to be placed into a longer-term programmatic footing rather than an ongoing emergency response, it was moved out of the SCC by mid-April and into a location in Fitzroy, the EOC. According to Ms Williams and Ms Bamert, this was done in the recognition that this would be a significant and complex program that was likely to be in place for 12–18 months.[394] Further, it was understood and accepted that the emergency management structure was not one that was designed for long-term, sustained responses.[395]

300. Ms Williams observed that a 'surge workforce', appropriate for an emergency over a few weeks, was harder to sustain over months. Ms Williams further stated that people recruited in a surge workforce come from a range of backgrounds and work experience and have a significant turnover rate. Longer-term appointments allow for a team structure and proper training and supervision.[396]

301. Ms Williams reflected that 'the extent and complexity of clinical needs in hotel quarantine was substantial; direct service provision by a public health service would have assisted in managing those needs, both at the hotel and when escalation to hospital care was necessary'.[397] Ms Williams also reflected that approval of public health policy and transfer into implementation of policy around infection control and cleaning needed to happen much more quickly.[398]

302. Ms Williams pointed out that, at the start of the Program and observing what was happening overseas, hospitals were preparing for large numbers of COVID-19-positive patients. Once this pressure abated, Alfred Health assumed its role at the Brady Hotel in mid-June 2020.[399]

303. While I accept the concern about hospitals getting overwhelmed by patients being a reason for not moving to this clinical model earlier, it was actually in the wake of the two outbreaks from hotel quarantine that Alfred Health accepted the role at the Brady Hotel.[400]

304. Notwithstanding that transfer with the intention of moving the Program out of the emergency management framework, Ms Williams and Ms Bamert (who came into the SCC on 30 April 2020[401]) continued with titles taken from the 'chain of command' emergency management structure: COVID-19 Accommodation Commanders and, ironically, DHHS named its new location as the 'Emergency Operation Centre'.

305. The move away from the SCC with the intention of setting the Program onto a longer-term footing was sensible and correctly assessed as consistent with the needs of the Hotel Quarantine Program. That it remained entwined with the emergency management structure, and that DHHS did not take the opportunity to re-conceptualise what was needed in the wake of that transition, was an opportunity lost in mid-April.

8.3.7 Chain of command inside DHHS: who was in command of whom?

306. Notwithstanding Ms Peake's evidence that 'there was a healthy and engaged relationship between the Public Health Command that was created to provide that input into all of the operations, including Operation Soteria',[402] the evidence was completely at odds with this, in particular on the topic of the chain of command within DHHS.

307. There was considerable evidence, some that emerged after the close of the evidence and final submissions, of confusion and tension about who was in command of whom inside DHHS. The split that emerged was as between the emergency management personnel within DHHS and the public health witnesses. There was conflicting evidence about reporting lines and chains of command as between these two groups.

308. Mr Helps, State Controller — Health, stated that he believed his role in the Program was 'very complex to navigate' and that '[t]rying to coordinate across very different levels of governance (Public Health Command, Government and Emergency Management) was a constant challenge'.[403] As explained above, in evidence, Mr Helps said that 'my role wasn't to effectively lead the decision-making in regards to public health or national or State policy'.[404] Mr Helps said that it was 'well known and well recognised' that he was not able to fulfil the full suite of responsibilities that usually fell to the State Controller because those decisions were being made elsewhere by other people, including by the CHO.[405] Ms Spiteri said that a lot of decisions were made by 'other people in other places'.[406] I accept from both Mr Helps and Ms Spiteri that their roles were vast and complex. That does not assist, however, in clarifying the chain of command inside DHHS.

309. In his affidavit of 4 November 2020, Mr Helps said that 'the governance and responsibility of the Hotel Quarantine Program was with Public Health Command'.[407]

310. On the other hand, Prof. Sutton's evidence to this Inquiry was that he understood the Operation Soteria Commander to be responsible for running the Hotel Quarantine Program.[408] In his affidavit of 4 November 2020, he was emphatic that the Program was not under the overall control of the Public Health Command, stating: 'I did not consider myself to be and was not the overall head of a chain of command in relation to Operation Soteria generally'.[409] He stated that he was so divorced from the command arrangements that he was not even aware of the detail of the governance arrangements:

> [W]hile I do not know in detail how policy or oversight of people in detention was handled in the Hotel Quarantine Program, I was aware that there was another management structure, in Operation Soteria and under the State Controller and Operation Soteria Commander.[410]

311. The account of the Public Health Team's role that was offered by Braedon Hogan (DHHS Agency Commander) fell somewhere between those diametrically opposed positions: by affidavit, dated 3 November 2020, Mr Hogan stated that 'there was involvement of the public health team in the decision-making process'.[411]

312. On 1 April 2020, Dr Romanes wrote to a number of senior people involved in Operation Soteria, stating:

> Just an important reminder: all policy and oversight of people in detention is being handled in a strict chain of command, from:
>
> • Chief Health Officer to
>
> • Deputy CHO (today — Simon Crouch) to
>
> • Deputy Public Health Commander Planning (Finn Romanes) to
>
> • Director Health Regulation and Reform (Meena Naidu) to
>
> • Authorised Officers (under Noel Cleaves and some other managers).
>
> It is important that all direction, policy, reporting and arrangements do not break this chain.[412]

313. This 'chain of command' was not reflected in version 2.0 of the *Operation Soteria Operational Plan,* which was authorised for release on 24 April 2020. The section of that Plan dealing with governance included the following:

> Operation Soteria is led by the Deputy State Controller (Operation Soteria) working to the State Controller — Health, to give effect to the decisions and directions of the Public Health Commander and Enforcement and Compliance Commander.[413]

314. Dr Romanes has since stated (by affidavit, dated 3 November 2020) that '[t]his chain of command I outline in my email was only intended to refer to the legal process and accountability of detaining people and allowing exemptions from that process'.[414]

315. However, on 9 April 2020, Dr Romanes sent an email to a number of senior officials within Operation Soteria, including Ms Spiteri. In it, he stated, in emphatic terms, that: '[t]here are now a considerable complexity and considerable risk that unless governance and plans issues are addressed there will be a risk to the health and safety of detainees'.[415]

316. On 10 April 2020, Deputy Secretary, Ms de Witts (who sat above, and was bureaucratically responsible for the work of, the Public Health Team), wrote to State Controller, Ms Spiteri, about escalation of detention issues. In that email she said that, in respect of general concerns raised by people in quarantine (for example, requests for exercise or pharmaceuticals), 'I think the public health commander just needs to receive regular reports on 'detention' issues and themes, and separately to be assured that the detention policy is being followed to promote the health and well-being of residents (e.g. exercise granted etc.)'.[416] In respect of serious matters of safety or welfare that were 'non-medical' in nature (such as family violence or child protection issues), Ms de Witts indicated that 'expedited reporting to the public health commander is needed on any issues that could impact the psychosocial or physical health of people detained in the hotel'.[417] In respect of both streams, Ms de Witts was clear that 'any human rights issues need to be escalated to the public health commander'.[418]

317. By email to Prof. Sutton, dated 13 April 2020, Prof. Wallace, in his capacity as State Health Coordinator, wrote as follows:

> I understand that there is a bit of tension between PH and EM - everyone trying to do their best.
>
> I have had a look at the health and wellbeing arrangements for the Operation - looks like there are some holes /opportunities for improvement.
>
> I really wanted to get your view re: governance etc

> I understand that the persons are detained under your order. Assuming this is correct, this brings with it a level of accountability/responsibility for the health and welfare of those detained. Is that a cause for concern to Annaliese, Finn etc?
>
> Is that the main pressure point or is there something else?[419]

318. Prof. Sutton responded by email within less than half an hour, stating that:

> I think the main point of tension is exactly that, Euan. Operation Soteria was – as an illustration – set up and put into place through EMV / State controller without even getting my approval or even input. Annaliese was similarly excluded. That, in and of itself, is astounding to us. It was seen as an almost wholly logistic exercise and had EM governance without an understanding of where accountability sat, or perhaps should sit.
>
> The mandatory quarantine regimen was a policy recommendation of National Cabinet, for all jurisdictions to put into place under relevant legislation. For us, that means that the CHO nominates and authorises an authorised officer to write a direction. In this case, Annaliese wrote the direction so was effectively the 'maker' of the entire scheme and has responsibility in law for it.
>
> I agree that everyone is trying to work constructively in this space. But there is clearly a disconnect with our EM colleagues, perhaps especially in EMV who understood their role as controller of the scheme and effectively excluded those with significant accountability. That is a source of unease - moral and legal![420]

319. Prof. Wallace conveyed concerns about the 'overall responsibility' of the Program to Ms Skilbeck by email, dated 1 May 2020:

> In essence, who is responsible for the quarantined detainees. there is not a consensus on this and lack of consensus/clarity fundamentally undermines governance and decisions.
>
> The structure suggests that the Accommodation Commander reporting to State Controller is responsible. However, there is also an opinion that PH is ultimately responsible because the passengers are detained under their direction.[421]

320. In an email to Ms de Witts on 17 May 2020, Mr Helps similarly raised serious concerns about governance and outbreak management:

> At present my greatest concern (quite selfishly) is that lack of engagement and reporting with the State Controller from Public Health, whilst it is recognised the Public Health Commander/ CHO have control of, and responsibility for, the Public Health aspects of this emergency, there is also legislative responsibilities and expectation on the State Controller for the broader risks, add to this the role of the missions and CCC and it is a complex space for us all to navigate, and one that exposes us all to risk if we are not connected and supporting each other.[422]

321. What was being raised at a senior level inside DHHS was a serious internal division of views about where the internal lines of command and responsibility lay, and the risks associated with the situation if left unaddressed.

322. Ms Williams stated that, as Operation Soteria Commander, she was 'responsible for the day to day management of Operation Soteria command'.[423] Ms Bamert (who was 'twinned' in the role with Ms Williams) similarly stated that, as Operation Soteria Commander, she was 'responsible for the day to day management of Operation Soteria' and that her 'responsibilities were to operationalise the public health policy developed by the Chief Health Officer and Public Health Command as well as coordinate activities for which other agencies were responsible'.[424]

323. In an email to Safer Care Victoria, sent on 21 May 2020, Ms Bamert stated 'I am not sure who you would say was in charge at that point'[425] as at 11 April 2020. That was the date of the first incident investigated by Safer Care Victoria.[426]

324. While Ms Bamert sought to clarify, in evidence, that she was describing a lack of clarity in the governance arrangements as at 11 April 2020, and that that was a catalyst for the transition to the EOC,[427] Mr Helps continued to express concerns about the governance arrangements as late as 17 May 2020, almost two months into the Program.[428]

325. In giving her view about the internal chain of command, Dr van Diemen stated that the State Controller – Health had oversight of the implementation of advice, guidance, policies and procedures issued by her as Public Health Commander.[429] That view followed from her stated position that '[t]he hotel quarantine program was not a public health function but an emergency management function and response relating to a health emergency'.[430] She was of the view that the implementation of health and welfare policies and protocols (promulgated by the Public Health Incident Management Team) would actually be performed by the Emergency Operation Command, which sat with Ms Williams.[431]

326. Dr van Diemen reflected, in her statement, that fragmented responsibilities 'were indicative of some inconsistencies in understandings between different staff and departments as to who was considered to be ultimately responsible for certain aspects of the program, including oversight of operations on the ground'.[432]

327. In his further affidavit of 12 November 2020, Prof. Sutton emphasised, consistent with his earlier email to Prof. Wallace, 'that public health were not briefed and were not involved and did not have operational control of matters in respect of which we felt we had a moral and perhaps legal responsibility'.[433] He further stated that 'public health were not in day to day decision making roles'.[434]

328. The above evidence leads to the inevitable conclusion that senior DHHS employees did not share a joint or even consistent understanding of who was 'in charge' of the Hotel Quarantine Program as between the various teams inside DHHS. There were divergent views as to who fulfilled what functions and what their respective roles were within the Program. There were also differing views amounting to a fundamental disagreement inside DHHS as to who was reporting to whom inside which chain of command, and who was subordinate to whom.

329. This level of confusion and disagreement inside the DHHS chain of command invariably contributed to the ultimate position that no division inside DHHS saw itself as having the power or authority or ability to be responsible for the operation of the Hotel Quarantine Program. For such a high-risk program to be left in this situation was a catastrophe waiting to happen.

8.3.8 Liaison officer as link to respond to governance issues

330. The Inquiry heard evidence that, in response to these and other concerns about the internal governance and chain of command issues raised in early April by the Public Health Team, a position of Public Health Liaison was to be created to embed in Operation Soteria the link between the DHHS Public Health Team and Operation Soteria.[435] Version 2.0 of the *Operation Soteria Operational Plan* included, under its Organisational Structure, the role 'SCC Public Health Liaison' with a direct line of report to the Public Health Commander.[436]

331. Prof. Sutton gave evidence that he was unsure when the role was specifically created but understood that the position was established, out of an agreement between Dr van Diemen and the State Controller — Health, shortly after the development of Version 2.0 of the *Operation Soteria Operations Plan*.[437] Prof. Sutton said that even the establishment of this role was 'not an optimal way of getting line of sight into the operation of the Program with respect to health and welfare'.[438]

332. When asked directly whether she agreed the role had been created, Dr van Diemen responded as follows:

> So, yes, in respect to the creation of the plans and policies around it. There were a number of members of my team who were on any given day the direct liaison points between the Operation Soteria team and the Public Health Team. It was more than one single formal role. There was in particular liaison into the planning team and liaison into the Case, Contact and Outbreak Management Team for the times when there were cases of more outbreaks in the hotels.[439]

333. Dr van Diemen gave evidence, however, of her continued advocacy for the establishment of a permanent clinical lead to be embedded in the Operation Soteria command structure to ensure health expertise in the operational aspects of the Program. She pressed for this role to be established even after the recognition of the need for a public health liaison officer.[440]

334. Dr van Diemen said that she commenced pushing for the creation of a clinical lead position in late-April 2020.[441] However, by the time she made her statement in mid-September 2020, she remained unsure as to whether that role had ever been filled. At the time she ceased her involvement with the Program in July 2020, there was no clinical lead or liaison in place to her knowledge.[442]

335. Ms Bamert gave evidence that, in response to Dr Romanes's request, she had sought the creation of a public health liaison role during the development of version 2.0 of the *Operation Soteria Operational Plan*. Ms Bamert said she 'had a job card written' for the role, then went on to explain:[443]

> ... in the end what we got was a clinical governance lead who was a nurse practitioner in infection control. It did take us some time to get that resource come in [sic], which was a fantastic resource.

336. Ms Bamert accepted that there were some delays in fulfilling the position of clinical governance lead, and this did not occur until the second week of June 2020.[444] I take Ms Bamert's evidence to refer to the Clinical Lead that Dr van Diemen was pressing for, noting that, as at the time of her statement, Dr van Diemen was unable to say whether such role had been filled. It is plain that there were some differences in the views of Ms Bamert (Commander, Operation Soteria) and Dr van Diemen (Public Health Commander) as to what roles, fulfilling which duties, were created and when.

337. Prof. Wallace gave evidence that the role of 'clinical governance lead' was created based on recommendations made by his organisation and only following the commissioning of two reports investigating serious incidents in the Hotel Quarantine Program.[445]

338. In an email, dated 27 April 2020 and addressed to Ms Williams and Dr Crouch, Senior Medical Advisor, Communicable Diseases Section at DHHS and Deputy Public Health Commander for CCOM, Ms Bamert noted that '[i]n our EOC structure planning we discussed early on having a Public Health Liaison Officer, EOC role that was based in the EOC and liaised and supported public health central teams'.[446] Ms Bamert asked Dr Crouch for his thoughts about the idea and proposed a way of progressing the proposal. Dr Crouch replied: '[i]n general a public health liaison does not sound unreasonable but give [sic] the wide ranging remitting [sic] Annaliese [van Diemen] would need to be happy and engaged with the process. I have cc'd her here'.[447]

339. Mr Helps gave evidence in relation to the possible value of a public health liaison role working within Operation Soteria command. When asked to reflect on whether he thought the public health liaison role was missing from Operation Soteria he said:

> I think a liaison officer would have made communication back to those really busy people within our Public Health Command at times easier. We may have got … we got a lot of queries from other Departments working, and I'm talking initially, into … that were working in the program, around things like PPE, et cetera. If we had had … and there was one built into the structure but as Ms van Diemen articulated yesterday, the number of doctors we had available at the time at times prohibited that being a full-time position. So yes, I probably would have pushed harder to have that. I think we would have got some more timely responses. But I don't want that to sound like a criticism. Our public health colleagues, they were busy. An additional resource would have potentially assisted.[448]

340. It would appear, on the basis of the foregoing, that, from the perspective of those within the EOC responsible for running Operation Soteria, there was no dedicated 'Public Health Liaison' role in Operation Soteria prior to the later creation of the Clinical Liaison role. This is so, despite Prof. Sutton's evidence that agreement had been reached to create such a position, and despite the role actually appearing in the Organisational Structure for Operation Soteria.

341. Putting to one side the differing evidence as to whether that position was actually created, the chain of command issues appeared to require more than the creation of 'a link'. In an email sent by Dr Romanes on behalf of the CHO and DCHO, he called for an urgent review of the governance of Operation Soteria. By that email, those members of the Public Health Team demanded the urgent creation of a 'single plan' to guide the Program.[449]

342. Following the close of evidence on 25 September 2020, the Inquiry sought and received a further statement from Mr Helps in the form of a sworn affidavit and accompanying material. As noted above, Mr Helps stated that 'the governance and responsibility of the Hotel Quarantine Program was with Public Health Command. I believe that all other Department staff (including Emergency Management Command, EOC Command, Compliance and Enforcement, Health and Wellbeing and others) were operating subordinate to, and in support of Public Health Command'.[450]

343. DHHS submitted that public health leadership, advice and expertise was sought by, and operationalised in, Operation Soteria, including through the CHO and Public Health Commander relying on the evidence of Dr van Diemen, Ms de Witts and the Infection Control Consultant, as well as from Ms Williams and Ms Bamert.[451]

344. The first issue to extract from this submission is the difference between the provision of guidance and advice and policy and the **implementation** of that guidance and advice and policy. Implementation requires more than passing on information; it implies the need for a system in place to ensure that this guidance and advice and policy is being adopted and used systematically, is fit for the purpose and is subject to monitoring and supervision.

345. The second issue of note with this submission is that it is not where the weight of the evidence lay. The Infection Control Consultant relied upon for this submission stated that she was not involved in the Hotel Quarantine Program apart from providing some advice from time-to-time. Ms Bamert, herself, saw the need to have public health embedded in the EOC[452] and Dr van Diemen described herself as remaining 'somewhat conflicted' over the removal of Prof. Sutton as the State Controller.[453] The further problem with this submission is that it relied on the views of those not in the Public Health Team.

346. Witnesses from inside the Public Health Team expressed the view that they did not consider they had sufficient oversight of what was happening inside the Hotel Quarantine Program. There was clearly a distinction being drawn between providing advice and guidance to various issues as they arose, as opposed to being properly embedded into the design and operation of the Program with the 'on the ground oversight' of the Program.

347. The DHHS submission that Public Health Command and advice was 'clearly significantly embedded in the Hotel Quarantine Program'[454] is not supported by the evidence of the Public Health Team members Dr Romanes, Prof. Sutton and Dr van Diemen or, indeed, Ms Bamert. There was advice and guidance being produced by public health members but that does not address the chain of command issues.

8.3.9 Lack of oversight 'on the ground'; who was in charge on-site?

348. Given all of the above, it comes as no surprise that there was confusion and misunderstanding on the ground as to who had what role and who was 'in charge' of the operation. Indeed, given the refusal of DHHS to see the Program as its responsibility to lead and manage, through its senior management, it effectively characterised the hotel quarantine sites as the bringing together of a range of agencies that all had accountabilities back up through their own management structures.

349. This difficulty with the conceptualisation of how hotel sites worked can be seen in the oral evidence of Ms Spiteri. She described the hotel site as a 'complex space'.[455] Ms Spiteri described the fact that a number of agencies and contractors were working in the space. Ms Spiteri summed up DHHS's responsibility as one in which its overall 'contribution to safety of the environment was to ensure that there was guidance and instructions provided specifically to this emergency. And what I mean by that is that the instructions around the public health aspects were provided into that environment'.[456]

350. Ms Spiteri went on to describe the space as follows: 'You had a hotel that was owned and managed by a hotel company. DHHS were renting space in it through DJPR … We had our own staff in that environment, so did DJPR, so did Victoria Police and so did a number of contracted companies as well'.[457]

351. Ms Spiteri saw DHHS's responsibility as providing information about PPE and behaviour such as social distancing, with responsibility from an occupational health and safety perspective, lying with every person and their organisations.[458]

352. Ms Williams's view was that 'each agency undertook responsibility for their own staff and contractors, including to ensure their contractors were provided with training as to correct use of PPE'.[459] According to Ms Williams, DHHS was responsible for providing training to its staff on-site (hotel Team Leaders and Authorised Officers) as to correct use of PPE and was also responsible for providing training to its contracted staff on-site (although she noted that 'the Department's contracted nursing and medical staff could be assumed to have familiarity with correct use of PPE').[460]

353. DHHS Team Leaders present at quarantine hotels were there to 'coordinate and problem solve'.[461] As set out above, Ms Williams explained that, if there was a problem with security, the Team Leader would raise it with security managers. If there was a problem with the hotel, the Team Leader would raise it with the hotel manager. If a problem needed to be escalated beyond security or hotel management, it would be escalated to DJPR.[462]

354. No one has sought to ascribe responsibility for managing IPC, welfare services or delivery of clinical care to the Department's Team Leaders. There is no evidence to suggest that it was their role.[463]

355. Ms Spiteri's description of how the sites worked is echoed by the following observation of Nurse Jen about her experiences working on-site as a nurse at the Park Royal Hotel: '… things were siloed — there was a sense that everything was nobody's job. The [DHHS] staff were in charge, but nobody really reported to anyone'.[464]

356. There were Authorised Officers on-site at each hotel. The evidence revealed that the perception of the role of Authorised Officers on-site depended upon who was being asked. There was considerable evidence that many on-site personnel assumed that it was the Authorised Officers who were 'in charge' on-site, as they were the ones with the legal powers to detain and discharge people in quarantine and grant fresh air breaks and temporary leave.

357. Luke Ashford, an Authorised Officer on secondment to DHHS, gave evidence that he was not clear as to what the role of the Authorised Officer would be when he was first seconded to Hotel Quarantine from Parks Victoria.[465] He was appointed as an Authorised Officer on 28 April 2020. At the time, his general idea was that Authorised Officers would be assisting Victoria Police to conduct door knocks and spot checks at homes.[466] By 25 May 2020, when Mr Ashford started his first shift, he still did not have any formal idea of what he would be required to do in his role as an Authorised Officer.[467] Mr Ashford's evidence was that he received no specialist training in respect of performing Authorised Officer duties for DHHS.[468] His training related to the use of the COVID-19 app and equality and diversity training. He had no training on infection control.[469] Mr Ashford did not receive any finalised documents or instructions as to his functions and role.[470]

358. Mr Cleaves said that Authorised Officers had no management or control over other aspects of the Hotel Quarantine Program; their role was heavily focused on the compliance aspects with the detention notices as they applied to the people under detention.[471]

359. Further, Mr Cleaves's evidence was that Authorised Officers were discouraged from helping others with tasks unrelated to detention. He said:

> Over time it became clear that we needed to settle into what was described as our lane, and one of our Commanders would regularly use that phrase of 'stay in our lane', which we clearly understood to be focusing on the things for which we were accountable, which was the legal detention process, as I've mentioned a number of times.[472]

360. Arrangements for Authorised Officers at each hotel posed challenges for those in hotel quarantine. Rostering arrangements meant that, often, Authorised Officers would work at different hotels and not at the same hotel over a period, leading to a lack of continuity at each hotel. As new Authorised Officers came into a new hotel, they would be faced with different situations and different experiences.[473] There were inconsistencies throughout hotels, particularly with handovers between shifts, in respect of walk-lists and temporary leave arrangements for compassionate leave.[474]

361. The evidence of Mr Cleaves was that Authorised Officers did not have operational control over security teams.[475] Similarly, Mr Cleaves stated he did not recall personally giving direct instructions to security guards regarding operational matters such as cleaning or the appropriate use of PPE, except when carrying out a specific Authorised Officer function.[476] He was clear that security did not report to Authorised Officers, nor did Authorised Officers supervise security or their teams.[477]

362. But they were not the views held by those providing security services at hotels. Evidence from security guards and security companies was that they saw Authorised Officers as 'in charge' at hotels. For example:

    A. The security guard known as Security 1 understood that Authorised Officers were in charge of quarantine at the site.[478] Similarly, the security guard known as Security 2 understood that 'DHHS [was] the ultimate authority, as the Authorised Officer'.[479]

    B. Greg Watson, from Wilson Security Pty Ltd, understood that Authorised Officers were in charge of the site, on the basis that they were mentioned in detention orders, mentioned as a point of escalation, and in correspondence where it is identified that the decision rested with Authorised Officers.[480]

C. Jamie Adams, from MSS Security Pty Ltd, understood that each hotel would have an Authorised Officer and that security would report to them at a site on a day-to-day operational level.[481]

D. Mo Nagi, from Unified Security Group (Australia) Pty Ltd, gave evidence that he understood the responsibilities of Authorised Officers at hotels included dealing with guest issues and managing fresh air walks.[482] He saw Authorised Officers as the 'overlay of any issues and concerns that were required where any authority needed to occur …' [483] Mr Nagi accepted that Authorised Officers could give directions to, or make requests of, security staff.[484]

E. Ishu Gupta, one of the directors of The Security Hub Pty Ltd, was critical of Authorised Officers whom he saw as 'running the program' without necessarily having relevant training and knowledge or a background in health.[485]

F. Commander Tim Tully of Victoria Police gave evidence that he observed that security guards would look to Authorised Officers for guidance on what could actually be undertaken in the hotel quarantine environment; however, his evidence was also that Authorised Officers were saying 'well, we're not in a position to empower you to do it'.[486]

363. It is understandable that many perceived that Authorised Officers were 'in charge' as they did represent the legal power to detain people in their rooms as well as grant fresh air breaks and leave and, ultimately, authorise the discharge of people from their mandatory quarantine period.

364. However, Authorised Officers on-site at the hotels had no role in overseeing IPC.[487] Mr Smith (Commander of COVID-19 Enforcement and Compliance) espoused the view that the Commander of Operation Soteria had overall responsibility for IPC and that DHHS Team Leaders were their representatives on-site. It was his understanding that this included responsibility for PPE but only for DHHS staff — as opposed to the other staff — working at the hotels.[488]

365. The evidence as to the perceptions and confusion, in particular from non-DHHS people about who was 'in charge' on-site, was a completely understandable and human response to this situation. Putting to one side the question of having the right expertise on-site, at a minimum, such a challenging and dangerous environment that mandated people into a 14-day detention demanded that the control agency provide an on-site supervisor whose role it should have included monitoring safety on-site and understanding and intervening when risks and dangers emerged on-site.

366. In her statement, Ms Spiteri, when asked what could have been done differently, sensibly and helpfully stated that '[e]arlier strengthening of the role of rostering of the Department's team leaders in hotels, as well as clearer communications about the roles of the Department's team leaders, Authorised Officers and DJPR site managers, would have assisted all staff working in the quarantine hotels to understand who to report to for escalation and resolution. A clear, consistent and communicated unified command structure at each hotel, with consistent staffing of key management positions, could have ensured all staff working in quarantine hotels knew who was in charge of which aspects of the operation'.[489] Ms Spiteri went on to explain that 'The ongoing challenge to resource Departmental Team Leader and Authorised Officer roles, given the speed with which the program was initially stood up and then the pace of standing up new quarantine hotels, was a key factor in preventing this from occurring'.[490]

367. Setting up this Program, bringing all of the disparate agencies together and not having a coherent on-site supervising presence was always going to fall short of what best practice required of such a dangerous site. It was not enough to provide advice and guidance and policies to a disparate group of people and rely on the various agencies to oversee themselves. Each site needed a supervisory role to ensure that the site operated safely and according to best practice.

368. This is why I recommended that the Quarantine Governing Body ensures that each facility has a Site Manager responsible for the overall operation of that facility, who is accountable to that Body, and who possesses experience in the management of complex healthcare facilities.[491] That Site Manager must ensure that all personnel working in the quarantine facility understand their role and responsibilities and to whom they report and are accountable.[492]

8.3.10 Clinical guidance and governance on-site

369. Having found that such a complex and dangerous site needed on-site supervision from the control agency, the next question was what skills and background people filling such roles should have had. The nature of the virus and constant and inherent dangers of transmission required nothing short of IPC expertise on-site, to embed best practice infection and control processes, oversee the induction and training of all personnel on-site, and maintain vigilant oversight and monitoring to minimise the risk of transmission of the virus.

370. As has been stated throughout this Report, the supply and use of PPE, cleaning procedures and IPC procedures are areas of expertise that cannot be left to chance, or, merely, to posters put up on-site or one-off pieces of training from time-to-time. Nothing short of constant on-site vigilance from those with the right expertise is what is required. For this reason, I have recommended that the Site Manager be responsible for IPC measures, including with respect to training and supervision arrangements.[493]

371. Dr van Diemen conceded that priority should have been given to ensuring there was oversight from clinically-trained personnel.[494] She observed that 'we all could have treated the hotel quarantine program more as a health program than a logistics or compliance exercise and viewed the overarching principles more from a health lens than occurred at the time, including standards of care and infection control'.[495] She also reflected that, in line with a greater health focus, there could have been regular external auditing and reporting on adherence to standards.[496]

372. On this issue, it was the evidence of Mr Helps that there was no overall risk register created across the Program.[497] Mr Helps noted that the risks and issues were such that they required immediate action and resolution. No argument can be taken with that, but it misses the value and importance of capturing what is happening at and across sites, and the value of having a central repository for this information to ensure that a risk addressed on one site is analysed and addressed to assess whether there may be a systems-wide issue to address. The maintenance of a risk register is a proper and necessary practice at each quarantine facility. It should be made available for the purposes of safety audits that should be undertaken by independent experts.[498]

373. Mr Helps was unaware if agencies working in the Program maintained a risk register,[499] but whether they did or did not, the agency with overall site responsibility, DHHS, should have maintained such a register to enable the necessary system-wide overview.

374. Incorporated into the safe operation of sites should be regular safety audits, which would include inspection of the risk registers. This would have assisted in a more cohesive and Program-wide view of the emerging risks across the hotel sites.[500]

375. The evidence was that there was public health guidance provided from time-to-time[501] to Operation Soteria. This guidance, which the Public Health Team had input into, included PPE advice for healthcare workers, security staff and Authorised Officers, advice about cleaning requirements, and guidelines for the health and welfare of the detainees.[502]

376. A number of witnesses from DHHS gave evidence about the various policies and procedures relating to infection control and welfare that were drafted and disseminated. But the process was *ad hoc*, fragmented and reactive.

377. Advice in respect of cleaning provides a useful illustration. I have described cleaning policies in more detail in Chapter 7 of this Report. Suffice to say, there were several iterations of cleaning advice provided at different times, to different people and entities and on a variety of different topics.[503] The process by which specific and tailored cleaning guidance was disseminated is an example. The document entitled *Cleaning and disinfecting to reduce COVID-19 transmission: Tips for non-healthcare settings* (dated 20 March 2020: pre-dating the set-up of Hotel Quarantine) was initially used as guidance for cleaning of quarantine hotels. According to that document '[t]he principles in this guide apply equally to domestic settings, office buildings, small retail businesses, social venues and all other non-healthcare settings'.[504]

378. By email, dated 2 April 2020, Ms Febey of DJPR wrote to the State Emergency Management Centre, asking for 'some advice which is more tailored to the context that we're operating in' and noting that quarantine hotels 'are running essentially health services'.[505] However, as at 27 April 2020, cleaning contractors were still being directed to that document as guidance for the cleaning of quarantine hotels.[506] Eventually, specific guidance was prepared that set out advice for cleaning requirements for hotels that were accommodating quarantined, close contacts and confirmed COVID-19 guests.[507]

379. Prof. Sutton explained that the Public Health Incident Management Team provided guidance and advice and policies to the Hotel Quarantine Program regarding the use of PPE and cleaning and other matters relevant to IPC but had no awareness of the level of compliance with those policies;[508] that is, at least until the outbreaks occurred and were the subject of investigation and scrutiny. Dr van Diemen also said that her team's lack of operational oversight meant that the Public Health Command was not aware of significant IPC issues plaguing the Program until after the outbreaks.[509] Indeed, the Public Health Team did not regard itself as responsible for the implementation or supervision of those policies on-site. That meant that there was no one on-site with the expertise to maintain the necessary vigilance and supervision required. That this gap in the Program existed was a serious danger inherent in the Program.

380. Certainly, public health expertise from within the Public Health Command was called upon during the Program. So, too, was external expertise from Infection Prevention Australia. However, from a control and governance perspective, that public health advice was developed and on-shared to other agencies and their contractors to implement. These other agencies and contractors did not have expertise in IPC.

381. There was no evidence presented of any overarching plan, oversight or accountability within the Program for IPC on-site. While there were obvious aspects of the Program designed to meet these ends, they were largely reactive and lacking in cohesion of plan and purpose. The evidence demonstrated that the need for overarching clinical governance was not identified in the initial planning and implementation of the Program. It was apparently not until after the first outbreak from Rydges that thought was given by DHHS senior management to instituting a system of a clinical governance framework with a clinical governance lead.[510] It had no real effect until the engagement of Alfred Health, on 27 June 2020, when it took over clinical governance and clinical leadership of the Program[511] to provide 'streamlined clinical governance and oversight functions at the COVID Positive hotel with clinical staff and auxiliary and security staff all being drawn from individuals experienced in the IPC requirements of hospital environments'.[512]

382. It is now clear that the expert guidance that was provided, by way of advice and policies, did not extend to the level of operational oversight that was essential to the minimising of risk to the operation of the Hotel Quarantine Program.

383. There were others within the SCC structure that had the relevant expertise in emergency planning and logistics, most notably, the Emergency Management Commissioner, Victoria Police and the Australian Defence Force. In a Class 2 health emergency, health should be the focus of DHHS. That is the expertise that DHHS was expected to bring to the emergency response, and the Department's decision-making should have reflected that focus.

8.3.11 Ministerial briefings

384. During the course of the Inquiry, the issue of the briefing of Ministers by senior public servants arose on more than one occasion. In the DHHS context, Ms Peake acknowledged that, as Secretary to DHHS, she was accountable to her Ministers, including the Health Minister.[513] She was also accountable to the Premier in her role as Mission Lead — Secretary for the COVID-19 response.[514] In each role, she was specifically accountable for keeping those Ministers informed of significant issues within their portfolios.[515]

385. In response to questions by Counsel Assisting about the set up and structure and lines of accountability for the Hotel Quarantine Program, former Minister Mikakos gave evidence that she was not consulted nor did she receive any advice as to the operational plan or the initial decisions taken in the setup of the Program.[516]

386. Former Minister Mikakos agreed that DHHS's involvement in the Hotel Quarantine Program, even initially, was a substantial undertaking and a significant issue that fell within her portfolio.[517]

387. Her evidence was that she did not 'approve' of the plan in the sense of signing off on it. She stated that she considered that to be the role of the Emergency Management Commissioner.[518]

388. Similarly, the evidence of former Minister Mikakos was that she was not consulted or involved in the decision to move to the emergency management framework in which DHHS was the control agency for the Program.[519] Neither was she consulted with respect to the decision not to appoint the CHO as the State Controller — Health in the face of the looming COVID-19 pandemic, although, it was the former Minister's evidence that she would not expect to have been briefed on that issue.[520]

389. Former Minister Mikakos did, however, express 'surprise' that she was not delivered copies of Safer Care Victoria reports that investigated two serious incidents in the Hotel Quarantine Program.[521] The reports contained recommendations about a range of matters that should be addressed to improve safety for people being detained in quarantine hotels.[522]

390. While the Premier became aware of the control agency arrangements early on in the Hotel Quarantine Program, he could not point to a specific document or briefing as to precisely when he became so aware.[523] He was aware, in general terms, of the concept of control agency and support agency for emergency management purposes, and the significance of those terms.[524] He stated that he may have had some sense of departmental arrangements, but not much awareness as to the agencies involved. He thought that he would have had a briefing on the operational structure of the Program ahead of the announcements he made at his press conference on 28 March 2020, but could not recall the specifics.[525] However, in the ordinary course of his duties, he said, he would not expect to see operational documents.[526]

391. DHHS submitted that 'there was very regular and appropriate briefing of Ministers, their offices, the Premier, his office and the Crisis Council of Cabinet on … the operation of the hotel quarantine program'.[527] This submission is at odds with aspects of the evidence of both the Premier and former Minister Mikakos.[528]

392. Another example of information that was significant to the operation of the Hotel Quarantine Program being provided to a senior public servant but not being passed on to a Minister can be found in an email exchange in early April 2020. That exchange was between Phil Gaetjens, Secretary to the Department of Prime Minister and Cabinet, and his Victorian counterpart, Mr Eccles.[529] Mr Eccles gave evidence that he had asked the Commonwealth to assist with the cost of private security at hotels.[530] Mr Gaetjens responded that NSW had been provided with support in the form of Australian Defence Force personnel and that the same support might be available to Victoria if it were to reconsider its model of operating the Hotel Quarantine Program.[531]

393. Mr Eccles did not, so far as the documentary evidence reveals, respond, other than by return email to say 'thanks'.[532] His oral evidence was that he could not recall taking any other action in response to this email.[533] In its submissions, DPC accepted that the evidence established that Mr Eccles did not draw the contents of Mr Gaetjens's email to the attention of the Premier. DPC further accepted that it was open to me to find that Mr Eccles should have drawn the contents of Mr Gaetjens's email to the attention of the Premier, because its contents concerned a significant issue.[534] These concessions are properly made. Apart from anything that has later been learned about the issues that arose with respect to the use of private security, their use in the Hotel Quarantine Program was at a cost of many millions to the public purse.

394. Similarly, Minister Pakula, as the Minister for DJPR, gave evidence that, while he received verbal briefings from time to time about the work of DJPR in the Hotel Quarantine Program, he only became aware of issues and concerns his department was having about such things as whether there should be a police presence at hotels or whether people should be allowed out of their rooms, as a result of evidence to this Inquiry.[535] Further, his evidence was that he was not aware that contracts were going to be entered into for the provision of private security services or cleaning services, or how those contracts were constructed.[536] Minister Pakula was unable to recall how he became aware that his department had entered into contracts with private security companies for the provision of services at quarantine hotels. He thought it may have been 'from media reportage' or 'a conversation'.[537] Minister Pakula thought it was 'usual' that he would not know about his department being engaged in these multimillion dollar contracts.[538] Indeed, the estimate given from DPC for the amount spent by DJPR for its part in the Hotel Quarantine program was $133.4 million to 30 June 2020.[539]

395. As can be seen from these examples taken from the evidence, the issue of the information that does or does not get passed on by senior public servants to Ministers responsible to Victorians for the operation of their portfolios came up in several significant ways across several departments. Ensuring that Ministers are thoroughly and properly briefed is part of our system of responsible government, in place to create checks and balances on bureaucratic decision-making. It is also in place to, thereby, confirm that the Minister for the department is performing the important function of maintaining oversight of his or her department's actions for which he or she is answerable to the people of Victoria.

396. It is beyond the remit of this Inquiry to engage in an examination of the Westminster system of ministerial and public service lines of accountability and responsibility. However, the evidence on this issue that emerged in the Inquiry dictates that an appropriate agency or entity should undertake an examination of what has occurred to assess what action may be necessary in response. Given the role and responsibilities of the Public Sector Commissioner, as set out in the *Public Administration Act 2004* (Vic), I am satisfied that this is the appropriate place to direct a recommendation.

397. For the above reasons, I make the following Recommendation:

Recommendation 76: That the Public Sector Commissioner examines the evidence that emerged in this Inquiry as to the lines of accountability and responsibility as between Departmental heads and Ministers to give guidance across the public service as to the obligations on heads of departments and senior public office holders, both in law and in practice.

8.3.12 Appropriateness of EMMV and Class 2 emergency

398. The evidence was that this was the first time that the EMMV framework was used in a large-scale health emergency. Mr Helps stated '[t]he complex structure did at times raise challenges as State controller-health with navigating the various governance structures and establishing if a response activity was tasked through EM arrangements, public health command or through other national and state government departments "business as usual" arrangements.[540] At times, because of this structure, it was difficult to track the origin of a decision, the role or position responsible and information, data or plans'.[541]

399. Given this evidence, together with the evidence of the layers of confusion and complexity that emerged as to the interaction between the emergency management framework and the statutory roles and responsibilities under the PHW Act of those in public health, a review and reconsideration is warranted as to whether the EM framework, in its current structure, is suitable for Class 2 public health emergencies. I note that both Mr Helps and Ms Spiteri considered such a review is called for.[542]

Recommendation 77: The Emergency Management Commissioner, in collaboration with the Chief Health Officer, Secretary DHHS and other relevant agencies, reviews the suitability of the emergency management framework to Class 2 public health emergencies, including how the framework intersects with the *Public Health and Wellbeing Act 2008* (Vic).

8.4 — Summary of conclusions

400. During that March weekend, the commencement of the Hotel Quarantine Program in DJPR created the first fracture in lines of accountability and governance from which aspects of the operation did not recover. Even though the Program was quickly reset within Victoria's emergency management framework, that DJPR held the contracts for hotels, security guards and aspects of cleaning contributed to the firmly-held view in DHHS that it was in a model of 'shared accountability' with DJPR for the operation of the Hotel Quarantine Program.

401. Victoria's emergency management framework contains an extensive range of documents, manuals and plans that endeavour to address the range of emergencies that could transpire, and sets out structures by which to respond to those various types of emergencies. One of the aims of the emergency management framework is to establish efficient governance arrangements that clarify roles and responsibilities of agencies and to facilitate co-operation between agencies.

402. The emergency management framework classifies emergencies into different classes depending on the type of emergency being faced. The framework also designates which agency will be designated as the 'control agency' depending on the expertise required to respond to that emergency. A pandemic is classified as a Class 2 emergency and designates that DHHS is the control agency.

403. The use of the emergency management framework to respond to the COVID-19 pandemic was the first time it had been used in Victoria for a large-scale Class 2 emergency.

404. While there was a range of plans in place in this framework, none of those plans contemplated mass mandatory quarantining of people in response to a Class 2 emergency.

405. While there was no controversy about the appointment of DHHS as the control agency for this Class 2 emergency, there was considerable controversy that persevered throughout the Inquiry as to what it meant to be the control agency.

406. The meaning of the term 'control agency' is defined in the emergency management framework as the agency with the **primary responsibility** for responding to a specific form of emergency. The control agency's responsibilities are set out in the EMMV and include the appointment of 'controllers' for the specific form of emergency.

407. The importance of having a control agency in emergency management is to ensure clear lines of command and control, as this is critically important to lead and manage the emergency, coordinate the response and ensure there is no ambiguity about who is accountable for the management of the emergency.

408. Notwithstanding that DHHS acknowledged it was the control agency, it characterised its role in the Hotel Quarantine Program as one in which it had a 'shared accountability' with DJPR. It relied on several lines of reasoning to characterise its role in this way. First and foremost, it relied on the concept that the overall response to the pandemic and the Hotel Quarantine Program, as part of that response, fell within the meaning of a *complex emergency* as contained in the EMMV. In such circumstances, the need for 'shared accountability' is referred to but the reference goes on to make clear that, in these collaborative responses as between agencies, there is a need for a single agency to be responsible as the lead agency.

409. To the detriment of the operation of the Hotel Quarantine Program, DHHS did not accept that role or responsibility of being the single lead agency, either during the running of the Program or, indeed, even on reflection, during this Inquiry. This left the Hotel Quarantine Program without a government agency taking leadership and control and the overarching responsibility necessary to run such a complex and high-risk program. DHHS was the government agency that had this responsibility. Not only was it the control agency in emergency management terms, but it was the repository of the public health expertise and was the government department that had responsibility for the legal powers exercised to detain people in quarantine.

410. Notwithstanding this fundamental mischaracterisation of its role and function, adopting the structure and language of the emergency management framework, DHHS appointed a range of 'controllers' and 'commanders' inside complex and, at times, inexplicable internal governance structures that served to complicate and obfuscate reporting lines and accountabilities rather than create clarity of role definition and lines of command.

411. Prior to the commencement of the Hotel Quarantine Program, the Secretary to DHHS, on the advice of one of her deputy secretaries, departed from the expectation of the emergency management framework that the CHO would be appointed State Controller for a public health emergency and, instead, appointed two emergency management experts as State Controllers. This was despite the disagreement of the CHO with this course of action. (Note that at 8.3.3 paragraphs 275 to 278, it appeared that Prof. Sutton was formally appointed as one of four State Controllers – Health but that he was not made aware of this.)

412. The decision to not (apparently) appoint Prof. Sutton was taken on the basis that the CHO would not have the 'bandwidth' to fulfil all of the functions he had in the context of the state-wide emergency, and on the basis that the role required emergency management logistics (hence, the appointment of two such experts).

413. The impact of this decision had three important ramifications. First, it contributed to the mischaracterisation of the operation of the Hotel Quarantine Program as a 'logistics' and 'compliance' exercise rather than a public health program. Second, it created another fragmentation in governance of the Program, as it removed the head of the DHHS Public Health Team from much-needed operational oversight of the Program and, third, it meant that those in leadership roles for the Program were not people with public health expertise.

414. It concerned both the CHO and the DCHO that people were being detained using the legal powers authorised by them and yet they did not consider they had sufficient authority or oversight or awareness as to how the operation was being run 'on the ground'. Further, there was considerable disquiet expressed from the senior members of the Public Health Team inside DHHS that there was a lack of clarity about the command structures inside DHHS.

415. Inside DHHS's internal governance structures, as between emergency management executives and the public health senior members, there was not an agreed view or consistent understanding as to who was fulfilling what functions and roles and who was reporting to whom. In the context of the operation of the Hotel Quarantine Program, this created confusion and fragmentation in governance structures.

416. The mischaracterisation of the Hotel Quarantine Program as a 'logistics' and 'compliance' exercise meant that focus did not fall on the need for expert infection and prevention oversight to be embedded into the Program.

417. The impact of the pandemic and its demands on the Public Health Team inside DHHS revealed, among other shortages, a significant lack of much-needed public health infection prevention expertise employed by DHHS.

418. By mid-April, it was recognised that the Hotel Quarantine Program would likely be in place for 12–18 months and, therefore, needed to be taken out of an emergency management response structure and run as a departmental program. To that end, a centre was set up, ironically called the Emergency Operation Centre, and run by DHHS 'commanders'. Unfortunately, DHHS did not take this opportunity to rethink its operation but, rather, continued to see itself as co-ordinating the day-to-day operation of the hotel sites but not taking overall responsibility for the Program.

419. DHHS executives continued to see DHHS as responsible for providing 'broad' policy support, supporting the health and wellbeing of people being held in quarantine, obtaining advice and guidance from the public health arm of DHHS and passing that on to various agencies on-site, including DJPR, hotel operators and private security firms, in the firm view that each agency was responsible for its own operation on-site.

420. The on-site presence that DHHS did have was through its Team Leaders and Authorised Officers. Neither of these roles had functions of oversight or direction or supervision. The Team Leaders were seen as problem solvers or liaison points on-site. The Authorised Officers were responsible for the exercise of legal powers to detain people in quarantine. They exercised the legal powers to grant leave and exemptions and discharge people from quarantine at the end of their 14-day period. Neither had any role or authority or expertise in supervising the safety of the site generally.

421. Just as DHHS did not see itself as the control agency responsible for the Program, it did not see itself as 'in charge' on-site. This left brewing the disaster that tragically came to be. This complex and high-risk environment was left without on-site supervision and management, which should have been seen as essential to an inherently dangerous environment. That such a situation developed and was not apparent as a danger until after the two outbreaks was the ultimate evidence of the perils of the lack of proper leadership and oversight.

422. Ultimately, the intractable problems of governance and control and leadership in the Hotel Quarantine Program presented like a 'Gordian knot' that was only 'cut'" after the outbreaks in July when the responsibility for the Program was removed from DHHS.

8.4.1 Summary of Recommendations

74. That the Emergency Management Commissioner clarifies the language used in the Emergency Management Manual Victoria to ensure that there is no possibility of any ambiguity about the role and responsibility of the control agency, including a more fulsome definition of what constitutes a complex emergency and the role of the designated control agency in a complex emergency.

75. That the Secretary of DHHS engages in discussions with the President of the Australian Medical Association to address the availability of medical expertise to meet current and future surge and planning demands for public health emergencies.

76. That the Public Sector Commissioner examines the evidence that emerged in this Inquiry as to the lines of accountability and responsibility as between Departmental heads and Ministers and gives guidance across the public service as to the obligations, both in law and in practice, on heads of departments and senior public office holders.

77. The Emergency Management Commissioner, in collaboration with the Chief Health Officer, the Secretary of DHHS and other relevant agencies, reviews the suitability of the Emergency Management Manual Victoria framework to Class 2 public health emergencies, including how the Emergency Management Manual Victoria intersects with the *Public Health and Wellbeing Act 2008* (Vic).

Endnotes

1 Exhibit HQI0130_RP Witness Statement of Ms Pam Williams, 40 [106].
2 Exhibit HQI0135_RP Witness Statement of Ms Merrin Bamert, 27 [94].
3 Transcript of day 15 hearing 10 September 2020, 1153–1154.
4 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 27 [94].
5 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 5 [15].
6 Ibid.
7 *Emergency Management Act 2013* (Vic) (EM Act), s. 3.
8 Exhibit HQI0140_P Witness statement of Mr Craig Lapsley, 2 [4].
9 EM Act, s. 5.
10 Ibid s. 5(b)(i), (ii).
11 Ibid s. 24(1).
12 Ibid s. 32(1)(a).
13 Ibid s. 32(1)(b).
14 Ibid s. 32(1)(e)(ii).
15 Ibid s. 32(1)(mb).
16 Ibid s. 3; Exhibit HQI0145_RP Annexure to first witness statement of Commissioner Andrew Crisp, DOJ.600.001.0275-0276.
17 Exhibit HQI0145_RP Annexure to first witness statement of Commissioner Andrew Crisp, DOJ.600.001.0275–0276.
18 Ibid DOJ.600.001.0719.
19 EM Act, s. 53(1)(a).
20 Transcript of day 15 hearing 10 September 2020, 1212.
21 EM Act, s. 54(a).
22 Ibid s. 54(b).
23 Ibid s. 54(c). See Part 7 for agencies' roles with respect to a specified emergency.
24 Ibid s. 54(d).
25 Ibid s. 54(ea)–(ec).
26 Exhibit HQI0145_RP Annexures to first witness statement of Commissioner Andrew Crisp, DOJ.600.001.0501.
27 Part 3 provides the State Emergency Response Plan; Part 7 describes Emergency Management Agency Roles; Part 8 sets out Response and Recovery Regions (Appendix 8).
28 Exhibit HQI0145_RP Annexures to first witness statement of Commissioner Andrew Crisp, DOJ.600.001.1026.
29 Ibid DOJ.600.001.1032.
30 Ibid DOJ.600.001.0325.
31 Ibid DOJ.600.001.0446.
32 Ibid DOJ.600.001.0239.
33 Ibid DOJ.600.001.0276.
34 Ibid DOJ.600.001.0735.
35 Ibid DOJ.600.001.0313.
36 Ibid DOJ.600.001.0319–0320.
37 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 3 [10.6].
38 Exhibit HQI0145_RP Annexures to first witness statement of Commissioner Andrew Crisp, DHS.600.001.0719.
39 Ibid.
40 Ibid DOJ.600.001.0279.
41 Ibid DOJ.600.001.1058.
42 Ibid DOJ.600.001.0288.
43 Exhibit HQI0140_P Witness statement of Mr Craig Lapsley, 21 [17].
44 Ibid.
45 Ibid 19 [14].
46 Exhibit HQI0145_RP Annexures to first witness statement of Commissioner Andrew Crisp, DOJ.600.001.0717.
47 Ibid.
48 Transcript of day 15 hearing 10 September 2020, 1212.
49 Transcript of day 19 hearing 17 September 2020, 1581.
50 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 3 [11(c)].
51 Transcript of day 17 hearing 15 September 2020, 1355.
52 Exhibit HQI0145_RP Annexures to first witness statement of Commissioner Andrew Crisp, DOJ.600.001.1054.
53 Ibid.

54 Ibid DOJ.600.001.0317.
55 Transcript of day 17 hearing 15 September 2020, 1352.
56 *Public Health and Wellbeing Act 2008* (Vic) (PHW Act), s. 200(1)(a).
57 Transcript of day 17 hearing 15 September 2020, 1366.
58 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 38 [191]; Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 5 [14].
59 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 5 [14].
60 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 2 [9].
61 Ibid 3 [10.6].
62 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 2 [8].
63 Transcript of day 18 hearing 16 September 2020, 1454.
64 The Hon. Daniel Andrews MP, Premier of Victoria, 'New Departments to deliver a healthier, fairer Victoria' (Media Release, 30 November 2020) <https://www.premier.vic.gov.au/new-departments-deliver-healthier-fairer-victoria>.
65 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 8 [36].
66 Ibid 8 [38].
67 Ibid 8 [37].
68 Exhibit HQI0126_RP Annexures to witness statement of Ms Melissa Skilbeck, DHS.0001.0001.0013.
69 Ibid DHS.0001.0001.0016.
70 Ibid DHS.0001.0001.0017.
71 Ibid DHS.0001.0027.0909-0910.
72 Exhibit HQI0125_RP Witness statement of Ms Melissa Skilbeck, 4 [20]–[21].
73 Ibid 4 [25].
74 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 12 [50].
75 Exhibit HQI0125_RP Witness statement of Ms Melissa Skilbeck, 4 [21].
76 Exhibit HQIO153_RP Witness statement of Prof. Brett Sutton, 15 [74]; Exhibit HQI0155_RP Annexures to witness statement of Prof. Brett Sutton, DHS.5000.0056.3664.
77 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 12 [51].
78 Ibid 12 [52].
79 Exhibit HQI0162_P Witness statement of Ms Andrea Spiteri, 2 [7].
80 Exhibit HQI0098_RP Annexures to witness statement of Dr Clare Looker, DHS.5000.0056.3655.
81 Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 3 [11].
82 Exhibit HQI0160_RP Witness statement of Dr Annaliese van Diemen, 4 [20].
83 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 5 [12(c)].
84 Ibid 16 [34]; Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 11 [44].
85 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 19 [46].
86 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 4 [11]; Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 10 [16(c)].
87 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 4 [9]–[10].
88 Ibid; Transcript of day 16 hearing 11 September 2020, 1267.
89 Exhibit HQI0126_RP Annexures to witness statement of Ms Mellissa Skilbeck DHS.0001.0001.1449.
90 Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 8 [34].
91 Transcript of Day 18 hearing 16 September 2020, 1454.
92 Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, 1 [5]; Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 2 [8].
93 Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 8 [35]; Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 2 [8]. The Public Health Incident Management Team also had two functions fulfilled by Executive Leads who report to the PHC, these were Strategic Communication and Public Health Operation Coordination (see, Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 8 [36]; Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 2 [9].
94 Exhibit HQI0151_P Witness statement of Ms Jacinda de Witts, 2 [7].
95 Previously titled Public Health Emergency Operation and Coordination until 1 July 2020 (see Ibid 1 [5]; [7(b)]).
96 Exhibit HQI0151_P Witness statement of Ms Jacinda de Witts, 1 [5].
97 Ibid 1 [4].
98 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 4 [11].
99 Ibid 4 [10].
100 Ibid.
101 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 6 [18].
102 Ibid 5 [17].

103 Exhibit HQI0126(1)_RP Annexures to witness statement of Ms Melissa Skilbeck, DHS.0001.0001.0812–0817.
104 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 3 [12].
105 Ibid 3 [13].
106 Transcript of day 23 hearing 23 September 2020, 1965.
107 Exhibit HQI0177_RP First witness statement of Mr Christopher Eccles, 21 [82].
108 Ibid.
109 Exhibit HQI0193_P Letter from the Hon. Daniel Andrews MP to Ms Kym Peake, DHS.0001.0031.0004.
110 Ibid.
111 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 4 [16].
112 Ibid.
113 Exhibit HQI0193_P Letter from the Hon. Daniel Andrews MP to Ms Kym Peake, DHS.0001.0031.0004–0005; Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 4 [15]–[16]; Transcript of day 22 hearing 22 September 2020, 1910.
114 Exhibit HQI0193_P Letter from the Hon Daniel Andrews MP to Ms Kym Peake, DHS.0001.0031.0004.
115 Ibid.
116 Transcript of day 22 hearing 22 September 2020, 1909.
117 Exhibit HQI0193_P Letter from the Hon. Daniel Andrews MP to Ms Kym Peake, DHS.0001.0031.0004.
118 Transcript of day 22 hearing 22 September 2020, 1903.
119 Ibid.
120 Exhibit HQI0193_P Letter from the Hon. Daniel Andrews MP to Ms Kym Peake, DHS.0001.0031.0004–0005.
121 Transcript of day 22 hearing 22 September 2020, 1910.
122 Ibid.
123 Ibid 1912.
124 Ibid 1910.
125 Ibid 1911–1912.
126 Ibid.
127 Ibid 1915.
128 Ibid.
129 Ibid.
130 Ibid 1903.
131 Ibid 1915.
132 Ibid 1916.
133 Ibid 1918.
134 Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 7 [30].
135 Ibid 6 [28], 7 [32(a)–(b)], [fn 6].
136 Exhibit HQI0125_RP Witness statement of Ms Melissa Skilbeck, 2 [10].
137 Ibid; Exhibit HQI0151_P Witness statement of Ms Jacinda de Witts, 2 [7].
138 Exhibit HQI0194_RP Mission Implementation Plan, DHS.0001.0013.0414.
139 Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 6 [26].
140 Exhibit HQI0151_P Witness statement of Ms Jacinda de Witts, 2 [8]; Transcript day 18 hearing 16 September 2020, 1453.
141 Exhibit HQI0125_RP Witness statement of Ms Melissa Skilbeck, 1 [5]–[6]; Exhibit HQI0152_P Annexures to witness statement of Ms Jacinda de Witts, DHS.1000.0004.0001.
142 Transcript day 18 hearing 16 September 2020, 1453.
143 Ibid 1455.
144 Ibid 1454.
145 Exhibit HQI0162_P Witness statement of Ms Andrea Spiteri, 2 [7].
146 Exhibit HQI0166_P Class 2 State Controller responsibilities, DHS.0001.0027.0196.
147 Transcript of day 19 hearing 17 September 2020, 1583–1584.
148 Ibid 1583.
149 Ibid 1583-1584.
150 Ibid 1584.
151 Ibid 1584–1585.
152 Ibid 1595.
153 Ibid 1595–1596; Exhibit HQI0162_P Witness statement of Ms Andrea Spiteri, 12 [40].
154 Ibid 1596.
155 Ibid.
156 Ibid 1596–1597.
157 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 12 [51].

158 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 10 [16(c)].
159 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 4 [11].
160 Transcript of day 17 hearing 15 September 2020, 1375.
161 Ibid.
162 HQI0149_RP Witness statement of Mr Christopher Eagle, 4 [18].
163 Transcript of day 17 hearing 15 September 2020, 1438.
164 Ibid 1375.
165 Ibid 1438–1439.
166 Ibid 1439, 1441.
167 Ibid 1439.
168 Ibid 1440.
169 Ibid 1441.
170 Ibid 1437.
171 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 13 [53].
172 Ibid; Exhibit HQI0162_RP Witness statement of Ms Andrea Spiteri, 21 [92]–[93].
173 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 13 [53].
174 Exhibit HQI0162_RP Witness statement of Ms Andrea Spiteri, 21 [92]; Transcript of day 19 hearing 17 September 2020, 1591.
175 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 6–7 [18]; Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 6 [18].
176 Transcript of day 19 hearing 17 September 2020, 1590.
177 Ibid.
178 Ibid 1591–1592.
179 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 6 [18].
180 Ibid.
181 Transcript of day 16 hearing 11 September 2020, 1269.
182 Ibid 1280–1281.
183 Exhibit HQI0126_RP Annexures to witness statement of Ms Melissa Skilbeck, DHS.0001.0001.1444, DHS.0001.0001.1450 (at [2.3]).
184 Transcript day 18 hearing 16 September 2020, 1553.
185 Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 8 [34]–[35].
186 Transcript of day 18 hearing 16 September 2020, 1455.
187 Exhibit HQI0252_P Second affidavit of Prof. Brett Sutton, 2 [10].
188 Exhibit HQIO153_RP Witness statement of Prof. Brett Sutton, 5 [15]–[16].
189 Ibid 5 [17].
190 Transcript of day 18 hearing 16 September 2020 1523–1524.
191 Exhibit HQIO153_RP Witness statement of Prof. Brett Sutton, 6 [25].
192 Transcript of day 18 hearing 16 September 2020, 1523.
193 Ibid.
194 Exhibit HQI0151_P Witness statement of Ms Jacinda de Witts, 3 [10].
195 Exhibit HQI0126_RP Annexures to witness statement of Ms Melissa Skilbeck DHS.0001.0001.0814.
196 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 2 [9].
197 Ibid 3 [15]–[16], 4 [20].
198 Ibid 3 [17].
199 Transcript of day 18 hearing 16 September 2020, 1522.
200 Exhibit HQI0126(1)_RP Annexures to witness statement of Ms Melissa Skilbeck, DHS.0001.0027.0912.
201 Submission 03 Department of Health and Human Services, 6 [28].
202 See, e.g. Exhibit HQI0167_RP EMV State Operational Arrangements, DHS.5000.0032.1862; Exhibit HQI0187_RP Annexures to first witness statement of Ms Kym Peake, DHS.0001.0001.0814.
203 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 4 [20].
204 Ibid 4 [21].
205 Transcript of day 18 hearing 16 September 2020, 1515.
206 Exhibit HQI0249_RP First affidavit of Prof. Brett Sutton, 6 [33].
207 Exhibit HQI0203_RP Witness statement of 'DHHS Infection Control Consultant', 5 [18]–[20]; Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 22 [97].
208 Exhibit HQI0203_RP Witness statement of 'DHHS Infection Control Consultant', 5 [22]–[23].
209 Transcript of day 18 hearing 16 September 2020, 1524–1525; Exhibit HQI0203_RP Witness statement of 'DHHS Infection Control Consultant', 4 [17].
210 Transcript of day 18 hearing 16 September 2020, 1531.

211 Exhibit HQI0203_RP Witness statement of 'DHHS Infection Control Consultant', 6 [26]–[28].
212 Transcript of day 18 hearing 16 September 2020, 1456.
213 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 41 [207].
214 Ibid; Transcript of day 23 hearing 23 September 2020, 2004.
215 Transcript of day 18 hearing 16 September 2020, 1525.
216 Exhibit HQI0103_RP Witness statement of Dr Simon Crouch 1 [5]; Exhibit HQI0097_RP Witness statement of Dr Clare Looker, 2–3 [13].
217 Exhibit HQI0105_RP Annexures to witness statement of Dr Simon Crouch, DHS.0001.0003.0054.
218 Ibid DHS.0001.0003.0054–0058.
219 Ibid DHS.0001.0003.0054; Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, 5 [25].
220 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 1 [5].
221 Transcript of day 14 hearing 8 September 2020, 1063.
222 Ibid 1063.
223 Ibid.
224 Ibid 1063-1064.
225 Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 3 [10].
226 Ibid 3 [12].
227 Transcript of day 18 hearing, 16 September 2020, 1515.
228 Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 6–7 [30].
229 Ibid 9 [45], 14 [70].
230 Ibid 14 [70].
231 Ibid 5 [23]; Exhibit HQI0114_RP Annexures to witness statement of Dr Finn Romanes, DHS.5000.0123.3241.
232 Exhibit HQI0113_P Witness statement of Dr Finn Romanes 8 [38]; Exhibit HQI0114_RP Annexures to witness statement of Dr Finn Romanes, DHS.5000.0126.1658.
233 Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 6–7 [30].
234 Transcript of day 16 hearing 11 September 2020, 1285–1286.
235 Ibid 1308.
236 Ibid 1286.
237 Ibid.
238 Ibid
239 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 24 [81].
240 Transcript day 16 hearing 11 September 2020, 1285.
241 Ibid 1286.
242 Ibid 1286–1287.
243 Ibid 1287.
244 Ibid.
245 Ibid.
246 Ibid 1307.
247 Exhibit HQI0075_RP Witness statement of Mr Noel Cleaves, 22–23 [117].
248 Transcript of day 13 hearing 4 September 2020, 915.
249 Ibid.
250 Transcript day 15 hearing 11 September 2020, 1189.
251 Exhibit HQI0085_RP Witness statement of Ms Janette Curtain, 6 [35(c)].
252 Exhibit HQI0090_RP Witness statement of Mr Eric Smith, 11 [27.1].
253 Compare with New South Wales. See Transcript of day 12 hearing 3 September 2020, 877.
254 PHW Act, s. 168, s. 175.
255 Ibid s. 169.
256 Ibid s. 200(6).
257 Ibid s. 203 prescribes a penalty of 120 penalty units for a natural person. Up until 30 June 2020, the value of a penalty unit under s 6 of the *Monetary Units Act 2004* (Vic) was $165.22: see *Victorian Government Gazette*, No. G16, 23 April 2020 <http://www.gazette.vic.gov.au/gazette/Gazettes2020/GG2020G016.pdf>.
258 Transcript of day 13 hearing 4 September 2020, 897.
259 Ibid 904.
260 Exhibit HQI0122_RP Witness statement of Mr Murray Smith 13 [57(a)(iii)–(iv)]; Exhibit HQI0124_RP Annexures to witness statement of Mr Murray Smith, DHS.5000.0025.4759 .
261 Exhibit HQI0124_RP Annexures to witness statement of Mr Murray Smith DHS.5000.0025.4775.
262 Ibid.
263 Ibid DHS.5000.0025.4778.

264 Exhibit HQI0122_RP Witness statement of Mr Murray Smith, 2–3 [8].
265 Ibid 3 [10].
266 Transcript of day 15 hearing 10 September 2020, 1187–1188.
267 Ibid 1188–1189.
268 Ibid 1187–1188.
269 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 13 [56].
270 Transcript of day 8 hearing 27 August 2020, 416, 419.
271 Transcript of day 15 hearing 10 September 2020, 1188–1189; Exhibit HQI0122_RP Witness statement of Mr Murray Smith, 4 [14].
272 Transcript of day 15 hearing 10 September 2020, 1188.
273 Exhibit HQI0145_RP Annexures to the first witness statement of Commissioner Andrew Crisp, DOJ.502.003.1765.
274 Transcript of day 15 hearing 10 September 2020, 1211.
275 Exhibit HQI0211_P First witness statement of the Hon. Jenny Mikakos, former MP, 4 [18]; Transcript of day 22 hearing 22 September 2020, 1892.
276 Transcript of day 22 hearing 22 September 2020, 1892; Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 5 [16].
277 With regard to the Hotel Quarantine Program, Ms Peake acknowledged that the role of DHHS was not entirely informed by the emergency management framework. It was required to contribute capabilities, skills, legal powers and resources 'some of which fit within the scope of [the EMMV] and an emergency multiagency response, some of which are just relevant to the normal functions of each Department administered under the Public Administration Act and Financial Management Act': Transcript of day 23 hearing 23 September 2020, 1991.
278 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 23 [115].
279 Ibid 32 [164].
280 Ibid 32 [162].
281 Transcript of day 23 hearing 23 September 2020, 1990.
282 Ibid 1991.
283 Transcript of day 15 hearing 10 September 2020, 1211.
284 Transcript of day 24 hearing 24 September 2020, 2064.
285 Exhibit HQI0211_P First witness statement of the Hon. Jenny Mikakos, former MP, 4 [19]–[21] .
286 Transcript of day 16 hearing 11 September 2020, 1287.
287 Transcript of day 19 hearing 17 September 2020, 1586.
288 Exhibit HQI0162_P Witness statement of Ms Andrea Spiteri, 9 [31].
289 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 15 [63].
290 Exhibit HQI0033(1)_RP Annexures to witness Statement of Ms Claire Febey, DJP.101.004.4572–4573.
291 Transcript of day 22 hearing 22 September 2020, 1905.
292 Submission 03 Department of Health and Human Services, 10 [51], quoting Exhibit HQI0145(1)_RP Annexures to first witness statement of Commissioner Andrew Crisp, DOJ.600.001.0717.
293 Submission 03 Department of Health and Human Services 10 [54].
294 Ibid 10–11 [56]–[57].
295 Ibid 10 [51], quoting Exhibit HQI0145(1)_RP Annexures to first witness statement of Commissioner Andrew Crisp, DOJ.600.001.026.
296 Exhibit HQI0140_P Witness statement of Mr Craig Lapsley, 21 [18].
297 Ibid 19 [14].
298 Transcript of day 17 hearing 15 September 2020, 1373.
299 Exhibit HQI0143(3)_RP, Transcript of audio recording of Operation Soteria meeting 6.00pm 28 March 2020, 20.
300 Transcript of day 17 hearing, 15 September 2020, 1374.
301 Exhibit HQI0218_P Witness statement of the Hon. Daniel Andrews MP, 1 [1].
302 Ibid 2 [8].
303 Exhibit HQI0211_P First witness statement of the Hon. Jenny Mikakos, former MP, 11 [56].
304 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 19 [91].
305 Transcript of day 23 hearing 23 September 2020, 1942.
306 Ibid 1949.
307 Exhibit HQI0169_RP Witness statement of Chief Commissioner Shane Patton, 11 [6.2].
308 Exhibit HQI0145(1)_RP Annexures to first witness statement of Commissioner Andrew Crisp, DOJ.600.001.0501, 0717.
309 Exhibit HQI0177_RP witness statement of Mr Christopher Eccles, 19–20 [77]–[78].
310 Ibid 16–17 [65].

311 Transcript of day 24 hearing 24 September 2020, 2064; Exhibit HQI0211_P First witness statement of the Hon. Jenny Mikakos, former MP, 4 [18], 6 [28], 11 [56], 12 [62]; Transcript of day 23 hearing 23 September 2020, 1989–1990.
312 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 62 [329].
313 Exhibit HQI0145(1)_RP Annexures to first witness statement of Commissioner Andrew Crisp, DOJ.600.001.0717.
314 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 16–17 [65].
315 Ibid 17 [27]; Transcript of day 8 hearing 27 August 2020, 405–406, 426–427.
316 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 17 [66].
317 Ibid 17 [68].
318 Ibid 17 [67]; Exhibit HQI0080_RP First witness statement of Ms Rachaele May, 3 [10].
319 Transcript of day 8 hearing 27 August 2020, 410.
320 Exhibit HQI0080_RP First witness statement of Ms Rachaele May, 5 [24].
321 Ibid 5 [22].
322 Transcript of day 13 hearing 4 September 2020, 962.
323 Exhibit HQI0080_RP First witness statement of Ms Rachaele May, 4 [16]–[17].
324 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 6 [19].
325 Transcript of day 23 hearing 23 September 2020, 2012; Transcript of day 24 hearing 24 September 2020, 2081.
326 Transcript of day 17 hearing 15 September 2020, 1357.
327 Submission 03 Department of Health and Human Services, 1 [3(c)].
328 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 3 [10.6].
329 Exhibit HQI0215_RP Initial response to the Board of Inquiry from DHHS, 3.
330 Ibid.
331 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 23 [111]–[113]; HQI0162_P Witness statement of Ms Andrea Spiteri, 9 [29]; Transcript of day 19 hearing 17 September 2020, 1587.
332 Submission 03 Department of Health and Human Services, 3 [11]; HQI0162_P Witness statement of Ms Andrea Spiteri, 9 [29]; Transcript of day 19 hearing 17 September 2020, 1587.
333 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 38 [191].
334 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 22 [100].
335 Transcript of day 18 hearing 16 September 2020, 1532.
336 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 22 [97].
337 Ibid 22 [101]; Transcript of day 18 hearing 16 September 2020, 1563; Exhibit HQI0151_P Witness statement of Ms Jacinda de Witts, 11 [40].
338 Exhibit HQI0095_RP Witness statement of Dr Nathan Pinskier, 1 [7].
339 Transcript of day 19 hearing 17 September 2020, 1603.
340 Transcript of day 18 hearing 16 September 2020, 1531.
341 Exhibit HQI0092_RP Witness Statement of Dr Julian Rait, 5.
342 Transcript of day 23 hearing 23 September 2020, 1967.
343 Ibid.
344 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 3 [16].
345 Exhibit HQI0162_P Witness statement of Ms Andrea Spiteri, 2 [7].
346 Ibid.
347 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 12 [53].
348 Transcript of day 15 hearing 10 September 2020, 1217.
349 Ibid 1219.
350 Exhibit HQI0126_RP Annexures to witness statement of Ms Melissa Skilbeck, DHS.0001.0001.0840.
351 Ibid.
352 Transcript of day 15 hearing 10 September 2020, 1219.
353 Transcript of day 18 hearing 16 September 2020, 1485.
354 Ibid 1486.
355 Ibid 1533.
356 Ibid.
357 Exhibit HQI0125_RP Witness statement of Ms Melissa Skilbeck, 6 [30].
358 Transcript of day 17 hearing 15 September 2020, 1364–5.
359 Transcript of day 15 hearing 10 September 2020, 1219; Transcript of day 23 hearing 23 September 2020, 1971.
360 Transcript of day 23 hearing 23 September 2020, 1981.
361 Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 17 [84].
362 Transcript of day 18 hearing 16 September 2020, 1489.
363 Transcript of day 23 hearing 23 September 2020, 1972–1973.
364 Ibid.

365 Ibid 1973.
366 Exhibit HQI0162_P Witness statement of Ms Andrea Spiteri, 8 [27].
367 Ibid 8 [28].
368 Ibid 9 [30].
369 Ibid 9 [31].
370 Transcript of day 19 hearing 17 September 2020, 1583.
371 Ibid 1584.
372 Exhibit HQI0164_RP Witness Statement of Mr Jason Helps, 5 [24].
373 Transcript of day 19 hearing 17 September 2020, 1586.
374 Ibid 1595–1597.
375 Exhibit HQI0198_RP Advice re appointment of DHHS Class 2 Controllers.
376 Ibid DHS.0001.0011.1101.
377 Transcript of day 23 hearing 23 September 2020, 1982.
378 Exhibit HQI0253_RP Exhibits to second affidavit of Prof. Brett Sutton, DHS.9999.0032.0145.
379 Transcript of day 19 hearing 16 September 2020, 1487.
380 Exhibit HQI0164_RP Witness Statement of Mr Jason Helps, 6 [29].
381 Ibid 6 [30].
382 Ibid.
383 Exhibit HQI0167_RP EMV State Operational Arrangements COVID-19, DHS.5000.0032.1856.
384 Transcript of day 18 hearing 16 September 2020, 1522–1523.
385 Ibid 1523.
386 Ibid 1524.
387 Ibid 1523.
388 Ibid 1524.
389 Transcript of day 15 hearing 10 September 2020, 1219; Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 18 [84].
390 Transcript of day 16 hearing 11 September 2020, 1328.
391 Transcript of day 18 hearing 16 September 2020, 1527.
392 Ibid 1487–1492; Exhibit HQI0153_P Witness statement of Prof. Brett Sutton, 29 [159]–[160]; Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 17–18 [84].
393 Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 17–18 [84].
394 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 4 [11].
395 Exhibit HQI0162_P Witness Statement of Ms Andrea Spiteri, 21 [93].
396 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 37–38 [98].
397 Ibid 37 [95].
398 Ibid 37 [97].
399 Ibid 37 [95].
400 Transcript of day 14 hearing 8 September 2020, 1024.
401 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 6 [18].
402 Transcript of day 23 hearing 23 September 2020, 1972.
403 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 31 [143].
404 Transcript of day 19 hearing 17 September 2020, 1584.
405 Ibid.
406 Ibid 1585.
407 Exhibit HQI0255_RP Affidavit of Mr Jason Helps, 8 [30].
408 Transcript of day 18 hearing 16 September 2020, 1504.
409 Exhibit HQI0249_RP First affidavit of Dr Brett Sutton, 7 [43].
410 Ibid 8 [48].
411 Exhibit HQI0257_RP Affidavit of Mr Braedan Hogan, 7 [43].
412 Exhibit HQI0229_RP DHHS email chain re 'Information – Chain of Command' and other ending 2 July 2020, DHS.5000.0133.6518.
413 Exhibit HQI0152(2)_RP Annexures to the witness statement of Ms Jacinda de Witts, DHS.5000.0001.3588.
414 Exhibit HQI0259_RP Affidavit of Dr Finn Romanes, 4 [26].
415 Exhibit HQI0158_RP Email from Dr Finn Romanes to Ms Andrea Spiteri and Mr Chris Eagle, DELW.0001.0011.2116.
416 Exhibit HQI0256_RP Documents referred to in affidavit of Mr Jason Helps, DHS.0001.0131.0027.
417 Ibid.
418 Ibid.
419 Exhibit HQI0253_RP Exhibits to the second affidavit of Prof. Brett Sutton, DHS.5000.0165.7865–6.
420 Ibid DHS.5000.0165.7865.

421 Exhibit HQI0120_RP Email from Mr Euan Wallace to Ms Melissa Skilbeck.
422 Exhibit HQI0256_RP Documents referred to in affidavit of Mr Jason Helps, DHS.0001.0131.0065. For further evidence of concerns raised about governance, see Exhibit HQI0258_RP Documents referred to in affidavit of Mr Braedan Hogan, DHS.0001.0132.0152–DHS.0001.0132.0158; DHS.0001.0132.0147; Exhibit HQI0256_RP Documents referred to in affidavit of Mr Jason Helps, DHS.5000.0072.9118–DHS.0001.0131.0077.
423 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 6 [18].
424 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 6 [18].
425 Exhibit HQI0137_RP Email from Ms Merrin Bamert to DHHS and Safer Care Victoria, SVC.0001.0002.0056.
426 Exhibit HQI0117_R Annexures to first witness statement of Prof. Euan Wallace AM, DHS.0001.0002.0058, DHS.5000.0089.2744.
427 Transcript of day 16 hearing 11 September 2020, 1312.
428 Exhibit HQI0256_RP Documents referred to in affidavit of Mr Jason Helps, DHS.0001.0131.0065.
429 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 4 [21].
430 Ibid.
431 Ibid 4–5 [24].
432 Ibid 32 [146].
433 Exhibit HQI0252_P Second affidavit of Prof. Brett Sutton, 1 [8].
434 Ibid 2 [10].
435 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 15 [68].
436 Exhibit HQI0145 Annexures to first witness statement of Commissioner Andrew Crisp, DOJ.501.001.9230.
437 Transcript of day 18 hearing 16 September 2020, 1492–1493.
438 Ibid; Exhibit HQIO153_RP Witness statement of Prof. Brett Sutton, 29 [160]
439 Transcript of day 18 hearing, 16 September 2020, 1530.
440 Ibid 1534; Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 18 [83].
441 Ibid.
442 Transcript of day 18 hearing 16 September 2020, 1535.
443 Transcript of day 16 hearing 11 September 2020, 1308 and 1328; Exhibit HQI0161_RP Annexures to witness statement of Dr Annaliese van Diemen, DHS.5000.0053.6652.
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COVID-19
Hotel Quarantine Inquiry

COVID-19 Hotel Quarantine Inquiry Final Report and Recommendations

VOLUME II

DECEMBER 2020

COVID-19 HOTEL QUARANTINE INQUIRY

Final Report and Recommendations

Volume II

The Hon. Jennifer Coate AO
Board of Inquiry

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CHAPTER 9

Outbreaks at Rydges and Stamford hotels

1. Following the commencement of mandatory quarantine at 11.59pm on 28 March 2020, the Hotel Quarantine Program ran 24 hours a day, seven days a week, up until the time that Victoria ceased accepting international arrivals on 30 June 2020.[1] Over that period, in excess of 20,000 returned travellers[2] were accommodated across approximately 20 contracted hotels.[3] From 17 June 2020, Alfred Health was engaged to provide quarantine services in the newly established facility at the Brady Hotel under the 'Health Hotel' model.[4] Alfred Health later expanded its service delivery to a number of other quarantine sites.[5]
2. Prior to the involvement of Alfred Health, there were outbreaks of COVID-19 from two of the 20 hotels; the Rydges Hotel in Carlton (Rydges) and the Stamford Plaza Hotel in Melbourne's CBD (Stamford).
3. Before turning to the details of those outbreaks, I make the observation, again, that best practice in running a healthcare facility, be it a hospital or a quarantine facility, does not guarantee that no infection transmission will occur. But what best practice does provide is that the risk of such transmission is minimised to the greatest extent possible.

What were the outbreaks?

4. The outbreaks of the COVID-19 virus from Rydges and Stamford were described in Chapter 2. But before any analysis of the outbreaks as to why and how they happened, their consequences and lessons of those outbreaks, I shall briefly set out the facts of the outbreaks here.

Rydges outbreak

5. The genesis of the Rydges outbreak was as follows:
    A. On 9 May 2020, a family of four returned from overseas and commenced mandatory quarantine at the Crown Promenade hotel, staying together in the same room.[6] On that same day, one family member became symptomatic and subsequently tested positive to COVID-19 on 14 May 2020. The other three family members became symptomatic between 10 and 12 May 2020, and tested positive for COVID-19 on 14, 17 and 18 May respectively.[7]
    B. On 15 May 2020, following the two initial COVID-19 diagnoses, the entire family was relocated to Rydges.[8]
    C. On 25 May 2020, three people who worked at Rydges began to experience COVID-19 symptoms.[9] This included one member of hotel staff and two security guards.[10] They were each, subsequently, diagnosed with COVID-19.[11] As at 18 June 2020, 17 confirmed cases were linked to Rydges.[12] This included eight individuals who had worked at Rydges[13] (including one hotel worker, a nurse and six security guards),[14] as well as household and social contacts of those staff.[15]

Stamford outbreak

6. And for the Stamford outbreak, it happened thus:

   A. On 1 June 2020, a traveller returned from overseas and commenced a 14-day period of mandatory quarantine at Stamford. On the same day, that person became symptomatic. The traveller was tested for COVID-19 on 3 June 2020 and was subsequently diagnosed with COVID-19 on 4 June 2020.[16]

   B. A security guard, who had been working at Stamford, became symptomatic on 10 June 2020 and tested positive for COVID-19 on 14 June 2020.[17]

   C. On 11 June 2020, a couple returned from overseas and commenced mandatory hotel quarantine at Stamford. On the same day, one of them became symptomatic. On 12 June 2020, the other became symptomatic. Both underwent testing on 14 June 2020 and both were diagnosed with COVID-19, on 15 and 16 June 2020 respectively.[18]

   D. By 13 July 2020, a total of 46 cases of COVID-19 had been epidemiologically linked to the Stamford outbreak.[19] This included 26 security guards and one healthcare worker,[20] as well as social and household contacts of staff members.[21]

7. These outbreaks led to disastrous consequences for the Victorian community. The transmission of COVID-19 from returned travellers to those working within the program and its subsequent proliferation into the community were underwritten by a considerable range of contributing factors.

8. Identifying factors that led to each outbreak, as well as understanding the epidemiological and genomic evidence of the consequences of those outbreaks is the work of this chapter. However, what is contained here is not to be read in isolation from other contributing factors identified in other chapters of this report.

9.1 The designation of a 'hot hotel'

9. Within the Hotel Quarantine Program, certain premises were used exclusively to accommodate returned travellers who had tested positive to COVID-19.[22] Those designated hotels were referred to as 'red hotels' or 'hot hotels'. According to Dr Finn Romanes, Deputy Public Health Commander with the Department of Health and Human Services (DHHS) public health team, the idea of a hot hotel 'is a manifestation of the concept of "cohorting", which is the practice of isolating individuals with an infectious disease together, and separate from others who do not have that disease'.[23]

10. In the initial phase of the Program, there was no designated hot hotel. Instead, hotels accommodating returned travellers as part of the Program had 'red floors' set aside for confirmed COVID-19 cases.[24] In the event that a returned traveller tested positive for COVID-19 during the course of their mandatory quarantine period, they could be relocated to a red floor.[25]

11. During April 2020, returned travellers who had been diagnosed with COVID-19 (and their close contacts) were moved to a single site, Rydges. It appears that it was determined that this site was to be used as a 'hot hotel' because it had been the hotel that received a large number of known COVID-positive returned travellers who had previously been on a cruise ship off the coast of South America.

Support for the idea of establishing a hot hotel

12. On 30 March 2020, Dr Romanes raised a policy proposal of moving positive COVID-19 cases to a 'dedicated hotel for people found to be positive'.[26] On 31 March 2020, he advised Merrin Bamert, Director of Emergency Management at DHHS and later the Commander of Operation Soteria, and others, of Public Health Command's recommendation to cohort positive COVID-19 cases. He noted Prof. Sutton's advice that this should 'ideally be in one hotel only, or if necessary, on one floor of one hotel'.[27]

13. Dr Annaliese van Diemen, Deputy Chief Health Officer (DCHO) confirmed, in her evidence before the Inquiry that she had recommended cohorting positive guests and indicated that the approach had been endorsed by the CHO.[28]

14. Jason Helps, State Controller — Health, stated in his affidavit of 4 November 2020 that the CHO's advice about the use of a single COVID-positive hotel as contained in Dr Romanes's email of 31 March 2020, 'initiated planning for hot hotels'.[29]

15. Notwithstanding the evidence of Dr Romanes, Dr van Diemen and Mr Helps, Prof. Sutton stated that, while he agreed that cohorting guests was a generally sound public health measure, he 'was not consulted about moving positive cases into one hotel floor or to a specific hotel'.[30] In this regard, his evidence is at odds with the content of the contemporaneous email of Dr Romanes (31 March 2020).

Rationale for hot hotels

PUBLIC HEALTH RATIONALE

16. According to Dr van Diemen, cohorting of positive cases, preferably in a single location (in this case, a hotel), is a recognised public health preventative measure.[31] The benefits of doing so include that it:

    A. creates less risk across the system, in this case the Hotel Quarantine Program, because the measure separates unwell or infectious people from those who are susceptible and, therefore, decreases the number of susceptible people to whom the infection can spread

    B. decreases the number of staff who are potentially exposed to infectious people

    C. allows for a higher concentration of medical and support staff to be allocated to the cohort in light of their higher risk of deterioration and potential need for medical attention.[32]

17. On 7 April 2020, Dr Romanes, in an email to Braedan Hogan, Agency Commander of DHHS, endorsed the idea of using the Novotel South Wharf (Novotel) hotel to cohort COVID-positive guests. He noted, in particular, that the approach:

> … has many advantages from a public health risk management perspective and is — as long as logistics can be handled — the favoured public health model. This approach reduces the low (but material) risk that, as a result of detaining well individuals in a hotel, we then create a risk that they acquire COVID-19 from the environment of the hotel …[33]

18. Dr Simon Crouch, Senior Medical Advisor, Communicable Diseases Section at DHHS, gave evidence that, in his opinion, it was 'not unreasonable' to have a hot hotel in order to minimise the risk of further transmission to others in quarantine.[34] While any returned traveller should be managed as a suspected positive case, he explained that cohorting offered the best option for oversight and public health management.[35]

19. In his statement to the Inquiry Prof. Sutton agreed that, from a public health perspective, 'combining positive cases into one location is generally a sound approach from an IPC [infection prevention and control] perspective as it minimises the risk of transmission created by positive cases being accommodated with people who have not been exposed'.[36]

20. Professor Lindsay Grayson, Professor of Infectious Diseases at Austin Health, also gave evidence to the Inquiry about the approach to cohorting taken in hospitals. He gave evidence that, ideally, and even within a ward of known positive cases, all cases would be kept separate due to the potential risk of exposing a patient to a different strain of the same virus, however, in some instances, this is not possible. In these cases, the hospital will attempt to cohort, 'that is, we cluster known infected cases together, where as best as we can tell they have an identical infection and so they are not going to pose a risk to each other'.[37]

OPERATIONAL RATIONALE

21. Prof. Sutton also gave evidence that the establishment of a hot hotel had operational benefits.[38] He noted this:[39]

> Creating a COVID-19-positive hotel, or a 'hot hotel' was intended to mitigate the current circumstances where COVID-19-positive people occupy a floor of each hotel, so that other rooms cannot be used for persons not COVID-19-positive.

22. Mr Hogan observed, in email communication to Dr Romanes on 7 April 2020, that the current model of using 'red floors [was] taking out hotel capacity from the overall system' and that they were proposing the Novotel as a hot hotel at that time in order to 'release capacity in the system, stand up a suitable model of care in one location to support these positive cases and negate issues with exiting'.[40]

23. Kym Peake, former Secretary to DHHS, gave evidence that it made sense, rather than having hot floors dispersed across multiple hotels, 'to have a hotel where there was clear knowledge … about the positivity [sic] of the clientele'.[41]

Designation of Rydges as a hot hotel: whose decision was it?

24. On 27 March 2020, agreement was reached for 95 rooms at Rydges to be allocated for use in the Hotel Quarantine Program.[42] On or around 30 March 2020, that agreement was formalised in writing and executed.[43] On 1 April 2020, the Department of Jobs, Precincts and Regions (DJPR) received information from staff at Rydges about its service offering, in particular its food offering, staffing levels and security practices.[44] This communication did not include any information about the suitability of Rydges to accommodate a concentration of COVID-19-positive guests.

25. On 31 March 2020, Andrea Spiteri, State Controller — Health at DHHS, contacted Claire Febey, Executive Director for Priority Projects at DJPR, in search of a hotel that could accommodate a homeless person who had tested positive for COVID-19. She was advised, on the same date, that the request was beyond the scope of the current contracts and that the hotels had refused to accommodate the homeless man.[45] Ms Spiteri told the Inquiry:

> On 1 April 2020, [DHHS] worked further with DJPR who subsequently advised that the Rydges Carlton would be stood up as a COVID positive hotel from 2 April 2020. I do not know who decided Rydges Carlton would be the best option to be designated the COVID-19-positive hotel.[46]

26. On 2 April 2020, Ms Febey confirmed, by email to Mr Hogan and Ms Spiteri, that Rydges had been 'activated' to take confirmed COVID-19 cases from that evening, including a person who needed immediate accommodation.[47] She noted that 'this hotel is set up to receive confirmed cases from the general community that are expected to comply with their isolation'.[48]

27. On 4 April 2020, in an email to the State Control Centre (SCC), Mr Hogan, Mr Helps and Ms Spiteri, Ms Febey wrote:

> We had some great conversations with Andrea [Spiteri] and Braeden [Hogan] this week and activated Rydges as a property that will take confirmed COVID-19 cases from the community (e.g. family violence context, no other appropriate place to self-isolate).[49]

28. By 7 April 2020, DHHS had become aware of the repatriation flight from Uruguay that may be arriving in Australia carrying cruise ship passengers.[50]

29. On 8 April 2020, Ms Febey (by email to Mr Hogan, the SCC, Ms Spiteri and others) stated that agreement had been reached that Rydges would, that day, take its first confirmed COVID-19 case and 'it will be kept for the purpose of accommodating confirmed cases from both Operation Soteria and the community'.[51]

30. On 8 April 2020, Mr Hogan sent an email to Denise Ferrier, Executive Lead, DHHS, and staff, including those officers at the State Emergency Management Centre (SEMC), stating:

> [W]e have agreed with Public Health Command to stand up a hotel to contain COVID positive cases to streamline the care needed — instead of spreading it out across 14 hotels.[52]

This email, which was only produced to the Inquiry in early November 2020, suggests that the public health team was, in fact, involved in the decision to stand up a hot hotel.

31. By 9 April 2020, it was identified that the cohort of travellers from Uruguay was from the Greg Mortimer cruise ship, that a significant proportion of the group had contracted COVID-19 or were close contacts of people who had tested positive for COVID-19[53] and that they were predominantly older Australians.[54]

32. On the same day, there was correspondence between senior DHHS officials as to how to accommodate these returning travellers. Ms Peake indicated, by email, that the Premier had expressed a preference that they use a hotel near the airport to accommodate the returning travellers, rather than a hotel in the CBD.[55]

33. Melissa Skilbeck, Deputy Secretary Regulation, Health Protection and Emergency Management at DHHS, responded:

> We have one contracted hotel who is ready willing and able to accept COVID-positive guests — Rydges Swanston Street. At this late stage of planning, it would be risky to seek to convince another hotel to contract to take such guests.[56]

34. Ms Peake gave evidence that, following these emails, she had conversations with both Ms Skilbeck and Simon Phemister, Secretary of DJPR, about the risks of establishing and staffing a new hot hotel at short notice. Her evidence was that Mr Phemister agreed to advise the Premier's Private Office that it would not be prudent to try and contract a different hotel at that late stage.[57]

35. Pam Williams, Commander Operation Soteria, DHHS, also explained that there was a general reluctance among a number of participating hotels to accommodate a concentration of COVID-positive returned travellers. She stated that only two hotels indicated a willingness to accommodate such a cohort. Rydges was one of those hotels.[58]

36. According to Dr van Diemen, the decision to use Rydges as a 'hot hotel' was made by the Emergency Operations Centre.[59] The Emergency Operations Centre was, of course, a facility set up by DHHS to manage Operation Soteria.[60] She told the Inquiry that she was first informed that Rydges had been selected as the designated hotel by Ms Skilbeck in the email of 9 April 2020.[61]

37. On 10 April 2020, Mr Hogan noted, during the Operation Soteria meeting at the SCC, that 'Rydges will be a COVID-19 positive [sic] with the Uruguay flight.'[62] In the same meeting, Ms Febey observed:

> In terms of the Rydges Hotel taking the Uruguay passengers, which consists of some COVID-19 confirmed cases. DHHS will lead this service, DJPR will not have the usual on-ground presence but will provide advice on what it can help with.

38. Ms Peake gave evidence that DJPR provided advice to DHHS about Rydges being available to be used as a hotel for COVID-positive returned travellers.[63] However, she also acknowledged that the successful quarantine of the Greg Mortimer cohort impacted the decision to thereafter use Rydges as a hot hotel.[64]

39. However, documents provided to the Inquiry following the conclusion of public hearings demonstrate that, on 27 April 2020, Ms Williams sought assistance with coordinating the movement of COVID-positive passengers to Rydges and that it was at that time she had formed a plan to move all guests to Rydges to 'provide a better more coordinated service to them'.[65]

40. The evidence demonstrated that Rydges was, initially, identified as a site that could be used to house members of the community who needed support to self-isolate. However, with the influx of COVID-positive cases and their close contacts from the Greg Mortimer, Rydges became a convenient option for that group as well.

41. This was not necessarily because it was considered a particularly suitable site for the purpose, but due to a number of factors that developed gradually. It seems that it was of critical importance that Rydges had indicated a willingness to take on those guests. It was available in early April to accommodate the group of returned travellers from the Greg Mortimer cruise ship, many of whom were known to have tested positive for COVID-19. This group was accommodated at Rydges.

Implications of uncertainty about the decision-making chain: Rydges chosen as a 'hot hotel'

42. As outlined above, there were several documents that indicated the decision to use Rydges for COVID-positive returned travellers, as well as other members of the community, was a decision made between 8 and 10 April 2020.[66] However, Ms Williams gave evidence that the DCHO only 'agreed' to house all COVID-positive guests in a single hotel (to improve operational efficiencies and focus support for those guests) much later, on 22 April 2020.[67]

43. Ms Williams's email of 27 April 2020 supported this, demonstrating that it was only at that time that a plan was being formulated to move all current COVID-positive guests housed in other hotels to Rydges.[68] That plan was being conveyed to Dr Crouch of the public health team but it does not appear from the correspondence that his input was being specifically sought.[69] Rather, Ms Williams was seeking information from him to support the logistics of the exercise.

44. There were no documents before the Inquiry that clearly documented the decision, the reasons for it or the identity of who made the decision to use Rydges to cohort returned travellers who had tested positive for COVID-19 (as opposed to people from within the community).[70] The uncertainty about the decision and the basis on which it was made suggested a lack of clarity about responsibility for decision-making in respect of hotels: what hotels were to be used, and for what purposes, or by which designation?

45. Given the public health consequences of concentrating, in a single location, people who were known to have tested positive for COVID-19, the decision to select Rydges for that purpose was a critical one. It required careful thought, and a weighing up of the criteria for making such a decision that should have included, as a minimum, an expert opinion as to the infection prevention and control aspects of the facility.[71] The responsibility for that decision and reasons for taking it ought to have been clear and capable of being produced to the Inquiry.

Consultation regarding infection prevention and control at Rydges

46. Dr van Diemen gave evidence about the measures taken, generally, to ensure that hotels and staff had adequate infection control measures in place across the Hotel Quarantine Program. Chapter 7 provides more detail as to the policy documents developed by DHHS. Dr van Diemen identified that DHHS had provided infection prevention and control advice that was in line with the nationally agreed standards set by the Australian Health Protection Principal Committee (AHPPC).[72] She also gave evidence that, in late March 2020, she formed the view that the Hotel Quarantine Program policy on personal protective equipment (PPE) and infection prevention and control (IPC) needed to be more coordinated and systemised. And so she established a new Infection Prevention and Control Cell (IPC Cell) led by a public health physician and comprising infection control consultants.[73] This represented an expansion from the single infection prevention consultant available earlier in 2020, at the start of the pandemic.[74] The structure of the IPC Cell is introduced in Chapter 7 and discussed in greater detail in Chapter 8.

DEVELOPING A MODEL OF CARE FOR RYDGES

47. On 1 April 2020, during an Operation Soteria meeting at the SCC, DJPR requested guidance from DHHS about cleaning practices for quarantine hotels.[75] That same day, Mr Hogan sent an email to Ms Febey indicating that he would collate the questions DJPR had about cleaning standards in the hotels, including whether there were different standards required for cleaning when a guest was known to have tested positive for COVID-19, and 'seek advice from Public Health if needed'.[76] Mr Hogan subsequently escalated questions and sought guidelines from Public Health Command (PHC), via Dr Crouch, on cleaning requirements for quarantine accommodation.[77]

48. On 2 April 2020, and in response, Dr Clare Looker, Deputy Public Health Commander, DHHS, provided the SEMC with a link to the Commonwealth's publicly available guidance on COVID-19 for hotels and hotel staff.[78] In her witness statement, Dr Looker noted that she had copied the DHHS infection prevention and control consultant in this email, on the basis they may have been able to provide additional resources to guide the hotels.[79] There was no evidence that the deployment of additional resources was, in fact, prompted by this email.

49. On 7 April 2020, in the context of seeking endorsement for the idea of a 'hot hotel', Mr Hogan sought input from Dr Romanes, asking: 'are there any key considerations about the model of care we need to stand up? Or preferences — do we link in with a single hospital to support etc?'[80] Dr Romanes did not respond to that question.[81]

50. However, Ms Bamert responded, saying, 'we have done this work already' and went on to discuss arrangements that were in place to transfer unwell people from hotels to hospitals.[82] In her oral evidence, Ms Bamert elaborated on her response to the email. She indicated that, by her response, she had wanted to convey to Mr Hogan that there was a process in place to escalate the movement of people from the hotel to hospital if required.[83] It was apparent from her evidence that she had not intended to convey to Mr Hogan that a model of care for a hot hotel had been identified, or that the work as to 'key considerations' had been done already.

51. On 8 April 2020, via the COVID-19 Project Management Office and its executive lead, Denise Ferrier, Mr Hogan, again, made enquiries about establishing a model of care for guests in the hot hotel. He initially stated, 'I am keen to develop and implement a model of care for these patients that will adequately support them and also link into a hospital for escalations if required'.[84] In a later email he elaborated on the matters he thought the model need to cover, stating:

> From my perspective we need to ensure adequate level of care for the COVID positive patients
>
> • Resolve who the primary physician over seeing there [sic] care is
>
> • Requirements for support in the hotel and systems to support this
>
> • Escalation points and support from which hospital
>
> • Supplies and consumables preferable from a hospital so cuts us out of the supply chain [85]

52. There were no documents before the Inquiry that showed what response, if any, Mr Hogan received to this request. I, therefore, infer there was no documented response. While Mr Hogan's affidavit notes that he sought to have a model of care developed as identified in the emails, it is silent as to whether that actually occurred.[86]

53. On the same day, 8 April 2020, Ms Febey sought information about the specific practices to be put in place at Rydges. Ms Febey asked whether there would be 'any additional requirements for the service model (e.g. additional security, people housed on different floors)' and sought confirmation about cleaning requirements as follows:[87]

> • Cleaning requirements for rooms once vacated, specifically those that have had confirmed COVID-19 cases.
>
> • Whether the disposal of rubbish should be treated any differently in hotels that are housing quarantined or isolated guests. We have been advised through hotels that in NSW this is treated as medical grade waste.
>
> • Any other steps that are required from a DHHS perspective before rooms are returned to general stock.

54. Mr Hogan replied to this email and noted 'DHHS is developing a more robust model of care for this hotel and linked in with a Hospital'[88] and provided two documents with information, but that was limited to information about cleaning requirements only. Mr Hogan referred Ms Febey to page 25 of the *Guidelines for health services and general practitioners* (v 17 5 April 2020), which provided information on 'environmental cleaning and disinfection in an outpatient or community setting (for example a general practice.)'[89] He also included DHHS guidelines on *Cleaning and disinfecting to reduce COVID-19 transmission — Tips for non-health care settings* (20 March 2020). Mr Hogan indicated this information would 'work for every space **aside from those with COVID positive people in the rooms** (emphasis added)'.[90]

55. Mr Hogan's email to Ms Febey was copied to Ms Spiteri, Deputy State Controller Chris Eagle, Ms Williams and Director Health and Human Services Regulation and Reform, Meena Naidu. However, it was not copied to any members of PHC or the IPC Cell.

56. It was unfortunate that Mr Hogan's prompting on the model of care did not draw substantive responses from those to whom it was directed. For those responsible for the standing-up and operating of the hot hotel, this was an opportunity lost. Had minds turned — collectively or individually — to the types of considerations commensurate with concentrating known cases in the one location, the model may have had the necessary improvements to it prior to the outbreaks. What was subsequently observed, in the wake of the Rydges outbreak, demonstrated obvious shortcomings, especially around infection prevention and control measures and practices at that location.

57. This decision to implement a cohorting model at a dedicated hot hotel provided a distinct opportunity to reflect on the systems that were then in play across the Program, with a focus specifically on the known risk posed by confirmed positive cases (as opposed to merely presumed positive cases, as should be the case in any quarantine program). Mr Hogan seemed, at least in part, alive to that issue. Notwithstanding his raising it expressly, it appears to have passed others by.

58. The evidence leads me to the conclusion that there was no meaningful response by anyone within Operation Soteria or the public health team to the issues raised by Mr Hogan or Ms Febey, specifically key considerations about the model of care needed in the context of cohorting COVID-positive travellers in the one place. Indeed, it would appear that, beyond the question being posed by Mr Hogan, and raised again in correspondence with the COVID-19 Project Management Office and Ms Febey later in April, that no further consideration was given to that question until, at the earliest, the advent of the health hotel model with the involvement of Alfred Health in mid-June.

59. There was no evidence available to the Inquiry that a 'model of care' specific to Rydges was ever established or implemented despite this having been the intention of both DHHS and DJPR staff at early points in the process of identifying and standing up a hot hotel.

INFECTION PREVENTION AND CONTROL ADVICE

60. Ms Peake gave evidence that, around the time that it had been determined that Rydges would be a hot hotel, an IPC expert was engaged to provide advice and that the IPC Cell gave assurances that what had been recommended was appropriate.[91] She went on to explain that DHHS commissioned advice from Infection Prevention Australia (IPA) that, in her view, involved:[92]

> … a risk assessment about operationalising health and wellbeing services and entering and exit and the IPC measures that were important for that hotel and that was the advice that we relied on.

61. DHHS's Infection Prevention Consultant provided evidence that, on 10 April 2020, she was copied into an email from the Deputy Manager, Emergency Operations at DHHS, explaining that Rydges had been designated as the COVID-positive site. It was requested that an Infection Prevention Consultant from DHHS attend Rydges on Sunday 12 April 2020 to provide a briefing to nurses and General Practitioners working on-site.[93]

62. DHHS's own Infection Prevention Consultant gave evidence that she did not have capacity, at that time, to meet the request and instead provided the contact details of a private IPC consultant from IPA.[94]

63. The IPC consultant from IPA subsequently conducted a site visit to Rydges on 11 April 2020.[95] The visit resulted in a number of recommendations being made.[96] Those recommendations were circulated to the IPC Cell, the SEMC, Dr Romanes and Coralie Hadingham, Acting Manager Emergency Operations at DHHS. They included recommendations that: [97]

A. passengers disembark in groups of two and undertake the check-in and medical history process over the phone once in their rooms to reduce risk of exposure for healthcare workers and staff

B. there be a donning and doffing station on each floor

C. all staff, on entering the building, be required to change into their provided uniforms

D. there be no movement of clients out of their room for the 14 days as this created a high-risk of exposure to healthcare workers and other staff.

64. Email correspondence between operational staff, including Mr Helps, on 12 April 2020, confirmed that the IPA consultant had been engaged to 'support the onboarding of Rydges hotel' and had informed operational staff that 'all nurses are feeling confident and comfortable with the current arrangements (from an infection control perspective). Nurses are clear on the process of physical distancing, donning and doffing of PPE, and process for undertaking health assessments'.[98]

65. On 5 May 2020, IPA provided a further document titled *Summary of findings — Review of Hotel accommodation for OS travellers in quarantine*. This included a review of PPE practices across the quarantine hotels and a discussion of a subsequent visit to Rydges to 'ensure staff are well prepared for the quarantine of any future confirmed cases of COVID-19'.[99] It is not clear when the subsequent site visit was undertaken. The document noted concern among staff about the allocation of healthcare workers at the site and included concerns that staff were not rostered to work at the same hotel during a 14-day period and that some staff were junior and had not worked in the Hotel Quarantine Program previously or were inexperienced in donning and doffing.[100]

66. IPA made two further recommendations, which focused on ensuring nursing staff be allocated to the same hotel for a minimum of 14 days to cover the entire quarantine period and that only staff who demonstrated competence in donning and doffing be rostered. IPA's review concluded:[101]

> ... there are no other recommendations that I could make to improve the position of the hotel in accepting confirmed cases. **It does however rely on all staff working in the service to comply with policy and procedure** (emphasis added).

67. Ms Bamert gave evidence that, on receipt of IPA's report, DHHS met with security services provider, Unified, and provided it with a copy of the document *PPE advice for hotel security personnel for COVID-19 quarantine clients*.[102] DHHS also contacted Your Nursing Agency and requested that it 'attempt to reduce the movement of staff across hotels' but this was to be 'balanced with ensuring we were able to staff the hotels'.[103]

68. Given the decision to cohort positive cases at Rydges, IPC expertise should have been embedded at the hotel to oversee the necessary measures and monitor what was happening. That was not done. I note, in particular, evidence from the following witnesses in this regard:

A. Dr Stuart Garrow, Clinical Lead Medical Practitioner for Onsite Doctors, who provided clinical services at various hotels, including Rydges, gave evidence that 'a clear line of command for infection control was not available' and that relevant policies, standards and arrangements were adapted from hospitals and general practice where doctors and nurses had worked outside the hotels.[104]

B. Dr van Diemen, who gave evidence that, while she had responsibility for the availability of IPC advice and guidance, she did not have accountability for or any direct understanding of its implementation.[105]

C. Dr Romanes, who gave evidence that, despite his role in developing policies and procedures for the Hotel Quarantine Program, he was not involved in overseeing IPC and, therefore, was unaware of whether specific control measures were in place, generally, or at Rydges.[106]

D. The Infection Control Consultant, DHHS, who gave evidence that while she was involved in the preparation of IPC practices and procedures they held no formal role in the Hotel Quarantine Program and were not involved in the implementation of infection control policies on the ground.[107]

Training was not sufficient

69. Ms Peake gave evidence that, on 11 April 2020, the Department decided that all hotel staff at Rydges, including security, would do a 'short tutorial on infection prevention, organised by DHHS'.[108] Ms Bamert's evidence was that a PPE briefing had been arranged 'for GPs and nurses working at the Rydges Hotel'.[109] However, the email of 12 April 2020, referred to above at paragraph 61, indicated that any briefing carried out by the IPA consultant was only provided to nursing staff. Further, the evidence was that the nurses were supplied via agencies and, consequently, were not necessarily being present for episodic training.

70. It was, therefore, unclear whether Ms Peake and Ms Bamert were speaking of the same training in these parts of their evidence. If so, it would seem to be incongruent that Ms Bamert would describe the training being delivered to GPs and nurses only, while Ms Peake thought that it was delivered to 'all staff' including security and hotel staff. In any event, for the reasons that follow, it is not necessary to resolve this discrepancy. It was clear from the findings of the outbreak squad's investigations that the training was not sufficient in the initial phase[110] of the Program, or thereafter, at Rydges or Stamford. Given there were no general safety audits being conducted across the quarantine sites, it is not possible to know how widespread the issues were.

71. Email correspondence from 10 April 2020 suggested that the PPE briefing for GPs and nurses was arranged at their, and not DHHS's, request.[111] Another email about the arrangements for that PPE briefing on around 11 April 2020 said 'Training was raised in our conversation but I have left that with the [DHHS Team Leader] and the [IPA Consultant] to work through'.[112]

72. Rosswyn Menezes, General Manager at Rydges, gave evidence that, on 11 and 12 April 2020, DHHS IPC staff visited the site and showed him, as well as a limited number of his staff, how to don and doff PPE and told them to pass this information on to other staff.[113] He gave evidence that, in the following weeks, there were ad hoc occasions when on-site nurses would provide refreshers on how to don and doff PPE but that, to his knowledge, the only training the hotel staff received from DHHS was in relation to donning and doffing.[114]

73. It was Ms Spiteri's evidence that there were 'ongoing reminders' and there was 'ongoing training' for staff in the hotels. She said that the staff in the hotels were 'occasionally refreshed' but that the IPC consultant 'had spent quite a bit of time in the Rydges Hotel retraining new security staff in particular, that had come into that environment'.[115]

74. Ms Spiteri observed:

> So, while I was satisfied that the appropriate and most up-to-date infection prevention and control measures were in place, it was a constant education process. We have seen that in hospitals and in other settings as well, that you need to continually refresh that education and training to keep it at the forefront of people's minds, particularly when they are working in environments for a long period of time.[116]

75. IPA's review of Rydges, dated 5 May 2020, noted that '[o]n entry to the hotel, security staff were not wearing PPE as is the recommendation. This is a major improvement'.[117] It went on to say, 'the Health care teams compliance with PPE and HH [hand hygiene] has been excellent, and they are working to educate the security and AO [Authorised Officer] staff about appropriate PPE and HH'.[118]

76. Ms Peake described the review as being 'generally positive' while drawing attention to 'overuse of PPE and gaps in hand hygiene by security guards'.[119]

77. On 13 May 2020, the head contractor for security at Rydges stood down its entire security team.[120] It was Ms Peake's evidence that the impetus for this was complaints from healthcare workers and departmental staff at Rydges that security guards were overusing PPE and not observing social distancing requirements.[121] It was unclear whether the IPA consultant, or anyone else, was brought in at this time to provide training to the new cohort of security guards at Rydges. Ultimately, it was noted in the Outbreak Management Report for Rydges that the risk of transmission the site posed was due to 'inadequate education and cleaning procedures' in place.[122]

78. On 17 June 2020, three days after the first reported diagnosed case in a worker from Stamford,[123] Outbreak Squad nurses attended Stamford and prepared an interim report.[124] There were a number of matters raised, including that hotel personnel and security were not adequately educated in simple things such as hand hygiene and PPE use.[125] Dr Sarah McGuinness, Outbreaks Lead at DHHS, said that those matters, as identified in the outbreak squad report, would have increased, or, at least, would not have sufficiently guarded against, the risk of COVID-19 transmission at Stamford.[126]

79. There was also evidence that (notwithstanding the outbreak at Rydges on 25 May 2020)[127] it was only following the outbreak at Stamford on 14 June 2020[128], that face-to-face training was provided to 87 security guards. A summary report of the training session, conducted on 24 June 2020, noted:

> … for most this was their first face-to-face training in this area, some who had been working for several weeks had only just completed online training of which they indicated to me personally that they did not totally comprehend the learning.[129]

80. It was apparent that infection prevention control advice and PPE training provided to those staffing the Hotel Quarantine Program (including at the 'hot hotels') was insufficient to guard against the risk posed by those environments, particularly at the time of their establishment. It was also apparent that more appropriate training was only provided after the outbreaks had occurred at Rydges and Stamford.

81. The evidence before the Inquiry did not provide a clear picture of what training was provided to who and when at Rydges as there were no documents provided to make it clear, and conflicting evidence from witnesses. Even accepting that training was provided to security and hotel staff, as well as nurses and GPs, at about 11 April 2020, the benefit of any such training was quickly lost. As noted above, the evidence plainly established that, by 13 May 2020, the head contractor at Unified, responsible for staffing the security guards at Rydges, stood down the entire security team that had been working there.[130] If any security guards had received the 'short tutorial on infection prevention organised by DHHS'[131] or benefitted from follow-up visits by the IPC consultant, the benefits of such training were lost to Rydges almost immediately.

82. In any event, and as Ms Peake said when asked, based on what transpired in the Hotel Quarantine Program, it would be prudent to have an IPC expert at each premises used for quarantine in the future.[132]

83. Furthermore, as many staff and personnel working in the Hotel Quarantine Program were engaged on a rotating rostered basis until at least 28 May 2020, the provision of a single training session, provided on a single date, was inadequate to mitigate against the risks posed by not only a 'hot hotel' environment, but any quarantine hotel. I described the particular challenges that security guards, as a cohort, posed to implementing proper infection control measures within a quarantine environment in Chapter 6 of this Report. The casualised nature of security guards, the manner in which large numbers of security guards could be sourced and stood up quickly, meant that there could be a different set of guards at each hotel each day. Every guard rostered on from time to time, should have had the benefit of that training.

84. While the matters described above specifically relate to the training and advice provided at Rydges and Stamford, there was evidence of systemic issues in the delivery of training and guidance to security guards and others working on other hotel quarantine sites.

85. There was evidence that indicated that even nurses and GPs working in the hotels were not given adequate infection prevention advice and guidance. On 8 June 2020, Dr Garrow noted that there was 'some debate amongst the doctors and nurses around PPE practices'. He requested a copy of DHHS policy on PPE and infection control procedures for use in the hotels and asked that an IPC officer meet with the doctors to discuss those issues.[133] He was subsequently provided with a copy of the *PPE Advice for Health Care Workers Policy*. It was unclear whether a member of the IPC Cell or the IPA consultant ever attended a meeting with the doctors as was requested.

86. Further, the DHHS Infection Control Consultant gave evidence that it was not until 16 June 2020 that updated cleaning advice, specifically for hotels accommodating quarantined close contacts and confirmed COVID-19 guests, was prepared and issued.[134] It was, then, not until 20 June 2020 that the DHHS IPC Cell prepared version 0.1 of the *DHHS COVID-19 Infection Prevention and Control Training — Security Guards*.[135] This training program was described in email correspondence from the time as being an 'interim measure (pending Alfred coming on board) to address an immediate identified need.'[136]

87. This evidence combined to demonstrate that there was little specific attention paid to developing and implementing sound IPC practices at Rydges during the set-up phase, that there was insufficient contribution by PHC or infection control experts to the design of Rydges as a 'hot hotel' and that there was insufficient training provided by DHHS to relevant security and hotel staff and personnel working in these high-risk environments.

Additional safeguards required in a 'hot hotel' environment

88. Prof. Grayson explained that quarantine environments are self-evidently 'dangerous spaces'. He opined that 'the rigour and processes in place need to reflect and reinforce this'.[137]

89. The 'danger' is increased in a cohorted, 'hot hotel'.

90. Following the outbreaks, Prof. Sutton formed the view that a COVID-positive hotel 'clearly represented a risk of transmission from quarantined individuals to contracted staff'[138] and agreed that the risk was greater than that posed by a 'pure quarantine hotel'.[139]

91. There was a general consensus among (both medical and lay) witnesses that they understood the concentration of positive cases in one location posed a greater infection risk, in particular to staff, than was posed at other quarantine hotels.[140]

92. Prof. Grayson identified the quantum of risk by reference to a broadly analogous setting: a COVID ward of a hospital.[141]

93. Dr Crouch noted that the starting premise for people in hotel quarantine was that they should all be treated as being potentially positive,[142] and 'therefore the precautions being taken in those environments should be essentially the same'.[143] This comparison can only be sensibly understood to mean that infection controls across all quarantine facilities should be as required for a known COVID-positive environment.

94. Dr Crouch expected that hot hotels (and by logical extension, all quarantine sites) would have appropriate cleaning practices[144] and that staff would not work across multiple sites.[145] He stated that 'having a hot hotel wouldn't negate the fact that you need to be doing suitable environmental cleaning or whatever measures as appropriate for that potential for environmental transmission'.[146]

95. Dr Crouch said that had he been consulted, he would have agreed that the establishment of a hot hotel 'was a good idea'.[147] He concurred with this idea, in theory, assuming that:

    A. staff managing those in quarantine were trained appropriately to manage the confirmed cases

    B. those staff members have the knowledge and skills to do that effectively.[148]

96. When asked about the set-up of a hot hotel, Prof. Sutton outlined that, while not an IPC expert himself, he would have sought 'the input of the IPC team and the broader groups that they engage with around what step-up level of infection prevention and control might be required'.[149] He would have expected the implementation of the following appropriate measures:

    A. increased requirements for PPE because staff are dealing with a high number of known positive cases or suspected cases[150]

    B. the establishment of infrastructural and structural elements to minimise the risk of transmission, which include:

        I. creating a greater distance between those staff supporting the program and anyone who was a client of the program

        II. stratifying, separate to staff, the zones where those positive individuals were located

        III. addressing ventilation and air[151]

    C. the oversight of all of those elements, in terms of training, auditing, review and revision.[152]

97. Ms Williams's evidence was that safeguards at Rydges were 'designed to minimise any time that people spent in common areas'.[153] She explained that specialised or limited forms of access were intended to ensure that people had a rapid means of ingress and egress.[154] Nevertheless, as evidenced by the Outbreak Report, the common areas, including lifts that were required to transport COVID-positive guests in and out of the hotel, were not cleaned appropriately or by specialist cleaners.[155] This increased the risk of environmental transmission.

98. In relation to PPE, Prof. Grayson stated that all staff working with COVID patients should have been required to undertake training in infection control procedures and PPE usage.[156] He specified that the **minimum** PPE required in **any** hotel quarantine setting should be a Level 2 surgical mask, eye protection, long-sleeved single-use disposable gown and appropriate hand hygiene measures (using a TGA-approved hospital-grade alcohol-based hand rub or soap/water handwashing). He would expect those minimum standards to apply to staff undertaking duties such as patrolling hotel corridors to 'enforce' quarantine by non-contact measures. He added that, if there was a likelihood of patient contact, gloves should also be worn.[157]

99. In order to ensure that people were wearing their PPE effectively and otherwise complying with infection control protocols, Prof. Grayson explained that regular monitoring and enforcement, similar to a hospital setting, was imperative.[158] He provided a useful summary of the ways in which monitoring and enforcement was implemented at the Austin Hospital, including:

    A. regular reinforcement to staff about COVID-19 infection control measures through weekly CEO-led webinar presentations with the Infectious Diseases Department

    B. direct monitoring of adherence by the Nurse Unit Manager in each clinical area

    C. regular visits by infection control staff to observe behaviour

    D. widely displayed infection control signage throughout the hospital

    E. biannual re-credentialing in hand hygiene.[159]

100. He further outlined that educational signs alone have 'limited value in reinforcing behaviour, unless they are updated frequently, since they quickly become ignored. In addition, if the signs are only in English, they may not be fully understood by people where English is not their first language'.[160]

101. This evidence typifies the point that effectively managing transmission risks in these environments requires that communication to staff and guests be accessible and clear to all. Ms Williams acknowledged that DHHS 'were really struggling to get the message across' to security guards who 'wanted as many barriers as they could between them and what they perceived as this invisible threat'.[161] Ms Skilbeck gave evidence that the poor adherence to physical distancing policies and hand hygiene observed at Rydges and Stamford indicated that neither the policies in place nor the extensive community messaging on these issues was getting through to workers on the ground.[162] This prompted DHHS, on 17 June 2020, to engage the Behavioural Insights Unit at the Department of Premier and Cabinet for the purpose of 'better engaging the security companies and the security personnel around why it was that we were giving this advice and how it would protect them'.[163]

102. Additional safeguards implemented in the hot hotels, as discussed in Ms Bamert's oral evidence, included:

    A. a higher ratio of nurses to returned travellers, with those nurses having effective training and experience to deal with COVID-positive patients, including an understanding of the rapid nature in which a COVID patient can deteriorate[164]

    B. introducing staff with specific skills and qualifications, including an emergency nurse [165]

    C. linking the hot hotel with a range of metropolitan hospitals, depending on the demographics of the cohort, in order to support the escalation of care for people who may require hospitalisation.[166]

103. According to Ms Bamert, there was no consideration, at the time the decision was made to nominate a COVID-positive hotel, of linking that hotel in with a health service for expert guidance and direction, including around IPC.[167] As mentioned earlier in this chapter, that suggestion was raised by Mr Hogan on 7 April 2020, but it appeared that suggestion fell away.[168]

Subsequent 'hot hotel' arrangements

104. Although not immediately, the outbreak at Rydges resulted in the hotel being temporarily closed from around 1 June 2020. It was, therefore, necessary to establish an alternative COVID-positive site for returned travellers.[169] Novotel South Wharf was designated as the replacement hot hotel.[170]

105. Separately, and prompted by the outbreak, DHHS contracted Alfred Health for the management of a 'health hotel' at the Brady, which commenced operation as such from 17 June 2020.[171] Alfred Health's role within the Hotel Quarantine Program then expanded to encompass the running of all quarantine hotels. This resulted in the 'health hotel' model discussed in Chapter 11 of this report.

9.2 Epidemiological and genomic evidence

106. In order to appreciate the full impact and effect of the outbreaks at the Rydges and Stamford Plaza hotels, it was necessary to consider the epidemiological and genomic evidence. This evidence offered an insight into how the virus spread, initially within the hotel quarantine environment and then beyond into the community at large.

107. For a more comprehensive exploration of the epidemiological methods and the science of genomic sequencing as touched upon below, see Chapter 2.

Rydges outbreak

108. By 31 July 2020, DHHS had received the final genomic sequencing reports for 14 of the 17 cases epidemiologically linked to the outbreak at Rydges, although the preliminary results making the link were available in mid-June.[172] Those final reports revealed that all 14 of those cases clustered genomically together and uniquely[173] with the family of returned travellers.[174] At the time of the outbreak, there were only a few other Victorian cases of COVID-19 that had been acquired in Australia, none of which had any known links to the cases at Rydges.[175]

109. In light of the genomic and epidemiological evidence available to him, Dr Charles Alpren, an expert epidemiologist within DHHS, concluded that it was highly likely that all 17 cases epidemiologically linked to Rydges, including those for which no genomic sequence was available, belonged to the same transmission network and could be traced to the family of returned travellers that was transferred to Rydges on 15 May.[176] In short, those 17 cases could be 'sourced' back to the identified family of returned travellers.

Stamford outbreak

110. Unlike the Rydges outbreak, where all cases were linked to one family, the genomic sequencing performed by MDU PHL showed that the Stamford outbreak consisted of two distinct chains of transmission.[177] This was indicated by two genomic clusters among the cases linked to the outbreak. One of the clusters was connected with the returned traveller who arrived on 1 June 2020, while the other was linked to the couple who returned on 11 June 2020.[178]

111. By 4 August 2020, DHHS had received genomic sequencing reports for 35 of the 46 cases linked to the Stamford outbreak. All 35 of those cases clustered genomically within one of the two chains of transmission identified above.[179] At the time of the Stamford outbreak, there were no other Victorian cases of COVID-19 acquired in Australia other than those linked to the Rydges outbreak. By the time that Dr Alpren gave evidence before the Inquiry, on 18 August 2020, no epidemiological or genomic links between the cases in the Rydges outbreak and the cases in the Stamford outbreak had been identified.[180] The Inquiry is not aware of any links having been made subsequently.

112. In his evidence, Dr Alpren explained that he had concluded that it was **highly likely** (emphasis added) that all 46 cases epidemiologically linked to Stamford, including those for which no genomic sequence was then available, belonged to one of the two transmission networks and can, therefore, be traced to the three returned travellers identified above.[181]

Genomic clustering since Rydges and Stamford outbreaks

113. Since the time of the initial outbreak at Rydges, with only two exceptions, all subsequent reported genomic sequences for Victorian cases of COVID-19 have clustered with transmission networks emanating from the returned travellers observed as the sources for the Rydges and Stamford outbreaks.[182] The first exception involved a returned traveller whose symptoms started on 29 June 2020. The returned traveller clustered genomically with a resident of metropolitan Melbourne who began to experience symptoms on 28 June 2020.[183] The second exception involved a healthcare worker who clustered genomically with a returned traveller who the worker had cared for following their admission to hospital with COVID-19 for the period 19 June to 9 July 2020.[184] Further on-spreading of those clusters had not been reported or observed.[185]

114. As of 29 July 2020, DHHS had received reports of sequences pertaining to 827 currently active cases. Of those, 817 (99 per cent) sequenced with Rydges-associated genomic clusters[186] and 10 (1 per cent) sequenced with the Stamford-associated genomic clusters.[187] As of 31 July 2020, of the 2,109 sequenced cases since 26 May 2020 (the date of the first confirmed case from the Rydges outbreak), 1,996 clustered with Rydges-associated genomic profiles and 96 clustered with those from Stamford.[188]

115. At the time of Dr Alpren giving evidence to the Inquiry (18 August 2020), further sequencing had been performed so he was able to provide updated figures. In total, sequencing had been successfully performed for 4,981 cases. Of those cases, 3,594 cases clustered with Rydges-associated genomic clusters and 110 clustered genomically with Stamford-associated genomic clusters.[189]

116. From the 12,000 cases within the previous month (as at 18 August 2020), sequence data was available for 3,234 cases. Of those, 3,183 were genomically linked to the Rydges-associated cluster.[190] Of cases with symptom onset in the previous month (again, as of 18 August 2020), 1,589 cases had been sequenced. Of those, 1,577 cases (99.2 per cent) clustered genomically with Rydges and the other 12 cases (0.8 per cent) clustered genomically with Stamford.[191]

117. Given the level of genomic sequencing that had occurred by that time, Dr Alpren agreed that he would have expected to see some evidence if there were any other independent clusters occurring.[192] He had not seen any such evidence. Dr Alpren was therefore of the opinion, based on the genomic sequencing and epidemiological investigation, that there was '**high level of certainty that almost all current COVID-19 cases in Victoria can be traced to the outbreaks at the Rydges and Stamford Plaza hotels** (emphasis added)'.[193]

118. Dr Alpren noted that he could not precisely indicate the number or proportion of cases that had separately arisen from each outbreak. However, he stated that it was likely that the large majority (approximately 90 per cent or more) of COVID-19 infections in Victoria at that time could be traced to the Rydges outbreak, while a smaller proportion (approximately 10 per cent or less) of COVID-19 infections in Victoria at that time could be traced to the Stamford outbreak.[194]

119. I accept the validity of the genomic and epidemiological evidence, and the conclusions drawn from that evidence by Dr Alpren, and note that it was not the subject of any challenge or contradiction.

120. As of 15 June 2020, Victoria had recorded 1,732 confirmed cases of COVID-19.[195] As of 24 November 2020, that number had increased to 20,345.[196]

121. On 23 May 2020, Victoria's COVID-19 death toll was 19.[197] There were no deaths attributed to COVID infection between 23 May and 24 June 2020.[198] The latter date was just under a month after the first cases were identified in connection with the Rydges outbreak and about a week after the first cases were identified in connection with the Stamford outbreak.[199]

122. According to publicly available information, the overall death toll attributed to Victoria's second wave was 801 people at the time of writing. Further, the publicly available information estimated that about 80 per cent of those deaths related to Victoria's aged care homes.[200]

9.3 The genesis of each outbreak

123. The movement of COVID-19 from hotel quarantine into the community can be understood as having been transmitted from returned travellers being held in quarantine to people working on-site in hotel quarantine and then into the community via those infected workers.

124. While the epidemiological and genomic sequencing evidence provided the scientific basis for the link between the workers who became infected and the returned travellers who were the original sources of the virus, the state of the science, together with the available evidence, did not allow for specific transmission 'events' to be identified at either Rydges or Stamford as to the actual moment that transmission happened, either as between returned travellers and workers or from worker to worker.[201] For example, the state of the science was not able to give a sequence as to which worker became infected first and then may have transmitted to another worker or workers on-site.

125. Importantly, however, there was evidence of environmental and behavioural factors that were likely to have contributed to the outbreaks at both hotels.

Transmission events

RYDGES

126. The epidemiological and genomic evidence provided the basis for a conclusion that a transmission event (or multiple transmission events) occurred at Rydges during the Hotel Quarantine Program.[202] However, and notwithstanding investigation, as set out above, the state of the science and the expert evidence did not allow a finding as to a specific occurrence of the virus moving from infected traveller (either directly or indirectly) to worker in the Program.[203]

127. In her statement, Dr McGuinness said the following: 'Ultimately, the Deputy Public Health Commanders and I were unable to draw a firm conclusion about the transmission event(s) that precipitated the outbreak'.[204] Similarly, Dr Alpren's position was that no specific transmission event was able to be identified in respect of the Rydges outbreak.[205]

128. The investigations at Rydges revealed several opportunities for transmission to have occurred at different times.[206] By way of example, records of the outbreak response team investigation indicated that an episode of likely environmental contamination occurred in the family's room on 18 May 2020, which required assistance from nursing staff to rectify.[207] There was also a suggestion that the index family walked outside its room and through common areas of the hotel, on which occasion they were accompanied by security guards.[208] It is possible a transmission event or events occurred at this point.[209]

STAMFORD

129. From the epidemiological and genomic data presented above, Dr Alpren concluded that at least two transmission events occurred at Stamford during the Hotel Quarantine Program.[210] However, as with Rydges, the expert evidence and the available information was unable to pinpoint the specific transmission events.[211]

Mode of transmission?

RYDGES

130. While the mode of transmission could not be categorically determined, there was evidence before the Inquiry, as detailed below, which makes environmental transmission a more likely explanation for the Rydges outbreak than person-to-person transmission.

131. It is acknowledged that it could not be definitively ruled out that the virus was spread from person-to-person. In his evidence, Dr Crouch was unable to say which was the most likely form of transmission from the returned traveller.[212]

132. However, in her evidence, Dr Looker referred to the tightly clustered symptom onset date for the first six cases at the Rydges, and the common work shift times, as supporting a 'point-source' transmission event, rather than a staggered person-to-person transmission.[213] There was also information that the person who was assessed as the index case at Rydges was involved in cleaning common areas at the hotel.[214] Both these factors, along with the patent risks identified by the inadequate cleaning practices adopted at Rydges, added to the possibility of environmental transmission.[215]

133. In her statement, Dr McGuinness said the following:[216]

> In my opinion, the possibility that the outbreak was precipitated by person-to-person transmission **is less likely** than the outbreak being precipitated by an environmental source (emphasis added).

134. Although the evidence does not conclusively establish the mode of transmission to the degree to which scientists would be satisfied, I accept the reasoning and conclusion arrived at by Dr McGuinness. The possibility that the outbreak was precipitated by person-to-person transmission is 'less likely' than the outbreak being precipitated by an environmental source.

135. That finding draws upon the observations made in the Outbreak Management Report, which was expressly adopted by Dr Crouch:[217]

> [T]here is a **high likelihood** of fomite spread from poor cleaning products being utilised, poor PPE used by security staff, and a lack of education surrounding cleaning practices (emphasis added).[218]

136. The findings of that report are discussed in greater detail below.

STAMFORD

137. In respect of the Stamford outbreak, the evidence established the equal possibility that there was environmental or person-to-person transmission.[219]

138. Dr McGuinness stated that, in her opinion, person-to-person transmission was more of a possibility in the context of the Stamford outbreak compared with the Rydges outbreak.[220] This was due to the various opportunities for person-to-person transmission to have occurred, including large gatherings of up to 70 security guards in a single room and instances of car-pooling by security guards.[221]

139. Being unable to distinguish the respective probabilities of person-to-person transmission versus environmental transmission, Dr McGuinness concluded in respect of the Stamford outbreak that:[222]

> Transmission from a COVID-19-positive case in quarantine may have occurred directly (through person-to-person transmission) or via fomites. There is insufficient evidence to support one mode of transmission over the other and both are possible.

140. Based on the expert opinions, I am unable to prefer one method of transfer over another. In respect of the Stamford outbreak, I find that it is not possible to say that one mode of transmission was more likely than the other. What I can conclude, based on the expert evidence, is that both possible modes of transmission were a source of danger.

Contributing factors

141. Despite the fact that specific transmission events were not identified, and the mode of transmission could not be pinpointed with scientific certainty,[223] there was ample evidence that highlighted specific environmental and behavioural factors that likely contributed to the outbreaks at both hotels.

142. This evidence largely comes from the Outbreak Management Plan reports as prepared by the Outbreak Management Teams (OMTs), a subset of DHHS Case Contact and Outbreak Management Team (CCOMT), which had overall responsibility for managing and investigating the outbreaks.[224] Each OMT directed an outbreak squad that deployed specialists, including IPC nurses, to the sites.[225] According to Dr Crouch, outbreak squads facilitated rapid testing, IPC, isolation of close contacts and generally supported the containment of a public health risk.[226]

143. The Inquiry received evidence from key DHHS personnel involved in investigating the outbreaks in Drs Crouch, Looker and McGuinness. The overall picture that emerged from their evidence (which was also reflected in other evidence) was that IPC measures at both hotels were ad hoc and inadequate, and that those inadequacies led to the transmission of the COVID-19 virus from returned travellers to those working in the Program. In particular, there were pervasive issues identified with **cleaning, PPE use, and staff training and knowledge**.[227]

144. There was also evidence that, despite the identification of these issues in the investigation of the Rydges outbreak in late May 2020, similar inadequacies were identified at Stamford up until mid-June 2020.[228] Indeed, the failure to heed the lessons from the Rydges outbreak was expressly cited as a factor in the decision by DEWLP to withdraw its entire staff from the Program.[229]

RYDGES

145. Investigation of the Rydges outbreak by the OMT revealed several significant problems with IPC practices, including inappropriate cleaning, inappropriate use of PPE and deficits in staff knowledge about hand hygiene and social distancing.[230]

146. The Outbreak Management Plan report from Rydges, authored by the OMT,[231] concluded that:

> There is a high risk of transmission from COVID positive cases being detained in the hotel to the staff members working at the hotel. This is due to the inadequate education and cleaning procedures that are currently in place. The cleaning duties of communal areas were the responsibility of the security staff; specifically, for the elevators used to transport COVID positive cases. Because of this, there is a high likelihood of fomite spread from poor cleaning products being utilised, poor PPE used by security staff, and a lack of education surrounding cleaning practices. At risk populations include staff members from the hotel, DHHS staff, nurses, and various other HCWs that were onsite to attend to the people in hotel detention.[232]

147. As discussed in Chapter 2, fomite transmission involves infection via surfaces or objects (including hands) that have become contaminated.[233] The evidence was that there was clearly an increased risk in a hot hotel that staff may come into contact with potentially infected surfaces or environments.

148. Considering Dr Alpren's evidence that '(i)t is likely that the large majority, approximately 90% or more, of current COVID-19 infections in Victoria can be traced to the Rydges Hotel,'[234] it is abundantly clear that effectively managing this transmission risk was paramount.

149. In respect of cleaning, a number of issues of concern were highlighted.

150. First, the hotel had no dedicated cleaning staff. As a result, general hotel staff and security staff were undertaking cleaning of common and thoroughfare areas of the hotel, [235] notwithstanding it was known that COVID-positive guests were travelling through those areas. This included evidence that one of the first security guards to contract COVID-19 had been performing a range of cleaning duties, including cleaning of the elevators used by COVID-positive guests, and evidence that a hotel staff member had removed likely contaminated rubbish from rooms occupied by COVID-positive guests.[236]

151. Secondly, and in addition to the absence of specialist trained cleaners, cleaning products and cleaning methods were inappropriate. The evidence from Dr McGuinness was that the cleaning products identified as being used by the OMT were unlikely to be effective against COVID-19.[237] Further, it was unclear whether cleaning cloths were being disposed of and replaced after use.[238] This evidence was not the subject of challenge or cross-examination when the witnesses who adopted the reports were called.

152. It should be noted, however, that Rydges Hotels Ltd sought to impugn this evidence, for the first time, in its written submissions, asserting:

> [T]he 'Environmental Investigation' within [the Rydges Outbreak Management Plan] contains both assumptions and clear errors. One significant error is the conclusion that cleaning products used were 'unlikely to be effective against SARS-CoV-2'. The author names two cleaning products. One of those products is specifically confirmed by the Therapeutic Goods Administration to be a 'disinfectant for use against COVID-19 in the ARTG for legal supply in Australia'.[239]

153. The website entry relied upon by Rydges in its final submission was not put in evidence before the Inquiry nor were its contents put to any witness. In any event, it does not stand for the evidential foundation in respect of which, I infer, it is called in aid. Rather, the website lists a range of products that have specific permission for the purposes of advertising claims.[240] I do not, therefore, accept Rydges' submissions in this regard and rely upon the evidence given by Dr McGuinness.

154. A third key area of concern identified was the inappropriate use of PPE. In particular, observations were reported to the OMT of security staff using vinyl gloves and unapproved masks.[241] There were also concerns that masks were not being changed as regularly as required.[242]

155. Finally, linked to the above, it was identified that comprehension was poor among hotel and security staff around hand hygiene, PPE, social distancing and other IPC measures.[243]

156. According to Dr Crouch, each of these factors would increase the risk of transmission.[244]

157. As well as the factors that increased the risk of transmission of the virus from those in quarantine at Rydges to those working in the Program, I find there were further issues that likely contributed to the spread and growth of the outbreak more generally into the community. They included the delays in undertaking deep cleaning, delays in quarantining staff and issues with contact tracing.

Delays in cleaning

158. Despite direction being given on 26 May 2020, with a clarification on 27 May 2020 that a full commercial bioclean was required, that clean was not thoroughly completed until the afternoon of 28 May 2020.[245] On 26 May 2020, the OMT identified that an immediate thorough clean of the site was to be undertaken as an initial control measure.[246] Some cleaning to common areas of the hotel was undertaken between 26 and 27 May 2020, however, it was not done to the satisfaction of the OMT, leaving the site 'uncontrolled' for longer than it may have otherwise been.[247]

159. On the afternoon of 27 May 2020, a request was made to IKON Services Australia Pty Ltd (IKON), at that time the only provider of specialist contract cleaning services to the Program.[248] It was requested to clean the common areas of Rydges,[249] but was not informed why this clean was being requested or what had precipitated this change to the areas it was being engaged to clean.[250]

160. Michael Girgis, General Manager of IKON, gave evidence that agreement was reached to conduct the clean the next day as IKON was unable to complete it that night.[251] The clean was subsequently undertaken on the afternoon of 28 May 2020.[252] According to Dr McGuinness, it was only after that had occurred that she could be confident the site no longer posed a risk of environmental transmission to staff.[253] Moreover, it was not until 1 June 2020 that quarantined guests at Rydges were relocated to the Novotel South Wharf.[254]

Delays in isolating staff

161. There was also a delay in quarantining or isolating people who had worked — and, thus, may have been exposed to the source of the outbreak — at the hotel. By 27 May 2020, only those staff identified as positive cases of COVID-19 and people deemed close contacts were told to quarantine. Other staff who had been on-site for 30 minutes or more from 11 May 2020, but who were not considered close contacts, were notified and asked to undergo testing.[255] Eventually, a decision was taken by the OMT to direct people who were not deemed close contacts, but who had attended the site for 30 minutes or more between 18 May 2020 and 28 May 2020, to quarantine for 14 days.[256] However, this direction did not occur until 30 May 2020.[257]

162. In her evidence, Dr McGuinness agreed that the delay between 27 and 30 May 2020 in deciding to quarantine staff may have had an impact on controlling the outbreak.[258] Dr Crouch also agreed that if a broader group had been quarantined at that time it may have helped.[259]

163. In light of the awareness of the significant risk of environmental transmission, those exposed to the site should have been quarantined immediately. The risk of fomite or environmental transmission had been flagged by the World Health Organization (WHO) in late-March 2020.[260] Ostensibly, it was this advice, and the advice from peak national bodies, that informed the policies and protocols that applied to the Hotel Quarantine Program.

164. In its final submissions to this Inquiry, DHHS stated that '… while fomite transmission was considered possible in late March 2020, the evidence from Dr Crouch, consistent with the position of WHO, is that it was considered secondary (WHO) and rare (Dr Crouch) and droplet transmission was considered more likely'.[261] While environmental transmission may not have been observed to have been responsible for significant transmissions in Victoria prior to late May 2020,[262] knowledge of the possibility of fomite transmission existed at the time of the Program's inception. That risk should have been given due attention.

165. Indeed, DHHS personnel in the public health team who wrote the policies were aware of the possibility of fomite transmission, even as early as the time of inception of the Hotel Quarantine Program. Appendix 2 of DHHS's Physical Distancing Plan (last updated on 27 March 2020) included the following:

> Early evidence suggests that SARS-CoV-2 (the virus that causes COVID-19) is primarily transmitted via respiratory droplets transmitted during close contact, **and via fomites**[263] (emphasis added).

Contact tracing

166. As explained by Dr Alpren, contact tracing refers to the identification, assessment and management of people who potentially have been exposed to disease (and so at higher risk of developing and spreading it) and working with them to interrupt the spread of the disease.[264] It allows the contact tracers to identify people who could have been exposed to the disease and to advise them to isolate.[265] The CCOMT was responsible for contact tracing.[266]

167. The efficacy of contact tracing relies on a number of factors, including good quality information being given to contact tracers. Contact tracers work with people to ascertain information from them, but they are limited to obtaining information that people are prepared to divulge.[267] Dr Alpren identified a challenge to contact tracers where a person interviewed had 'competing priorities', that is, they want to limit others from getting sick, but they also want to remain in a position where they can meet their financial obligations, such as the need to keep working and earning an income.[268] These 'competing priorities' may affect how forthcoming people are with the information about their health status or with whom they have been in contact.

168. The OMT encountered difficulties in performing effective contact tracing in these outbreaks. This was partly due to poor record-keeping, which created difficulty in obtaining reliable and timely information about security guards' and other staff movements within the hotel. Staff records and rosters made available to the OMT did not identify, for example, which guards accompanied guests on breaks, including the family of four that clustered genomically with the subsequent staff cases. This complicated (and inhibited) the tracing of close contacts.[269]

169. Further complications can arise from households of those who are infected by the COVID-19 virus. The Inquiry heard evidence that contact tracing is made much more difficult when people are living in the same household and are not well known to each other.[270] This challenge was particularly evident in the context of security guards. Dr Looker, for example, gave evidence about security guards, as a cohort, being likely to impede contact tracing efforts by nature of their employment and living arrangements. I have considered the vulnerabilities of security guards as a cohort earlier, in Chapter 6, but suffice to say that according to Dr Looker: '[c]ontact tracing efforts were impeded by a workforce [that is, the security workforce] that often worked in multiple jobs and in many cases lived in large or dense housing'.[271]

170. In addition, the OMT noted that there were issues with the provision of reliable and truthful information. Dr Crouch said that a number of those who tested positive were less than forthcoming about their close contacts.[272] For example, one of the cases linked to the Rydges outbreak failed to disclose that they had been in close contact with a housemate during the infectious period. The housemate subsequently travelled to Queensland where they became symptomatic and tested positive.[273] In Dr Crouch's view, the efforts undertaken by the OMT were hampered by the information provided and the challenges they faced in getting accurate information.[274] Drs McGuinness and Looker agreed that a key limitation in identifying contacts was that it depended on the quality of the information being provided.[275]

171. Contact tracing is overwhelmingly done through a voluntary and cooperative engagement with the infected or potentially infected people.[276] The question becomes whether that is a sufficient method by which to obtain critical information, the truthfulness of which, so says the evidence, may have significant consequences on the spread of the virus.

172. Section 188(1) of the *Public Health and Wellbeing Act 2008* (Vic) permits the CHO to direct a person to provide information specified in a direction, which the CHO believes is necessary to investigate whether there is a risk to public health or to manage or control a risk to public health. If a person fails or refuses to comply with that direction (without reasonable excuse) that person could be subject to a maximum penalty of around $10,000.[277] It is an offence to give information that is false or misleading in a material particular to the CHO under this Act. The penalty for doing so is also around $10,000.[278]

173. Despite this statutory power, it was not used as a way to overcome the risks of truthful information not being forthcoming. Rather, the evidence was that focus was on building trust, rapport and an ongoing engagement with the people from whom information was being sought. [279] The evidence from the experts was that this method of engagement, rather than a punitive and threatening one, was more conducive to obtaining reliable information efficiently.

174. Prof. Sutton's evidence was that he had not used his powers to compel information. He presumed that was because the OMT had not recommended he do so.[280]

175. I accept that it is necessary to build trust and familiarity with relevant people to enhance good and accurate information being collected. It is for this reason I recommended embedding a contact tracing team in the facility-based model in the Interim Report and adopted this recommendation in this Final Report (see Recommendation 38).

THE CASE CONTACT AND OUTBREAK MANAGEMENT TEAM

176. Dr Alpren explained that, as at early 2020, the Health Protection Branch of DHHS housed the Communicable Disease section.[281] He stated that the Communicable Disease section was responsible for the collection and management of incoming notifications and any relevant public health actions. In response to the novel coronavirus being listed as a notifiable disease in January 2020, the Public Health arm of the COVID-19 response was set up. It was within this newly set up Public Health arm where the collection of information and contact tracing was performed by the CCOMT. Dr Alpren explained that this team was not part of the Intelligence Team.[282]

177. He went on to explain, in his statement, that the duties of the Intelligence Team contained the management, development and maintenance of the infectious disease passive surveillance database used by the department, the Public Health Event Surveillance System (PHESS) in as far as its use pertained to COVID-19, data entry, classification and checking, and provision of data to assist case, contact and outbreak management and compliance with quarantine and isolation and development of centralised, integrated reporting of COVID-19. According to Dr Alpren, both the CCOMT and Intelligence Team 'evolved' from teams within the Communicable Disease section of the Health Protection Branch in response to the COVID-19 pandemic.

178. Dr Alpren made his statement on 4 August 2020. In that statement, in response to questions asked of him about workloads and resourcing, he said: 'Intelligence and Pathology are a [sic] new teams and did not exist prior to January 2020. The Incident Management Team was established in mid-January at which point I joined as Intelligence Officer in addition to my regular work as Principal Epidemiologist in Blood-Borne Viruses and Sexually Transmissible Infections. During February three people with regular positions in CDES (Communicable Disease Epidemiology and Surveillance) also worked on novel coronavirus. This has increased and we now have over 200 people in the Intelligence team, that I manage. It has been a significant scale up. Workloads have substantially increased. In order to fulfill [sic] the requirements of the response, Intelligence and CCOM are staffed 24hrs a day, 7 days a week'.[283]

179. Dr Alpren identified a list of six factors that affected the accuracy and completeness of information available to DHHS about the rate of COVID-19 cases. He noted among that list 'the capacity of the Department to enter cases and contacts to PHESS in a timely manner' and 'the capacity of the Department to review PHESS records for accuracy and ensure records reflect the content of the interview'.[284]

180. The above figures speak for themselves with respect to the 'significant scale up' of resources needed to respond to the contact tracing response to COVID-19. Inside DHHS, the response to the second wave was still unfolding throughout the course of the Inquiry. I understand that issues as to the adequacy of the data collections systems supporting those efforts have become the subject of a Parliamentary Inquiry. While not within the Terms of Reference or time constraints of this Inquiry, I do not consider it a 'long bow' to draw an inference that data management issues had an impact on the ability of the CCOMT to respond to the 'second wave' outbreaks from Hotel Quarantine.

ASYMPTOMATIC TRANSMISSION

181. I do not underestimate the difficulty for epidemiologists and contact tracing posed by COVID-19 not only being a highly infectious disease but that it can be transmitted from person-to-person despite the infectious person not experiencing any symptoms. It was estimated by Dr Alpren that about 17.9 per cent of cases will be asymptomatic.[285] This makes the disease difficult to control from an epidemiological perspective.[286] This, put together with the evidence that a person may be infectious for up to two days prior to experiencing symptoms, also adds its own complexity.

STAMFORD

182. During the investigation of the Stamford outbreak, a significant area of concern identified was that hotel and security personnel were not adequately educated in hand hygiene and the correct use of PPE. This included reports of irregular and inconsistent use by security guards of the alcohol-based hand sanitiser available on-site.[287] In addition, DHHS staff were concerned with guards incorrectly using PPE and wearing gloves for long periods of time, including while touching their phones and going to the bathroom.[288]

183. Another identified issue involved the lack of clearly designated areas or zones for handling clean and soiled items. For example, hotel staff removed rubbish and dirty, bagged linen from the rooms of positive cases and transported these items in a service elevator that was also used to deliver food.[289]

184. Failure to comply with social distancing requirements was another key concern. According to evidence given by Ms Peake, on 14 June 2020, a DHHS team leader at Stamford reported concerns about security guards hugging and approximately 70 people attending a handover meeting in a small room.[290] That meeting was held in a six-by-six metre room where the required physical distancing was plainly not possible. These activities all increased the risk of person-to-person transmission of COVID-19.[291]

185. Other concerns as to potential cross-contamination at Stamford were also identified. Particular points of concerns identified by Dr McGuinness included:[292]

> • the common use of a security guard room (including by other staff)
>
> • the use of non-disposable food utensils
>
> • the use of a shared coffee machine in the security guard room
>
> • security staff having access to the room used by nurses and other Department staff
>
> • shared use of elevators
>
> • shared use of some bathrooms.

186. Dr McGuinness observed that each of these matters may have increased the risk of COVID-19 transmission at Stamford, or at least would not have adequately protected against that risk.[293]

187. Dr McGuinness also agreed, in her evidence, that the poor IPC practices seen at Stamford mirrored what had been observed in relation to the Rydges outbreak.[294] Dr McGuinness stated it was 'disappointing' that such practices continued to present in the Program at that time.[295]

188. That said, it appeared that some of lessons were learned from the management of the Rydges outbreak. Dr McGuinness stated that swifter, more decisive action was taken at the Stamford as a result of what was learned from the Rydges outbreak.[296]

189. A full clean occurred almost immediately upon learning of the first COVID-positive staff member on 16 June 2020,[297] having been undertaken at 1.00 pm on 17 June 2020.[298] Importantly, on 16 June 2020, a decision was made that all staff who had worked from 1 June 2020 were required to be tested and all staff who had worked since 7 June 2020 were immediately stood down, with new staff deployed to the hotel following the deep clean.[299] By 18 June 2020, all staff members and contractors who had spent 30 minutes or more at Stamford from 8 June–17 June 2020 were considered close contacts and required to isolate for 14 days.[300]

190. As with the Rydges outbreak, difficulties in contact tracing were apparent. By way of example, the first case from the Stamford outbreak was identified by DHHS on 16 June 2020, after having reported symptom onset on 15 June 2020. It was later discovered that a case notified to the Department on 14 June 2020 after reporting symptom onset on 10 June 2020 was, in fact, also a Stamford worker.[301] When this person was first interviewed, they falsely stated that they did not work outside of the home.[302] This misinformation, undoubtedly, impeded the prompt identification and proper investigation of the Stamford outbreak.

9.4 Conclusions as to the impact of inadequate infection prevention and control measures on the outbreak

191. The specific factors that led to the transmission of COVID-19 from people in quarantine to workers in the Program, and beyond, to other members of the community, mirror some of the inherent problems with the Program as identified and explored in detail in this Report. Without repeating the detail of each of those systemic factors, it is important to focus attention on the ways in which those shortcomings created the conditions for the outbreaks that eventuated.

192. As has been noted, the Hotel Quarantine Program was predominately approached as a logistical or compliance exercise, rather than a health program.[303] Although the Program had important logistical and compliance aspects, those were to be called in aid of, and were necessarily ancillary to, its primary objective as a public health program: to prevent the further spread of COVID-19.

193. It appears that one of the consequences of the failure to conceive of the Program as, first and foremost, a health response was that inadequate attention was given to the primacy of IPC measures on the ground at quarantine hotels. This resulted in inadequate cleaning practices, unsafe PPE practices, risks of cross-contamination between different 'zones' and insufficient training in infection prevention and control, especially for those who were most at risk of exposure.[304]

194. Related to this, and as discussed in Chapter 8, there was insufficient public health, specifically IPC, expertise embedded in the Program. It was absent in the high-level management of the Program and in the personnel with the day-to-day implementation of the Program at hotel sites.

195. Infection prevention and control was inadequate across the Hotel Quarantine Program, and was particularly inadequate at Rydges following its designation as a hot hotel. The outbreaks that occurred, and the findings that emerged from their OMT investigation, are demonstrative of those inadequacies.

196. Those inadequacies, specifically as they materialised at Rydges, increased or, at least, substantially failed to mitigate the known risks presented at the hot hotel.

197. At all material times in the Hotel Quarantine Program, while scientific knowledge has continued to grow and develop throughout 2020, there was scientific guidance as to COVID-19 modes of transmission, including the possibility of environmental transmission.[305] Had public health experts in infection prevention and control played a greater role in the design and operation of the program, it is likely that IPC practices would have been more rigorous and more effective.

198. The proliferation of policies, without operational line of sight into the implementation of those policies, was insufficient to guard against what was known to be a pernicious virus.

199. The presence of a full-time designated IPC monitor at each quarantine hotel would have undoubtedly improved compliance with necessary practices and procedures.

200. The deficiencies in practices and procedures were plainly evident to the Outbreak Squads when they investigated the outbreaks at Rydges and Stamford.[306] Had IPC experts been present at each hotel throughout the program, those deficiencies would likely have been observed and addressed, and the risk of outbreaks reduced.[307]

201. I conclude that many of the deficiencies identified in IPC practices, which increased the risk of outbreaks, would have been detected and remedied, perhaps preventing the consequences that have flowed, had this relatively modest, but critically important, resource been appreciated.

202. A further systemic issue that emerged from the evidence concerned the nature of the workforce called upon to staff the Hotel Quarantine Program. Some of the characteristics of this workforce[308] exacerbated the risk created by the deficiencies in the IPC practices I have referred to in Chapter 6 and further interacted, in turn, to increase the risk that infected workers would transmit the virus into the community.

203. At the frontlines of the Program, agency nursing staff and private security contractors were used. It has been recognised that the private security workforce that was engaged, through a web of subcontracting arrangements, represented an inherently vulnerable cohort. Their vulnerabilities certainly bear emphasis in terms of their impact on the outbreak:

    A. Dr Crouch observed that, with hindsight, as a cohort, security guards, (through no fault of the individual workers) did not have an adequate understanding of necessary precautions, had poor health literacy, and were more likely to work multiple jobs or to have personal and employment circumstances that limited their ability to take leave when sick[309]

    B. there was also evidence before the Inquiry of 'potential cultural and language issues with respect to understanding the policies and procedures of physical distancing and the broader infection prevention and control measures that were in place'.[310]

204. These factors all drove difficulties with contact tracing, with personnel working across multiple sites within the Program and presenting a higher risk of further spread of the virus into the broader community.

205. The role of these systemic factors in the outbreaks is evident in the high proportion of transmission to private security guards (as opposed to other frontline workers)[311] and in the Outbreak Squad's concerns about security guards' misuse of PPE and non-compliance with IPC practices.[312] The use of the 'wrong cohort', including the highly casualised nature of much of the private security workforce,[313] exposed those people and, in turn, the broader Victorian community to a significant and increased risk. (See Chapter 6 for a more detailed discussion on the use of private security guards.)

9.5 Causation at law

206. The outbreaks at Rydges and Stamford — and their causal connection to the ensuing devastation on the Victorian community — was the subject of some controversy.

207. Counsel Assisting the Inquiry invited me to find that the failure by the Hotel Quarantine Program to contain the COVID-19 virus was responsible for the deaths of 786 people and the infection of some 18,418 others.[314] Counsel Assisting submitted such a finding was open to be made 'in light of the epidemiological, genomic sequencing, positive case data and mortality rates'[315] before the Inquiry.

208. DHHS, however, submitted that such a finding was not open on the evidence.[316]

209. It submitted that the Inquiry had only limited evidence before it and so there was no basis on which to make any reliable finding as to the mechanism of transmission from hotel guests at Rydges and Stamford to staff, nor as to what occurred after there was transmission and the chain of events that led to the spread in the community.[317]

210. DHHS contended that the evidence before the Inquiry did not include categories of evidence that would be relevant to the question of causation:

    A. whether the transmission event came about from environmental contamination or from the family to case 1, an intermediary person or to one or any of cases 2–5

    B. the consequences of deciding, on 30 May 2020, to cohort staff that had worked at Rydges, as opposed to making that decision earlier

    C. whether the eight hotel workers, and the other staff members that were so asked to isolate did, or did not, and whether they thus caused onward transmission

    D. how COVID-19 spread from the eight personnel that worked at Rydges and tested positive to the wider Victorian community, including to their household contacts

    E. the consequences of the delay in cleaning the hotel, from the evening of 26 May to the evening of 28 May

    F. the consequences of the timing of the outbreak and the general easing of restrictions in the Victorian community at that time

    G. whether the index family quarantined appropriately on release or caused onward transmission in the community.[318]

211. DHHS also noted difficulties faced by its OMT, such as with respect to contact tracing for some of the security guards and some continuing to work while symptomatic.

212. It would be unsafe, so submitted DHHS, to make a finding that 'the movement of the virus through the barriers of quarantining is responsible for some 99 per cent of the recent COVID-19 infections in Victoria', nor indeed any reliable finding as to the relationship of the events examined in the Program and the ultimate consequences in the community.[319] DHHS submitted that there were various matters that contributed to the community spread, and cautioned against making a finding as to why these transmission events spread in the way that they did.[320]

213. No doubt DHHS had in mind such factors, among others, as the high percentage of loss of life in the second wave being related to aged care facilities and, therefore, what other factors in that environment contributed to that loss and should be considered as part of the 'chain of causation'.

214. As to who, or what, was responsible for the Rydges outbreak and its impact on the community, Rydges submitted that the Inquiry did not explore many other points in time that the family of four (to whom the Rydges outbreak was traced) may have passed on the genomic strain to others.[321] It submitted that there was no way of determining whether one of the security guards, the hotel employee or the nurse first contracted COVID-19 from the family of returned travellers or passed COVID-19 on to any other person in the broader community.[322] Rydges, further, submitted that there were many points at which the family of four would have come into contact with others, both before and after their time at Rydges.[323]

215. Unified contended that there was no causal link between the conduct of any security worker engaged by Unified and the outbreak.[324] In particular, it submitted there was no causal link between Unified's reliance on subcontractors or not having received prior approval to use those subcontractors, or its training and supervision measures and the virus outbreak.[325]

216. Rather, it submitted that the 'second wave' of COVID-19 in Victoria was caused by systemic failures at the highest levels of government, in particular the failure of DHHS to adequately consider and assess the risks involved in the Program and the need to take responsibility for the Program as the agency in charge.[326] Unified stated another contributing factor was that Rydges was a hot hotel without necessary infection controls.[327]

217. Unified invited me to make a positive finding that Unified did not cause the outbreak at Rydges.[328]

218. MSS, on the other hand, submitted that, in considering the circumstances of the outbreak, the evidence did not afford a positive finding from a scientific perspective as to the cause of the outbreak.[329] MSS submitted that there was 'no direct evidence which conclusively illustrates the precise circumstances in which COVID-19 made its way from infected travellers to private security staff and beyond'.[330]

219. At their foundation, these submissions invited me to make findings as to what were the precise events in a chain of causation that led to the second wave of COVID-19 in Victoria.

220. The question of causation, in the way in which the law grapples with this issue, is a legally and factually complex one as all who have ventured into it will agree. The question of causation as a matter of law is one, if it is to be pursued, that must be properly pleaded before a court, seized of the jurisdiction, where the rules of evidence and procedure apply and arguments and submissions on the law can be made and ruled upon.

221. But what I can, and do, find is that the 'second wave' of COVID-19 that so catastrophically affected Victoria was linked to transmission events out of both Rydges and Stamford via returned travellers to personnel on-site, who then transmitted COVID-19 into the community. I do so having accepted the uncontroverted genomic and epidemiological evidence of Dr Howden and Dr Alpren and their conclusions from that evidence.

222. In terms of factors which contributed to those transmission events and the proliferation into the community, I rely on all of the contributing factors I have identified both in this Chapter, and throughout this Report.

9.6 Conclusions

The designation of a 'hot hotel'

223. The idea of cohorting positive COVID-19 cases together in a single location or a 'hot hotel' was a sound public health measure. If effectively and appropriately done, it would have ensured that others in quarantine who were not infected had a reduced chance of being infected by reason of their quarantine. In principle, a COVID-positive hotel should have had in place the same IPC measures as were implemented at all hotel quarantine sites. That is because the presumption for all quarantine facilities is that all people should be treated as carrying the virus. However, that does not set the bar for a COVID-positive hotel according to the lowest common standard. Rather, it requires that all quarantine sites employ the high standards expected of a COVID-positive environment.

224. Once the decision was made to establish a hot hotel, it behoved those involved in deciding to implement that concept to pay particular attention to the IPC measures deployed at that location to ensure that the standards and policies were appropriate and that there was appropriate compliance and adherence to them. They were to have particular regard to the make-up of the workforce and habits of those undertaking duties there.

225. I am unable to make a firm conclusion as to who made the decision to use Rydges as a 'hot hotel' (as between DHHS and DJPR), and why that decision was made, because there are no documents before the Inquiry that clearly answer those questions, and a dispute among the witnesses on this issue. There should be documents that record not only this significant decision, but the rationale for doing so and why this particular facility was considered appropriate, what investigations were made, what criteria was considered, including risks and benefits and risk mitigation strategies for this facility and the personnel on-site, and who was consulted. Falling short of documents setting this out, at least the witnesses involved in the decision-making should agree on what was decided and on what basis. This is another instance of where it could not be made clear to the Inquiry who was responsible for critical decisions in the Program.

226. At the time the decision was made to cohort COVID-positive cases at Rydges, insufficient regard was being paid to the IPC standards across the entire Program and, in particular, to that location, given the appreciable and known increased risk of transmission at that location commensurate with concentrating positive cases in one location.

Consultation regarding infection prevention and control at Rydges

227. Mr Hogan raised his view about the need to establish a model of care for guests in hot hotels. His view was a sound one. Mr Hogan's proposal for a model of care was not heeded, it seemed, which led to DHHS having missed an opportunity to develop, at an earlier opportunity, a quarantine environment at hot hotels that better protected against virus transmission.

Additional safeguards required in a 'hot hotel' environment

228. IPC measures, including advice and ongoing training, were not well-managed in practice. The training that was provided to security guards was provided far too late, being only after the outbreaks had occurred at both Rydges and Stamford in June 2020.

229. Nurses, GPs and security guards working at Rydges were not given adequate and timely infection prevention advice and guidance. IPC expertise was not sufficiently embedded in the design of Rydges as a 'hot hotel.'

230. Furthermore, as many staff working in the Hotel Quarantine Program were engaged on a rotating rostered basis until at least 28 May 2020, the provision of episodic training sessions was inadequate to mitigate against the risks posed by not only a hot hotel environment, but any quarantine hotel.

Epidemiological and genomic evidence

231. Breaches of containment in the program, in May and June 2020, contributed to the 'second wave' of COVID-19 cases in Victoria, with all of its catastrophic consequences to life, health, wellbeing and the economy of the State.

232. Around ninety per cent of cases of COVID in Victoria since late May 2020 were attributable to that outbreak at Rydges.

233. Just under 10 per cent of positive cases in Victoria were attributable to the outbreak at the Stamford in mid-June.

234. The limits of the scientific evidence did not allow me to find, with certainty, what specific event caused the transmission from infected traveller to worker. But I do consider the likely mode of transmission at Rydges was through environmental transmission, particularly in light of the evidence from the outbreak team of poor cleaning products, poor PPE use by security staff and the lack of education around cleaning practices.

235. The evidence does not permit me to find, conclusively, whether the Stamford outbreak was due to person-to-person contact on the one hand or environmental transmission on the other.

236. Issues in respect of poor IPC practices at Stamford mirrored what had been observed during the investigation into the Rydges outbreak.

237. Notwithstanding the considerably higher number of frontline staff who became infected at the Stamford, measures taken, whether by way of prompt and appropriate cleaning or because of the immediate and swift quarantining of all staff, or both, were more effective in preventing the spread of the virus into the community.

Contributing factors to each outbreak

238. IPC measures at both hotels were inadequate, namely in terms of **cleaning, PPE use, and staff training and knowledge**. Those inadequacies contributed to the transmission of the COVID-19 virus from returned travellers to those working in the Program. In particular, there were pervasive issues identified with delays in deep cleans and in quarantining exposed staff, which may have also contributed to the outbreaks.

239. The need to quickly quarantine exposed staff was significant. As DHHS was aware of the risk posed by fomite transmission and given there was no reliable data to exclude or limit its likelihood, I am of the view that a more prudent, safety-based approach would have been to furlough every member of staff that had been exposed to all reasonably perceived primary and secondary sources of transmission. This was a reasonable option that would have been apparent to those with the mandate to contain the virus. That this would have required effectively shutting down the hotel or bringing in a replacement cohort of staff (with corresponding substantially increased PPE and IPC measures) ought not to have been persuasive arguments against such cautious measures. The former approach was taken merely days later, without apparent adverse consequence.

240. With respect to contact tracing, timely and accurate information is vital to efforts to contain outbreaks. In particular, detailed information about the movements of cases and close contacts is vital to the work of the contact tracers.[331]

241. A 'two way' flow of information is important for contact tracing. Just as it is important for individuals to be forthcoming with public health authorities, it is important for health authorities to provide all on-site entities and personnel with information that will enable those individuals and entities to understand and accept their obligations to provide accurate and timely information in the event of a possible or actual infectious outbreak. Developing those relationships enhances trust and understanding and, thereby, enhances safety for workers and the community alike.

242. Although the use of hotels as a setting for mass quarantine may have been unprecedented, factors that played a part in the outbreaks from Rydges and Stamford were not unique to hotels as environments and these factors all contributed to an increased risk that eventuated, with tragic consequences.

243. These risks were foreseeable and may have actually been foreseen had there been an appropriate level of health focus in the program from the top down to the sites themselves.

9.7 Recommendations

Recommendations 24, 27–30, 33 and 38 of the Interim Report, and adopted in this Final Report apply directly to this chapter:

INFECTION PREVENTION AND CONTROL UNIT ON EACH SITE

24. The Quarantine Governing Body ensures that each quarantine facility has a properly resourced infection prevention and control unit embedded in the facility with the necessary expertise and resources to perform its work.

TRAINING AND WORKPLACE CULTURE

27. The Site Manager be responsible for ensuring that all personnel working on-site are engaged in ongoing training in infection prevention and control provided by those with the expertise to deliver such training tailored to the specific roles to be performed on-site.

28. The Site Manager ensures that the personnel on-site who have the expertise in infection prevention and control are engaged in ongoing monitoring and supervision of all of the requirements in place for infection prevention and control, which includes matters such as individual behaviour, the use of personal protective equipment (PPE) and cleaning practices.

ACQUISITION AND USE OF PPE

29. The Site Manager ensures that the infection prevention and control experts direct the acquisition, distribution and use of PPE with specific, clear and accessible directions to all personnel on-site (acknowledging that such instructions may vary according to role).

CLEANING PRACTICES IN QUARANTINE FACILITIES

30. The Site Manager ensures that all cleaning practices throughout the site are developed, directed and overseen by personnel with infection prevention and control expertise, and include 'swab' testing as directed by the infection prevention and control experts.

COHORTING OF POSITIVE CASES

33. Any decision to cohort known positive cases at a particular quarantine facility should only occur after proper consultation with the appropriate experts as to suitability of the facility, any necessary adjustments to the facility, and the experts being satisfied that all necessary infection prevention and control precautions are in place at that facility.

CONTACT TRACING UNIT

38. That the Quarantine Governing Body ensures that each quarantine facility has a contact tracing unit embedded in the facility that can build familiarity and trust with on-site personnel and has accurate and up-to-date information for such personnel, to enable a rapid and efficient response to any possible outbreak and provide ongoing training to all personnel as to what is required in the event of potential or actual infection.

Endnotes

1 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 27 [62].
2 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 5 [15].
3 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 7 [22]–[23]; 17.
4 Exhibit HQI0099_RP Witness statement of Ms Simone Alexander, 2 [11]–[14].
5 Exhibit HQO0100_RP Appendix to the witness statement of Ms Simone Alexander, ALFH.0001.0001.0025-0029.
6 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 19 [81].
7 Ibid 19-20 [81]–[85].
8 Ibid 20 [83].
9 Ibid [86].
10 Exhibit HQI00104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0147.
11 Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 20 [86].
12 Exhibit HQI0008 Witness statement of Dr Charles Alpren, 20 [87]; Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0149.
13 Transcript of day 14 hearing 8 September 2020, 1095; Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0147.
14 Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0147-0149; 0161; 0166.
15 Ibid DHS.0001.0036.0147; Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 20 [87].
16 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 21 [95].
17 Ibid [97]; Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness 28 [98].
18 Ibid [96].
19 Ibid 22 [98].
20 Exhibit HQI0155_RP Annexures to witness statement of Prof. Brett Sutton, DHS.0001.0032.0204 (Outbreak Management Plan Stamford Plaza Hotel).
21 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren 22 [98].
22 While Rydges was the primary 'hot hotel' the Novotel South Wharf was used temporarily following closure of the Rydges Hotel, see Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 7 [32].
23 Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 12 [57].
24 Transcript of day 12 hearing 3 September 2020, 869; Exhibit HQI0153_P Witness statement of Prof. Brett Sutton, 27 [148]; Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 12 [59].
25 Transcript of day 12 hearing 3 September 2020, 869.
26 Exhibit HQI0116_RP Annexures to witness statement of Dr Finn Romanes, DHS.5000.0054.6660.
27 Exhibit HQI116_RP Annexures to witness statement of Dr Finn Romanes, DHS.5000.0054.9039.
28 Exhibit HQI0160_RP Witness statement of Dr Annaliese van Diemen, 29 [135].
29 Exhibit HQI0164 Affidavit of Mr Jason Helps, 9 [34].
30 Exhibit HQI0153_P Witness statement of Prof. Brett Sutton, 27–28 [146]; Transcript of day 18 hearing 16 September 2020, 1498.
31 HQI0160_RP Witness statement of Dr Annaliese van Diemen, 29 [136].
32 HQI0160_RP Witness statement of Dr Annaliese van Diemen, 29 [136].
33 Exhibit HQI0114_RP Annexures to witness statement of Dr Finn Romanes, DHS.5000.0131.0505.
34 Transcript of day 14 hearing 8 September 2020, 1066–1067.
35 Ibid 1066.
36 Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 28 [151].
37 Transcript of day 3 hearing 17 August 2020, 43.
38 Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 27 [150].
39 Ibid [149].
40 Exhibit HQI0114_RP Annexures to witness statement of Dr Finn Romanes, DHS.5000.0131.0505.
41 Transcript of day 23 hearing 23 September 2020, 2026.
42 Exhibit HQI0045_RP Witness statement of Mr Rosswyn Menezes 4 [11].
43 Ibid.
44 Exhibit HQI0185(2)_RP Further attachments to witness statement of Mr Simon Phemister, DJP102.007.9311–9313.
45 HQI0162 Witness statement of Ms Andrea Spiteri, 16 [66].
46 Ibid [67].
47 Exhibit HQI0163(1)_RP Annexures to witness statement of Ms Andrea Spiteri, DHS.5000.0001.1240.
48 Ibid.
49 Exhibit HQI0033(1)_RP Annexures to witness statement of Ms Claire Febey, DJP.102.009.3461.
50 Exhibit HQI0185(2)_RP Further Annexures to Witness Statement of Mr Simon Phemister, DJP.102.007.5658.

51 Exhibit HQI0133(1)_RP Annexures to witness statement of Ms Claire Febey, DJP.102.006.9546.
52 Exhibit HQI0258_RP Annexure to Affidavit of Mr Braedan Hogan, DHS.5000.0053.6633.
53 Transcript of day 16 hearing, 11 September 2020, 1282.
54 Transcript of day 24 hearing 24 September 2020, 2076.
55 Exhibit HQI0199_RP DHHS emails re returning passengers from Greg Mortimer cruise, DHS.0001.0013.2566; Exhibit HQI0161_RP Annexures to witness statement of Dr Annaliese van Diemen, DHS.0001.0013.2566.
56 Exhibit HQI0199_RP DHHS emails re returning passengers from Greg Mortimer cruise, DHS.0001.0013.2566; Exhibit HQI0161_RP Attachments to Witness Statement of Dr Annaliese van Diemen, DHS.0001.0013.2566; Transcript of day 23 hearing 23 September 2020, 1985.
57 Transcript of day 23 hearing 23 September 2020, 1987.
58 Transcript of day 16 hearing 11 September 2020, 1282.
59 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 28 [134].
60 Transcript of day 13 hearing 4 September 2020, 959.
61 Ibid; Exhibit HQI0199_RP DHHS emails re returning passengers from Greg Mortimer cruise, DHS.0001.0013.2566.
62 Exhibit HQI0133_RP Minutes of Operation Soteria Meeting 10 April 2020, DJP.102.007.3065.
63 Transcript of day 23 hearing 23 September 2020, 2023; 2027.
64 Transcript of day 23 hearing 23 September 2020, 2026. See also evidence of Ms Bamert, transcript of day 16 hearing 17 September 2020, 1320-1321.
65 Exhibit HQI0165_RP Annexures to affidavit of Mr Jason Helps, DHS.0001.0131.0073.
66 Exhibit HQI0199_RP DHHS emails re returning passengers from Greg Mortimer cruise, DHS.0001.0013.2566; Exhibit HQI0033(1)_RP Annexures to witness statement of Ms Claire Febey, DJP.102.006.9546; Exhibit HQI0204, Annexures to witness statement of 'DHHS Infection Control Consultant', DHS.5000.0087.4479; Exhibit HQI0258_RP Annexures to Affidavit of Mr Braedan Hogan, DHS.5000.0053.6633; Exhibit HQI0133_RP Minutes of Operation Soteria Meeting 10 April 2020, DJP.102.007.3065.
67 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 20 [41(f)].
68 Exhibit HQI0165_RP Annexures to affidavit of Mr Jason Helps, DHS.0001.0131.0073.
69 Ibid.
70 Exhibit HQI0162_P witness statement of Ms Andrea Spiteri, 16 [68].
71 Acknowledging that DHHS did engage Infection Prevention Australia to review the environment at the Rydges Hotel, which is discussed further below at [58]–[65].
72 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 20 [94]–[95].
73 Ibid 21 [97].
74 Transcript of day 18 hearing 16 September 2020, 1531.
75 Exhibit HQI0033(1)_RP Annexures to witness statement of Ms Claire Febey, DJP.102.007.2385.
76 Exhibit HQI0098_RP Annexures to witness statement of Dr Clare Looker, DHS.5000.0054.4766-–4769.
77 Ibid.
78 Ibid.
79 Exhibit HQI0097_RP Witness statement of Dr Clare Looker, 3 [20].
80 Exhibit HQI0114_RP Annexures to witness statement of Dr Finn Romanes, DHS.5000.0131.0504.
81 Exhibit HQI0257_RP Affidavit of Mr Braedan Hogan, 8 [46].
82 Exhibit HQI0114_RP Annexures to witness statement of Dr Finn Romanes, DHS.5000.0131.0504.
83 Transcript of day 16 hearing 11 September 2020, 1324.
84 Exhibit HQI0258_RP Annexures to affidavit of Mr Braedan Hogan, 5000.0053.6633.
85 Ibid 5000.0053.6632.
86 Exhibit HQI0257 Affidavit of Mr Braedan Hogan, 4 [43]–5 [47]. .
87 Exhibit HQI0033_RP Annexures to witness statement of Ms Claire Febey, DJP.102.006.9546.
88 Exhibit HQI0033_RP Annexures to witness statement of Ms Claire Febey, DJP.102.006.9545.
89 Available at Exhibit HQI0033_RP Annexures to witness statement of Ms Claire Febey, DJP.102.006.9548.
90 Exhibit HQI0033_RP Annexures to witness statement of Ms Claire Febey, DJP.102.006.9545.
91 Transcript of day 23 hearing 23 September 2020, 2004.
92 Ibid.
93 Exhibit HQI0204_RP Annexures to witness statement of 'DHHS Infection Control Consultant', DHS.5000.0087.4479.
94 Exhibit HQI0203_RP Witness statement of 'DHHS Infection Control Consultant', 19 [89].
95 Exhibit HQI0204_RP Annexures to witness statement of 'DHHS Infection Control Consultant', DHS.5000.0128.7672–7673.
96 Ibid.
97 Ibid.

98 Exhibit HQI0256_RP Annexures to Affidavit of Mr Jason Helps, DHS.5000.0072.9119.
99 Exhibit HQI0136_RP Annexures to witness statement of Ms Merrin Bamert, DHS.0001.0021.0020–0021.
100 Ibid DHS.0001.0021.0021.
101 Ibid.
102 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 13 [40(a)].
103 Ibid [40(b)].
104 Exhibit HQI0088_RP Witness statement of Dr Stuart Garrow, 9 [29]–10 [30].
105 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 22 [103]; Transcript of day 18 hearing 16 September 2020, 1552.
106 Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 13 [63].
107 Exhibit HQI0203_RP Witness statement of 'DHHS Infection Control Consultant', 6 [26]–[28].
108 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 44 [229].
109 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert 10 [28].
110 Up to the time when the outbreaks occurred.
111 Exhibit HQI0204, Annexures to witness statement of 'DHHS Infection Control Consultant', DHS.5000.0087.4479.
112 Ibid DHS.5000.0087.8605.
113 Exhibit HQI0045_RP, Witness statement of Mr Rosswyn Menezes, 14 [44]–[45].
114 Ibid.
115 Transcript day 19 hearing 17 September 2020, 1599.
116 Ibid.
117 Exhibit HQI0136_RP Annexures to witness statement of Ms Merrin Bamert, DHS.0001.0021.0021.
118 Ibid.
119 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 44 [230].
120 Ibid 45 [234.3].
121 Ibid 44 [231].
122 Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0156.
123 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 22 [97].
124 Exhibit HQI0204_RP Witness statement of Dr Sarah McGuinness, 21 [73].
125 Ibid [73]–[74].
126 Ibid [73].
127 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 20 [86].
128 Ibid 22 [97].
129 Exhibit HQI0204_RP Annexures to witness statement of 'DHHS Infection Control Consultant', DHS.5000.0095.6927.
130 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 45 [234.3].
131 Ibid 44 [229].
132 Transcript of day 23 hearing 23 September 2020, 2007–2008.
133 HQI0204_RP Annexures to witness statement of 'DHHS Infection Control Consultant', DHS.5000.0108.1504.
134 Exhibit HQI0203_RP Witness statement of 'DHHS Infection Control Consultant', 9–10, [40].
135 Ibid 16 [72]; Exhibit HQI0204_RP Annexures to witness statement of 'DHHS Infection Control Consultant', DHS.5000.0099.6387; DHS.5000.0095.6935.
136 Exhibit HQI0204_RP Annexures to witness statement of 'DHHS Infection Control Consultant', DHS.5000.0099.6387.
137 Exhibit HQI0001a_P Witness statement of Prof. Lindsay Grayson, 15 [65].
138 Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 28 [152].
139 Transcript of day 18 hearing 16 September 2020, 1499.
140 Exhibit HQI0153_P Witness statement of Prof. Brett Sutton 28 [151]–[152]; Transcript of day 18 hearing 16 September 2020, 1498-1499; Transcript of day 16 hearing 11 September 2020, 1282.; Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0156–0157.
141 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 17 [68(c)].
142 Transcript of day 14 hearing 8 September 2020, 1069; See also Exhibit HQI0001a_P Witness statement of Prof. Lindsay Grayson 19 [76].
143 Transcript of day 14 hearing 8 September 2020, 1069. Transcript of day 14 hearing, 8 September 2020, examination of Dr Crouch, 1069.17–22; on the point that all returned travellers should be treated as potentially positive see Exhibit HQI0001a_P Witness statement of Prof. Lindsay Grayson, [76].
144 Transcript of day 14 hearing 8 September 2020, 1069.
145 Ibid 1069–1070.
146 Transcript of day 14 hearing, 8 September 2020, examination of Dr Crouch, Ibid 1069.17–22
147 Ibid 1065; Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, 9 [42(a)].

148 Transcript of day 14 hearing 8 September 2020, 1066.
149 Transcript of day 18 hearing, 16 September 2020, 1499.
150 Ibid.
151 Ibid.
152 Ibid.
153 Transcript day 16 hearing 11 September 2020, 1281.
154 Ibid.
155 Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0154.
156 Exhibit HQI0001a_P Witness statement of Prof. Lindsay Grayson, 14–15 [61].
157 Ibid 19 [76].
158 Ibid [75].
159 Ibid.
160 Ibid.
161 Transcript day 16 hearing 11 September 2020.
162 Exhibit HQI0125_RP Witness statement of Ms Melissa Skilbeck, 24–25 [135].
163 Ibid 1288; Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 23 [49(d)].
164 Transcript day 16 hearing 11 September 2020, 1321.
165 Ibid 1321.
166 Ibid 1324.
167 Ibid 1321.
168 Exhibit HQI0114_RP Annexures to witness statement of Dr Finn Romanes, DHS.5000.0131.0504.
169 Exhibit HQI0186 First witness statement of Ms Kym Peake, 46 [240].
170 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 7 [32]; Transcript of day 13 hearing 4 September 2020, 974.
171 Exhibit HQI0099_RP Witness statement of Ms Simone Alexander, 2 [11].
172 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 21 [90].
173 That is, they did not share any sufficient genomic similarity to link them with any other known cases in Victoria.
174 Transcript of day 4 hearing 18 August 2020, 103; Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 21 [90].
175 Transcript of day 4 hearing 18 August 2020, 104; Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 21 [91].
176 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 20–21 [87]–[94].
177 Ibid [99].
178 Ibid.
179 Ibid [100].
180 Ibid [101]; Transcript of day 4 hearing 18 August 2020, 104.
181 Ibid, 23 [105]–[106]; 25 [113]–[114]; Transcript of day 4 hearing 18 August 2020, 104.
182 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 23 [105].
183 Ibid 24 [108].
184 Ibid 23 [109].
185 By the time the genomic and epidemiological evidence was presented to the Inquiry in mid-August, by the close of evidence in September, or subsequently.
186 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 26 [119].
187 Ibid 28 [127].
188 Ibid 23 [106].
189 Transcript of day 4 hearing 18 August 2020, 106.
190 Ibid.
191 Ibid.
192 Ibid 107.
193 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 25 [114].
194 Ibid 27 [122]; 28 [130].
195 Transcript of day 26 hearing 28 September 2020, 2234; DHHS 'Media release–Coronavirus update for Victoria — Monday 15 June' (Media Release, 15 June 2020) <dhhs.vic.gov.au/updates/coronavirus-covid-19/media-release-coronavirus-update-victoria-monday-15-june>.

196 DHHS, 'Coronavirus update for Victoria — 24 November 2020' (Media Release, 24 November 2020) <https://www.dhhs.vic.gov.au/coronavirus-update-Victoria-24-November-2020>.
197 DHHS 'Coronavirus update for Victoria — 23 May 2020 (Media Release, 23 May 2020) <https://www.dhhs.vic.gov.au/coronavirus-update-victoria-23-may-2020>.
198 DHHS 'Coronavirus update for Victoria — 24 June 2020' (Media Release, 24 June 2020), <https://www.dhhs.vic.gov.au/coronavirus-update-victoria-24-june-2020>.
199 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 20 [82]-[87].
200 DHHS 'Victorian coronavirus (COVID-19) data' (web page, 15 December 2020) <https://www.dhhs.vic.gov.au/victorian-coronavirus-covid-19-data>; DHHS 'Coronavirus update for Victoria — 30 November 2020' (Media Release, 30 November 2020) <https://www.dhhs.vic.gov.au/coronavirus-update-victoria-30-november-2020>; DHHS 'Case locations and outbreaks' (web page, 15 December 2020) < https://www.dhhs.vic.gov.au/case-locations-and-outbreaks>; The Age 'Ten graphs that show the rise and fall of Victoria's COVID-19 second wave' (Article, 27 October 2020) < https://www.theage.com.au/national/victoria/ten-graphs-that-show-the-rise-and-fall-of-victoria-s-covid-19-second-wave-20201027-p5694b.html>.
201 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 25 [117]; 27 [123]; 28 [126].
202 Ibid 25 [115].
203 Ibid 26 [117–118].
204 Exhibit HQI0106_RP, Witness statement of Ms McGuinness, dated 21 August 2020, DHS.9999.0004.0001 at 17 [64].
205 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 26 [118]; Transcript of day 4 hearing 108–10918 August 2020, 108–109.
206 Transcript of day 4 hearing 18 August 2020, 110.
207 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 26 [118].
208 Ibid.
209 Ibid.
210 Ibid 27 [123].
211 Ibid 27 [123]; 28 [126].
212 Transcript of day 14 hearing 8 September 2020, 1075.
213 Exhibit HQI0097_RP Witness statement of Dr Clare Looker, 17 [83].
214 Transcript of day 14 hearing 8 September 2020, 1075.
215 Transcript of day 14 hearing 8 September 2020, 1075–1076.
216 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 17 [64].
217 Transcript of day 14 hearing 8 September 2020, 1076–1077.
218 Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0156.0157.
219 Transcript of day 14 hearing 8 September 2020, 1114.
220 Ibid.
221 Ibid.
222 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 24–25 [89].
223 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren [118].
224 Exhibit HQI0105_RP Annexures to the witness statement of Dr Simon Crouch, DHS.0001.0003.0054.
225 Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, [31]–[32].
226 Exhibit HQI0105_RP Annexures to the witness statement of Dr Simon Crouch, DHS.0001.0003.0070.
227 See eg: Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0156.0157; Exhibit HQI0155_RP Annexures to witness statement of Prof. Brett Sutton, DHS.0001.0032.0205 (Outbreak Management Plan Stamford Plaza Hotel).
228 Transcript of day 14 hearing 8 September 2020, 1109.
229 Exhibit HQI0112_RP Annexures to the witness statement of Ms Kate Gavens, DELW.0001.0001.0653; Exhibit HQI0111_RP Witness statement of Ms Kate Gavens, 10 [42]–[43].
230 Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0156-0157.
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232 Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0156-0157.
233 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 9 [42].
234 Ibid 27 [122].
235 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 13 [48].
236 Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, 12 [54(a)].
237 Ibid 12 [54(c)]; Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 13 [48].
238 HQI0103_RP Witness statement of Dr Simon Crouch, 12 [54(c)].
239 Submission 08 Rydges Hotel Ltd, 19 [62].

240 Therapeutic Goods Administration, Disinfectants for use against COVID-19 in the ARTG for legal supply in Australia Department of Health (Cth), 12 November 2020 <https://www.tga.gov.au/disinfectants-use-against-covid-19-artg-legal-supply-australia>.
241 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 14 [50].
242 Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, 12 [54(b)].
243 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 14 [51].
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245 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 13 [49].
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264 Transcript of day 4 hearing 18 August 2020, 96.
265 Exhibit HQI0008_RP Witness statement of Dr. Charles Alpren, 9–10 [40]–[41].
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267 Ibid.
268 Ibid.
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273 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 28 [99].
274 Transcript of day 14 hearing 8 September 2020, 1090.
275 Transcript of day 14 hearing 8 September 2020, 11021103.; Exhibit HQI0097_RP Witness statement of Dr Clare Looker, 18 [86].
276 Transcript of day 18 hearing 16 September 2020, 1462.
277 PHW Act, s 188(2): at 1 July 2020, the value of a penalty unit is $165.22 (see Government Gazette No G16, 23 April 2020).
278 PHW Act, s 210(1): it is no offence if the person indicates in respect of which the information is false or misleading and if practicable, providing the correct information, or the person otherwise believed on reasonable grounds that the information was true and was not misleading.
279 Transcript of day 18 hearing 16 September 2020, 1462.
280 Ibid.
281 Exhibit HQI0008_RP Witness Statement of Dr Charles Alpren, 5 [25].
282 Ibid 5 [26] – [27].
283 Ibid 8-9 [36] – [37].
284 Ibid 18 [77].

285 Ibid 14 [57].
286 Ibid 13 [54] – [56].
287 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 21 [74].
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301 Exhibit HQI0106_RP, witness statement of Dr Sarah McGuinness, 28, [98].
302 Ibid.
303 See eg Exhibit HQI0160_RP Witness statement of Dr Annaliese van Diemen, 32 [147].
304 Exhibit HQI0140 Outbreak Management Plan Rydges Hotel, DHS.0001.0036.0156–0157 Exhibit HQI0155_RP Annexures to Witness Statement of Prof. Brett Sutton, DHS.0001.0036.0205.
305 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 17 [64].
306 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 21–23 [73]–[79].
307 See e.g. Ms Peake's evidence in which she agrees it would be prudent to have a dedicated infection prevention and control person on-site as a feature of any model going forward: Transcript of day 23 hearing 23 September 2020, 2007–2008.
308 Review of Victoria's Private Security Industry–Victoria's Private Security Industry: Issues Paper for consultation Police Policy and Strategy (15 June 2020) <https://engage.vic.gov.au/private-security-review-2020>
309 Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, 9 [42(d)].
310 Transcript of day 18 hearing 16 September 2020, 1494–1495.
311 Exhibit HQI0140_RP Outbreak Management Plan Rydges Hotel, DHS.0001.0036.0148; Exhibit HQI0155_RP Annexures to Witness Statement of Prof. Brett Sutton, DHS.0001.0036.0205 (Changed to the Outbreak Management Plan Stamford Plaza contained in Sutton material as this has been cited above consistently).
312 Exhibit HQI0097_RP Witness Statement of Dr Clare Looker 21 [95]; HQI0103_RP Witness statement of Dr Simon Crouch, 9 [42(d)]; 13 [57].
313 Transcript of day 18 hearing 16 September 2020, 1496.
314 Transcript of heading day 26, 28 September 2020, 2234.
315 Ibid.
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321 Submissions on Behalf of Rydges Hotel Ltd dated 5 October 2020, 4 [14].
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323 Ibid, 18 [60]
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326 Board of Inquiry into the COVID-19 Hotel Quarantine Program–Submissions on behalf of Unified Security Group (Australia) Pty Ltd, 2 [1.5]
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CHAPTER 10

Testing for COVID-19 at quarantine hotels

10.1 The initial testing regime for the Hotel Quarantine Program

1. Testing of those detained in the Hotel Quarantine Program was clearly an important aspect of its stated aim, being to minimise the possibility of COVID-19 transmission into the community via returning travellers and to, accordingly, determine the exit management of detainees.
2. The initial testing regime for the Hotel Quarantine Program was only offered to those people placed in quarantine who reported symptoms of COVID-19. The evidence was that this was consistent with the public health advice at the time.[1] The Chief Health Officer (CHO), Professor Brett Sutton, stated that:

> In the beginning of the Hotel Quarantine Program across Australia, there was certainly a view that anyone who became symptomatic needed to be tested because they were developing the signs and symptoms of the coronavirus and they needed to be either excluded from having that illness or to be confirmed as positive and, therefore, managed in isolation.[2]

3. This initial testing regime raised three separate issues:
    A. First, what was happening to those people who had completed their 14 days of mandatory detention but had tested positive and remained so?
    B. Second, was the release of people reporting no symptoms after 14 days an appropriate strategy?
    C. Third, was there a risk that people were reporting no symptoms to ensure their release from mandatory detention?

Release of people from quarantine who had tested positive

4. Pam Williams, Department of Health and Human Services (DHHS) COVID-19 Accommodation Commander, outlined that between 28 March and 28 June 2020 and consistent with the public health advice and directions in place at that time, all returned travellers were permitted to exit quarantine once the 14-day quarantine period expired.[3]
5. In the event a returned traveller tested positive during their stay in hotel quarantine:
    A. the guest was permitted to depart if the guest could safely self-isolate, as required by the Isolation (Diagnosis) Direction[4] (as amended from time to time), consistent with the requirements that applied to members of the community who tested positive

B. travel to an interstate residence was not permitted until after the relevant isolation direction had been complied with and clearance provided

C. if the guest was subject to the Isolation (Diagnosis) Direction (as amended from time to time) and did not have a safe place to self-isolate, DHHS would support that guest with emergency relief hotel accommodation, subject to the relevant public health direction.[5]

6. In his evidence, the Deputy Public Health Commander, at DHHS Dr Finn Romanes, stated the following with respect to this policy:

> A further situation requiring judgement was what to do if someone whose detention period was ending was a confirmed case of COVID-19. Our assessment was that it was appropriate for someone to leave mandatory detention if they were a confirmed case of COVID-19 so long as we transitioned the person to a safe place to self-isolate for the remainder of their infectious period, as was required under the Diagnosed Persons and Close Contact Directions in force at the time, in keeping with other diagnosed persons already self-isolating in the community. This was because the key public health imperative was knowing whether or not someone was infected with COVID-19 and being clear with the person what actions were needed to prevent transmission. That way, we could agree and implement clear isolation arrangements, with a recognition between the person and the department that the person was potentially infectious and must carefully isolate.[6]

7. When questioned about the tension between allowing COVID-positive detainees to be released into the community after 14 days and the overriding objective of infection control, the Deputy Chief Health Officer at DHHS, Dr Annaliese van Diemen, stated:

> I see that a tension could be perceived. I believe that people's behaviour shifts significantly when they know that they have an infectious disease that is causing a worldwide pandemic, compared to when they have not been diagnosed with that condition, and that people … most people don't believe they will get COVID until they get it, if that makes sense. I also know that the compliance and daily check activities around cases was significantly greater than for contacts and returned travellers before the Hotel Quarantine Program, simply by virtue of numbers. There was physically no way of calling every returned traveller who was coming into the country in early March; there was tens of thousands of them.
>
> So that was a discussion that was had and there was a risk assessment that was undertaken in determining whether those people would be allowed to go home to quarantine. And one of the reasons for that was that we didn't want people to refuse to have a test because they knew that they would be kept in quarantine. So, in part, there was a degree of incentive there that, you know, if you have a test at day 10 or 11 and you're positive and you've got a safe place to go home to isolate and you're… we can see that you're cooperative and you're receiving daily phone calls and you're being required to state that you are staying home in isolation, that that was an incentive to ensure that people did report when they had symptoms and ensure that a test was undertaken. I can see that there could be a tension perceived there.[7]

8. I accept the assessments and opinions of these two public health experts with respect to their rationale for approving the release of those who tested positive and were assessed as suitable to be released on directions to self-isolate. I discussed this rationale in the Interim Report, which formed part of the basis for the recommendations for the home-based model, particularly at section 2.8: Risk of spread from non-compliance during self-quarantine.[8]

Release of people reporting no symptoms who may have been asymptomatic

9. As noted above, the initial testing regime in the Hotel Quarantine Program involved only those returned travellers reporting symptoms and consenting to a test before being released from the Program. This appeared to have been, somewhat, at odds with the more precautionary approach recommended by the Australian Health Protection Principal Committee (AHPPC) in its 29 January 2020 statement on the issue of asymptomatic and pre-symptomatic transmission of COVID-19:

> AHPPC is aware of:
>
> • very recent cases of novel coronavirus who are asymptomatic or minimally symptomatic, and
>
> • reports of one case of probable transmission from a pre-symptomatic case to other people, two days prior to the onset of symptoms.
>
> These data are very limited and preliminary and AHPPC still believes that most infections are transmitted by people with symptomatic disease. However, AHPPC believes that we should take a highly precautionary approach and is making the following new recommendations:
>
> 1. People who have been in contact with any confirmed novel coronavirus cases must be isolated in their home for 14 days following exposure;
> 2. Returned travellers who have been in Hubei Province of China must be isolated in their home for 14 days after leaving Hubei Province, other than for seeking individual medical care.
>
> Given the lower number of cases in China reported outside of Hubei Province, we do not currently recommend self-isolation for travellers from other parts of China or other countries. We are closely monitoring the development of cases outside of Hubei Province and will update this advice if necessary.
>
> AHPPC recognises that the evidence for pre-symptomatic transmission is currently limited, and this policy is highly precautionary. At this time, the aim of this policy is containment of novel coronavirus and the prevention of person to person transmission within Australia.
>
> Further details of the extent of pre-symptomatic transmission is being monitored and may result in changes to policy.[9]

10. Without doubt, asymptomatic cases had added considerable complexity to the task of addressing infection control, particularly if one was only testing on the basis of an individual presenting symptoms, which was the case at the start of the Hotel Quarantine Program.

11. In its submissions, DHHS referred to Dr van Diemen's evidence that, in the first few weeks of the Program, no jurisdictions in Australia were doing asymptomatic testing.[10] I accept that evidence and its implications as to why people in quarantine not reporting symptoms were being released, without testing, at the completion of their 14-day quarantine period.

12. However, Prof. Sutton acknowledged that the initial testing regime resulted in a situation where it was possible that people could have been released from quarantine while carrying the virus and while still infectious.[11]

13. He agreed that, in addition to a known case where a driver contracted COVID-19 from a returned traveller picked up from the Stamford Plaza Hotel, there were, potentially, other returned travellers who had been released whose COVID-19 status was undetermined.[12]

14. In his evidence, Prof. Sutton noted that the possible asymptomatic presentation of the virus or the spectrum of symptoms ranging from mild to more severe was something that became more known over time:

> What became known over time is that some people can have extremely mild symptoms, some people might develop asymptomatic illness, some with no symptoms whatsoever but potentially be infectious.[13]

Was there a risk that people were reporting no symptoms to ensure their release from mandatory detention?

15. Prof. Sutton's evidence identified that there may have been people in quarantine who minimised or downplayed their symptoms so that they would not have to be detained (or self-isolate) for longer than the 14-day quarantine period.[14] In other words, people who claimed to be symptom-free and who had not been tested, either because they were ineligible for testing or because they declined testing, were released into the community with no further requirement to quarantine.[15]

16. It was in this context that the approach to testing changed.

17. From early May 2020, a testing blitz was undertaken in Victoria. At this point, all returned travellers, even if asymptomatic, were offered voluntary COVID-19 testing on Day 3 and Day 11 of their detention. The evidence was that Victoria was the first jurisdiction to offer testing to people who were not symptomatic.[16]

18. The policy recommending testing on Day 3 and Day 11 for people in the Hotel Quarantine Program was codified in the *Operation Soteria Enhanced Testing Programme for COVID-19 in Mandatory Quarantine* on 21 May 2020, which specified that:

> Routine testing for COVID-19 is recommended for all individuals in mandatory quarantine on Day 3 and Day 11 of the quarantine period … COVID-19 testing is voluntary. Quarantined individuals cannot be forcibly tested.[17]

19. A fact sheet about the availability of Day 3 and Day 11 testing was provided to returned travellers[18] in the following terms:

Figure 10.1: Summary of routine testing process on days three and 11 from the *Operation Soteria Enhanced Testing Programme for COVID-19 in Mandatory Quarantine*

Routine testing on Day 3 and Day 11

The purpose of Day 3 testing is to detect cases of COVID-19 early in the quarantine period, so that appropriate isolation arrangements can be made both for the case and their close contacts, but also to reduce the possibility of an extended quarantine (and possibly detention) period.

The purpose of Day 11 testing is to detect cases of COVID-19 before they are due to exit mandatory quarantine, so that appropriate isolation arrangements can be put in place, and to reduce the risk of transmission in the community.

Tailored information on the Day 3 and Day 11 testing process must be provided to individuals at the beginning of the quarantine period and again before testing is carried out. Consent should be sought and documented as per the above procedure.

Day 3 and Day 11 testing will **NOT** be requested of the following groups:

- persons who are confirmed cases of COVID-19 (unless specifically indicated (e.g. if there is a specific clinical or public health indication, as determined by the treating medical practitioner and the department's CCOM)).
- persons who already have a COVID-19 test result pending.
- approved transit passengers who are generally in transit for less than 72 hours.

It should be noted that close contacts of confirmed cases who are residing at the COVID-19 designated hotel **should** be offered Day 3 and Day 11 testing, as per standard practice.

Where it is identified in advance that individuals are observing Ramadan and are unable to have a swab taken on the morning of Day 11, the test may be conducted on the evening of Day 10.

Confirmed cases should not be tested again unless specifically indicated (e.g. if there is a specific clinical or public health indication, as determined by the treating medical practitioner and the department).

Source: Exhibit HQI0131(2)_RP Annexures to witness statement of Ms Pam Williams.

20. 1 July 2020, a further public health direction[19] was issued, which required returned travellers who refused a COVID-19 test to undergo a further 10 days of hotel quarantine.[20] This was not a measure to compel testing *per se* but, rather, a measure to incentivise submission to voluntary testing by making refusal more disadvantageous. It was introduced to ensure that, in circumstances where a person refused a test, they could be detained for the full incubation period and full infectiousness period of the virus.[21]

21. In his evidence, Prof. Sutton stated that these more stringent requirements for testing were introduced to make the Hotel Quarantine Program as robust as possible.[22] Notwithstanding the acknowledged need to make the testing regime more robust, the coercive powers to require testing under the *Public Health and Wellbeing Act 2008* (Vic) (PHW Act) were not drawn upon.[23]

22. In her evidence, Dr van Diemen stated that the use of these powers was considered to ensure people were not released from quarantine while COVID-positive.[24] However, on balance, it was decided that it was less intrusive to require an additional 10 days' quarantine for people who refused to get tested.[25]

23. As explained by Prof. Sutton:

> It didn't come to mandatory testing, but there was a change in the directions, in the public health directions, which specified that those who were refusing testing at the day 11 or thereabouts mark would be held for an additional 10 days if they didn't get tested. And those additional 10 days are really a conservative measure of the infectious period if someone were to become unwell on the very last day of quarantine. Most people who develop illness have recovered and are no longer infectious before seven days are up and, certainly, the great majority will not be infectious at the 10-day mark. So that mechanism was used instead.[26]

24. The evidence was that, during the early stages of the Hotel Quarantine Program, people who were asymptomatic, not reporting symptoms or declined testing when offered were being released into the community while potentially infectious.[27]

25. DHHS submitted the following in respect of these matters:

> The Board should find that the testing policies deployed and applied in Hotel Quarantine were appropriate and adequate for the following reasons:
>
> A. throughout the program, testing was always offered to symptomatic guests as soon as they exhibit COVID-19 symptoms;
>
> B. there is no evidence of any break down in testing policies and procedures leading to unidentified community transmission. The limited circumstances of transmission because of untested positive guests leaving quarantine were isolated and, subsequently addressed by the 10-day extension to quarantine for people refusing testing;
>
> C. the Victorian position on testing was the most robust in Australia;
>
> D. the family of returned travellers at Rydges was tested and known to be positive at the time of the transmission event;
>
> E. there is no evidence to support a finding that the testing policies and procedures were not adequate or appropriate.[28]

26. The submission that testing policies deployed and applied in the Hotel Quarantine Program were not inadequate or inappropriate must come with some qualification. The extent to which testing policies prior to 1 July 2020 increased the risk of transmission was clear from the case of a guest at the Stamford Plaza Hotel guest who was released, without knowing he was COVID-positive, and infected the person who drove him away from the hotel.[29] The fact that this did not result in unidentified community transmission was fortunate, but served as a clear indication of the dangers arising from the policy at that time.[30]

27. I accept that the policy must be viewed having regard to the state of knowledge held in respect of COVID-19 at that time. Over time, as knowledge advanced and the risks posed by releasing people without testing for COVID-19 was acknowledged, the policy was revised and people refusing to be tested were subject to an additional 10 days' quarantine. I accept that this was appropriate.

10.2 Should mandatory testing powers have been used?

28. In his evidence, Professor Lindsay Grayson, Professor of Infectious Diseases at Austin Health, stated that:

> ... it would be sensible to test all people at the end of their quarantine period to see whether they are infected with the virus, irrespective of symptoms. If the criteria that people are not showing symptoms after 14 days is used as the sole determinant for whether people are released from quarantine, a proportion of those who are infected with the virus and potentially infectious, but who remain asymptomatic, could be released into the community.[31]

29. It goes without saying, the ability to test all people at the end of quarantine depends on people consenting to tests being undertaken and the availability of mandatory testing powers in the absence of consent.

30. Under s. 113 of the PHW Act, the CHO may make an examination and testing order if the CHO believes that:[32]

> A. a person has an infectious disease or has been exposed to an infectious disease in circumstances where a person is likely to contract the disease; and
>
> B. if infected with that infectious disease, the person is likely to transmit that disease; and
>
> C. if infected with that infectious disease, a serious risk to public health is constituted by —
>
> I. the infectious disease; or
>
> II. the combination of the infectious disease and the likely behaviour of that person; and
>
> D. the making of an order under this section is necessary to ascertain whether the person has the infectious disease; and
>
> E. a reasonable attempt has been made to provide that person with information relating to the effect of the infectious disease on the person's health and the risk posed to public health or it is not practicable to provide this information before making the order.

31. The penalty for non-compliance with a mandatory examination and testing order was nearly $10,000.[33]

32. While a person to whom such an order applies may be physically detained for up to 72 hours for the purposes of undergoing a test,[34] a requirement that a person undergo an examination or test could not be applied by the use of force.[35]

33. Prof. Sutton acknowledged the existence of these powers in his evidence, but said that he did not consider using them in the context of the Program, stating:

> [The powers] have, again routinely … not routinely, but they have historically … been used from time to time for individual persons for those issues. They relate to infectious diseases and some other settings such as with respect to food safety, where directing individuals or directing premises is warranted on an individual basis. Testing orders, for example, might be applied if a healthcare worker has been exposed to a needlestick injury and you want to know the status with respect to infectious diseases, hepatitis B or C or HIV, of the person whose blood was in the syringe who was involved in that needlestick injury. And if that information is not forthcoming and if you think it's appropriate and proportionate to make sure that person is tested to find out, then those orders can be applied in that instance. So that's an example.[36]

34. When asked about the issue of using coercive powers for testing, Dr van Diemen said the following:

> I did consider it. I considered it when we were discussing implementing testing in the hotel program. I also considered it on a number of occasions early on, very early on, in the pandemic when there were returned travellers who were suspected cases of COVID and refused to be tested. And in those instances, they weren't required because the individuals decided that they would accept a test. At the time of the … when we were determining the next steps to ensure that all returned travellers were tested, it was decided that a less intrusive route would be to extend the quarantine requirements for a further 10 days for people who had refused testing, in order to ensure that should they continue to refuse a test, that they had completed both a full incubation period and a full infectiousness period, should they happen to have become infectious at the end of their 14-day incubation period.[37]

35. DHHS submitted the following in this regard:[38]

> Other coercive powers of the CHO include the power under s. 113 for the making of an examination and testing order of a person in certain quite narrow circumstances. Prof. Sutton was asked about whether he considered using any of these powers and explained that he did not consider using them because they historically have been used infrequently and in the context of individuals. He was not specifically asked to address whether the legal conditions would have been satisfied for any specific persons, such as the class of persons subject to hotel quarantine. It is relevant here to note certain of these relevant circumstances:
>
> A. a person has an infectious disease or has been exposed to an infectious disease in circumstances where a person is likely to contract the disease (s. 113(1)(a)). There is no evidence to suggest that it would have been possible to ascertain in any rapid time frame whether returning travellers would fall into this category, given that few would know if they had got COVID-19 or been exposed to it;
>
> B. if infected with that infectious disease, the person is likely to transmit it (s. 113(1)(b)), a matter which, given the evidence as to the infectious nature of COVID-19 could, contrary to the first requirement, be readily assumed; and
>
> C. if infected with that infectious disease, a serious risk to public health is constituted by –
>
> I. the infectious disease; or
>
> II. the combination of the infectious disease and the likely behaviour of that person: s. 113(1)(c) –
>
> It [sic] unlikely to be possible to make determinations about the likely behaviour of large numbers of returning travellers, so whether this requirement, properly construed, is satisfied would depend on whether the fact that a person has COVID-19 of itself constitutes a serious risk to public health.

36. I accept that the exercise of power under s. 113 of the PHW Act was subject to limitations, including:

A. The CHO would need to exercise this power, and make an examination and testing order, in respect of each person refusing to undergo a COVID-19 test. It could not be exercised in respect of a class of people.

B. In order to exercise this power, the CHO must have the requisite 'belief'. This belief must include the belief that the person has at least been exposed to an infectious disease in circumstances where the person is likely to contract the disease. The belief must be evidence-based[39] and proportionate.[40] It is doubtful this belief could be based merely on the elevated risks generally associated with overseas travel or that this power could be exercised solely by reference to a person's placement in hotel quarantine. Further considerations, such as the person's country of origin, symptomology and contact with other persons carrying COVID-19 would likely need to be taken into account.

C. The exercise of this power is subject to s. 112 of the PHW Act, which provides that, where alternative measures are equally available that are equally effective in minimising the risk that a person poses to public health, the measure that is the least restrictive of the rights of the person should be chosen. A similar condition is placed upon the exercise of this power by s. 7(e) of the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (Charter), which relevantly provides that a human right may be subject, under law, only to such reasonable limits as can be demonstrably justified, taking into account relevant factors including any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve. When compared with other available measures, such as the extension of their quarantine period, it is not certain that a naseo-pharangeal swab would be the least restrictive means of minimising the risk of spreading COVID-19 from a person refusing a COVID-19 test at the end of their quarantine period. The first course would involve an intrusion upon their liberty while the latter would necessarily involve a physical intrusion upon a person. These are not easily quantifiable matters that can conveniently be measured against one another.

37. Another power that could conceivably have been exercised to enforce mandatory testing was s. 200(1)(d) of the PHW Act, which applies where a state of emergency has been declared and provides that an Authorised Officer may give any direction they consider is reasonably necessary to protect public health. While the exercise of this power is not subject to s. 112 of the PHW Act, it is subject to the 'least restrictive' principle contained in the Charter.

38. Like s. 113, it is also subject to the requirements contained in ss. 5 and 9 of the PHW Act, which require that decision-making be evidence-based and proportionate. It seems likely that similar considerations would, therefore, have needed to be taken into account when exercising this power. That is, in order to 'consider' whether a mandatory COVID-19 test was reasonably necessary to protect public health, among other things, the Authorised Officer would likely have needed to consider where the person has travelled from, their symptomology and close contacts.

Obtaining further clarity on these matters

39. These matters created ambiguity for the CHO and his delegates about the extent of mandatory testing powers available to them. This ambiguity needs to be remedied. The Responsible Minister should take steps to achieve clarity by obtaining legal advice from the Solicitor-General on the range of circumstances in which ss. 113 and 200(1)(d) of the PHW Act may be exercised to require that those refusing testing at the conclusion of their quarantine period undertake mandatory testing.

40. The request for such advice should provide a detailed list of practical scenarios that commonly arise, or are expected to arise, in the context of returned travellers refusing to undergo testing in the Hotel Quarantine Program.

41. Recognising that it will not be possible to provide absolute certainty on the range of circumstances in which these powers may be available, the advice should provide practical guidance to the CHO and Authorised Officers in their exercise of the powers under ss. 113 and 200(1)(d) of the PHW Act and consider matters, including:

    A. whether the power under s. 200(1)(d) of the PHW Act may be exercised for the purposes of mandatory testing

    B. if so, the criteria that must be met in order to exercise that power

    C. whether the powers available under s. 113 and/or s. 200(1)(d) of the PHW Act would be available to enforce mandatory testing in the scenarios provided in the request for advice

    D. the meaning of 'exposed' as it is contained in s. 113(1)(a) of the PHW Act and the considerations that should be taken into account when determining whether that condition is satisfied

E. whether naseo-pharangeal testing is likely to be considered the least restrictive option for addressing the risks posed by returned travellers who refuse testing when compared with the option of imposing an additional 10 days' detention

F. whether the powers contained in s. 113 and/or s. 200(1)(d) of the PHW Act should be exercised to enforce mandatory testing

G. if so, how the mandatory testing regime should operate in conjunction with the option of imposing an additional 10 days' detention

I. are both options equally available?

II. if not, in what circumstances should each option be preferred?

H. having regard to these matters, whether any of the following would be warranted in order to provide more certainty and serve the public interest sought to be achieved by mandatory testing:

I. an overriding declaration made by parliament pursuant to s. 31 of the Charter stating that the Charter does not apply to the exercise of powers in s. 113 and/or s. 200(1)(d) of the PHW Act for the purposes of mandatory testing

II. a declaration by the Minister for Police and Emergency Services pursuant to s. 24(2)(b) of the *Emergency Management Act 1986* (Vic), suspending the application of the Charter and/or relevant sections of the PHW Act (for example, ss 9 and 112) to the exercise of powers in s. 113 and/or s. 200(1)(d) of the PHW Act for the purposes of mandatory testing and/or

III. temporary legislative change.

42. The request for advice should also include a request for a 'checklist' to be developed in order to assist those working in the Hotel Quarantine Program to determine when mandatory testing powers and/or the option of imposing an additional 10 days' quarantine should be exercised.

43. To accompany this advice, the Responsible Minister should identify an appropriate person who will be available to provide legal advice, at short notice and when required, to the CHO and delegates, on the exercise of mandatory testing powers and/or the option of imposing an additional 10 days' quarantine.

Testing of those working in the Hotel Quarantine Program

44. The evidence in this Inquiry established that one of the most substantial risks associated with the Hotel Quarantine Program was the risk of infection spreading from returned travellers to staff and personnel working in the Program.

45. This much was clear from the circumstances of Victoria's second wave that, as discussed in Chapter 9, involved on-site personnel becoming infected then spreading the virus to household and other close contacts who, in turn, spread the virus into the broader community.

46. Public reports of on-site personnel in hotel quarantine in other states becoming infected via those held in quarantine confirms this is a significant ongoing risk.

47. In order to address this risk, it is vital that staff working in any future quarantine program undergo mandatory and regular COVID-19 testing. Failing this, the State's efforts to prevent and minimise the spread of the virus into the community will be significantly compromised.

48. The Inquiry understands, from recent media reporting, that in the revised Victorian hotel quarantine program, all on-site personnel, including frontline workers and cleaners, will be required to undergo daily saliva testing and weekly nasal swab testing.[41] The Inquiry also understands that regular, voluntary testing will be available for the families and household members of those working in the revised program.[42]

49. In my view, these are important and appropriate measures for addressing the substantial risks associated with infection spreading from international arrivals to personnel working on-site at quarantine facilities and into the wider community.

10.3 Conclusions

50. A significant, if not dominant, purpose of the 14-day quarantine period was to ascertain the COVID-19 status of those detained in the Program, and to allow for their post-release arrangements to be managed in an informed manner. To this end, the testing regime was of fundamental importance.

51. Initially, only those who showed symptoms were offered a test, and testing in the Hotel Quarantine Program remained entirely voluntary. The mandatory testing powers contained in the PHW Act were considered but not used.

52. A new approach was implemented in July 2020, when an additional 10 days of quarantine was introduced for those who refused testing on Day 11. This new approach was justified and appropriate.

53. It is understood that this new approach will be bolstered in the revised hotel quarantine program by mandatory testing of staff and all on-site personnel working in the program, along with voluntary testing of their families and household contacts.

54. Both approaches represent sound approaches and substantial improvements to the initial testing program that risked undermining, at least to some degree, the efficacy and intentions of the Hotel Quarantine Program and, in doing so, risked transmission of COVID-19 from those detained in the Program into the community.

55. To further protect against these risks, the legal basis for, and utility of, a testing regime requiring returned travellers who refuse testing at the conclusion of their 14-day quarantine period to undergo mandatory testing should be further explored.

10.4 Recommendations

78. To provide clarity to the CHO and his delegates on the circumstances in which mandatory testing powers may be exercised and to further minimise the risks of community transmission arising from the revised hotel quarantine program:

    - the Responsible Minister should obtain detailed legal advice from the Solicitor-General on the range of circumstances in which ss. 113 and 200(1)(d) of the PHW Act may be exercised to require that those refusing testing at the conclusion of their quarantine period undertake mandatory testing
    - the request for such advice should provide a detailed list of practical scenarios that commonly arise, or are expected to arise, in the context of returned travellers refusing to undergo testing in the Hotel Quarantine Program
    - recognising that it will not be possible to provide absolute certainty on the range of circumstances in which these powers may be available, the advice should provide practical guidance to the CHO and Authorised Officers in their exercise of the powers under ss. 113 and 200(1)(d) and consider matters including those listed above in paragraphs 41.a–41.h

- the request for advice should also include a request for a 'checklist' to be developed in order to assist those working in the Hotel Quarantine Program to determine when mandatory testing powers and/or the option of imposing an additional 10 days' quarantine should be exercised
- to accompany this advice, the Responsible Minister should identify an appropriate person who will be available to provide legal advice, at short notice and when required, to the CHO and delegates, on the exercise of mandatory testing powers and/or the option of imposing an additional 10 days' quarantine.

79. To protect against the risk of infection spreading to the community via staff or personnel working in the program who have contracted the virus from returned travellers, the Responsible Minister should ensure, or continue to ensure, that:
    - all on-site staff and personnel, including frontline workers and cleaners, are required to undergo daily saliva testing and weekly nasal swab testing
    - family and household members of such frontline staff and personnel are provided with, and given support to access, voluntary testing on, at least, a weekly basis.

Endnotes

1 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 33 [76].
2 Transcript of day 18 hearing 16 September 2020, 1463.
3 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 32 [74].
4 See Isolation (Diagnosis) Direction, <https://www.dhhs.vic.gov.au/sites/default/files/documents/202003/Isolation%20%28Diagnosis%29%20Direction%20-%20signed.pdf>.
5 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 32 [74].
6 Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 16 [77]. Note: The Diagnosed Persons and Close Contact Directions are a more recent iteration of the Isolation (Diagnosis) Direction, issued 25 March 2020, and referred to in Ms Williams' evidence above.
7 Transcript of day 18 hearing 16 September 2020, 1551.
8 Board of Inquiry into the COVID-19 Hotel Quarantine Program (Interim Report, 6 November 2020) <https://www.quarantineinquiry.vic.gov.au/reports>.
9 Australian Health Protection Principal Committee (AHPPC), 'Australian Health Protection Principal Committee (AHPPC) Statement on novel coronavirus', Australian Government Department of Health (Statement, 29 January 2020) <https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-novel-coronavirus-on-29-january-2020-0>.
10 Submission 03 Department of Health and Human Services, 45 [242].
11 Transcript of day 18 hearing 16 September 2020, 1465.
12 Ibid 1464–1465.
13 Ibid 1463.
14 Ibid.
15 Transcript of day 26 hearing 28 September 2020, 2248.
16 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 33 [77]; Transcript of day 18 hearing 16 September 2020, 1463.
17 Exhibit HQI0131(2)_RP Annexures to witness statement of Ms Pam Williams, DHS.0001.0001.2353.
18 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 33 [78]; See also Exhibit HQI0131(1)_RP Annexures to witness statement of Ms Pam Williams, DHS.5000.0003.1670.
19 Detention and Direction Order (No. 6) <https://www.dhhs.vic.gov.au/sites/default/files/documents/202007/Direction%20-%20Detention%20Notice%20%28No%206%29.pdf>.
20 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 33 [79].
21 Transcript of day 18 hearing 16 September 2020, 1548–1549.
22 Ibid 1464.
23 Ibid.
24 Ibid 1548.
25 Ibid 1548–1549.
26 Ibid 1464.
27 Ibid 1464–1465; Submission 03 Department of Health and Human Services, 46 [246].
28 Submission 03 Department of Health and Human Services, 45 [241].
29 Transcript of day 18 hearing 16 September 2020, 1464–1465.
30 Cf Submission 03 Department of Health and Human Services, 45 [241], where the contrary is argued.
31 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 12 [56].
32 PHW Act s. 113.
33 Ibid s. 116.
34 Ibid s. 113(3)(c).
35 Ibid s. 123(2).
36 Transcript of day 18 hearing 16 September 2020, 1461–1462.
37 Ibid 1548.
38 Submission 03 Department of Health and Human Services, 4 [19].
39 PHW Act s. 5.
40 Ibid s. 9.
41 Ashleigh McMillan, 'Help Wanted: Would you work in Victoria's quarantine hotels for $85k?', The Age (online, 29 November 2020) <https://www.theage.com.au/national/victoria/help-wanted-would-you-work-in-victoria-s-quarantine-hotels-for-85k-20201129-p56ivx.html>. Quote regarding testing was from Victoria's Chief Testing Commander, Jeroen Weimar.
42 Premier of Victoria, 'A Stronger Quarantine Program to Protect What We've Built' (Media Release, 30 November 2020) 1 <https://www.premier.vic.gov.au/stronger-quarantine-program-protect-what-weve-built>.

CHAPTER 11

Correcting the course: the 'pivot' to a health hotel model

1. On 30 June 2020, work was already underway to transfer responsibility for some aspects of the Hotel Quarantine Program away from the Department of Health and Human Services (DHHS) and to make changes to the workforce involved in the Program.

2. On 27 June 2020, a submission prepared for the Crisis Council of Cabinet (CCC) described the Hotel Quarantine Program in the following terms:

> DHHS currently has overall accountability for delivery of the hotel quarantine scheme. However, current operations utilise a combination of DHHS staff, Department of Jobs, Precincts and Regions [DJPR] staff, private security contractors, contract nurses and hotel support staff. This model has been built through a series of contractual arrangements across multiple departments, and security subcontracting arrangements.[1]

3. The submission identified that there had been 'incidents of non-compliance with infection prevention and control and physical distancing requirements, particularly from security contractors'.[2] The submission further identified the highest risk activities in hotel quarantine as including inconsistent application and use of PPE, entry and exits of large numbers of quarantined people, goods handling and the provision of fresh air and exercise breaks.[3]

4. On 27 June, 8 July and 27 July 2020, the CCC approved a series of actions and measures intended to address those high-risk activities and the incidents of non-compliance that had been described.[4]

5. On 27 July 2020, full responsibility for quarantine hotels resided with the Department of Justice and Community Safety (DJCS).[5] Although the Program, as it related to international travellers, was in abeyance because of the pause on international arrivals, designated hotels were still accommodating a number of COVID-positive persons who, for a range of reasons, were not able to safely self-isolate at home.[6] Such people remained subject to directions and detention orders issued under the *Public Health and Wellbeing Act 2008* (Vic) (PHW Act), but responsibility for administering certain emergency powers under that Act, insofar as they related to the Hotel Quarantine Program, had been transferred away from the Minister for Health to the Attorney-General.[7] Information provided to the Inquiry indicated that the plan was for DJCS to be the department responsible for quarantine arrangements if, and when, international arrivals to Victoria were to resume.

6. The transfers and changes that occurred in late June and July 2020 appear to have reflected assessments made by people at a range of levels within government that the model for hotel quarantine, as it stood in late June 2020, was not suitable and required remodelling.[8]

7. As explored in this Chapter, the three most significant elements of that remodelling or 'pivot' from DHHS-led quarantine to a program administered by DJCS were:

    A. the involvement of Alfred Health as the provider of clinical and infection prevention and control services

    B. the recruitment of a specialised workforce to work in the hotels, later complemented by a 24/7 Victoria Police presence

    C. the consolidation of responsibility for all aspects of the Program, including contracts, into one department.

8. The evidence before the Inquiry richly demonstrated the necessity of these elements for a successful quarantine program. It was entirely appropriate that the Government took steps to insert these elements into the program. As set out in the Interim Report, those elements should be central to any future program.

11.1 The involvement of Alfred Health

9. The participation of Alfred Health in the Hotel Quarantine Program commenced in late May 2020, after the Rydges outbreak (see Chapter 9). Pam Williams, DHHS COVID-19 Accommodation Commander, gave evidence that Alfred Health was asked to provide clinical staff and infection control governance and training.[9]

10. Simone Alexander, Chief Operating Officer of Alfred Health, gave evidence of the elements of the model established by Alfred Health and implemented at the Brady Hotel when it became the 'health hotel'.[10] The necessary elements of a facility-based model, including those described by Ms Alexander, are set out in the Interim Report.[11]

11. At the time of the CCC decision, on 27 June 2020, Alfred Health was in place at the Brady Hotel and DHHS was working towards introducing Alfred Health-led clinical and infection prevention and control services across all quarantine hotels.[12] Subsequent reports to CCC, in July 2020, indicated the model included separate health teams at each hotel being placed on separate rosters, with those in control moving towards having staff not work at more than one quarantine hotel.[13]

12. Ms Alexander gave evidence that, as of 8 September 2020, Alfred Health had clinical responsibility for all hotels that were part of the Hotel Quarantine Program.[14]

11.2 The need for an alternative workforce

13. As set out in chapters 6 and 7, and as summarised in the CCC submission of 27 June 2020, the Hotel Quarantine Program was led by DHHS but delivered by a combination of various government departments, agencies, personnel and private contractors.

14. As of late June 2020, the outbreaks were understood, within the Government, to have been due, in part, to the conduct of private security guards or to vulnerabilities caused by the security guard cohort, including limited understanding of infection prevention measures and some difficulties associated with contact tracing. These issues were discussed in more detail in chapters 6 and 9.

15. The evidence of former Minister for Health, the Hon. Jenny Mikakos, was that, from the time of the Stamford Plaza outbreak, she had formed the view that private security was not the appropriate workforce for the Program, and that she asked her department to investigate other options.[15] It was this view that led to the preparation of an options paper, a request (later rescinded) for Australian Defence Force (ADF) support as a temporary workforce[16] and the decision to use Corrections Victoria staff in the first stage of what became a transfer of the whole Program away from DHHS.

16. It should be noted here (as has been discussed earlier, in Chapter 5) that an email exchange, produced in response to a compulsory notice from the Inquiry, revealed that, in early April 2020, an email was sent from Phil Gaetjens, Secretary to the Department of Prime Minister and Cabinet, to his Victorian counterpart, Chris Eccles AO, the then Secretary to the Department of Premier and Cabinet.[17] Mr Eccles gave evidence that he had requested that the Commonwealth assist with the cost of private security at hotels.[18] Mr Gaetjens responded that New South Wales had been provided with support in the form of ADF personnel and that the same support might be available to Victoria if it were to reconsider its model of operating the Hotel Quarantine Program.[19]

17. Mr Eccles did not, so far as the documentary evidence reveals, respond other than by return email to say 'thanks'.[20] His oral evidence was that he could not recall taking any other action in response to this email.[21] He did not pass on this information to the Premier.[22] This was an opportunity lost to reset the model insofar as the use of private security was concerned. I cannot make a finding about the outcome had those responsible for Operation Soteria or the Minister for Health or the Premier been made aware of the specific potential for ADF support as security in hotels. What I do find is that, given the issue he sought to address by making contact with the Commonwealth (the significant cost to the public purse), it was a most unfortunate and inexplicable oversight on the part of Mr Eccles not to pass on this significant information to the Premier and Minister for Health.

18. In late June 2020, the Government revisited the availability of the ADF to provide support. After a discussion on 23 June 2020, Melissa Skilbeck, a deputy secretary at DHHS, was asked by the then Secretary of DHHS, Kym Peake, to prepare an options paper setting out alternatives to the use of private security.[23] One option was the increased use of ADF, although the preferred option was to use police and Protective Services Officers.[24]

19. Also on 23 June 2020, the Premier had a conversation with the Prime Minister during which the possibility of additional ADF resources was discussed.[25] The following day, Mr Eccles sought, and received, information from Ms Peake about the forms of ADF assistance that Victoria required. Ms Peake's email identified a number of different forms of support unrelated to the Hotel Quarantine Program but included a request for 50–100 people for 'ADF security support for passengers entering and exiting hotel quarantine'.[26] Mr Eccles then sent an email to Mr Gaetjens giving a 'heads up' that the request would be made.[27]

20. As the Emergency Management Commissioner for Victoria, it was Mr Crisp's role to make formal requests to the ADF.[28] He gave evidence that, after a meeting on 24 June 2020 with Ms Skilbeck, he was asked to make a request for 850 ADF officers, that being the number needed to replace private security in full (rather than the smaller number of 50–100 that had originally been identified in the options paper).[29] He made that, as one of a number of requests, having been asked by DHHS to do so.[30] The request was approved by the Commonwealth.[31]

21. On the morning of 25 June 2020, Commissioner Crisp exchanged text messages with Rebecca Falkingham, Secretary of DJCS, and the Hon. Lisa Neville MP, Minister for Police and Emergency Services, regarding the request that had been made the previous day.[32] Ms Falkingham and Ms Peake exchanged emails suggesting their view that Minister Neville would have a strong reaction to the use of the ADF.[33] Minister Neville, herself, said she had been surprised to learn of the ADF request via media reporting, rather than being informed.[34]

22. In the course of the day, Commissioner Crisp spoke to Ms Falkingham, who told him that other options to replace private security were being investigated.[35] At the request of Ms Falkingham, Commissioner Crisp rescinded the request for the 850 ADF personnel.

23. At 12.21pm on 25 June 2020, Mr Eccles received an email from Ms Peake that referred to 'multiple conversations yesterday … to scope options to replace hotel security, which is a priority, and the RFA [request for assistance] is being rescinded as further options are being developed'.[36]

24. A document summarising an alternative model was circulated by Ms Falkingham on 26 June 2020.[37] She noted that because of 'capacity issues with using VicPol we are using primarily Corrections [Victoria] staff'.[38] The model was described as a multi-agency response that would not change governance arrangements but that would 'phase out reliance on private security providers and ensure a more disciplined approach to infection control in hotel quarantine'.[39] In essence, it proposed leaving health services with DHHS, provided by DHHS workers and Alfred Health, and making supervision of those in detention the responsibility of DJCS, led by Corrections Victoria.

25. The following day — 27 June 2020 — CCC was presented with a submission inviting a decision to give effect to the alternative model.[40] Consistent with the document circulated by Ms Falkingham, the submission retained DHHS as the agency in overall control but advocated for DJCS as being well placed to 'quickly mobilise an effective, disciplined and well-trained workforce to deliver the supervision function'.[41] That workforce was to comprise Residential Support Officers (RSOs), who were to be drawn from the existing DJCS workforce and from contracted agencies, and to be built up over time to gradually replace the private security workforce.

26. As of 9 July 2020, the RSO role involved:

    A. supervising entry and exit points

    B. monitoring entry and exit of guests

    C. escorting and supervising guests for outdoor exercise as directed by the Authorised Officer

    D. escalating issues to the hotel's Team Leader.[42]

27. RSOs reported to the Team Leader at each hotel, who was responsible for working with the relevant Authorised Officer.[43]

28. The proposal to use the Corrections Victoria workforce was based on its staff having skills in supervision, communication, de-escalation and conflict management, and on them being bound by the Victorian Public Service Code of Conduct, and skilled at maintaining professional boundaries.[44]

29. Use of that workforce necessitated engagement with the Community and Public Sector Union (CPSU) regarding its likely concerns about workplace health and safety and the need for robust risk assessment and management processes.[45] As was noted in subsequent CCC submissions, there was a risk that DJCS staff would contract COVID-19 as private security guards had, and there were information and briefing materials developed by Alfred Health and the DHHS Infection Prevention Cell, and statewide operating procedures designed to minimise that risk.[46]

30. The planning for this new workforce included 'robust recruitment processes, clear communication of expectations and roles, operating model design, high quality supervision and swift consequences for any misconduct and unacceptable behaviour'. These measures were intended to 'manage the risk of RSOs failing to provide more effective supervision than private security contractors, leading to more outbreaks'.[47]

31. Those proposing the model were alive to the risk that use of Corrections Victoria staff might create the perception that those in quarantine were being treated too forcefully and might raise issues with the *Charter of Human Rights and Responsibilities Act 2006* (Vic).[48]

11.3 Transfers of accountability

32. From 2 July 2020, Corrections Victoria assumed progressive responsibility for the first tier of enforcement at quarantine hotels (re-named 'supervision services'), while responsibility for the overall program remained with DHHS.[49]

33. On 9 July 2020, CCC was asked to approve a general shift in accountability, from the Minister for Health to the Attorney-General, for delivery of the Hotel Quarantine Program.[50] The Chief Health Officer was to advise the Minister for Health on all matters related to the COVID-19 response and the Attorney-General in relation to the Hotel Quarantine Program. The Chief Health Officer, Deputy Chief Health Officers and Authorised Officers would be subject to the directions and control of both the DHHS Secretary and the DJCS Secretary so far as the Hotel Quarantine Program was concerned.[51]

34. As part of that shift, DJCS assumed responsibility for:

    A. detention oversight

    B. management of health services through a contract with Alfred Health

    C. management of hotel services (including any incidents at hotels)

    D. coordination of the enforcement function provided by Victoria Police.[52]

35. This meant the transfer of contracts previously held by DJPR, which had been in the process of being transferred to DHHS,[53] went to DJCS.[54]

36. The three private security firms originally contracted by DJPR (all of whose contracts had expired on 30 June 2020)[55] were transitioned out by 11 July 2020,[56] and all returned travellers were consolidated to a reduced number of sites.[57] As of 10 July 2020, there was a pause on international arrivals into Victoria, so numbers in hotel quarantine were reducing, but other COVID-related accommodation needs were supplementing those numbers.[58]

37. On 27 July 2020, further changes were reported to CCC and a decision was made to transfer overall administrative responsibility for Operation Soteria from DHHS to DJCS.[59] This meant that the whole of the Program would lie with DJCS, with relevant administrative changes to make the Attorney-General responsible for relevant sections of the PHW Act. The change was part of the transfer of responsibility for all COVID-19 emergency accommodation to DJCS.

38. The Commissioner for Corrections was appointed as the Deputy State Controller Health — Soteria to report to the State Controller — Health and the Emergency Management Commissioner, and to be a member of the State Control Team.[60]

39. A feature of the new model was a different level of police presence when compared to the quarantine hotels prior to this pivot or remodelling. A request was made on 16 July 2020 by DHHS to Victoria Police to provide a 24/7 on-site enforcement presence.[61] This followed the assessment that the security services subcontracted by Alfred Health had demonstrated some of the same vulnerabilities identified in the private security guards contracted by DJPR, including insufficient training, poor communication, inappropriate subcontracting and a lack of understanding of infection control practices.[62]

40. Victoria Police agreed to the request. Noting that Victoria Police had never been formally asked to provide a 24/7 presence at the quarantine hotels, Chief Commissioner of Police (CCP) Shane Patton said that the decision to provide such a presence at the 'hot' or 'health' hotels was influenced by the fact that those in the hotels presented with particular vulnerabilities and a range of risks that elevated the requirement for police presence.[63] That presence took the form of controlling access and egress, having a presence in the foyer and having a mobile presence patrolling the floors in support of the customer support officers.[64]

41. At the request of the Inquiry, CCP produced and described, in evidence, the documentation developed to support the police presence.[65] He said that there had been a full risk assessment, which had led to the creation of detailed procedures to ensure member safety. They included a Senior Sergeant taking the role of Safety Officer, briefings for all members, written instructions for different roles and the delineation of 'green' and 'red' zones with training for contamination events and specific locations for decontamination.[66]

11.4 Implications of the pivot

42. Commissioner Crisp's evidence was that the pivot to allocate control functions for the Hotel Quarantine Program to DJCS reflected the overall scale of the required COVID-19 response rather than any suggestion that DHHS was not the right agency to have been given initial control.

> We got to a point with all these operations that one State Controller could not sit above so many Deputy State Controllers with a whole range of different operations. Some of them were escalated to the Secretary that DHHS has taken on. So part of that control piece is that span of control and, in my opinion, the Secretaries could not sit over all those operations.[67]

43. The Premier agreed, in evidence, that the three significant shifts made to the Hotel Quarantine Program reflected some of what had gone wrong in the Program as it was initially established.[68] It did not have a sufficient clinical focus. It did not have an appropriate workforce. Although under the control of DHHS in emergency management terms, its reliance on private contracts held by DJPR meant there was no single point of accountability.

44. However, instead of consolidating responsibility for all aspects of the Program in DHHS, the department responsible for public health and communicable disease, the decision was made to transfer it all to DJCS.[69] An initial decision to replace private security guards with Corrections Victoria workers became,[70] within the month, the wholesale removal of the Program from DHHS to DCJS as part of the transfer of all COVID-19 accommodation programs.[71]

45. That the Program was removed from DHHS, the department with public health expertise, and given to DJCS, a department with no such expertise, including relevant accountabilities under the PHW Act, leads me to conclude that there was a view within government that DHHS was not capable of running the Program on its own, at least at that time. References in CCC submissions to DJCS being the department best placed to have sole accountability and operational control of the Hotel Quarantine Program[72] underpins the inference I draw that the CCC formed a view that DHHS was not best placed to hold those functions.

46. Former Minister Mikakos, in effect, seemed to share this view in her evidence, commenting that the multi-agency response to the Hotel Quarantine Program meant there were 'too many cooks spoiling the broth'; that DHHS lacked the contractual levers with either the hotels or security contractors, which was a significant weakness in how the Hotel Quarantine Program had been structured. She provided support for the transition of the Hotel Quarantine Program to a single agency (DJCS) that would be responsible for running all aspects of the Program.[73]

47. Mr Eccles, when asked whether the pivot suggested that the Program should not have been placed with DHHS under the emergency framework, resisted that suggestion. His answer particularly related to workforce issues.

> I don't think it's as simple as saying everything would have been … everything would have been better if originally Corrections [Victoria] had been responsible for the program. I mean, it emerged over time what the particular complexities were with the cohorts of people who were being detained and the supervisory arrangements, and I think the skill set of Corrections Victoria staff, it became apparent that private security was facing particular challenges, the sort of skill set that Corrections Victoria staff have in managing complex individuals with vulnerabilities, their ability to de-escalate particular situations, which is a feature of the hotel quarantine experience, so it's less about Corrections Victoria per se and more about the skill set of the workforce that is fit for a contemporary purpose. I wouldn't want to go back and use that as the basis for saying that there was an error in the original … the original arrangement.[74]

48. Inconsistent with this answer was the fact that Corrections Victoria recruited significant numbers of new staff for the Hotel Quarantine Program rather than using existing workers.[75] As of 9 July 2020, only 100 of the estimated 1,000 workers needed had come from inside Corrections Victoria, with recruitment from furloughed airline workers and other COVID-affected workforces also in train.[76] This suggested that it was not, in fact, a specific Corrections Victoria skill set that was required.

49. The decision to replace private security guards with RSOs[77] — a change in title while leaving the duties largely unchanged — reflected the extent to which the role played by private security guards had been well outside the scope of usual static guarding.

50. As set out in Chapter 6, the role creep that occurred in the duties assigned to security guards, plus the range of other issues identified in Chapter 6, meant that the roles they ultimately performed, in the absence of a clear supervisory structure and proper training, were not suited to such personnel. It was not reasonable to assume, with the tasks they had gradually thrust upon them, that those trained as static security guards would have the skill set and training necessary to work in this complex and dangerous environment. The submissions in June and July 2020 to CCC recognised the true nature of the role and the skill set required.[78]

51. A clear conclusion to draw from the pivot is that it was designed to provide for a greater degree of direct supervision and control exercised by the responsible department (DJCS) over those working in the Program. With RSOs being government employees, and Alfred Health providing services pursuant to a contract administered by DJCS,[79] none of the issues of subcontracting or contract management by different departments would arise. The Government, through DJCS, retained direct control over service delivery and was directly accountable for the safety of those in quarantine.[80] Whereas, in the initial model, security guards, nurses and cleaners were hired by and, in the first instance, accountable to external contractors, the model after the pivot created a line of control within government; for instance, there were team leaders for all RSOs, who were, themselves, government employees, rather than team leaders being security contractors or subcontractors.

52. The anticipated and actual involvement of unions in the planning of the new model — there were multiple references in the CCC submissions to the importance of consultation with the CPSU, the Transport Workers Union and the Police Association[81] — reflected the greater degree of concern attached to workplace health and safety for those government employees than appeared to have been the case when planning for workplaces that were to be largely staffed by private contractors.[82] Rather than contracting out responsibility for training and PPE, the Government retained that responsibility. The hotel environment, after the pivot, became a safer workplace for those working in it, and this was, in part, attributable to the higher expectations — enforced where appropriate by union engagement — that government employees have of their employers.

53. The decision to place Victoria Police in a 24/7 role in the health hotels occurred in the context of the hotels housing COVID-positive people from a range of community locations, including public housing towers, which were locked down in early July 2020 as the pivot in the Hotel Quarantine Program was taking place.[83] In fact, any cohort of future returning travellers and international arrivals going into quarantine will be a diverse cohort and will, as the evidence of expert trauma psychologist, Dr Rob Gordon, suggests (see Chapter 12.2) include a substantial percentage of people with additional needs or vulnerabilities.[84] This suggests a role for Victoria Police in any future iteration of a Hotel Quarantine Program.

54. Whether enforcement in any future model is provided by police members or not, the model of operating instructions used for Victoria Police members provides a guide to the level of detail required in the operating procedures for a future enforcement workforce. That degree of detail and rigour ought to have been present in the instructions provided to private security guards. As set out in chapters 6 and 7, the Government took inadequate steps to ensure the safety of contractors working in the Hotel Quarantine Program, with heavy reliance on contractors to supervise themselves and obtain their own advice and develop their own safe systems of work. Whether a future quarantine model uses private contractors or not, there should be no departure from the principle that it is for the State to set, and to enforce, proper training and infection prevention and control measures for all those working in the system. This must be done to provide the safest system possible for workers at quarantine hotels, the people in quarantine and, thereby, the entire community.

55. The changes made to the Hotel Quarantine Program in June and July 2020 reflected deficiencies in the operating model that were apparent from much earlier than June 2020. The changes indicated that those deficiencies, once identified, were capable of being addressed.

56. DHHS had identified the need for a greater clinical focus but was slow to bring that focus to all of the hotels.[85] By late June, after the second outbreak, only one hotel — the Brady — was operating under the Alfred Health model.[86] An approach to Alfred Health could have been made sooner and the training and clinical governance developed by Alfred Health implemented more broadly than at one hotel.

57. In particular, the decision made by DHHS, in late June, to seek an alternative workforce to replace private security[87] indicated that DHHS had the power and authority to make that decision and could have done so earlier, either by consultation with DJPR or by having the contracts transferred to DHHS.

11.5 Conclusions

58. Notwithstanding the various explanations and justifications given in evidence, the Government's decision to remove the operation of this public health program (Hotel Quarantine) away from the department responsible for public health, DHHS, leads me to conclude that the Government formed a view by July 2020 that a single department needed to run the Program, and that it did not have confidence that DHHS was capable of running the Program on its own at that time.

59. The pivot created a governance framework whereby DJCS had clear and direct supervision and control over — and accountability for — those working within the Program, compared to the fragmentation and obfuscation of responsibility in the earlier iteration of the Program.

60. DHHS was slow to realise it needed to bring a greater clinical focus to the Hotel Quarantine Program. It was aware of, at least, some of the deficiencies in the Hotel Quarantine Program well before June 2020; it could and should have remedied them sooner.

61. By late June, after the second outbreak, only one hotel — the Brady — was operating under the Alfred Health model. An approach to Alfred Health could have been made sooner and the training and clinical governance developed by Alfred Health implemented more broadly than at one hotel.

62. The decision made by DHHS, in late June, to seek an alternative workforce to replace private security indicated that DHHS had the power and authority to make that decision and could have done so earlier, either by consultation with DJPR or by having the contracts transferred to itself.

    A. Replacing private security guards with RSOs employed, trained and supervised by Corrections Victoria reflected and confirmed that privately contracted security guards were not the appropriate cohort to provide the roles that had expanded over time in the complex environment of the Hotel Quarantine Program.

    B. Whereas, in the initial model, security guards, nurses and cleaners were hired by and, in the first instance, accountable to external contractors, the model after the pivot created a line of control within one government department rather than a structure that conceived of each on-site contractor or agency supervising itself.

    C. The hotel environment after the pivot was a safer environment in which to work, due, in part, to greater attention to workplace safety following the engagement of a cohort with higher expectations of workplace rights and safety.

63. The 24/7 police presence at the health hotels recognised the value of a trained, salaried security presence that had supervised occupational health and safety operating procedures as required by a strong industrial advocate in the Police Association, and a recognition by Victoria Police of the need for worker safety operating procedures.

64. In the development of this 'health' model, there were multiple references in the CCC submissions to the importance of consultation with the CPSU, the Transport Workers Union and the Police Association. The involvement of unions and industrial advocates in the planning of the new model reflected the far greater degree of concern attached to workplace health and safety.

Endnotes

1 Exhibit HQI0177_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0012.0001.0464, DPC.0008.0001.3213.
2 Ibid DPC.0012.0001.0464.
3 Ibid.
4 Exhibit HQI0218_RP Witness statement of the Hon. Daniel Andrews MP, 1 [2], 2 [5]; Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 28 [63].
5 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0012.0001.0835.
6 Ibid DPC.0012.0001.0837.
7 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 49 [254]; Exhibit HQI0211_P Witness statement of the Hon. Jenny Mikakos, former MP, 5 [27]; Administrative Arrangements Order (No. 236) 2020, <https://resources.reglii.com/VGG.2020.7.9.S347.pdf/>.
8 Exhibit HQI0211_P Witness statement of Hon. Jenny Mikakos, former MP, 5 [26]; Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0012.0001.0464.
9 Exhibit HQI0130_RP Witness Statement of Ms Pam Williams, 24 [51].
10 Exhibit HQI0099_RP Witness Statement of Ms Simone Alexander, 10–12 [41]–[50].
11 Board of Inquiry into the COVID-19 Hotel Quarantine Program (Interim Report, 6 November 2020) 13 <https://www.quarantineinquiry.vic.gov.au/reports>.
12 Exhibit HQI0099_RP Witness Statement of Ms Simone Alexander, 2 [11]–[12]; Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0001.0001.6545–6546.
13 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0012.0001.0534.
14 Transcript of day 14 hearing 8 September 2020, 1042.
15 Exhibit HQI0211_P Witness statement of the Hon. Jenny Mikakos, former MP, 5 [25].
16 Ibid; Exhibit HQI0212_RP Annexures to the witness statement of the Hon. Jenny Mikakos, former MP, MIK.0144.0002.0001.
17 Exhibit HQI0180_RP Annexures to second witness statement of Mr Christopher Eccles, DPC.0014.0001.0004.
18 Exhibit HQI0179_RP Second witness statement of Mr Christopher Eccles, 4 [19]; Transcript of day 21 hearing 21 September 2020, 1772.
19 Exhibit HQI0180_RP Annexures to second witness statement of Mr Christopher Eccles, DPC.0014.0001.0004.
20 Ibid.
21 Transcript of day 21 hearing 21 September 2020, 1773.
22 Transcript of day 25 hearing 25 September 2020, 2150–2151.
23 Exhibit HQI0125_RP Witness statement of Ms Melissa Skilbeck, 10–11 [60]–[65].
24 Exhibit HQI0126(1)_RP Annexures to witness statement of Ms Melissa Skilbeck, DHS.0001.0001.2236.
25 Transcript of day 25 hearing 25 September 2020, 2152.
26 Exhibit HQI0180_RP Annexures to second witness statement of Mr Christopher Eccles, DPC.0018.0001.0002–0003.
27 Ibid DPC.0014.0001.0006. See also Transcript of day 21 hearing 21 September 2020, 1778.
28 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 6 [12(j)].
29 Ibid 29 [69]; Transcript of day 17 hearing 15 September 2020, 1389.
30 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 29 [69]–[70].
31 Exhibit HQI0142_RP Voluntary submission from the Commonwealth of Australia, HQI.0001.0002.0147–0148.
32 Exhibit HQI0148_RP Annexures to third witness statement of Commissioner Andrew Crisp, DOJ.515.001.0033–0034, DOJ.515.001.0018–0019.
33 Transcript of day 23 hearing 23 September 2020, 1958–1959.
34 Ibid 1960.
35 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 29 [71].
36 Exhibit HQI0180_RP Annexures to second witness statement of Mr Christopher Eccles, DPC.0018.0001.0006.
37 Ibid DPC.0020.0001.0031–0032.
38 Ibid DPC.0020.0001.0031.
39 Ibid DPC.0020.0001.0032.
40 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0012.0001.0463, DPC.0008.0001.3213.
41 Ibid DPC.0012.0001.0468–0469.
42 Ibid DPC.0012.0001.0536.
43 Ibid DPC.0001.0001.6541.

44 Ibid DPC.0012.0001.0468.
45 Ibid DPC.0012.0001.0472.
46 Ibid DPC.0012.0001.0545.
47 Ibid DPC.0012.0001.0546.
48 Ibid DPC.0012.0001.0546, DPC.0012.0001.0548.
49 Ibid DPC.0012.0001.0532.
50 Ibid DPC.0012.0001.0532; Exhibit HQI0177_RP First witness statement of Mr Christopher Eccles, 13 [51(g)].
51 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0012.0001.0535.
52 Ibid DPC.0012.0001.0534.
53 Ibid DPC.0001.0001.5282.
54 Ibid DPC.0012.0001.0835; Exhibit HQI0195_RP Witness statement of the Hon. Martin Pakula MP, 5–6 [26]–[27].
55 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 21 [101].
56 Exhibit HQI0069_RP Witness statement of Mr David Millward, 13–14 [79]; Exhibit HQI0061_RP Witness statement of Mr Gregory Watson, 25 [102]; Exhibit HQI0065_RP Witness statement of Mr Jamie Adams, 15 [109].
57 Exhibit HQI0178_RP Annexures to witness statement of Mr Christopher Eccles, DPC.0001.0001.6542.
58 'Information for overseas travellers' Coronavirus (COVID-19) Victoria (Web Page, 4 December 2020) <https://www.coronavirus.vic.gov.au/information-overseas-travellers#cap-on-international-arrivalsnbsp>.
59 Exhibit HQI0178_RP Annexures to witness statement of Mr Christopher Eccles, DPC.0012.0001.0835, DPC.0012.0001.0832; Exhibit HQI0177_RP First witness statement of Mr Christopher Eccles, 14 [51(h)].
60 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0012.0001.0838.
61 Exhibit HQI0170_RP Annexures to witness statement of Chief Commissioner Shane Patton, APM VPOL.0005.0001.1276.
62 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0012.0001.0842.
63 Transcript of day 19 hearing 17 September 2020, 1653–1654.
64 Ibid 1657.
65 Exhibit HQI0171_RP Victoria Police safety officer instructions.
66 Transcript of day 19 hearing 17 September 2020, 1657.
67 Transcript of day 17 hearing 15 September 2020, 1392.
68 Transcript of day 25 hearing 25 September 2020, 2165.
69 Exhibit HQI0195_RP Witness statement of the Hon. Martin Pakula MP, 5 [24].
70 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0008.0001.3213, DPC.0012.0001.0463.
71 Ibid DPC.0012.0001.0835.
72 Ibid DPC.0001.0001.6538.
73 Exhibit HQI0211_P Witness statement of the Hon. Jenny Mikakos, former MP, 5 [26].
74 Transcript of day 21 hearing 21 September 2020, 1783.
75 Exhibit HQI0178_RP Annexures to First witness statement of Mr Christopher Eccles, DPC.0012.0001.0538–0539.
76 Ibid.
77 Exhibit HQI0215_RP Initial Responses of Parties, DOJ.516.001.0006–0007.
78 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0008.0001.3213–3214, DPC.0001.0001.6536–6552, DPC.0012.0001.0832–0833.
79 Exhibit HQI0099_RP Witness statement of Ms Simone Alexander, 20 [72]–[73].
80 Exhibit HQI0177_RP First witness statement of Mr Christopher Eccles, 14 [51(h)].
81 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0001.0001.6552, DPC.0012.0001.0854.
82 Transcript of day 26 hearing 28 September 2020, 2216.
83 Exhibit HQI0169_RP Witness statement of Chief Commissioner Shane Patton APM, 10 [4.6]; Transcript of day 19 hearing 17 September 2020, 1652–1654.
84 Exhibit HQI0176_P Witness statement of Dr Rob Gordon; Transcript of day 20 hearing 18 September 2020.
85 Transcript of day 14 hearing 8 September 2020, 1040–1041; Exhibit HQI0099_RP Witness statement of Ms Simone Alexander, 2 [12].
86 Ibid 2 [10]–[11].
87 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 49 [254], 52 [271]–[272].

CHAPTER 12

Building consideration of returned travellers' rights and welfare into a future program

1. This chapter analyses whether and how the rights and welfare of returned travellers were approached in the Hotel Quarantine Program and considers how a future quarantine program could be strengthened in this regard. It comprises two sections:

    A. **Section 12.1** — discusses the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (Charter) and its application to the Hotel Quarantine Program during its establishment. It also considers whether there may be less restrictive measures to combat the threat of COVID-19 entering the community

    B. **Section 12.2** — highlights the psycho-social impacts of quarantine on returned travellers and how a future program can better support the health and wellbeing of returned travellers during their quarantine period.

12.1 The Victorian Charter of Human Rights and Responsibilities

12.1.1 The relationship between mandatory quarantine and the *Charter of Human Rights and Responsibilities Act 2006* (Vic)

2. The existence of the Charter has relevance to the Hotel Quarantine Program. It was not contentious that compelling people to undertake 14 days in a quarantine facility had obvious and significant impacts on their rights and liberties. As the Premier explicitly recognised in his 27 March 2020 media conference:

> It's a big step to take away someone's liberty — in effect to make them go to a certain place and stay there for two weeks — but this is life and death. There's too much at stake to do otherwise.[1]

3. The principle that mandatory quarantine was an acceptable public health response to a pandemic such as this was also not in dispute during the Inquiry.

4. Nor was it in dispute that the Charter was applicable to the actions of the Victorian Government, such as it related to the decision to issue the Direction and Detention Notice (Direction) mandating people into the Hotel Quarantine Program.

5. Whether there was compliance with the rights protected under the Charter was not a matter over which this Inquiry had any jurisdiction. However, given that those various government officials engaged in decision-making central to the Hotel Quarantine Program were bound to make their decisions in accordance with the Charter, it would have been unfair and artificial to ignore the considerations they were required to observe. It was for this reason that some attention was paid to the Charter.

6. The second purpose for consideration of the Charter was its contextual relevance to recommendations for the features of a future Quarantine Program as contained in the Interim Report, which I adopt in this Final Report.

12.1.2 The application of the Charter in this context

7. The Charter's main purpose is to protect and promote human rights, including by setting out rights that the Victorian Parliament specifically seeks to protect and promote,[2] and by imposing an obligation on all public authorities to act in a way that is compatible with these rights.[3]

8. It was important, therefore, to identify those rights protected by the Charter, insofar as they were particularly relevant to the Hotel Quarantine Program, before turning to how public authorities must act compatibly with them.

9. The rights protected are set out in Part 2 of the Charter. Importantly, for the Hotel Quarantine Program, those rights are not without limitation. Rights under the Charter may be limited in accordance with s. 7(2) of the Charter. That is, they may be subject, under law, only to such reasonable limits as can be demonstrably justified in a free and democratic society, based on human dignity, equality and freedom, taking into account all relevant factors.[4] Those factors include:

    A. the nature of the right

    B. the importance of the purpose of the limitation

    C. the nature and extent of the limitation

    D. the relationship between the limitation and its purpose

    E. any less restrictive means reasonably available to achieve the purpose of the limitation.[5]

12.1.3 Several relevant rights are protected by the Charter

10. In the context of a mandatory quarantine program, intended to stop the transmission of an infectious disease into the Victorian community by restricting the movement and ability of returned travellers to go about their ordinary lives, six Charter rights are particularly important. They are set out below.

A person has a right to life

11. Section 9 of the Charter provides that every person has the right to life and the right not to be arbitrarily deprived of life.[6] The Victorian Government has an obligation to give proper consideration to the right to life of all persons when making its decisions.[7] A mandatory quarantine program, designed to protect the lives of Victorians, necessitates consideration of that right.

A person has a right to liberty and security of person

12. Section 21 of the Charter provides that:

    A. every person has the right to liberty and security

    B. a person must not be subjected to arbitrary arrest or detention

    C. a person must not be deprived of his or her liberty except on grounds, and in accordance with procedures, established by law.

13. Quarantining involves a person's detention and, thus, a restriction of their liberty. A person's rights under s. 21 may be limited, but only where their detention is not arbitrary, is done in accordance with the law, and the limitation is reasonable and proportionate in all the circumstances, consistent with s. 7(2) of the Charter.

14. Section 200(6) of the *Public Health and Wellbeing Act* (Vic) (PHW Act) requires a review, every 24 hours, of the decision to detain a person to ascertain whether the continued detention is reasonably necessary. Failure to conduct such a review may render the detention unlawful for the purposes of s. 21 of the Charter.

15. The issue of *how* those reviews were conducted during the period of the Hotel Quarantine Program was the subject of some evidence before the Inquiry and the subject of some closing submissions as to whether there was or was not compliance with the Charter. DHHS, in its closing submissions, took exception to the issue being raised, but addressed it in any event.[8]

16. DHHS submitted that the reviews were based on the medical advice of the Chief Health Officer (CHO) and the Deputy Chief Health Officer (DCHO) that returned travellers should spend 14 days in quarantine on the basis of what was understood about the incubation period of the virus. Thus, the review was constituted by checking as to whether or not a returned traveller had completed his or her 14 days. DHHS provided various memoranda it had received containing legal advice on this issue that appear to support its submission and are summarised below.

17. A DHHS memorandum from Jacinda de Witts, Deputy Secretary, Legal and Executive Services Division and General Counsel to DHHS, to Dr Annaliese van Diemen, DCHO, dated 28 March 2020 (and signed by Dr Van Diemen on the same date), noted that the Legal Services Branch had assessed that the Isolation (International Arrivals) Detention Notices were compatible with the Charter.[9]

18. Part B of the same memorandum contained a section called 'Charter Assessment' and contemplated the human rights considerations in paragraphs 8–13 therein. For example, paragraph 9 told Dr van Diemen that her decision to sign the Isolation (International Arrivals) and Detention Notices would be compatible with the Charter.[10]

19. Paragraph 10 went on to identify eight rights impacted by the Detention Notices. These were:

    A. section 21 — right to liberty

    B. section 12 — freedom of movement

    C. section 14 — freedom of religion

    D. section 19 — cultural rights

    E. section 16 — freedom of peaceful assembly and association

    F. section 13 — rights to privacy, family and home

    G. section 17 — protection of families and children

    H. section 22 — right to humane treatment when deprived of liberty.[11]

20. Paragraph 12 stated that the Detention Notices were compatible with the human rights in the Charter.[12]

21. There was also Attachment D (12 pages) that detailed DHHS's assessment of human rights issues arising from the Detention Notices,[13] and Attachment C6 (14 pages), which was another memorandum of legal advice, summarising the human rights considerations related to individual Detention Notices.[14]

22. Also, in the bundle was an email from Rowena Orr QC of Counsel to Ms de Witts, dated 28 March 2020, saying that the Notice 'likely amounts to detention' and that the presence of police and military reinforced the idea that people required to stay in hotels were in some sort of 'custodial' setting.[15]

23. A further email from Sarala Fitzgerald of Counsel, dated 28 March 2020, to Ms de Witts referred to the 24-hourly review and what would be required for the purposes of s. 200(6) of the PHW Act. She suggested that, to satisfy this requirement, the authorised officer must ask themselves: 'is the continued detention of this person reasonably necessary to eliminate or reduce a serious risk to public health?' She stated that this was a simple question based on medical advice and need not be time consuming. She then suggested the review could be completed by simply appraising information on a database.[16]

24. For the reason contained in paragraph 4 above, that is, that I have no jurisdiction to rule on compliance or otherwise with respect to the Charter, I go no further on that point. I raise these matters to give an example of how DHHS gave consideration to this Charter right when making decisions as to detention.

A person deprived of liberty must be treated humanely

25. Under s. 22(1) of the Charter, all people deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person.

26. It could hardly be contentious that the Hotel Quarantine Program deprived people of their liberty. A person in quarantine should not be subject to any hardship or constraint in *addition* to that resulting from the deprivation of their liberty.[17]

27. Self-evidently, those conditions can include the nature of the accommodation itself, facilities for personal hygiene, opportunities for exercise, access to fresh air breaks and availability of medical and general health services. The conditions faced by individuals in quarantine should take into account any particular vulnerabilities of those in detention.

A person has a right to move freely

28. Section 12 of the Charter provides that every person lawfully within Victoria has the right to move freely within Victoria, and to enter and leave it, and has the freedom to choose where to live.

29. Clearly, a person's freedom of movement is restricted where they are required to quarantine within a particular hotel room. Whether or not the restriction is reasonable and proportionate so as to be justifiable under s. 7(2) of the Charter depends upon consideration of all of the circumstances.

A person has the right to freedom of conscience and religion

30. Section 14(1) of the Charter gives every person the right to freedom of thought, conscience, religion and belief, including the freedom to demonstrate his or her religion or belief in worship, observance, practice and teaching, either individually or as part of a community, in public or in private.[18]

31. Self-evidently, the ability of a person in hotel quarantine to participate in a religious life is restricted when they cannot attend face-to-face expressions of their religion. The right to observe or practice their beliefs within their rooms may also be restricted where they are not afforded the opportunity to observe customary dietary regulations.[19]

A person has rights to privacy, family and a home

32. Section 13(a) of the Charter provides that a person has the right to not have his or her privacy, family, home or correspondence unlawfully or arbitrarily interfered with. 'Privacy' is a broad term, which must relate to the autonomy and inherent dignity of the person.[20]

33. The private life of a person who is quarantined within a hotel is limited because it restricts the person's ability to go about their private lives; so, too, is their right to home limited where they are required to live in a hotel room and prevented from living in their home.[21]

34. Other Charter rights, as noted in the summary extract of advices to DHHS, are relevant to the Hotel Quarantine Program, such as:

    A. cultural rights under s. 19

    B. freedom of peaceful assembly and association under s. 16

    C. protection of families and children under s. 13

    D. protection from treatment or punishment in a cruel, inhuman or degrading way under s. 10(b).

12.1.4 Public officials are required to act and make decisions that are compatible with human rights

35. Each public official, including the DCHO, relevant departmental employees and Authorised Officers, is subject to the obligations imposed on public authorities by the Charter.[22]

36. Section 38(1) of the Charter states that it is unlawful for a public authority to act in a way that is incompatible with a human right or, in making a decision, to fail to give proper consideration to a relevant human right. This obligation is not limited to individual decisions relating to individual people; it extends to policy or program design where there is a potential impact on the Charter rights of a class of people.[23]

Are there less restrictive means to achieve the purpose of quarantine?

37. The need for public health measures, including quarantining, to limit the spread of the virus that affected the rights of all Victorians, was not in question before the Inquiry. Compulsory quarantining of people impacts Charter rights. What the Charter requires, among other considerations, is that the limit on rights is reasonable and proportionate. Of critical importance to the proportionality test is the existence of 'any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve' at s. 7(2)(e) of the Charter.

38. I accept the evidence of the DCHO that, in contemplating whether the detention orders would be compatible with human rights under the Charter, she considered a number of factors relevant to the purpose of the quarantine program including, by way of summary:

    A. The exceptional circumstances in which the Direction was proposed to be made. That is, there was a continued widespread international outbreak of a viral pandemic for which there was no current vaccine or cure.[24]

    B. The Direction purported to minimise community exposure to COVID-19 and prevent or, at the very least, reduce the risk of the Victorian health system becoming overwhelmed with COVID-19 cases.[25]

    C. It was considered that, on the available medical evidence, it was the 'least restrictive means reasonably available to stem the spread of [COVID-19], particularly since less restrictive measures for international arrivals failing to self-isolate in their homes for 14 days — in clear defiance of previous directions — had caused the further spread of the virus'.[26]

39. Two observations may be made from the decision to give the Direction:

    A. The purpose of the limitation on people's rights (that is, to stop transmission of COVID-19 to the community) and the nature of the rights under the Charter were considered in general terms and without specific consideration to individual needs or circumstances, including health and wellbeing needs. It was understood that this was because the decision was made with respect to a cohort and the threat that was being posed to the rights of all the people of Victoria.

    B. It was understood, on the evidence, that it was not possible or practical, in the circumstances of the initial onslaught of hundreds of people arriving in planes and, potentially, threatening a major spread of the virus, to give proper and individual consideration to less restrictive measures for individual travellers at that time.

Concern about non-compliance with self-isolation directions

40. As I set out in the Interim Report, in particular at Sections 2.7 and 2.8, a key consideration in the decision to direct mandatory hotel quarantining was concern about the levels of non-compliance with the self-isolation orders under the Non-Essential Mass Gatherings and Self-Quarantine following Overseas Travel Directions[27] but, more significantly, those of the Airport Arrivals Direction of 18 March 2020.[28]

41. For clarity, references to 'self-isolation orders', 'home-detention' and 'home quarantine requirements' in this section are used to mean those orders and directions that were issued to returned travellers to isolate at home, as distinct from orders and directions that were applicable to other cohorts of the Victorian community; for example, those required to self-isolate at home due to testing positive for COVID-19 or for being a close contact of a positive case or awaiting the outcome of test results.

42. The Inquiry heard evidence about instances of non-compliance with such orders and directions,[29] but there was no empirical data provided as to the scale of non-compliance. Instead, evidence was provided regarding a lack of confidence in the compliance of returned travellers isolating at home,[30] being that they not only 'stay in their own home, but (that) others do not come within 1.5m of them, and actually further isolated'.[31] This lack of confidence was based on 'a significant amount of public commentary concerning the non-compliance of self-isolation [and] the observation by other jurisdictions and the discussion around AHPPC of significant non-compliance in their own jurisdictions'.[32] Dr van Diemen outlined that 'we had a reasonable amount of evidence, albeit over a short period of time, that people were not adhering to the home quarantine requirements as strictly as we needed them to do'.[33]

43. This evidence led to a view, understandably held by Dr van Diemen at the time she formed her opinion, that returned travellers were not complying with self-isolation orders.[34]

44. Dr van Diemen gave evidence that she had given thought to issuing individualised notices detaining people in their own homes under the threat of a $20,000 fine.[35] However, it appears that this option was not pursued because there was a close to (if not equal) fine associated with existing orders, which did not appear to have deterred a number of people from breaching the order[36] and Dr van Diemen had already formed the view, at that particular time, that she agreed with the requirement for hotel quarantine as opposed to home-based quarantine.[37] Dr van Diemen understood there were a number of people not complying with home-detention, based on intelligence gained through contact tracing.[38]

45. As noted in the Interim Report (at page 74) the former Chief Commissioner of Police, Graham Ashton, gave evidence about Victoria Police's reports of returned travellers' non-compliance with home-quarantine orders. He said:

> … there were regular occasions when people were found not to be home when they were checked upon and that we then had to go through [an] exercise of locating them, working out where in fact they were when they were supposed to be at home. I should add that in many occasions people were isolating but they weren't isolating at the place where the Australian Border Force thought they were going to be, and so we had to adjust records, et cetera, and try and clean the data a lot on where people actually were. But there were levels of non-compliance as well.[39]

46. Despite those identified levels of non-compliance, Mr Ashton could not recall being asked for his view about the sufficiency of home quarantine as a model for dealing with people who were being required to isolate.[40]

12.1.5 Future options: home quarantine model and the Charter

47. I accept the evidence of Dr van Diemen that, in making the mandatory detention orders, she did give serious and proper consideration to her Charter obligations, in the circumstances, and she assessed her obligations with the evidence available to her at that time.

48. While it is accepted there were extraordinary pressures and concerns impacting upon the decision to impose the mandatory Hotel Quarantine Program in the circumstances of March 2020, a more considered and orderly approach to finding measures that are the least restrictive should now be properly undertaken for the next iteration of a quarantine program for returning travellers.

49. I adopt the recommendations made in Section 2 of the Interim Report regarding the option of a home-based quarantine model.

50. Mandatory home quarantine or a hybrid model involving initial reception into a quarantine hotel for a form of 'triage', taking into account all relevant factors for each returned traveller, with increased compliance mechanisms, should be given consideration, consistent with Charter requirements.

51. Such a model may also be, at least, as effective at achieving the objective of containing the virus, balancing the Charter obligations with the need to protect the health and wellbeing of all Victorians.

12.1.6 Recommendations

52. Recommendations 58–69 in Section 2 of the Interim Report apply to this Section. For reference, the recommendations are listed below.

Recommendations 58–69 of the Interim Report

HOME-BASED QUARANTINE AS AN OPTION

58. In conjunction with a facility-based model program for international arrivals, the Victorian Government develops the necessary functionality to implement a supported home-based model for all international arrivals assessed as suitable for such an option.

CONTROL ON NUMBERS ARRIVING

59. The Victorian Government does all things possible to ensure that appropriate controls are put in place to limit the number of international arrivals at any given time to make the necessary individual engagement and assessment for a home-based model practical and achievable.

ASSESSMENT OF RISK FACTORS FOR HOME QUARANTINE

60. The Victorian Government engages the appropriate expertise to develop a list of risk and protective factors to be used in the assessment of individual suitability for the home-based model.

61. To assist the Chief Health Officer and Authorised Officers in making such assessments, the Victorian Government engages personnel with the appropriate expertise and training, supported by the necessary resources, to support the Chief Health Officer and Authorised Officers to apply those risk factors to the individual circumstances of international arrivals.

62. The Victorian Government ensures that the Chief Health Officer and Authorised Officers are provided with the capacity and necessary resources to efficiently confirm the accuracy of information being provided for individual assessments of international arrivals.

INDIVIDUAL ENGAGEMENT

63. The Victorian Government takes all necessary steps to address the language and cultural needs of all international arrivals to ensure that accurate information is both obtained for assessment purposes and received and understood by the person subject to the Home Quarantine Directions.

64. The Victorian Government takes all reasonable steps to assess and provide any reasonable supports that may assist an individual or family to quarantine at home.

CONDITIONS OF HOME QUARANTINE DIRECTIONS ACCEPTED IN THE FORM OF A PERSONAL UNDERTAKING

65. Accepting the need to do all things necessary to mitigate against the risk of non-compliance with a Home Quarantine Direction made by the Chief Health Officer or Authorised Officer, the Chief Health Officer or Authorised Officer could consider making the Home Quarantine Direction conditional upon the eligible person entering into a written undertaking, which could contain specific requirements that they must agree to, including (but not limited to):

    A. to submit to such COVID-19 testing during the period of home quarantine as is specified by the Chief Health Officer or Authorised Officer

    B. to allow such people as are required to carry out such testing to enter the premises at which the person is detained to conduct such testing

    C. to provide during the period of detention such information as is reasonably required by the Chief Health Officer or Authorised Officer in order to review whether their detention continues to be reasonably necessary.

66. Further, to underscore the gravity of any non-compliance, such an undertaking or agreement could also include an assurance from each person (over the age of 18 years) that they understand and agree to comply with each of the conditions of their quarantine and have understood the penalties that apply to any breaches.

MONITORING AND COMPLIANCE

67. The Victorian Government considers enhancing the range of methods for monitoring compliance with Home Quarantine requirements, such as electronic monitoring using smart phone technology and the use of ankle or wrist monitoring systems.

PENALTIES FOR NON-COMPLIANCE

68. The Victorian Government, in recognition of the risks to public health associated with any non-compliance with the Home Quarantine Directions, considers whether the current penalty regime is sufficiently weighted to enforce compliance.

69. The Victorian Government, in recognition of the risks to public health associated with any non-compliance with the Home Quarantine Directions, considers whether an offence should be created to apply to any person who knowingly enters a place where a person has been directed to Home Quarantine, unless that person has been authorised by the Chief Health Officer or Authorised Officer to do so.

12.2 Psycho-social impacts of quarantine on returned travellers

70. To confine a person within a hotel room for a period of 14 days (even with some breaks) is to significantly interfere with a person's normal life. For those who have not been subject to such quarantine, it may be difficult to imagine the impact such an experience would have on their social and private lives, as well as their physical and mental wellbeing.

71. It should not be forgotten that, while the Hotel Quarantine Program aimed to protect the Victorian community from the risk of COVID-19 virus transmission, at its heart, it involved people whose freedoms were suspended while they had no choice but to remain detained at their assigned hotels.

72. Within the context of such a large and unplanned program, it was always going to be a challenging task to meet the needs of people who had specific requirements or vulnerabilities. The standards and processes for the health and wellbeing of those detained were, therefore, matters that required a commensurate level of care and attention.

73. This section highlights how such a program might — and did — impact the wellbeing of those within it, so that potential psycho-social impacts can be considered and incorporated into any future model of mandatory hotel or facility-based quarantine.

74. More than 20,000 people went through the Hotel Quarantine Program in Victoria.[41] No doubt, the experience of returned travellers in the Hotel Quarantine Program and its impact varied greatly.

75. The Inquiry, of course, did not hear about the experience of every one of those returned travellers or, indeed, even a significant proportion of them. The Inquiry did, however, hear evidence from some returned travellers during its public hearings; moreover, it received information from people who contacted the Intake and Assessment Team to take the opportunity to speak about their experience otherwise than as formal witnesses.

76. The Inquiry heard evidence from Safer Care Victoria, the peak State authority for quality and safety improvement in healthcare.[42] Safer Care Victoria produced two reports that identified significant shortcomings in the health and welfare aspects of the Hotel Quarantine Program, and that recommended better onboarding processes to understand the needs of those undertaking quarantine.[43]

77. The Inquiry heard evidence from those working in various roles across the Program, such as Nurse Jen, who observed that returned travellers 'who had no particular health needs and who were tech-savvy did okay in quarantine'.[44] However, she thought others, particularly those with health concerns — even minor ones — had a more challenging time.[45]

78. Quiet compliance does not necessarily mean the Program did not have an impact on individuals within it. The Inquiry heard evidence on this matter, and the ways in which quarantine might have impacted on returned travellers, from experienced trauma psychologist, Dr Rob Gordon, whose evidence was not challenged.

79. Dr Gordon stated that compliance can be a reflection of our culture and of the confidence or trust most people have in the authorities. According to Dr Gordon, research demonstrates that people will often subject themselves to high levels of stress, for long periods of time, for a variety of reasons personal to them. In other words, compliance does not necessarily reflect a lack of impact on an individual.[46]

80. It was clear from some of the evidence that some returned travellers found the hotel quarantine experience stressful, given the necessary denial of the usual freedoms that returning travellers would otherwise have in their day-to-day lives. The experience of hotel quarantine had a negative emotional and psychological impact in respect of some returned travellers.

Figure 12.2.1: Quotes from returned travellers about their experience in the Hotel Quarantine Program

Returned Traveller 3: Being detained at the hotel was a degrading and dehumanising experience for me. I contacted the Inquiry to share my experience in the hope I can spare other people such needless pain and grief.

Returned Traveller 4: It was honestly the worst 2 weeks of my life!!!

Returned Traveller 5: I wasn't mentally strong enough to deal with hotel quarantine.

Returned Traveller 9: I knew it would be difficult, but I felt that we were being 'incarcerated' and we had 'no rights'.

Returned Traveller 11: I felt like a prisoner, not someone in quarantine. My experience was that hotel quarantine felt like jail: you are locked in your room 24 hours a day, I had one 10-minute fresh air session in 14 days, and I had no choice on what to eat.

Returned Traveller 12: I am now being treated by my GP for the trauma I experienced whilst away and in quarantine and am still trying to deal with the way the general community treats a person who has been COVID positive.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

12.2.1 A proportion of people in quarantine will be vulnerable and require particular support

81. Dr Gordon gave evidence that it was his understanding that the cohort of returned travellers entering quarantine would reflect the spectrum of people in the Victorian community.[47] From Dr Gordon's experience and research, his evidence was that the population can be split approximately 80-20 in terms of the level of underlying needs and vulnerabilities, and ability to cope in stressful situations.[48] That is, about 20 per cent of the population has various forms of needs, instabilities or personal issues that require a higher level of support than the remaining 80 per cent.[49] These include, for example, mental health problems, disabilities, social disadvantage and other problems, such as a history of loss or illness.[50] The 20 per cent will have experience accessing government services, while the remaining 80 per cent will likely have had little or no contact with support services throughout the course of their lifetime.[51]

82. In the Hotel Quarantine Program context, the cohort changed over time and became more complex, requiring a more nuanced assessment of its health and wellbeing needs.[52] Pam Williams, from the Department of Health and Human Services (DHHS), noted that those returned travellers who initially arrived were mainly business travellers or people returning from an overseas holiday.[53] As time went on, and the Commonwealth repatriated Australian citizens who may have been living overseas, the cohort changed to include 'more families with young children, people with diverse languages and cultures, and [those with] complex medical and mental health issues'.[54]

83. Ms Williams said that if the Commonwealth was more directive in dealings with airlines, it would have assisted with better planning for arrivals, the numbers of travellers and their specific needs, and, especially, the needs of families with young children.[55]

84. Kym Peake, then Secretary of DHHS, gave similar evidence in this regard. She stated that there was little advance notice of the needs of returning travellers or even demographics; flight manifests often did not list children under two years of age and there was little information on unaccompanied minors.[56]

Figure 12.2.2: Narrative from Returned Traveller 5

I needed to get to Australia for family support after leaving my relationship overseas due to family violence.

I had given birth to my daughter two weeks earlier via c-section and was still in severe pain. I was in a wheelchair and carrying a mobility crutch, still recovering. I travelled with my newborn, toddler son as well as my mother.

I was very distressed when I arrived at the airport. I was crying and pleading with the Department of Health and Human Services (DHHS) staff to not make me go into quarantine. I had too many physical problems and mental scarring.

I was told to go to the hotel and just get through the first night, and that an exemption would be processed the next day for me and my family to complete quarantine at home.

On the first night, I called the coronavirus hotline as I had no nappies. The operator advised me to make a Woolworths order which would take 3–4 days to arrive. In the end the nurses got nappies for me, as I needed them urgently. I had come with nothing — I left my whole life in less than a week. The nurses also got me maternity pads and toys for my son.

By 4pm on day two, I had not heard anything. I soon realised no one had started the exemption process for me.

The next day, DHHS told me an exemption had been granted for me to quarantine in a 'Mother Baby Unit'. I contacted this unit and they told me they'd never heard of me and explained they were not able to accommodate a person requiring quarantine. Based on this, my exemption was revoked.

I struggled with this outcome. I felt suicidal. That night, the Crisis Assessment and Treatment (CAT) team had to be called to help me. They spoke to DHHS and finally, an exemption was granted for me and my family to quarantine at home.

Three nurses really helped me while I was in Quarantine, I believe they kept me alive during this time. The nurses did everything for me, the hotel staff, DHHS staff and coronavirus line didn't want to know about me. When I spoke to DHHS on the phone, I felt like a problem.

I wasn't mentally strong enough to deal with hotel quarantine. I was not in a position to be there and things needed to be done differently. After escaping family violence, I found being made to stay in one room very hard, wrong and dehumanising. I had no way to get rid of dirty nappies which piled up. I had no information provided in relation to laundry and there was no way to wash clothes.

In my opinion, the biggest gap in the quarantine program was the lack of assistance for my children. Families were being placed in unsuitable accommodation and it doesn't surprise me that children would get distressed, my son became distressed almost immediately.

He didn't understand quarantine and he'd been through so much already. I experienced a complete behavioural change with him, and he became very clingy. At least once we were at home, he could run around in the garden and have space.

I understand the need for quarantine, but the cost of this program was too high for some people. For me, the mental impacts were devastating. I had just escaped domestic violence and to be locked up again was very difficult.

Families being quarantined should be placed into serviced apartments with balconies, this would be more appropriate.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

85. Despite the increase in the Commonwealth's efforts at repatriation, Ms Williams observed there should have been better management of the numbers and the arrival port of incoming travellers on the part of the Australian Border Force and the Commonwealth Department of Foreign Affairs and Trade.[57] Ms Williams gave evidence that those agencies could have been more directive in their dealings with airlines; to that end, she noted that, at times, the Program received flights with up to 40 per cent of arrivals being from other states, many of whom found it difficult to get to their home states and who had to undergo a second period of quarantine.[58]

86. The increasingly diverse cohort of arrivals with varying medical needs added a further layer of complexity for the staff running the Program. A number of travellers who contacted the Inquiry said that their medical conditions were ignored or not taken seriously.

Figure 12.2.3: Narrative from Returned Traveller 6

My partner and I had returned from overseas. My partner has stage four terminal cancer, so we needed to urgently return home to Brisbane for his chemotherapy. When we arrived at the airport, I told a DHHS officer about my partner's circumstances and asked about getting an exemption from quarantine. They told me to speak to someone from the hotel. We had to wait a long time before we were allowed to get off the bus. My partner was in severe pain and the delay made it worse. We waited for the exemption but never received any response. I ended up contacting the Chief Medical Officer and Minister for Health in Queensland, and the Victorian Minister for Health. I was then told that the exemption was never lodged. Eventually an exemption application was lodged about six days later. I felt like the staff misinformed me.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

87. Returned Traveller 3 highlighted that dirty air in their hotel room exacerbated their chronic asthma:

> I had three asthma attacks, so had to take a lot of asthma medication. This made my heart race, and the nurses called a doctor. He suggested I needed to go to hospital for steroids. I told them that just having fresh air breaks would assist my breathing. The doctor asked four DHHS officials if I could be given fresh air breaks - they all refused.[59]

88. Meanwhile, Returned Traveller 4 experienced delays in receiving medical attention after falling sick while in quarantine:

> I woke up at 4am with excruciating stomach cramps and diarrhoea. I felt feverish and could not eat or drink. After two phone calls, a doctor came up to my room to see me around 10am, wearing goggles, gloves and a mask. He called an ambulance. Seven hours later an ambulance arrived. I was taken to the Royal Melbourne Hospital and stayed overnight. They did tests and put me on an IV drip. They discharged me the following morning and told me to eat a 'bland diet'. Back at the hotel, I told a nurse that I needed a bland diet. I felt worse the next day so spoke again to the nurse who consulted a doctor. She said my case wasn't an emergency, so wasn't much she could do.[60]

89. Nurse Jen told the Inquiry that she was gravely concerned for the physical wellbeing of one returned traveller who suffered from endometriosis and was in considerable pain. The woman treated her condition with Chinese herbs but was refused access to a kettle to boil water to prepare the medicine by DHHS.[61] Nurse Jen stated:

> I was really concerned. If I ever had a patient in my care like that in a hospital, it would definitely be a medical emergency just to get the pain under control straightaway. In this situation we unfortunately couldn't really do much.'[62]

90. Dr Gordon's evidence was that, in a normal social setting, experience shows when members of the community can meet together, the more functional members of the 80 per cent will play a supportive role towards those who are more vulnerable or struggling to cope. This usually reduces the stress experienced by those in the 20 per cent and also reduces the need for external assistance.[63] Of course, meeting together while in quarantine was not a possibility, so this type of informal support that exists in other emergency scenarios was not possible.

91. Dr Gordon stated, based on previous studies, that the only way to effectively intervene with populations carrying high levels of stress but who have not previously experienced it, is to initiate communication, drawing people into the discussion. Otherwise, those in the 80 per cent will usually not reach out until things get desperate.[64]

92. An example of this can been seen in the evidence of Sue and Ron Erasmus. Ms Erasmus was a registered nurse and Mr Erasmus the CEO of an Indian branch of an Australian business. They returned to Australia with their two children following the sudden death of Mr Erasmus's father in South Africa. Mr Erasmus found quarantine very difficult, as he was not only dealing with grief following the loss of his father, he was continuing to work in his role as CEO and was unable to exercise, which was his usual method to deal with stress. When the situation became too much, Mr Erasmus did reach out to a DHHS staff member about his difficulties and was provided with a number for bereavement counselling. It was a big step for Mr Erasmus to ask for this kind of support. Unfortunately, he stated that, when he did speak with the counsellor, it was clear that information about his personal difficulties had not been shared with her, and Mr Erasmus did not feel cared for or supported. It exacerbated the difficulties he was experiencing in quarantine.[65]

93. Returned Traveller 4 shared their quarantine experience regarding a daily 8.30am welfare call by a nurse and daily fresh air breaks.

> During one welfare check the nurse asked if I had any thoughts of self-harm. I said 'of course I do, I'm locked in a room every day. I am sick and every day has been a fight to get the medical treatment that I need. I am tired of fighting to get appropriate food for my bland diet … I just want to go home.' I got a call later saying my first 'fresh air break' was at 3.15pm. But no one called or came to collect me.[66]

94. Witness Liliana Ratcliff, who, during her own quarantine period expressed ongoing concerns to Hotel Quarantine Program staff about the mental health of returning travellers, said that she told the staff: 'If I was going to commit suicide, I would do it just after their daily call, because I would know that no one would check on me for another 24 hour'.[67]

12.2.2 Potential stressors for some people in quarantine

95. Dr Gordon identified some of the types of stressors that some people placed in quarantine were likely to experience. He described these as the 'key threats' likely to be perceived by returned travellers in the context of a hotel quarantine program: the threat of the virus itself, the threat of isolation and the threat of disruption to lifestyle.[68]

The threat of COVID-19 as a stressor

96. Dr Gordon's evidence was that the threat posed by COVID-19 itself was an abstract one for which most returned travellers would have no firsthand experience.[69] Dr Gordon said that the threat posed by the virus was likely to engender mixed responses.[70] It was possible, he said, that some returned travellers may not take the threat seriously.[71]

97. One example of the threat of the virus itself causing additional anxiety was the evidence of Ms Ratcliff, who experienced quarantine with her two children. Ms Ratcliff was a health professional and familiar with infection control in the hospital setting. She suffered from an auto-immune disease and was especially anxious about getting COVID-19.[72] Her anxiety about contracting the virus was increased because she observed lax infection prevention and control measures throughout her time in the Hotel Quarantine Program. It was Ms Ratcliff's level of understanding about infection prevention and control that increased her anxiety, because she believed the Program was not being run correctly and that those working within it were not adequately trained in infection control. She observed that 'the approach was so different to what she was used to from working in hospitals'.[73]

98. The stress that could be caused by the risk of being infected by COVID-19 were not limited to within the hotel quarantine environment. Indeed, the Inquiry heard evidence of unsafe PPE use and social-distancing practices in the process of transporting returned travellers to their quarantine hotels. Witnessing — and being required to participate in — practices that increased the risk of virus transmission, would doubtlessly have compounded returned travellers' anxiety about being exposed to the COVID-19 virus.

99. The process of transporting returned travellers to their hotels involved travellers being escorted from an area at the back of Melbourne Airport, where there were SkyBuses waiting for them.[74] Those buses were used to transport returned travellers to their hotels.

100. Kaan Ofli, returned traveller, described his experience on the bus used to transport him to his hotel. He recalled his bus as being 'quite full', with approximately 40–50 people on board.[75]

101. There was evidence given to the Inquiry that there was no social distancing observed between passengers.[76] Hugh de Kretser, a returned traveller and Executive Director of the Human Rights Law Centre who was detained with his wife and two children, observed that it was very difficult to maintain physical distancing on the bus from the airport to the hotel, creating unnecessary risks of transmission.[77] He did not remember being asked to wear a mask on the bus,[78] nor were there any instructions around maintaining distance on the bus; however, Kate Hyslop and Ricky Singh, returned travellers, recalled that they were required to wear their masks.[79]

102. Some witnesses reported that, when the bus arrived at a quarantine hotel, security guards carried returned travellers' luggage from the bus and into the hotel. Professor Lindsay Grayson, Professor of Infectious Diseases at Austin Health observed, in the context of security guards assisting in the movement of returned travellers disembarking from those buses, the risk of transmission would be restricted if those guards wore a gown, a mask, eye protection and, if they were going to handle objects that belong to the individuals, they wear gloves, because those objects may be contaminated.[80]

103. Returned Traveller 1 said, however, that they saw security guards handling luggage without wearing gloves or other PPE.[81]

104. Returned travellers were, from the moment they arrived in Victoria, subject to the Hotel Quarantine Program. In chapters 6 and 7 I set out, in detail, why and how the Government was responsible for infection prevention and control measures in the Program. The evidence of Prof. Grayson shows that infection prevention and control measures were necessary to be taken well before returned travellers entered their hotels.

105. Transporting large numbers of potentially infected returned travellers, on buses designed to carry passengers sitting or standing in close proximity to one another, necessarily creates a risk of infection transmission. That is particularly so given what we know about how the COVID-19 virus is transmitted, including by way of surface contamination.

106. It is imperative that proper infection prevention and control measures are adopted on those buses (and also after passengers have alighted) so as to minimise the risk of infection transmission.

107. The conclusions as to what are proper infection prevention and control measures set out in this Final Report — and also in the Interim Report — apply with equal force to transit arrangements. That includes, as a minimum, a need to enforce social distancing, implement cleaning and PPE practices, and reduce the potential for those involved in transporting returned travellers to be exposed to other members of the public.

108. Moreover, where proper infection prevention and control measures are implemented in the transit process — and are also seen to be implemented — it would go a significant way to reducing anxiety that returned passengers may feel about being exposed to the risk of COVID-19 infection.

Isolation as a stressor, and the need for human connection

109. The second threat identified by Dr Gordon was that posed by the isolation of hotel quarantine.[82] Any effective quarantine program necessitates a loss (albeit temporary) of the ordinary and spontaneous social interactions inherent in everyday life. Dr Gordon stated that, in the absence of these interactions and the feedback about one's self that is routinely provided, the hotel quarantine experience had the potential to undermine an individual's internal sense of identity.[83] He explained this would not apply to everyone. Those people who had a strong, stable sense of their own personal identity would be able to manage without constant social feedback. However, individuals who needed that constant feedback to maintain their identity would find its sudden removal disorientating and stressful.[84]

110. Returned Traveller 11 described their experience of isolation in quarantine:

> It is not as easy to sit in a room by yourself, as people think. Being locked up is definitely bad for mental health, but what makes it way worse is the way the system and the staff who run the system treat you — in my 15 interactions with different people, why did only a few people ever follow up? Why couldn't a friend drop something off, yet a taxi was able to?[85]

111. Another returned traveller highlighted that the mental health needs of those in quarantine needed to be better considered:

> The government should have been much more proactive in how they handle the mental health needs of quarantined travellers. It's definitely no picnic or luxury holiday, and for those with existing mental health issues, it can be too much to bear. A more proactive attitude is especially important for men, who are unlikely to reach out for help whilst in distress and much more likely to harm others or themselves. If it were up to me, I'd make it policy that all quarantined travellers receive daily mental health check-ups and daily access to fresh air as a matter of right.[86]

112. In contrast, Returned Traveller 10 shared that they found their quarantine experience more pleasant:

> I coped quite well with the 14 days and felt that the program was run well. I passed the time by discovering WhatsApp, and spending time on my tablet. I was allowed to receive a care package during my detention, which helped. I had friends call me, and I had a lovely view so I could watch the ships come and go and see the traffic on Kings Way.[87]

113. Of the experiences described by returned travellers who contacted the Inquiry, the description of a positive quarantine experience was limited to a small minority. Many returned travellers described feeling isolated, unsupported and punished. I accept that the motivation to contact the Inquiry to report negative experiences may have been a driver, at least in part, for this result. This does not detract from the importance of the information provided, though, in terms of its relevance to improvements to future quarantine programs.

114. One of the nurses working in the Program, Michael Tait, identified the loneliness experienced by some. Mr Tait observed that many people became depressed because they were lonely, in particular the elderly guests, as they were not comfortable using technology to stay connected. As he observed: 'you could tell they were struggling as they just needed some human connection'.[88]

Disruption of lifestyle as a stressor

115. Dr Gordon identified a third threat posed by hotel quarantine; namely, the disruption of lifestyle.[89] He explained that, while regular routines and habits are often taken for granted, disruption to this stable fabric in the context of hotel quarantine can result in an eruption of anxiety and unstable emotional responses.[90] He explained that this disruption of routine is common in disasters and has a destructive influence itself. Because people often do not recognise the importance of routines, or that they even have a routine, losing that stability can lead to a loss of resilience, self-management and understanding.[91]

116. Dr Gordon stated that it is important to bring this loss of routine to the attention of those in quarantine, as they often do not realise that is what they are experiencing. This would enable the returned traveller to identify what was important to them, and to build a routine for themselves for the 14 days of isolation.[92]

117. In addition to the specific potential threats of hotel quarantine, Dr Gordon described the most common effect of a high-stress situation was an increasingly self-centred focus; that is, one's focus becomes solely on the stressor. He described this as an 'adaptive reorganisation to maximise resources' with the result that attention to contextual factors and systems was compromised.[93] What compounds this problem, in the quarantine scenario, is the link between this self-focus and the strong desire for reunification with loved ones.[94]

118. As Dr Gordon described it '... this really is a consequence of the fact that our attachments with our most important people are the fundamental cornerstones of our personality and the most highly-valued aspects of our experience and the very basis for security, comfort and everything we need to counteract the stress'.[95] Accordingly, the separation from loved ones during the quarantine period would, itself, be an added stressor for returned travellers.[96]

119. The Inquiry heard from some returned travellers who shared that they desperately needed contact with their loved ones because they were experiencing grief.

Figure 12.2.4: Narrative from Returned Traveller 3

I am an Australian citizen. I came back to Australia because my father was gravely ill. I was desperate to get home to my family.

I took a COVID-19 test before I left to ensure I wasn't positive. I got a flight to Adelaide and applied for an exemption from quarantine. I wanted to travel on to Melbourne to be close to the hospital and my family. I would never have sought an exemption if I had been COVID positive. In transit I heard from DHHS that my exemption was refused, but it might be possible to quarantine in Melbourne. I had a second COVID-19 test when I arrived in Adelaide, which was also negative.

The officials in SA were understanding of my situation. They supported my request to complete quarantine in Melbourne, liaised with DHHS and told me to book a flight. I was later told DHHS considered that my father's condition was not serious enough to warrant me coming to Melbourne. I was told to cancel my flight.

Not long after this my brother called me to say Dad was not going to make it, and could I come to Melbourne sooner. I was then granted the right to transfer and finish my quarantine in Melbourne.

Sadly, this was too late for me. My father passed away the night before I was allowed to return to Melbourne. I had to watch my father take his last breath over messenger video, while I was alone and distressed in a quarantine hotel in Adelaide.

I feel it was unnecessarily cruel that DHHS did not let me return to Melbourne sooner, and give me the chance to see my Dad one last time.

I was grieving and then I faced further difficulties in my remaining days of quarantine.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

120. Having identified the potential threats that may be perceived by those in a hotel quarantine scenario, Dr Gordon was able to provide suggestions to assist in the design of a hotel quarantine program that seeks to counteract those potential stressors. In summary, his advice about the fundamental thing to get right is **communication**.[97]

12.2.3 Clear, consistent and accurate information needed

121. A key theme that emerged from the evidence of returned travellers who gave evidence or provided information to the Inquiry was a perceived failure by the authorities to provide clear, consistent and accurate information regarding the operation of the Program, and a lack of clear points of escalation to raise issues or concerns. Returning travellers who gave evidence or contacted the Inquiry variously described receiving information at intake that was inaccurate, requesting and being denied access to relevant policy documents, and information changing without clear explanation.

122. Some returned travellers identified this lack of clear, consistent and accurate messaging as having contributed to feelings of uncertainty, unpredictability and stress.

> We had both tested positive to the virus, but it was not explained to us exactly what this meant, and what would happen next. The whole quarantine situation was extremely stressful for us — separated from our family, and also especially hard due to my father passing away. No one listened to our concerns at the time.[98]

123. Others felt that the language used in documents and the attitude of some staff was cruel and punitive, as highlighted in Figure 12.2.5 below.

Figure 12.2.5: Quotes from returned travellers about use of language in the Hotel Quarantine Program

Returned Traveller 3: I had my birthday during this time and friends and family dropped off gifts and care packages for me. I was required to sign a 'consent for inspection' form. This was harshly worded and written with a tone of intimidation. I was told in a sarcastic and authoritarian tone by a DHHS official that if I didn't sign the form, I would not get my birthday presents. I felt like I was being punished.

Returned Traveller 12: Even the wording of the Detention Notice was harsh. There seemed to be no thought given to the possibility that some of us are already in a fragile state of mind when we land … I felt like I was being punished for going overseas for a trip of a lifetime.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

124. The evidence of Dr Gordon assists in analysing and explaining why some returned travellers found the experience of hotel quarantine stressful and difficult. Dr Gordon identified the types of threats that may be experienced by those in hotel quarantine and potential strategies to overcome those threats.

125. Dr Gordon identified the ability to recruit people's confidence and trust as essential to the management of the hotel quarantine scenario. Trust and confidence lead to acceptance and an understanding that what people are being asked to do is necessary, thus leading to cooperation.[99] Dr Gordon explained that the ability to maintain security, trust and confidence of returned travellers will counteract, to some extent, the anxiety, stress and perceived threat they may experience while in quarantine.

126. Some of the returned travellers who contacted the Inquiry described that it was very difficult to get responses from staff and they had to have many conversations, raising the same concerns, before their issues were resolved.

Figure 12.2.6: Quotes from returned travellers regarding issues with communication and processes

Returned Traveller 7: My experience over the two weeks of quarantine was that it seemed like no one knew what was going on. I don't think that the staff knew who was in our room - at least twice during my stay, I got calls from staff asking to speak to my two-year-old daughter. I said, 'I'm happy to give her the phone, but she's 2 years old.'

Returned Traveller 11: I repeatedly asked for drinks to be delivered to my room, but they never got delivered. Staff would promise to follow things up and get back to me, but they only got back to me about 20 per cent of the time.

Returned Traveller 12: There was no clear process, the left and right hand didn't know what they were doing, the incompetence was absurd.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

127. Indeed, Ms Ratcliff repeatedly raised concerns about infection control at the Stamford Plaza Hotel. As well as using the daily calls from nurses as a means of raising a range of concerns, she also made a complaint to DHHS by email. Ms Ratcliff received an automated reply from DHHS's 'Feedback Management System' on 18 May 2020 but, as at the time of giving evidence to this Inquiry, Ms Ratcliff still had not received a proper response from DHHS.[100]

> I felt that I was brushed off. I believe there should have been proper processes for escalating concerns and complaints.[101]

128. Luke Ashford, who was an Authorised Officer in the Program, stated that '[t]here was no formal procedure for complaints or issues to be raised'.[102]

129. Moreover, there was some evidence that DHHS held a view that the Government helpline ought not proffer advice to detainees that they reach out to parliamentary representatives to raise concerns about their treatment in hotel quarantine.

130. When she appeared before the Inquiry, Merrin Bamert, Director — Emergency Management, DHHS, confirmed that she recalled receiving email correspondence that indicated the helpline run by the Department of Jobs, Precincts and Regions (a 1800-number available to people in quarantine) was saying that people should advocate via their local Members of Parliament.[103] Ms Bamert replied, via email, saying that that was not appropriate at all.[104] Ms Bamert described what she recalled of the complaint that had given rise to the relevant email chain and to explain that it was not appropriate to tell people to ring their local Members because '[t]here should be internal mechanisms' that would allow for a more timely and appropriate response.[105]

131. Ms Bamert was correct that there should be internal mechanisms to enable a timely and proper response to issues and concerns raised by people being held in quarantine. However, internal mechanisms for responding to health and welfare needs and external avenues for escalating concerns are not mutually exclusive.

132. In fact, external oversight (whether by the Ombudsman or by a local Member of Parliament) should operate to strengthen internal processes. The option of complaining to a local Member provides an avenue for people in quarantine to escalate concerns in the event that internal processes are inadequate, either broadly or in a specific respect. Noting the inherent vulnerability of people in mandatory quarantine, it is not 'inappropriate' for people in quarantine to be informed of the full range of options available to them if they have concerns or issues for which they believe they are not getting an adequate response.

133. Dr Gordon stressed that the quarantine program needed to be communicated as being protective against the threat of COVID-19, so that the isolation and disruption is more readily accepted.[106] Returned travellers need to be active participants in discussions and have the opportunity to ask questions.[107] Authorities need to provide clear, repeated information about the situation,[108] as well as channels through which to communicate.[109] As part of this process, the relevant authorities should provide advice on issues returned travellers are likely to experience.[110] Having an understanding about what to expect can greatly lessen the stress of unfamiliarity.

134. Dr Gordon emphasised the importance, in particular, of repetition of information and ensuring the authorities, to the best of their ability, provide consistent information. As Dr Gordon put it:

> I think a very demoralising feature for people who are in any kind of disaster or trauma situation is losing confidence in the clarity and consistency of the authorities, because they are very, very dependent on them, and if they can't feel confident in them, then you see this massive escalation in their level of anxiety. So therefore we come to the notion of regularly repeating all the basic information in varying forms and in varying modalities, speech, written information, stuff on the internet, television, whatever, and just having this circulating through. It's better to bore them than for them to go into this state where they just don't know what's going on.
>
> … With the best intentions, any inconsistency, contradictions or serious failure of coordination has a very profound effect on the confidence and security and therefore the anxiety management of the people concerned. So, I'd say that that would be a really important point to be monitoring and watching. Again, it's about the social psychology of the information management.[111]

135. The evidence of some of the returned travellers who experienced difficulties in the Hotel Quarantine Program demonstrated how communication was vital to ensure trust and confidence in the system. For example, Ms and Mr Erasmus had already been subject to a harsh lockdown in South Africa prior to being able to arrange a mercy flight back into the country, which was a difficult prospect at that time. Due to their challenging personal circumstances, they communicated with the authorities, in advance, to make them aware of some of the issues they were experiencing.[112]

136. However, while they were in quarantine, it became clear that the information was not being shared.[113] This led to the family having to, repeatedly, explain their difficult circumstances, causing re-traumatisation. As they observed: 'Communication was appalling and inconsistent and added to the overall stress … at what was already a difficult time for our family … it really was made so much harder by how disorganised and disjointed the while [sic] process was'.[114]

137. Mr de Kretser, who was detained with his wife and two children, gave evidence about the inconsistency of information being provided to him and his family. Mr de Kretser was aware of the procedure under the PHW Act that required a daily review of each person detained. He asked three different people from DHHS whether his family's detention was being reviewed daily. As he observed: 'One officer seemed surprised by the question and told me we were being detained for 14 days. Another told me that the nurses do the review (presumably referring to the daily nurse welfare check) and another told me that the detention "wasn't really reviewed"'.[115]

Fresh air breaks

138. The importance of fresh air breaks for health and wellbeing is addressed in the Interim Report at page 49, as follows:

> Fresh air breaks are necessary and will need to be factored into not only the layout of the facility, but also a robust and appropriately developed process for safely facilitating such breaks. The process should include clear instructions to facility personnel as to how these breaks are to be safely conducted, together with good communication with people in quarantine as to what they can expect, and what they are required to do and not do during such breaks.[116]

139. In this context, the Interim Report also addressed the need for the facility to be one that can provide a physical environment that facilitates safe access to fresh air and exercise.

140. In relation to information about 'fresh air breaks', availability of fresh air breaks and the impact of not having access to fresh air and exercise breaks for 14 days, the evidence and information obtained by the Inquiry set out in this section speaks to those issues.

141. Mr de Kretser described the information he was provided with to be inconsistent and his family was not given a break from their room until their second last day in quarantine.[117] In fact, when he sought a copy of the policy governing fresh air breaks, Mr de Kretser faced a number of, what he described as, evasive responses from DHHS personnel until eventually he was told to make a Freedom of Information request.[118] Irrespective of the unsatisfactory state of the evidence as to what policies applied at what time, there was at least some form of a fresh air policy in existence when Mr de Kretser asked for it.

142. Ms Hyslop and Mr Singh, who were quarantined in mid-April 2020, received documents upon arrival into Australia, including a letter stating that they were not to leave their rooms.[119] They never left their room and were not told they were allowed fresh air breaks.[120]

143. Ms Ratcliff shared that she and her children had one fresh air break, and chose to not have more, as the fresh air break caused them stress. 'My kids and I only had one walk while in quarantine, despite being offered more fresh air breaks. After the first walk I did not want to go outside again, as I did not feel that safe practices were being observed and the children felt it made them stressed, being watched by four strange men.'[121]

Figure 12.2.7: Narrative from Returned Traveller 4

I got a call … saying my first 'fresh air break' was at 3.15pm . But no one called or came to collect me. At 3.30pm I called hotel staff. I was frustrated. They booked me another fresh air walk for 7.15pm that night, which went ahead. The walk, and the opportunity to talk with the security guards during the walk, made me feel a lot happier … I became friends with one security guard who treated me kindly. He and two other security guards I also became friends with arranged extra fresh air breaks for me and escorted me on those breaks. I had a factsheet that said that fresh air breaks are 'weekly'. But because of those three security guards, I usually got two to four fresh air breaks every day. I felt like no one else showed me kindness, except the security guards.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

Inconsistent information: multiple data sets

144. Mr Tait described inconsistency in DHHS policy with advice constantly changing, often quickly and without explanation. He learned, as a result, not to make any promises to the returned travellers.[122]

145. Mr de Kretser witnessed DHHS staff changing constantly and inconsistent information about policies being given to those staying in the hotel as a result.[123] This experience of staff changing everyday was also observed by Ms and Mr Erasmus, again leading to inconsistent and difficult communication while in quarantine.[124]

146. With better data collection and management systems in place, returned travellers' experiences could have been improved in this regard. Both Ms Bamert and Ms Williams identified that data collection and management were areas requiring improvement.[125] Ms Williams gave evidence that multiple data sets were not adequately harmonised, improvements were slow due to pressures on staff and skill shortages, and that there was the need to develop a tailored technological solution across the whole operation.[126] Ms Bamert similarly recognised the need for improved efficiency in the development and uptake of IT systems, data collection and reporting.[127]

Building trust and acceptance through clear communication

147. Dr Gordon emphasised in his evidence that the key to maintaining management of the quarantine program was fundamentally an exercise in social psychology; that is, recruiting the confidence and trust of those in the system.[128] Dr Gordon explained, as set out above, that returned travellers in hotel quarantine could be expected to perceive three key threats: the threat posed by illness in contracting COVID-19, the threat posed by isolation and the threat posed by disruption of lifestyle.[129] 'Where quarantine is felt as threatening and causes a state of high arousal, the best way to reduce the stress caused by the combination of these three threats is to hold on to the illness as the major threat, and to view the other problems as safety procedures designed to protect from the threat, rather than impositions which are felt as threats in themselves'.[130] Communicating this effectively will motivate adherence and build trust that the measures are necessary.[131] It is much easier to accept personal difficulty and sacrifice if one understands why it is necessary.

148. This ability to build trust and acceptance with returned travellers was compromised due to the difficulty in accessing helpful information; as much can be found from the evidence outlined above. Moreover, Mr de Kretser said that, when planning for his family to return to Australia in May 2020, he found the available information from the Government about hotel quarantine was very poor. He largely relied upon information from Facebook groups set up by returned travellers already in quarantine.[132]

149. Ms Hyslop and Mr Singh shared a similar experience. They conducted research into what to expect of the quarantine program prior to returning to Australia but did not understand how it operated.[133] They agreed that Facebook became a key source of information because they found it was hard to get information from staff.[134]

150. Dr Gordon stressed the importance of the supportive way in which returned travellers need to be communicated with. He explained that 'supportive' in this context means communicating in a way that demonstrates understanding. It is a qualitative feature of communication, not an outcome-based one;[135] in other words, even if a request cannot be met, the person will still feel supported and understand why something cannot be done in the circumstances.

151. Dr Gordon described what it means to create a 'supportive environment':

> Support is a quality of interpersonal contact. It is [a] qualitative not quantitative characteristic of communication. A person will feel supported if they know who to contact with their concerns and if they get timely and consistent responses. Support is created when the person needing support gets a clear understanding that the person they are talking to understands their experience, even if they cannot do anything to change the situation.[136]

152. Ms Ratcliff spoke of the kindness of the nurses toward her children,[137] which she noted was appreciated at the time and made her feel that the staff were trying to address some of her family's needs.

153. Returned Traveller 5 shared that they felt particularly supported by the nurses:

> Three nurses really helped me while I was in Quarantine, I believe they kept me alive during this time. The nurses did everything for me; the hotel staff, DHHS staff and coronavirus line didn't want to know about me. When I spoke to DHHS on the phone, I felt like a problem.[138]

154. Some returned travellers felt unsupported during their stay in hotel quarantine, leading to additional stress and anxiety. For example, a witness, identified as Returned Traveller 1 was in quarantine with his wife, who was 28 weeks pregnant, as well as two young children, aged two and three. Returned Traveller 1 told the Inquiry about shortcomings in communication, including being given inconsistent information and instructions, and being treated in a way that he felt was unsupportive:

> We were often told by people from the Department that 'you knew what you were getting into'. We were told words to the effect that 'you knew we were being locked in and wouldn't get certain things, like walks every day' and 'no one promised you walks'. Hotel quarantine staff were not always understanding and at times my wife was told words to the effect that 'you're not the first pregnant woman to come here'.[139]

155. Dr Gordon stated that '[o]pportunities for regular, caring, informal unsolicited communication supports a person's sense of identity, as well as providing emotional support and confidence'.[140] He suggested that one way of achieving this is through a daily check-in: 'this should be a genuine chat in which being a human being is the focus rather than just checking for symptoms or needs'.[141]

Creating a sense of community

156. Finally, Dr Gordon identified that creating a sense of community among those in hotel quarantine could assist in bringing down a sense of stress or arousal. As he observed:

> … one of the greatest assets to the containment and processing and therefore bringing arousal down of the situation is to help the whole group that's affected communicate together … that creates a sense of common identity, which counteracts the sense of isolation, which is one of the most damaging factors in the quarantine situation.[142]

157. Communication between those in quarantine should be facilitated in a constructive way,[143] such as through moderated discussion groups.[144] While some returned travellers formed their own groups via social media, Dr Gordon was of the view that it would be more effective to integrate these discussions into the government communication process.[145]

158. Dr Gordon explained the benefits of a sense of community solidarity and support being fostered among the people in quarantine:

> Creating a sense of community solidarity and support amongst quarantined people would give the 80% of the quarantine population who are more resilient opportunities to support and reassure the 20% who are more likely to be struggling with the situation. The constructive effects of promoting community formation and interactions for supporting and managing distress are well understood in the emergency management context. Emergency management workers use information, humour, satire, shared experiences, problem solving and morale boosting. Communication networks encouraging them to express their fears, which helps to think about them and manage them. Being part of a group reduces the sense of solitary exposure.[146]

12.2.4 Safer Care Victoria reports

159. Two Safer Care Victoria reports[147] identified shortcomings in the health and welfare aspects of the Hotel Quarantine Program.

160. Findings in the reports included that there were insufficient staff to conduct the required welfare checks, and that welfare checks were delayed or infrequent.[148]

161. The reports were undertaken at the request of the Secretary of DHHS following two critical incidents that occurred in early April 2020 and which uncovered significant risks to the health and wellbeing of detainees.[149]

162. The reports identified contributing factors relevant to the incidents and made a number of findings that revealed, first, a lack of safe processes in the Program and, second, that extraordinary demands were being placed on all Operation Soteria staff, who were significantly under-resourced for the task.[150]

163. These reports were requested to identify and address any ongoing risks to those who were being detained in hotel quarantine.[151]

164. This was what was found:

KEY FINDINGS AND RECOMMENDATIONS FROM THE SAFER CARE VICTORIA REPORT REGARDING INCIDENT ONE

165. Incident One occurred on 11 April 2020, when a returned traveller was found deceased in their room at the Pan Pacific Hotel, Docklands.[152] The traveller had been detained in quarantine since 3 April 2020.[153] There had not been any indications that the traveller was particularly vulnerable or under significant stress.

166. The Incident One report found that staff were often not able to access all detainee health and welfare information that they needed in order to provide adequate care to detainees, due to the lack of a comprehensive, central, accessible repository for such information,[154] and that detainee health and welfare information was collected in a fragmented manner.[155]

167. The report noted that, at the time, none of the required forms asked about mental health concerns or whether the detainee may wish to speak with someone about any issues of concern regarding their health and welfare.[156]

168. The report also found that there was a lack of specific formal policy about the threshold for escalating concerns about repeated unanswered COVID-19 assessment calls, and a lack of formal procedure for tracking these.[157] In addition, due to workload and delegation challenges, Authorised Officers were sometimes required to prioritise multiple competing demands, resulting in delays in attending to potential health and welfare concerns of returned travellers.[158]

169. The Incident One report made 13 recommendations, including:

    A. improved 'onboarding' processes

    B. daily health and welfare calls

    C. targeted risk assessments

    D. improved information in the form of a central repository

    E. clear processes for escalation of concerns

    F. rapid response surge capacity for staff, such as AOs, if they are overloaded with tasks or demands.[159]

KEY FINDINGS AND RECOMMENDATIONS FROM THE SAFER CARE VICTORIA REPORT REGARDING INCIDENT TWO

170. Incident Two involved the care of a traveller who developed COVID-19 symptoms and deteriorated rapidly, requiring an intensive care unit admission at The Alfred Hospital.[160]

171. The Incident Two report found that on-site clinicians were constrained in their ability to conduct face-to-face clinical assessments due, in part, to an insufficient supply of readily accessible and reliable PPE.[161]

172. The report also found that there was unavailable or unreliable access to clinical equipment for physical examination and clinical monitoring of returned travellers, such that clinical decision-making was being based on incomplete clinical information and assessment.[162] Further, the report found that some staff were unclear on the scope of their role, as well as the delineation of roles and responsibilities within and between teams, which affected care delivery and completion of tasks to address returned traveller health and welfare needs.[163]

173. There was also no clear agreement between the hotel quarantine system and Ambulance Victoria about managing the hospital transfer needs of returned travellers. The report found this contributed to improvised clinical decision-making by frontline staff.[164]

174. Other factors that contributed to the incident included the absence of an accessible, comprehensive, central repository for health and welfare information, and an inability to identify returned travellers with high and/or escalating health and welfare risks because of this. This resulted in the impairment of staff's ability to have good visibility, in a timely manner, of the full clinical picture of unwell returned travellers.[165]

175. Further, the in-room communication system (such as the hotel room telephone) was not able to be used by some returned travellers in order to make calls external to the hotel, and not all returned travellers had access to a functioning mobile phone.[166] The report noted that, while this may not have directly been a contributing factor to the incident, there was an opportunity to make improvements.[167]

176. The Incident Two report made 18 recommendations, including:

    A. implement measures to ensure an adequate and reliable on-site supply of PPE that is readily accessible to all staff working in the hotel quarantine system, and policies to ensure appropriate use of PPE by staff

    B. development of policies and processes to enable visual telehealth consultations

    C. a centralised information system

    D. clear role descriptions for all staff and formal communication and handover

    E. clear processes and communications regarding escalation of issues

    F. implement a formal agreement between all relevant parties in the hotel quarantine system and Ambulance Victoria regarding the ambulance service requirements of returned travellers

    G. on arrival, returned travellers should have suitable access to a functioning mobile telephone

for the duration of their mandatory detention.[168]

177. Additionally, in the Incident Two report, Safer Care Victoria identified that '[t]here was inconsistent language used to describe returned travellers in hotel quarantine (e.g. passengers, guests, detainees)' and observed that '[s]ome of the terms have connotations that could bring unconscious bias to the way they are cared for by the personnel working in the hotel quarantine environment'.[169]

178. As stated in the Interim Report, that inconsistency in language persisted throughout the Inquiry's hearings, where people in quarantine were variously referred to as 'returned travellers', 'detainees', 'guests' and 'patients'. It was admirable that the hospitality personnel of hotels consistently referred to the people in quarantine as 'guests'.[170]

179. The language used to describe the people in quarantine in a facility is important. It adds a quality to the culture of the facility that is likely to reflect behaviour. Language that is dehumanising or derogatory or invokes a sense of fault or blame in those being contained in a quarantine facility risks having a negative effect on the culture of the facility. The word 'detainee' was derived from the section of the PHW Act that provides the power to issue a Detention Direction mandating people into quarantine.[171]

180. However, inside a quarantine facility, it would be appropriate to adopt more neutral language such as 'resident' rather than 'detainee' when referring to those people compelled to stay there through no fault of their own.

181. It is not the focus of this section to consider the extent to which, and when, the Safer Care Victoria recommendations were implemented in the Hotel Quarantine Program. I am looking to what the findings and recommendations mean for a future model.

182. Suffice to say, the findings of the two Safer Care Victoria reports highlighted many areas of risk to the welfare of returned travellers in quarantine, and that safeguarding the health and wellbeing of those in quarantine proved to be far more complex than had, perhaps, first been anticipated.

183. The need to focus on health and welfare earlier and better than it was, was the subject of some evidence by Operation Soteria leaders.

12.2.5 Health and welfare were initially not the main focus of DHHS in the Program

184. Jason Helps, the State Controller — Health, gave evidence that the initial welfare arrangements that were put in place for the commencement of the Program had limited understanding of the risks or issues that may arise in the Program.[172] He said that they had no passenger health or demographic information and no experience in how people might react in a quarantine environment, other than to draw on a comparison to what people's needs were in other emergency and crisis situations.[173]

185. Ms Williams held the view that there was an assumption in the Hotel Quarantine Program that detention within the Program could be achieved without undue impact on the health and wellbeing on the detainee.[174] Ms Williams observed that the Program 'was criticised on human rights grounds' for its impact on the mental health and wellbeing of guests.[175] She said, and I agree, that DHHS should have made a more nuanced assessment of the balance between transmission risk and guest health, wellbeing and human rights.[176]

186. In any case, it was Mr Helps's evidence that, around 28 March 2020, the focus on welfare expanded from providing welfare calls to quarantined returned travellers to embedding welfare in the *Operation Soteria Operational Plan* as one of the 'highest priorities' for the Program.[177] This was an appropriate addition to the Operation Soteria plan.

12.2.6 Implications of quarantine on people's health and wellbeing

187. Returned travellers who contacted the Inquiry consistently raised concerns about the conditions of their detention, including access to fresh air, the cleanliness of the hotel rooms, difficulties with dietary requirements, concerns about being infected with the virus due to poor infection control procedures, and poor communication that resulted in confusion as to who was in charge.[178]

188. Indeed, Mr Ofli shared that he and his partner only received enough food for one person. 'It was not until later that we realised we weren't getting enough food because they didn't know I was in the room as well'.[179] He also noted that his specific dietary requirements could not be met. 'I had been eating the food we had been given previously, thinking it was Halal, because my partner had told them that I was Halal in the beginning. It was a shock for us when we realised the meat I had been eating was not Halal'.[180]

Figure 12.2.8: Quotes from returned travellers about dietary issues in quarantine

Returned Traveller 3: The food was unhealthy, and I found the majority of meals to be inedible. I spoke with a woman in charge of the quarantine meals and she encouraged me to order from the in-house menu instead. These meals were very expensive. I felt like this was exploiting a 'captive' market for the hotel to profit from. I was not very hungry anyway, as I was grieving my father.

Returned Traveller 11: When I arrived at the hotel, I hadn't had anything to eat for about 20 hours, and as the hotel wouldn't provide anything simple to eat that I could eat, I ended up not eating for 30 hours. I eventually gave up and ordered Uber Eats.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

Figure 12.2.9: Quotes from returned travellers about the cleanliness of hotel rooms

Returned Traveller 3: The air in the hotel room was dirty. This was a serious problem for me as I am a chronic asthmatic. I had to change rooms four times due to cigarette smoke and one room not being clean. When I reported that I could still smell that there was a smoker next door to me, I was told by staff that I was ridiculous. I don't blame people for smoking as it is a stressful experience to be quarantined, but for me, it was a health issue because of my asthma.

Returned Traveller 12: After taking 5 hours to get off plane and get to hotel the first thing I needed was to use was the amenities. To my horror when I opened the toilet lid in our room, there were faeces in the toilet and around the lid and seat was filthy. There were a lot of stains in the room also. It made me wonder if any checks had been done on the cleanliness of the rooms to see they were up to standard.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

189. Issues were likely exacerbated for returned travellers who required a higher level of care due to physical or mental health concerns, or who simply felt unable to cope with being detained. As one returned traveller told the Inquiry:

> Many of us returning to Australia are doing so out of necessity. We are returning to a dying relative or a death in the family. Others have lost their jobs, homes and residency rights and visas in a country they adopted as their home. Many of us are already in a fragile state of mind when we land and this harsh, corrections model is inappropriate for returning citizens who have not committed a crime other than return to their homeland in a time of crisis.[181]

12.2.7 Exemptions and temporary leave arrangements as a means to promote welfare

190. DHHS did make efforts to cater to the needs of returned travellers. In its submissions, the department gave examples of having done so,[182] such as:

    A. Dr Finn Romanes, Deputy Public Health Commander, being responsible for a *Physical Distancing Policy*, which included policies and procedures to address the health and wellbeing of people in quarantine, and included content regarding welfare checks.[183]

    B. Dr Romanes' evidence about an *Interim Healthcare and Welfare Mandatory Quarantine Plan*, which included an initial assessment of welfare, a welfare check requirement and protocols regarding smoking, fresh air breaks and exercise, nutrition and food safety, care packages and safety, and family violence risks.[184] However, Dr Romanes could not say, with certainty, whether all of the measures in that Plan were adopted by Operation Soteria.[185]

    C. Consideration of human rights, consistent with the Charter.[186]

191. Efforts were also made to provide for the health and wellbeing needs of returned travellers through the process of considering and granting exemptions from the requirement to quarantine in a hotel setting.

192. Dr van Diemen gave evidence that the detention directions applied to all returned travellers and that exceptional circumstances were required for people seeking not to be ordered into hotel quarantine.[187] Dr van Diemen and Chief Health Officer, Professor Brett Sutton, agreed with each other that exemptions should be granted in limited circumstances.[188] Exemptions from the requirement to quarantine were initially granted for the following reasons:

    A. attending a medical facility to receive medical care

    B. where it was reasonably necessary for physical or mental health

    C. on compassionate grounds

    D. in case of emergencies.[189]

193. By mid-May 2020, the categories for which exemptions could be granted by the Enforcement and Compliance Commander expanded to include:

    E. unaccompanied minors in transit to another state

    F. unaccompanied minors where a parent or guardian does not agree to come into the hotel

    G. foreign diplomats coming into the country

    H. people with a terminal illness

    I. people whose health and welfare cannot be accommodated in a hotel environment (mental health or requirements for in-facility health treatment)

    J. people who are transiting directly to another country (and who do not need to travel domestically first)

    K. air crew including medevac crew

    L. maritime workers who have come off a boat and would be leaving by boat, depending on their particular movements

    M. maritime workers who have come off a plane and would be leaving by boat within the quarantine period, depending on their particular movements.[190]

194. For those categories, exemptions could be granted (on certain conditions) for non-complex cases without the need for Dr van Diemen to approve those exemptions.

195. The *Physical Distancing Plan* in place allowed for applications for permission to leave in certain circumstances, including in 'instances where a person has a reasonably necessary requirement for physical or mental health or compassionate grounds to leave the room, as per the Detention Notice'.[191]

196. Authorised Officers were to make decisions as to exemptions and temporary leave applications. Dr van Diemen said that Authorised Officers were required to balance the needs of the person and public health risk. In this context, Dr van Diemen referred to the *Physical Distancing Plan*, which provided that:

> If the person needs immediate medical care, public health risks need to be managed appropriately, but the expectation is that the leave would automatically be granted. This would be more nuanced and complex when the request is made on compassionate grounds where there is a question about how public health risks might be managed. However, again, human rights need to be considered closely.[192]

197. DHHS said that more than 439 temporary leave permits were granted to allow people to take leave from quarantine for compassionate reasons.[193]

198. Ms Peake gave evidence that there were '440-odd exemptions that were provided to people so that they could complete their quarantine program in an alternative setting, and often that was on the basis of input of the assessment of either the mental health nurses or the CART team, that someone with complex needs, that this setting wasn't appropriate for them'.[194]

199. That this happened 'often' was not borne out by the evidence. Material from DHHS's answer to questions put to Ms Peake showed that a total of 426 individuals were granted an exemption. Of those exemptions, 269 were for travellers in transit; that was, travellers continuing to a further international or interstate destination, with only 56 granted on medical or compassionate grounds.[195] Therefore, around 13 per cent of exemptions granted were related to a person's welfare.

200. I consider that exemptions could and likely should have been granted in more situations with proper regard having been given to the welfare needs of returned travellers. That would be especially so in circumstances where it was inappropriate for a returned traveller to be confined in a hotel room because of their needs, whether they be mental health needs, physical needs or needs arising from their family situation, and in situations where the returned traveller could demonstrate that they could safely and reliably quarantine in their own home or some other suitable residential premises.

12.2.8 Conclusions

201. The health and welfare needs of people in the Hotel Quarantine Program had a very considerable impact on the manner in which the Program operated and developed.[196] These needs created many problems for those in quarantine, in circumstances where the Program had to be deployed to receive hundreds of people at great speed, with little or no information about returning travellers before they arrived.[197]

202. In some instances, the manner in which these needs were handled increased the risk of transmission,[198] detrimentally affected the health and wellbeing of people detained in quarantine and created considerable strain on those working in the Program.

203. The health and wellbeing needs of returned travellers include the need to not be unnecessarily exposed to a risk of infection while being transported from the airport to the quarantine hotel. It is necessary that proper infection prevention and control measures be implemented with respect to the transit of returned travellers to their hotels, just as those measures are required to be implemented in hotels.

204. In order to address health and wellbeing issues, the health, wellbeing and needs of those in quarantine must be a central feature of a future quarantine program.

205. In the Hotel Quarantine Program, expert advice should have been obtained in order to understand and account for the risks that this type of quarantine arrangement posed to people and to provide guidance to the Program on how to best manage them. Such expertise could have spoken to the challenging behaviours that would likely be encountered as a result of the deprivation of liberty involved in the Program, and the measures that were needed to proactively account for them and other health and welfare issues.

206. The fact that such advice was not obtained is likely to be attributable to several factors: the speed with which the Program had to be set up, that there was no developed plan or experience for holding people in mass quarantine facilities, and what I have found to be a disproportionate focus by those designing and implementing the Hotel Quarantine Program on logistics, when health should have been given greater attention. What this evidence showed was that there was some, but in my view insufficient, attention given to the mental health and overall wellbeing of returned passengers.

207. There were areas where there were shortcomings or systemic gaps in meeting the health and human needs of those in quarantine. These can be summarised from this section as follows:

    A. not initially understanding or adequately addressing the fact that:

        I. being detained in quarantine in a hotel room for 14 days would be a very difficult and stressful experience for some

        II. a percentage of the people held in quarantine would have significant health needs, either physical or mental, or both, and would need particular support

        III. having no access to fresh air or exercise would be extremely difficult for some people

B. that the information provided by airlines and/or Commonwealth officials to allow the State to make proper preparations to accommodate people's health and wellbeing needs was limited and inadequate

C. that the State had no control of the numbers arriving at short or no notice, which made the health and wellbeing aspects of the Program very difficult to address adequately

D. transport arrangements on arrival at airports created an immediate stressor for some people as PPE was not consistently available or worn and buses were reported by some to be crowded

E. that clear, consistent and accurate information was necessary but not available or it was difficult to find or it was in a language that was not accessible

F. that the system for acquiring and maintaining information on people in quarantine was inadequate

G. that there was no clear and consistent and communicated process for people to raise issues and concerns about health and wellbeing and to receive a timely response

H. that the process of access to applications for leave and/or exemptions was not clear or consistent.

208. The difficulties this posed were then not sufficiently revisited over time. This was particularly the case in the areas of communication and the degree of responsiveness when those in quarantine attempted to resolve issues. There was a distinct lack of consistent, easily accessible and transparent information available to people detained in the Program regarding the circumstances of their detention and the policies that applied to it.

209. I accept that efforts were made to keep all returning travellers safe and comfortable and to offer appropriate support to all of them. But meeting the health and wellbeing needs of a range of returned travellers is a complex and nuanced task that needs proper attention. Those responsible for the welfare of those in quarantine must be continuously mindful of performing their roles in a way that does not impose additional stressors beyond those already imposed by reason of a highly stressful and unusual situation.

12.2.9 Recommendations

Transitioning into quarantine facilities

80. The Quarantine Governing Body (called COVID-19 Quarantine Victoria) should ensure proper infection prevention and control measures are applied in the transit of returned travellers to their quarantine facility, in the same manner as those measures are applied at hotels. Those measures should include proper social distancing, cleaning and PPE practices.

81. To further reduce the risk of transmission during transit, the Quarantine Governing Body should require that:

A. buses used to transport returned travellers to quarantine facilities must be used only for that purpose and not to provide non-quarantine related transport services to members of the public

B. every effort be made to ensure that drivers of buses used to transport returned travellers to quarantine facilities are not permitted to work in other forms of employment (or to drive buses for any other purpose), consistent with Recommendation 22.

Recommendations 2–6, 37 and 40–57 of the Interim Report have been adopted for the purposes of this Report and apply directly to this chapter. I have set out these recommendations below.

Recommendations 2–6, 37 and 40–57 of the Interim Report

Control of the numbers

FACILITY-BASED MODEL

2. To achieve an orderly and manageable process, the Victorian Government must do all things possible to ensure appropriate and necessary processes are put in place to control the numbers of international arrivals at any given time, informed by the availability of fully operational facilities that are ready and able to receive the agreed numbers.

HOME-BASED MODEL

3. The numbers of international arrivals also be controlled to make practical and achievable the individual engagement and suitability assessments required for home-based quarantine (see Recommendation 59).

INFORMATION GATHERING

4. The Victorian Government takes all possible steps to obtain the co-operation and assistance of Commonwealth agencies and officials, to ensure that the best available and most relevant information is provided to State officials as far in advance as possible for each international arrival, in order to facilitate an informed suitability assessment for appropriate placement in the Quarantine Program (including suitability to quarantine at home).

ELECTRONIC RECORD-KEEPING

5. The Victorian Government liaises with the Commonwealth to develop a process whereby such information about each international arrival bound for a Victorian point of entry can be placed in an electronic file made available to the state authorities as expeditiously as possible prior to the arrival, and for that file to contain targeted information for State officials to assist in the management of the necessary quarantine arrangements.

6. All necessary actions be taken to have that electronic file follow the individual from international arrival through to the completion of their quarantine obligations and include all relevant information to assist in that person's safe transition into the community.

SAFE TRANSPORT ARRANGEMENTS

37. Given the possible COVID-19-positive status of an individual in a quarantine facility or home-based quarantine, arrangements and protocols for the safe transporting of a person for either urgent or non-urgent health reasons should be developed.

DAILY HEALTH AND WELFARE CHECKS

40. The Quarantine Governing Body ensures that daily health and welfare checks be embedded into the operation of each quarantine facility.

41. Site Managers arrange standard daily health and welfare checks on people in quarantine, to be conducted with the assistance of available technology, such as a visual telehealth platform, where the individual is willing and able to participate in this way or as otherwise directed by the Clinical Manager (as per the model I set out at paragraph 21 of Section 1 of my Interim Report).

42. The Quarantine Governing Body provides direction, advice and resourcing as to the use of visual telehealth platforms to enable a case management approach to an individual's health needs, which may enable family, interpreters and existing or preferred healthcare professionals and supports to participate in case conferencing directed to the health and wellbeing of those in quarantine facilities.

43. The daily health and welfare checks be conducted by appropriately skilled personnel who are also able to screen for any unmet needs or concerns, rather than limited to a check on COVID-19 symptoms.

44. Suitable health and welfare checks by appropriately skilled personnel should be conducted on those in home-based quarantine.

FRESH AIR AND EXERCISE BREAKS

45. The Quarantine Governing Body ensures the ability to provide daily fresh air and exercise breaks for people placed in quarantine facilities is factored into not only the physical layout but also the staffing of the facility, to ensure there is provision for safe, daily opportunity for people in quarantine facilities to have access to fresh air and exercise breaks.

COMMUNICATION WITH AND TO PEOPLE IN QUARANTINE FACILITIES OR PRIOR TO ENTRY INTO THE QUARANTINE PROGRAM

46. The Quarantine Governing Body ensures that each facility operates on an understanding and acknowledgment that a number of people placed in quarantine facilities will experience a range of stressors as a result of being detained in a quarantine facility for 14 days.

47. The Quarantine Governing Body ensures that all reasonable steps are taken to assist those who will be particularly vulnerable and require additional skilled support by reason of their being held in quarantine.

48. The Quarantine Governing Body ensures that every effort is made to provide multiple forms of communication of information throughout the period of quarantine to assist in reducing the distress and anxiety that some people will experience in quarantine.

49. The Quarantine Governing Body should address the need to provide accurate, up-to-date and accessible information to all people seeking to enter Victoria through international points of entry, including in community languages, to ensure best efforts at communication are made for all international arrivals.

50. Site Managers ensure that clear, accessible and supportive styles of communication should be regularly used to enable people to have consistent and accurate information about what supports are available to them and who to contact if they have a complaint, concern or enquiry while quarantined in a facility.

51. To assist in creating support for people in quarantine facilities and ensuring that there is information available in a range of formats and languages, Site Managers should assign a role to an appropriate person who can coordinate communications and use various platforms (for example visuals, signs, social media, etc.) to encourage those in quarantine facilities to connect with one another. These platforms can also be used to regularly communicate general and relevant information.

EXEMPTIONS AND TEMPORARY LEAVE

52. Authorised Officers ensure that each person placed in quarantine, whether facility or home-based, is made aware of the process for requesting temporary leave or an exemption and the criteria upon which such requests will be assessed.

53. Authorised Officers make decisions about whether or not to grant an exemption or temporary leave as promptly as practicable.

54. Authorised Officers ensure that any conditions or restrictions on such grants should be clearly communicated to the person making the request and address the need to manage the risk of transmission of COVID-19 while that person is in the community and is monitored for compliance.

55. To assist Authorised Officers and enhance consistent decision-making, that each Authorised Officer be provided with a checklist and guidance material on all relevant considerations when determining applications for exemptions and temporary leave applications.

LANGUAGE IS IMPORTANT

56. Language such as 'resident' rather than 'detainee' be used to reduce the risk of such language having a negative effect on the culture of the facility and to reflect that quarantine is a health measure and not a punitive measure.

TRANSITIONING OUT OF QUARANTINE FACILITIES

57. People leaving quarantine facilities should be offered an opportunity for a 'de-brief' to assist with their transition out of the facility and also to enable the opportunity for feedback to be passed to the Site Managers to assist in maintaining a culture of continuous improvement.

Endnotes

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17 Human Rights Committee, General Comment No.21: Article 10 (Humane Treatment of Persons Deprived of Their Liberty), 44th sess, UN Doc HRI/ GEN/1/Rev.9 (10 April 1992) 1 [3] <https://www.refworld.org/docid/453883fb11.html>.
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34 Transcript of day 15 hearing 10 September, 1230–1231.
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36 Ibid; Transcript of day 15 hearing 10 September 1230–1231.
37 Transcript of day 18 hearing 16 September 2020, 1538; Transcript of day 15 hearing 10 September 2020, 1230–1231.
38 Transcript of day 18 hearing 16 September 2020, 1540.
39 Transcript of day 19 hearing 17 September 2020, 1681.
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43 Exhibit HQI0117_RP Annexures to the first witness statement of Prof. Euan Wallace AM, DHS.0001.0002.0068–0076, DHS.0001.0002.0042–0053.

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65 Exhibit HQI0019_P Witness statement of Ms Sue and Mr Ron Erasmus, 4 [23]–[24].
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CHAPTER 13

Victoria's Quarantine Program: future options

13.1 Introduction

1. This Inquiry has investigated why the Hotel Quarantine Program was established and how it was managed. It has identified failings in the Program's design and administration, including with respect to where focus, responsibility and accountability lay. Fundamentally, this Inquiry has highlighted that the Hotel Quarantine Program was administered without the focus on infection prevention and control that was needed to properly contain the COVID-19 virus and reduce the chance of its spread into the community.
2. This Inquiry has not been solely about identifying deficiencies or finding fault. To do so would be to miss opportunities for strengthening a quarantine model for international arrivals into Victoria. The Inquiry heard evidence from some witnesses about not just what went wrong, but also, what could have been done better. Where deficiencies have been identified throughout the course of the Inquiry, it has given rise to lessons that can be learned. This Inquiry has been about identifying not just what the Hotel Quarantine Program was but, also, what it could or should be in the future. It has accordingly given rise to 81 recommendations.
3. Those 81 recommendations include the ones I made in the Inquiry's Interim Report, as to options for future quarantine for international arrivals. Those recommendations set out two models that would operate concurrently: the first being a facility-based model and the second being a home-based model.[1] Those models were proposed having taken into account, and in response to, the issues that were raised during the Inquiry.
4. The Interim Report and attached recommendations deal, first, with a facility-based model. Many aspects of the facility-based model apply generally to both components of this future program.

13.2 A facility-based quarantine model for the future

5. The way forward from the Hotel Quarantine Program is the development of a future model for quarantine that has, at a minimum, certain key features. I have described those features in the Interim Report[2] but, for completeness, provide a general overview of those features here.

There should be clarity of roles and in the governance structure for the program

6. First, there should be a governance structure that sits across the entire Program with clear lines of accountability and with clarity of roles throughout that structure.[3] Built into that governance structure should be a framework for supporting decision-making that is informed by appropriate expertise and oversight.[4]

7. Within that governance structure, overall accountability should lie with one Responsible Minister and one responsible agency[5] — which I called the 'Quarantine Governing Body' — accountable to that Minister.

8. With clarity of roles comes a need to set clear expectations as to what is required from all personnel operating at the facility, with appropriate monitoring and oversight of those personnel.[6]

On-site management and role clarity

9. Second, and related to the first feature, is the need for clear definition of roles at the on-site leadership level and throughout the facility.

10. At the operational level, there should be one position that holds — and is clearly seen to hold — authority on-site for the overall operation of the quarantine facility.[7] I have called that role the 'Site Manager'. The Site Manager should report to the Quarantine Governing Body.[8] It should be filled by a person with expertise in managing complex healthcare facilities.[9]

11. Every person working at the quarantine facility needs to understand their role and responsibilities, how their role relates to the roles of others and who on-site has ultimate authority to control the site.[10]

Facilities need to be staffed with an appropriate mix of on-site personnel

12. Third, there ought to be a suitable mix of personnel engaged on-site so as to meet the objectives of a facility-based quarantine program.[11] Just as the overarching objective of a quarantine program should be to prevent the transmission of COVID-19 from international arrivals entering the community,[12] the objective of protecting the safety of those placed within the Program, and those working within the Program, should also be paramount.[13]

13. There should be a focus on infection prevention and control, and infection prevention and control measures should be both proactive and reactive, with infection prevention and control experts embedded within each facility.[14]

14. A dedicated contact tracing unit should be embedded in each facility,[15] along with COVID-19 testers, food service providers, cleaners, and compliance, enforcement and security personnel.[16] Facilities should be staffed with clinical personnel (including healthcare workers) who can meet the mental and physical health needs of returned travellers.[17]

Facilities should be staffed with security services provided by an appropriate cohort, with Victoria Police involved

15. Fourth, on-site security personnel should be directly employed by the Quarantine Governing Body and be bound by the Code of Conduct for Victorian Public Sector Employees.[18] Those providing security services should have skills in supervision, communication, de-escalation, conflict management and maintaining professional boundaries.[19]

16. Victoria Police should have a 24/7 presence in facilities.[20] Victoria Police members should be supported by appropriate safety measures, training and instructions.[21] Their role should be to control access, entry and exit points, maintain a presence in the facility foyer and to patrol floors.[22]

A dedicated mix of personnel is necessary

17. Fifth, employment conditions are important to reduce the risk of transmission between the facility and elsewhere in the community. Those conditions should require that personnel in a facility, wherever possible, be limited to working at that facility.[23] That applies to clinical and non-clinical personnel.[24]

18. To reduce the potential for personnel to work across multiple sites or to continue to work even if symptomatic (so as to not absent themselves and risk their wage), personnel should be salaried and appropriately remunerated.[25] Their terms of employment should contain sick-leave entitlements in the event they receive a positive COVID-19 diagnosis or are otherwise required to self-isolate.[26] Personnel should be financially supported to encourage self-isolation where they show symptoms or are otherwise at risk of contracting COVID-19.[27] Following self-isolation, personnel should be permitted to return to work after having received a negative swab result.[28]

19. There should be ways to control the number of returning travellers at any one time so as to properly and consistently manage personnel levels and not become reliant on the need to build a 'surge capacity' of additional personnel.[29]

There should be an appropriate focus on training and the building of an infection prevention and control culture

20. Sixth, each person within a facility should be appropriately trained in infection control requirements, PPE usage, physical distancing and hand hygiene.[30] They must have a thorough understanding of the range of COVID-19 symptoms, as well as the need to self-isolate if they show symptoms.[31] They must also have a clear understanding of their responsibilities with respect to contact tracing, should contacts need to be identified, tested and isolated.[32]

21. The Site Manager should continually reinforce, supervise and monitor this training, understanding and practice.[33]

22. The approach to infection prevention and control should be a collaborative one, focusing on education, auditing personnel and processes, and ensuring clear and apparent lines of escalation.[34]

23. The workplace infection prevention and control culture should be enhanced through the adoption of a range of measures, such as health screenings, changing PPE after arrival, leaving uniforms and equipment at facilities, decontamination procedures, briefings upon entry and assessment of rules relating to movement within and around common facilities.[35]

24. To protect against the risk of transmission, it should remain a presumption at all facilities (whether or not COVID-positive cases are cohorted in one facility) that those in quarantine are infected until it is known that they are not infected.[36]

25. Cleaning is particularly important to infection prevention and control measures. It requires experts to train and direct cleaning personnel, both with respect to areas to be cleaned, the standard to which areas must be cleaned and the products and methods used to properly clean those areas.[37]

26. A culture of safety is important. It should be actively fostered and reinforced.[38]

PPE should be made available and properly used

27. Seventh, appropriate PPE should be made available,[39] together with up-to-date advice on its proper use.[40] The use of PPE should be subject to monitoring and supervision.[41]

28. All personnel must receive training on how to properly use PPE,[42] with personnel being tested on their ability to properly use PPE before being permitted to work in the facility.[43] Those providing training must be experienced in the use of PPE.[44] PPE training should be delivered (at least, in part) in person, with physical supervision and instruction; remote or online training is not sufficient. [45]

Implementing audits and rapid responses to issues in order to serve continuous improvement

29. Eighth, there should be regular and independent compliance audits to ensure best practice is maintained.[46] In particular, cleaning practices should be regularly audited using industry-standard swab tests of surfaces.[47]

30. Concerns identified (through audit or otherwise) should be responded to quickly and effectively.[48] As part of internal governance procedures, a risk register should be maintained and reviewed, and provided to safety auditors.[49]

Make efforts to manage the influx of returned passengers and their health and welfare needs

31. Ninth, the number of returned travellers should be managed by reference to available facilities. Efforts should be made to control the number of returned travellers at any given time.[50] There must be appropriate engagement with, and cooperation between, Commonwealth and State officials to achieve a more manageable procedure for arrivals.[51]

32. That engagement is not only to determine the number of new arrivals but to also determine the demographics of the returning cohort and to identify any complexities or particular health and wellbeing requirements of those returning.[52] Officials should proactively seek information about the returning travellers.[53] The quality of that information is important: it should be accurate, detailed and current.[54]

33. The health, wellbeing and needs of those in quarantine must be a central feature of a future quarantine program.[55]

34. Each returning traveller should be assessed to determine and understand, as completely as possible, their individual needs and risk factors.[56] Steps should be taken to address any communication needs for people being mandated into quarantine, such as language barriers or physical impairments that necessitate additional supports.[57]

35. Clinical equipment to service the needs of returned travellers should be made available on-site, and their availability and use should be based on medical advice.[58]

36. There is a need for a consistent, appropriate and safe method for medical, nursing and healthcare personnel to maintain daily health and welfare checks on people in quarantine.[59] Consideration should be given to using technology to maximise care without unnecessarily exposing personnel to risk of exposure to the virus.[60]

37. Where people require high levels of monitoring or care, they should be placed in a hospital or other suitable equivalent and dedicated health facility, not a quarantine facility.[61]

Proper information collection, storage and sharing of processes and practices is necessary

38. Tenth, it is important to collect, share and use information to provide for the welfare of returned travellers.

39. Once travellers are placed into quarantine, their information should be stored on a real-time information sharing and tracking system that is accessible by all staff with a role in providing services, care and support to returned travellers.[62]

40. To assist in their care and support, information about returned travellers should be stored on an electronic record[63] with the functionality to alert personnel of key activities, such as welfare or symptoms checks, and whether they have been missed.[64]

41. The maintenance of such records will assist with communication between personnel at a facility. There should be formal processes to ensure proper and thorough handover occurs within, and between, teams.[65]

The program should include testing for returned travellers

42. Eleventh, accepting that the 14-day quarantine period has a rational evidentiary basis,[66] COVID-19 testing is nevertheless critical to identify people who have contracted the disease but are asymptomatic (or have minor symptoms) before their discharge from the quarantine program.[67]

There should be provision for exemptions from quarantine

43. Twelfth, there must be a process for allowing temporary, partial or complete exemptions from quarantine,[68] which must be made known to people to enable requests for exemptions to be made.[69] The criteria for assessing requests for exemptions should also be made known.[70] Exemptions should be assessed using guidance material anchored in advice regarding risk of infection and wellbeing issues, together with legal advice regarding the application of the *Public Health and Wellbeing Act 2008* and *Charter of Human Rights and Responsibilities Act 2006*.[71]

44. Decisions to allow temporary exemptions should be made promptly, and subject to conditions to manage the risk of transmission of COVID-19, where necessary.[72] These conditions should be clearly communicated to the international arrivals and recorded on the traveller's file.[73]

Safe transport arrangements need to be implemented where necessary

45. Thirteenth, where travel is required, it must be safe. A range of travel options might exist; the most appropriate will differ depending on individual circumstances.[74] It is for this reason that there should be an effective triage process in place to determine safe modes of transport for a relevant traveller, which includes the need for those making that assessment to have the appropriate skills and training.[75]

The facility must be safe and suitable to provide for the maintenance of health and wellbeing

46. Fourteenth, the selection of an appropriate facility should take into account a number of factors, such as its proximity to a hospital,[76] commuting distance for adequate numbers of appropriately skilled personnel[77] and adaptability for proper implementation of infection prevention and control requirements and physical separation of people and zones.[78]
47. When considering a facility to stand up, special consideration should be given to the physical environment for accommodating children and their particular needs.[79] There should also be additional supports for those with nicotine, drug or alcohol dependency issues.[80]
48. The facility should accommodate safe access to fresh air for all those in quarantine.[81] Fresh air breaks are important for health and wellbeing of people in quarantine. They should all have the same opportunity for fresh air and exercise breaks each day.[82]
49. Access to fresh air should be supplemented by a robust and appropriately developed process for safely facilitating such breaks.[83] The process should provide clear instructions to those conducting fresh air breaks and clearly communicate to people in quarantine what to expect from those breaks.[84]
50. In the case of emergencies, the facility should have an emergency evacuation plan. Each Site Manager must develop an emergency evacuation plan for the facility that is well understood and regularly rehearsed by all personnel.[85] The plan must address safe evacuation practices in a manner consistent with minimising the risk of infection to guests, personnel and the community.[86]

It is critical to promote access to information and provide for various communication channels

51. Fifteenth, effective and supportive communication is important to reduce stress for people in quarantine. It is important to provide people in quarantine with information about how the COVID-19 virus works and what people need to do to protect themselves against it.[87] By communicating the link between the virus and arrangements in place to reduce its spread, compliance with — and trust in — the program should increase.[88]
52. Personnel within the facility should practice 'supportive communication' and be trained in it, where appropriate.[89]
53. People in quarantine may also need to make complaints about their experiences. Each facility should have a process for those people to give feedback, communicate and (if necessary) escalate unaddressed or inadequately addressed concerns about their needs.[90]

54. Communication between people in quarantine should be encouraged.[91] Developing a sense of community solidarity and support is a way to manage fears and reduce a sense of solitary exposure.[92] Technology may be used to safely disseminate information and foster a sense of community, such as through social media and moderated online discussion groups.[93]

55. When referring to people in quarantine, it is necessary to use consistent and neutral terms in a way that promotes a positive culture within a facility: for example, 'resident' is a preferable descriptor to 'detainee'.[94]

56. When people exit the quarantine program, it is important that there is a framework within which they can debrief, or reflect upon, their experience.[95] This provides an opportunity for the Site Manager to be made aware of issues and respond to them, and to promote continuous improvement.[96]

Endnotes

1 Board of Inquiry into the COVID-19 Hotel Quarantine Program (Interim Report, 6 November 2020) 24 [5] <https://www.quarantineinquiry.vic.gov.au/reports>.
2 Ibid 29–62.
3 Ibid 29 [10].
4 Ibid 29 [12].
5 Ibid.
6 Ibid 29 [15].
7 Ibid.
8 Ibid 29 [16].
9 Ibid.
10 Ibid 29–30 [17]–[19].
11 Ibid 30 [20].
12 Ibid 27 [4], citing Ms Melissa Skilbeck, Deputy Secretary Regulation, Health Protection and Emergency Management, DHHS: Exhibit HQI0125_RP Witness statement of Ms Melissa Skilbeck, 6 [34].
13 Board of Inquiry into the COVID-19 Hotel Quarantine Program (Interim Report, 6 November 2020) 27 [5] <https://www.quarantineinquiry.vic.gov.au/reports>.
14 Ibid 18 [24], 30 [20], 57 [21], [24].
15 Ibid 19 [38], 34 [39]–[41].
16 Ibid 30 [21].
17 Ibid.
18 Ibid 32 [25].
19 Ibid.
20 Ibid 32 [28].
21 Ibid 32 [26]–[27].
22 Ibid.
23 Ibid 33 [29].
24 Ibid.
25 Ibid 33 [31].
26 Ibid 33 [32].
27 Ibid 36 [52].
28 Ibid.
29 Ibid 33 [34].
30 Ibid 34 [36].
31 Ibid 34 [38].
32 Ibid 37 [53].
33 Ibid 34 [38].
34 Ibid 35 [43].
35 Ibid 36 [48].
36 Ibid 40 [76].
37 Ibid 39 [67].
38 Ibid 35 [42].
39 Ibid 37 [55].
40 Ibid 37 [56].
41 Ibid 38 [61].
42 Ibid 37 [57].
43 Ibid 37 [60].
44 Ibid 37 [58].
45 Ibid 37 [59].
46 Ibid 38 [63].
47 Ibid 39 [68].
48 Ibid 38 [63].
49 Ibid 38 [65].
50 Ibid 39 [70].
51 Ibid 39 [72].
52 Ibid 40 [77].

53 Ibid 40 [78].
54 Ibid 40 [78], [80].
55 Ibid 46 [116].
56 Ibid 40 [77].
57 Ibid 52 [163].
58 Ibid 19 [36].
59 Ibid 47 [122].
60 Ibid 48 [125].
61 Ibid 47 [121].
62 Ibid 41 [87].
63 Ibid 42 [90].
64 Ibid 43 [91].
65 Ibid 43 [93].
66 Ibid 43 [97].
67 Ibid 44 [98].
68 Ibid 44 [102].
69 Ibid.
70 Ibid.
71 Ibid 44 [101].
72 Ibid 44 [103].
73 Ibid.
74 Ibid 44 [104].
75 Ibid 45 [107].
76 Ibid 48 [131].
77 Ibid 48 [132].
78 Ibid 48 [133], 49 [134].
79 Ibid 49 [135].
80 Ibid 49 [136].
81 Ibid 49 [137].
82 Ibid 49 [139].
83 Ibid 49 [140].
84 Ibid.
85 Ibid 45 [110].
86 Ibid.
87 Ibid 50 [142].
88 Ibid.
89 Ibid 50 [146]–[147].
90 Ibid 51 [151]–[152].
91 Ibid 52 [158].
92 Ibid 51 [156].
93 Ibid 52 [159]–[160].
94 Ibid 53 [168].
95 Ibid 53 [169].
96 Ibid 54 [172].

CHAPTER 14

How we went about our work

1. Boards of Inquiry set up pursuant to s. 53 of the *Inquiries Act 2014* (Vic) (Inquiries Act) are relatively new statutory investigatory bodies. To date, they have not been widely used. This particular Board of Inquiry was set up and operated in an unchartered environment for Inquiries in general, including operating in circumstances where the consequences of the subject-matter of the Inquiry were still unfolding, resulting in the Inquiry having to change its physical location and adapt its methodology as it was running.
2. For these reasons and others, it seemed important to outline how the Inquiry went about its work from establishment through to this Final Report, and to provide copies of Practice Directions and letters and various notices (see Appendices D and F).

14.1 Establishment of the Inquiry

3. The Inquiry was established by an Order of the Governor in Council on 2 July 2020, which set out the Terms of Reference (available at page 136).
4. Pursuant to the Order in Council, the Inquiry was directed to examine, report on and make any recommendations in relation to its terms of reference, including:
    A. decisions and actions of Victorian government agencies, hotel operators and private service providers
    B. communication between Victorian government agencies, hotel operators and private service providers
    C. contractual arrangements
    D. information, guidance, training and equipment provided to relevant personnel
    E. policies, protocols and procedures
    F. any other matters necessary to satisfactorily resolve the above matters.

14.2 Engagement of staff to support the Inquiry's work

5. Following the appointment of the Chief Executive Officer, administrative and legal teams were set up to support the work of the Inquiry.
6. Mr Tony Neal QC was engaged as Senior Counsel Assisting the Inquiry. Soon after Mr Ben Ihle SC, Ms Rachel Ellyard, Mr Steven Brnovic and Ms Jessica Moir were also engaged as Counsel Assisting the Inquiry.
7. Additional staff were seconded to the Inquiry to provide expertise and assistance across its key categories of work. This included administrative, legal, communications and media staff, and staff to support the policy, research, writing and public engagement functions of the Inquiry.

8. Inquiry staff were engaged to assist the Board pursuant to s. 56 of the Inquiries Act.

9. Section 56(2) of the Inquiries Act empowers the Board to (among other things):

    A. enter into any agreements or arrangements for the use of services of any staff of a Department, statutory authority or other public body

    B. engage people with suitable qualifications and experience as consultants

    C. if authorised to do so by the establishing Order for the Board of Inquiry, engage one or more Australian legal practitioners to assist the Board of Inquiry as counsel

    D. enter into agreements or arrangements for the provision of any other services to the Board of Inquiry.

10. Section 56(4) of the Inquiries Act also provides that:

    > The employment or engagement of members of staff of a Board of Inquiry may be on any terms and conditions the chairperson considers appropriate and all members of staff are subject to the direction lof the chairperson.

11. In addition, s. 57 of the Inquiries Act provides:

    > If the public sector values referred to in section 7(1)(a)(i) and (c)(iii) of the *Public Administration 2004* (Vic) would, but for this section, apply to a member of staff of a Board of Inquiry, those public sector values do not apply to the member of staff in respect of their employment or engagement with the Board of Inquiry.

12. Sections 7(1)(a)(i) and (c)(iii) of the *Public Administration Act 2004* (Vic) deal with providing advice to the government and implementing government policies and programs.

13. A total of 34 people were employed to support the Chair of the Inquiry to undertake its work.

Table 14.1: Staff engaged by the Inquiry

Category of work	Number of staff engaged by the Inquiry
Chief Executive Officer	1
Senior Counsel Assisting	1
Counsel Assisting	4
Legal Associate to the Board	1
Office/Project Coordinator	1
Intake and Assessment	3
Community, Digital and Media	2
Policy, Research and Report Writing	4
Office of Solicitors Assisting the Inquiry	17

14.3 Shift to remote working

14. Initially, I and a small number of administrative and legal staff supporting the Inquiry were physically located in the Inquiry's office in Melbourne's CBD. Inquiry staff were provided with training and induction to ensure a COVID-safe work environment.

15. On Wednesday 8 July 2020 at 11.59pm, one week after the Inquiry was established, Stage 3 coronavirus restrictions were reinstated in metropolitan Melbourne and Mitchell Shire.[1] Consistent with these restrictions, Inquiry staff shifted to, largely, working from home. The Inquiry's office remained open to Inquiry staff who needed to use it, with COVID-19 safety protocols in place, until Stage 4 restrictions came into effect in Melbourne on 2 August 2020.[2] Further detail on the implications of Stage 4 restrictions on the Inquiry's work is provided below.

14.4 Community engagement and Intake and Assessment

16. Efforts in the early weeks of the Inquiry focused on putting in place processes to allow media, members of the public and lawyers to contact the Inquiry to provide information relevant to its Terms of Reference or seek advice or direction.

17. On 15 July 2020, the Inquiry's website went live with information about its establishment, purpose and contact details for media enquiries.[3] From 15 July to 3 December 2020, the Inquiry's website received approximately 139,000 unique visitors, with the website receiving an approximate total of 755,000 page views by those unique viewers.

18. A dedicated email address, 1800 number and post office box were also established by 15 July 2020 to facilitate contact from members of the public.[4]

19. Between 15 July and 3 December 2020, the Inquiry received a total of 186 phone calls and 847 letters and emails from a wide range of sources. Those sources included returned travellers, security staff, cleaners and nurses involved in the Hotel Quarantine Program, as well as members of the public who witnessed activity at quarantine hotels or ran businesses near quarantine hotels.

20. Information provided to the Inquiry via these various forms of communication assisted in informing aspects of the Inquiry's investigations. A number of witnesses who gave evidence to the Inquiry were also identified via these channels.

14.5 Practice Directions

21. The Inquiry issued five Practice Directions on 15 July, 6 August and 31 August 2020 to set out the practice and procedure of its hearings. A copy of each Practice Direction is located at Appendix D. A summary of each Practice Direction is outlined below.

15 JULY 2020

- Practice Direction 1: set out the way in which the Inquiry would deal with claims of 'reasonable excuse' in response to a Notice to Attend (a notice compelling a person who received it to attend the Inquiry to give evidence) or a Notice to Produce (a notice compelling the production of specified documents or things), and how the Inquiry would receive materials in response to a Notice to Produce or an informal request for information.
- Practice Direction 2: provided general guidance about applications for leave to appear at the evidentiary public hearings of the Inquiry.
- Practice Direction 3: set out the way in which the evidentiary public hearings of the Inquiry would be conducted.

6 AUGUST 2020

- Practice Direction 4: related to the conduct of the evidentiary public hearings that would be held as part of the work of the Inquiry in a virtual environment.

31 AUGUST 2020

- Practice Direction 5: related to the handling of documentary evidence produced to the Inquiry.

14.6 Notices to Produce

22. On 10 and 11 July 2020, the Inquiry commenced sending letters to a range of government departments, security firms and hotels that were identified by the Inquiry as potentially being relevant to the Hotel Quarantine Program. These letters requested an initial response from parties to help the Inquiry understand which parties and matters were directly linked to the work of the Inquiry. The letters also notified parties that they would receive a Notice to Produce and provided information on the Inquiry's hearings, including timelines and likely requests for witness statements.

23. From 14 July 2020, Notices to Produce were sent to government departments, security firms and hotels seeking documents relevant to the Hotel Quarantine Program and the Inquiry's Terms of Reference. Given the tight timeframes to which the Inquiry was working, parties were asked to provide, by 24 July 2020, documents that were publicly available or not subject to a claim excusing their production, with remaining documents to be provided by 31 July 2020. While a substantial number of documents were received by 31 July 2020, there were significant delays in many critical documents being provided to the Inquiry. Further detail on these delays is provided at paragraphs 34 to 43.

24. It was through receipt of these documents, as well as information received via community engagement, that the Inquiry was able to identify possible witnesses who could provide the Inquiry with critical insight and evidence.

25. The Inquiry issued a total of 170 Notices to Produce, comprising 62 notices to produce documents and 108 notices to produce witness statements or affidavits.

26. In excess of 70,000 documents were received by the Inquiry, comprising more than 350,000 pages.[5] The Inquiry's legal team was expanded to undertake the significant amount of work required to review these documents ahead of, and during, the Inquiry hearings.

14.7 Inquiry hearings

27. All Inquiry hearings were live streamed with a closed caption service on the Inquiry website. Hearing transcripts and exhibits were published on the Inquiry website.[6] Visitors could also view previous hearings on the website as all were recorded and uploaded onto the website.[7]

28. The Inquiry had viewers from all over the world including Hong Kong, Canada, Malaysia and the Netherlands. Approximately 300,000 unique viewers tuned in to the hearings, via the live link on the Inquiry's website, over the course of all 27 hearing days. That link to the livestream was hosted by an external provider and the number of unique viewers is therefore treated separately to the number of unique visitors to the Inquiry's website, as identified at paragraph 17. The unique viewer count also does not include those who tuned into the hearing via links provided on other websites or on broadcast networks.

29. On 20 July 2020, Senior Counsel Assisting the Inquiry, Mr Tony Neal QC, delivered an opening statement from a hearing room that had been hired for the Inquiry at the Fair Work Commission (FWC), in a COVID-safe environment. On this day, it was announced that public evidentiary hearings would commence on 6 August 2020.[8]

30. On 2 August 2020, a State of Disaster was declared for Victoria and Stage 4 restrictions were introduced in Melbourne.[9] This led to an unscheduled public sitting (extraordinary sitting) on 5 August 2020 to announce the Inquiry would reset its working arrangements. To continue as intended, the Inquiry had to set up the capacity to conduct the entire working and hearing process electronically and virtually with me, the entire staff and Counsel Assisting all working from home. To achieve this, the evidentiary hearings were adjourned to commence on 17 August 2020. As a result of this disruption and the massive amount of material being received by the Inquiry, an extension to the Inquiry's reporting deadline was sought and granted.[10] Further detail on the extraordinary sitting is provided at paragraphs 38 and 39.

31. Public evidentiary hearings commenced on 17 August 2020 and concluded on 25 September 2020. Counsel Assisting delivered oral closing submissions on 28 September 2020. An additional extraordinary hearing was held on 20 October 2020 to tender additional documents (discussed further at paragraph 41). In total, 27 hearing days were held.

32. Ninety-six witnesses gave evidence via witness statements and/or affidavits, with 63 of these witnesses appearing at hearings to give evidence. Witnesses comprised medical experts, returned travellers, security staff, hotel staff, public servants, Ministers and the Premier. A full list of witnesses who provided evidence and witnesses who appeared is available at Appendix G.

33. Thirty parties were granted leave to appear before the Inquiry and 263 exhibits were tendered during the course of the hearings. A list of parties with leave to appear is available at Appendix E and a list of exhibits tendered at hearings is available at Appendix H.

14.8 Extensions to the Inquiry's reporting deadline

34. The Inquiry's Terms of Reference originally required delivery of the final report by 25 September 2020. It became clear, during the early stages of the Inquiry, that further time would be needed to complete the work.

35. On 3 August 2020, following the declaration of the State of Disaster and the introduction of Stage 4 restrictions, I wrote to the Premier seeking a six-week extension to the reporting date of the Inquiry due to:

    A. logistical difficulties arising from the introduction of Stage 3 restrictions in metropolitan Melbourne, including delays in the Inquiry being provided with many critical documents in an inaccessible form

    B. the volume of documents received from government departments and private entities (106,000 pages had been received as at 2 August 2020)

    C. the impact of the declaration of a State of Disaster for Victoria and Stage 4 restrictions for metropolitan Melbourne on 2 August 2020.

36. These factors added to significant concerns Counsel Assisting already held about the feasibility of completing the Inquiry within the allocated timeframe.

37. On 5 August 2020, the Premier wrote to me approving an extension to the Inquiry's reporting date to 6 November 2020. On the same day, the Order of the Governor in Council was to extend the Inquiry's reporting date to no later than 6 November 2020.

38. As stated above, on the afternoon of 5 August 2020, the Inquiry held an extraordinary sitting where I addressed the impact of the State of Disaster and Stage 4 restrictions for metropolitan Melbourne on workplaces across Victoria, including the Inquiry's workplace.

39. At that sitting, I announced that the Inquiry would continue its work despite these obstacles but do so remotely. The Inquiry vacated the hearing room at the FWC and its offices in the CBD. As noted above, the first public evidentiary hearing was rescheduled to 17 August 2020 so the relevant technology could be installed in my home and the homes of Counsel Assisting, and so that associated testing and training could be delivered.

40. The public evidentiary hearings concluded on 25 September 2020, whereupon the final stage of the Inquiry's work — report writing — commenced.

41. However, following the receipt of additional material in early October, another extraordinary sitting of the Inquiry was held on 20 October 2020. I announced that the Inquiry was continuing to conduct investigations, following new documents coming to light, and that this may impact on the delivery of this report. The delays to the Final Report are discussed further at paragraphs 48 to 73.

42. I then wrote to the Premier, on 28 October 2020, to advise that the Inquiry would not be able to deliver a final report by 6 November 2020. I proposed that an interim report, instead, be delivered on that date, with the final report to follow on 21 December 2020.

43. On 29 October 2020, the Premier responded and advised he agreed that the final reporting date should be extended.

14.9 Interim Report

44. The Interim Report was delivered, as per the revised timeline, on 6 November 2020.[11]

45. My view was that, as restrictions started to ease and Victoria began to consider re-opening to international arrivals, it was important that the Inquiry contribute to the ongoing work of developing and implementing a robust quarantine system for our State. It was in this context that the Interim Report was prepared, including recommendations for a future quarantine program in Victoria.

46. The recommendations I made in that Interim Report are set out in this Final Report at pages 38–46 of Volume I.

14.10 Final Report

47. The Inquiry's Final Report synthesises evidence provided through documents from government departments, hotels, security firms, medical staff and medical experts, mental health experts and returned travellers. Inquiry staff produced hearing summaries during the course of the Inquiry to assist with the considerable task of preparing this Final Report.

14.10.1 Delays to the Final Report

48. On 25 September 2020, Counsel Assisting the Board announced the close of evidence.[12] In the eight weeks that followed, new evidence was produced to the Board, generally relating to four issues:

    Issue 1: decision to engage private security

    Issue 2: Prof. Sutton and private security

    Issue 3: role of the Department of Health and Human Services (DHHS) Public Health Team in Operation Soteria

    Issue 4: document production.[13]

49. I sought documents relating to Issue 1 in response to issues raised by Parties with Leave to Appear in closing submissions.

50. Documents relating to Issues 2–3 were sought in response to matters separately reported to the Inquiry subsequent to the close of evidence. These matters, and the belated production of documents in response to Issues 2–3, gave rise to a further issue about the approach taken by DHHS and its lawyers, MinterEllison, to document production (Issue 4). I sought information on this issue from DHHS and MinterEllison in the form of correspondence and affidavit evidence. Counsel Assisting and DHHS subsequently made Further Written Submissions on the following matters relating to this issue:

    A. whether the material produced by DHHS subsequent to the close of evidence should have been produced earlier

    B. whether Prof. Sutton 'instructed' MinterEllison not to produce one of the latterly produced documents when it was raised with him after the close of evidence

    C. compliance by DHHS and MinterEllison with the Model Litigant Guidelines.

51. These, and other related matters, are discussed in this section. Issues 1 and 2 are addressed in Chapter 5 and Issue 3 is addressed in Chapter 8.

Should the material produced by DHHS subsequent to the close of evidence have been produced earlier?

52. A total of 494 documents were produced by DHHS after the close of evidence. At least 138 of these documents were new documents being produced for the first time.

53. In its Further Written Submissions, DHHS rejected 'in the strongest possible terms' those aspects of Counsel Assisting's Further Written Submissions that suggested a failure on the part of DHHS and its legal team to produce relevant documents.[14] DHHS submitted that:

    A. DHHS's production obligations were limited by the Board, including by reference to the concept of 'critical documents' informed by s. 26 of the *Civil Procedure Act 2010* (CPA), the standard for which is not the same as 'relevance' and is significantly narrower than general discovery[15]

    B. the concept of 'critical documents' involved the Department making a 'good faith assessment' as requested by the Inquiry[16]

    C. certain practical circumstances should be acknowledged, including:

        I. the volume of documents being dealt with, which included 500,000 documents on 'the database' and 4,542 documents being produced

        II. the short timeframes for producing documents and the long hours required of DHHS's legal team working remotely during stage 4 restrictions

        III. the volume of witness statements and evidence concurrently required, which included 26 witness statements and 14 witnesses giving *viva voce* evidence

        IV. DHHS's ongoing pandemic response activity.[17]

54. Having regard to these matters, I accept that latitude must be afforded when considering the approach taken by DHHS and its lawyers to document production.

55. I am, nevertheless, satisfied that there is at least one instance where a document should have been produced earlier by DHHS, being Exhibit 230. Exhibit 230 is a chain of emails sent on 27 March 2020, which includes a request from the Commonwealth Department of Home Affairs to Prof. Sutton for information on the Victorian hotel quarantine arrangements then in place, a response from DHHS Agency Commander, Mr Braedan Hogan stating that private security would be contracted, and a reply from Prof. Sutton thanking Mr Hogan for providing that response.[18]

56. This email chain was the subject of specific enquiries as it appeared to conflict with evidence previously given by Prof. Sutton stating that he was unaware that private security had been engaged in the Hotel Quarantine Program until after the outbreaks at the Rydges Hotel had occurred in late May 2020. As discussed in Chapter 5, I accept the evidence subsequently given by Prof. Sutton on this matter. That is, while emails such as those contained in Exhibit 230 presented an opportunity for Prof. Sutton to become aware that private security had been engaged before late May 2020, I accept his sworn evidence that he did not 'register' such information at that time.

57. Exhibit 230 was also the subject of specific enquiries regarding why this email chain was not produced until 15 October 2020.

58. In its Further Written Submissions, DHHS submitted that this document was not produced earlier upon it being identified by DHHS and its lawyers, because:

    A. it is doubtful that the document was captured by the Notice to Produce issued to DHHS on 14 July 2020 (NTP-001) as it did not 'evidence a decision or action (in particular to use private security)', it did not constitute a 'communication between Victorian Government agencies, hotel operators and Private Security Providers' and no other category contained in NTP-001 has 'any realistic application'[19]

    B. it was not 'critical', in the sense conveyed by s. 26 of the CPA, because the document had no bearing on the issue of who determined to use private security, and merely recorded arrangements then in place, in respect of which a large amount of consistent evidence had already been led[20]

    C. Prof. Sutton had a 'strong view' that the document did not change his evidence — because, as explained in his 4 November 2020 affidavit, he did not register that Exhibit 230 referred to private security being used. Because Exhibit 230 did not mean that Prof. Sutton wished to alter anything in his statement or oral evidence, the DHHS's legal team also concluded that there was no legal obligation for the document to be produced to the Board in order to make any correction to his earlier evidence.[21]

59. I do not accept these submissions as a complete response, for reasons including the following:

    A. the terms of NTP-001, which reflected the Board's Terms of Reference, are wide and are to be interpreted broadly at law

    B. Exhibit 230 clearly evidences the decisions and actions of Victorian government agencies involved in the Hotel Quarantine Program in respect of COVID-19 Quarantine Containment, and is therefore captured by NTP-001

    C. even if Exhibit 230 was not a 'critical document' before Prof. Sutton gave evidence on 16 September 2020 (a matter about which I have reservations), it became a 'critical document' when Prof. Sutton gave evidence that was apparently inconsistent with the contents of this document on that date

    D. even if DHHS and its lawyers did not turn their minds to that issue on that date, the evidence is that Exhibit 230 and other documents were sent by a DHHS employee to a DHHS manager who was assisting in connection with the Inquiry on 20 September 2020.[22] The matter was raised again on 28 September 2020, when the same DHHS employee made enquiries with MinterEllison and/or DHHS, as to whether Exhibit 230 had been produced to the Inquiry[23]

E. At that point, it should have been clear that there was an apparent inconsistency between Exhibit 230 and the evidence previously given by Prof. Sutton. Exhibit 230 should have been promptly produced to the Inquiry both because it was (by that point at the latest) a 'critical document' and to avoid the Inquiry reaching findings based on incomplete and potentially misleading evidence. Instead, Exhibit 230 was not produced until 15 October 2020, the same day a specific request was made by the Inquiry for that particular document

F. DHHS was requested to provide an explanation as to why this document was not produced prior to 15 October 2020.[24] I do not accept the reasons advanced by DHHS in respect of the delay between 28 September and 15 October 2020. While Prof. Sutton may have advised that he did not consider he needed to correct his evidence in light of Exhibit 230, it is for me to determine how Exhibit 230 should be reconciled with Prof. Sutton's previous evidence. Further, while I accept that DHHS was busy with other matters at this time, promptly producing Exhibit 230 to the Inquiry with confirmation that an explanation would be forthcoming shortly thereafter, would have involved minimal time and effort and should have been done.

'Instructions' by Prof. Sutton on Exhibit 230

60. By letter dated 19 October 2020, MinterEllison wrote to the Inquiry (in response to my request for an explanation)[25] about the belated production of Exhibit 230 and other issues on behalf of DHHS, stating:

> Prof. Sutton instructed us he had not read the detail of the email at the time and that the evidence that he gave to the Board was truthful at the time and remains so. In other words, Prof. Sutton stands by that evidence which was provided honestly. Prof. Sutton further instructed us that he did not consider he needed to clarify his evidence and therefore the email did not need to be provided to the Board for that reason.[26] (emphasis added)

61. When specifically asked whether he had instructed MinterEllison not to produce Exhibit 230, Prof. Sutton gave affidavit evidence stating:

> It was not my role to give instructions on behalf of the Department about document production.
>
> I did not instruct MinterEllison or solicitors to the Department that the emails (in exhibit 230) not be produced. As set out in my answer to question 21, my discussion with [MinterEllison] was about the bearing of exhibit 230 on my evidence; it was not about production more generally. My natural view was it was for MinterEllison and the Department to determine what is in scope of requests issued by the Board and what was appropriate.[27]

62. In its Further Written Submissions, Counsel Assisting raised this issue and submitted that it should be the subject of further submissions from DHHS.[28]

63. In its Further Written Submissions, DHHS submitted the following:

> Counsel Assisting refer to the use of the word "instructed" in the 19 October 2020 letter, referring to a discussion with Prof. Sutton about the production of exhibit 230. That letter does not state that Prof. Sutton directed MinterEllison not to produce exhibit 230, but refers to Prof. Sutton providing factual information as to the bearing of exhibit 230 on his earlier evidence — namely, that he did not think exhibit 230 would have changed his statement or evidence and so he did not consider he needed to change, clarify or explain his evidence. That was apparent from the relevant part of the letter when it is read in context. It is in any event clear from the evidence that the Department was actively considering producing the document when the Board requested production.

> The 19 October 2020 letter is not in tension with, but is consistent with, Prof. Sutton's 4 November 2020 affidavit, when it is understood that the word "instructed" did not convey that Prof. Sutton was directing that exhibit 230 not be produced.[29]

64. I do not accept these submissions from DHHS. It was at least open, on a reasonable reading of the above extract from MinterEllison's letter dated 19 October 2020, to conclude that Prof. Sutton had *instructed* MinterEllison that Exhibit 230 'did not need to be provided to the Board'. As a very experienced law firm, MinterEllison would have been well-aware of what the term 'instructions' means as between lawyers and clients. It is well understood to mean 'what your client is telling you to do'. Had MinterEllison not intended to convey that meaning, more care should have been taken to avoid that impression when preparing and settling MinterEllison's correspondence dated 19 October 2020.

Model Litigant Guidelines

65. In its Further Written Submissions, Counsel Assisting submitted that the conduct of both DHHS and its lawyers in this Inquiry had fallen short of the standards set by the Model Litigant Guidelines.[30]

66. Having regard to the Further Written Submissions subsequently made by DHHS, I accept that, in order to make such a serious finding, there would need to be a more detailed set of specific allegations as to why that finding should be reached and a more thorough exploration of those issues. In the absence of such, I do not make such a finding.

Initial Response

67. I do, however, note with respect to DHHS's response to this Inquiry, more generally, that, putting to one side the question of document production, and taking into account the pressures under which DHHS and its lawyers were labouring more generally, I would have been assisted by DHHS providing a more forthcoming and articulated account of the internal issues arising in that Department during the Hotel Quarantine Program.

68. By way of example, in its Initial Response to this Inquiry, DHHS identified certain challenges faced by it in the Program and provided some indicators as to where these issues and challenges lay. Accepting DHHS's advice to the Inquiry that it had not had the opportunity to conduct its own forensic review of what had happened at the time the Inquiry commenced, there was enough known at that time to have caused the government decision to move the Program away from DHHS as the governing agency. It would have been more helpful to have had the offer and assistance of DHHS with identifying the detail of the shortcomings on its part more clearly, at least to the extent that such 'shortcomings' either were, or should have been, known to DHHS at the time its Initial Response was being prepared.

69. DHHS is not to be singled out on this issue, however. Similarly, the Initial Responses of the Department of Jobs, Precincts and Regions and the Department of Premier and Cabinet could also have been more reflective and forthcoming about the issues, challenges and shortcomings identified in the course of their engagement with the Hotel Quarantine Program.

Impact on the Board's work

70. As I said, in my opening remarks on 20 July 2020, for me to perform my task, I expected no less than full, frank and timely cooperation from all relevant Government departments, entities and persons.[31]

71. The belated production of documents by DHHS and others after the close of evidence resulted in the need for further Notices to Produce to be issued, Further Written Submissions to be prepared and further hearings to be convened.

72. By correspondence to the Inquiry dated 11 November 2020, DHHS and MinterEllison conceded that the belated production of documents after the close of evidence contributed to a delay in the issue of my final report, and that this was clearly a regrettable outcome.[32]

73. This concession is properly made. As stated in my request for Initial Responses, the purpose of this process was to assist the Inquiry by identifying those matters that may be uncontroversial, and that need not unnecessarily occupy the time of the Inquiry. It is unfortunate that this opportunity was not taken by DHHS, DJPR and DPC in their Initial Responses. Had they done so, and openly identified the shortcomings they had already identified by July 2020, a significant amount of time and energy could, no doubt, have been saved.

14.11 Funding

74. The Inquiry received funding of $5.7 million to carry out its work.

75. As at the time of printing this Final Report, the Inquiry had spent $4.815 million. Any unspent funds were returned to government at the conclusion of the Inquiry.

Endnotes

1 Premier of Victoria, 'Statement from the Premier' (Media Release, 7 July 2020), <https://www.premier.vic.gov.au/statement-premier-74>.
2 Premier of Victoria, 'Premier's statement on changes to Melbourne's restrictions' (Media Release, 2 August 2020) <https://www.dhhs.vic.gov.au/updates/coronavirus-covid-19/premiers-statement-changes-melbournes-restrictions-2-august-2020>.
3 See COVID-19 Hotel Quarantine Inquiry, 'Home' <https://www.quarantineinquiry.vic.gov.au/about-hotel-quarantine-inquiry>.
4 See COVID-19 Hotel Quarantine Inquiry, 'Contact us' <https://www.quarantineinquiry.vic.gov.au/contact-us>.
5 Note that these figures are an approximation and will include documents that were produced to the Inquiry multiple times by one or more Parties with Leave to Appear.
6 See COVID-19 Hotel Quarantine Inquiry, 'Transcripts' <https://www.quarantineinquiry.vic.gov.au/hearings-transcripts> ; 'Exhibits' <https://www.quarantineinquiry.vic.gov.au/exhibits>.
7 See COVID-19 Hotel Quarantine Inquiry, 'View hearings' <https://www.quarantineinquiry.vic.gov.au/hearings>.
8 Transcript of day 1 opening statements 20 July 2020, 8.
9 Premier of Victoria, 'Premier's statement on changes to Melbourne's restrictions' (Media Release, 2 August 2020), <https://www.dhhs.vic.gov.au/updates/coronavirus-covid-19/premiers-statement-changes-melbournes-restrictions-2-august-2020>.
10 Transcript of day 2 extraordinary sitting 5 August 2020, 13–16.
11 See COVID-19 Hotel Quarantine Inquiry, 'Reports' <https://www.quarantineinquiry.vic.gov.au/reports>.
12 Transcript of day 25 hearing 25 September 2020, 2186; Transcript of day 26 hearing 28 September 2020, 2190.
13 See Further Submission 01 Counsel Assisting the Board of Inquiry.
14 Further Submission 03 Department of Health and Human Services, 1 [3].
15 Ibid 3 [11]–[13].
16 Ibid 3 [14].
17 Ibid 4 [17].
18 Exhibit HQI0230_RP DHHS emails re VIC Hotel Quarantine Arrangements, DHS.0001.0123.0011–0013.
19 Further Submission 03 Department of Health and Human Services, 5 [22].
20 Ibid 5 [23].
21 Ibid 5–6 [24].
22 Letter from MinterEllison to Solicitors Assisting dated 21 October 2020; Exhibit HQI0263_P Affidavit of Ms Rebecca Bedford, 2 [6].
23 Exhibit HQI0232_P Letter from Solicitors for DHHS to Solicitors Assisting dated 19 October 2020, HQI.0001.0053.0002; Exhibit HQI0255_RP Affidavit of Mr Jason Helps, 2 [11].
24 Exhibit HQI0231_P Letter from Solicitors Assisting to Solicitors for DHHS dated 16 October 2020.
25 Ibid.
26 Exhibit HQI0232_P Letter from Solicitors for DHHS to Solicitors Assisting dated 19 October 2020, 2.
27 Exhibit HQI0249_RP First witness statement of Prof. Brett Sutton, 18 [110]–[111].
28 Further submission 01 Counsel Assisting the Board of Inquiry, 17 [59]–[63].
29 Further submission 03 Department of Health and Human Services, 6 [25]–[26].
30 Further submission 01 Counsel Assisting the Board of Inquiry, 16 [54].
31 Transcript of day 1 opening statements 20 July 2020, 10.
32 Exhibit HQI0261_P Letter from Solicitors for DHHS to Solicitors Assisting dated 11 November 2020, HQI.0001.0072.0001.

Appendices

Appendix A

List of Abbreviations

Acronym	Meaning
ABF	Australia Border Force
AC	Assistant Commissioner
Action Plan	Victorian Action Plan for Influenza Pandemic 2015
ADF	Australian Defence Force
AFP	Australian Federal Police
AHMPPI	The Commonwealth Government's Australian Health Management Plan for Pandemic Influenza
AHPPC	Australian Health Protection Principal Committee
AHS	AHS Hospitality Pty Ltd
AMC	AMC Commercial Cleaning
AO	Authorised Officer
ARTG	Australian Register of Therapeutic Goods
AV	Ambulance Victoria
CBD	Central Business District
CCC	Crisis Council of Cabinet
CCOM Guidelines	COVID-19 Case and Contact Management Guidelines for Health Services and General Practitioners
CCOMT	Case, Contact and Outbreak Management Team
CCP	Chief Commissioner of Police, State of Victoria
CDNA	Communicable Diseases Network Australia
CEA program	COVID-19 Emergency Accommodation program
CHO	Chief Health Officer, State of Victoria
Cleaning Protocol	Cleaning and disinfecting to reduce COVID-19 transmission, Tips for non-healthcare settings
COAG	Council of Australian Governments
COMDISPLAN	Australian Government Disaster Response Plan
COVID-19 PHC Division	COVID-19 Public Health Command Division
CPSU	CPSU (Community & Public Sector Union)
DCHO	Deputy Chief Health Officer, State of Victoria
DELWP	Department of Environment, Land, Water and Planning
DFAT	Department of Foreign Affairs and Trade
DHHS	Department of Health and Human Services
DJCS	Department of Justice and Community Safety

Acronym	Meaning
DJPR	Department of Jobs, Precincts and Regions
DoT	Department of Transport
DPC	Department of Premier and Cabinet
DPHC	Deputy Public Health Commander
DPHC CCOM	Deputy Public Health Commander — Case, Contact and Outbreak Management
DPHC — Planning	Also known as DPHC, Strategy and Implementation
DPHC, Strategy and Implementation	Also known as DPHC — Planning
DSC — H	Deputy State Controller — Health
DTF	Department of Treasury and Finance
EM	Emergency Management
EM Act	*Emergency Management Act 2013* (Vic)
EMC	Emergency Management Commissioner
EMLO	Emergency Management Liaison Officer
EMMV	Emergency Management Manual Victoria
EOC	Emergency Operations Centre
ERC	Expenditure Review Committee
GP	General Practitioner
Head Contracts	Contracts with security service providers Wilson, MSS and Unified
HCW	Healthcare worker
HPB	Health Protection Branch
HQP	Hotel Quarantine Program
IKON	IKON Services Australia Pty Ltd
IMT	Incident Management Team
IPA	Infection Prevention Australia
IPC	Infection Prevention and Control
IPC Consultant	Infection Prevention and Control Consultant
IPC Cell	Infection Prevention and Control Cell
MCC	Mission Coordination Committee
MDU PHL	Microbiological Diagnostic Unit Public Health Laboratory
MERS/MERS COV	Middle East respiratory syndrome caused by COVID-19
MSS	MSS Security Pty Ltd
MSS Contract	Purchase Order Contract between the Department of Jobs, Precincts and Regions and MSS Security Pty Ltd entered into on 23 April 2020
NCM	National Coordination Mechanism
OMP	Outbreak Management Plan
OMT	Outbreak Management Team
PH	Public Health
PHC	Public Health Commander

Acronym	Meaning
PH — IMT	Public Health — Incident Management Team
PHT	Public Health Team
PHW Act	*Public Health and Wellbeing Act 2008* (Vic)
POC	Purchase Order Contract
PPE	Personal Protective Equipment
RFT	Request for Tender
RSO	Residential Support Officer
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
SCC	State Control Centre
SC — H	State Controller — Health
SCM	State Consequence Manager
SCV	Safer Care Victoria
Self-isolation Directions	Self-Quarantine following Overseas Travel Direction/Airport Arrivals Direction
SEMC	State Emergency Management Centre
SERP	State Emergency Response Plan
SH — IMT	State Health Incident Management Team
SHEMC	State Health Emergency Management Coordinator
SHERP	State Health Emergency Response Plan
Sterling	Sterling Security Group
TGA	Therapeutic Goods Administration
The Charter / Charter	*Charter of Human Rights and Responsibilities 2006* (Vic)
Trades Hall	Victorian Trades Hall Council
Unified	Unified Security Group (Australia) Pty Ltd
Unified Contract	Purchase Order Contract between the Department of Jobs, Precincts and Regions and Unified Security Group (Australia) Pty Ltd) entered into on 9 April 2020
URM	United Risk Management
VicPol	Victoria Police
Victoria Pandemic Plan	Victorian Health Management Plan for Pandemic Influenza 2014
VSB	Victorian Secretaries Board
WHO	World Health Organization
Wilson	Wilson Security Pty Ltd
Wilson Contract	Purchase Order Contract between the Department of Jobs, Precincts and Regions and Wilson Security Pty Ltd entered into on 6 May 2020

Appendix B

Glossary

Term	Meaning
Action Plan	Victorian Action Plan for Influenza Pandemic 2015
Airport Arrivals Direction	Direction issued 18 March 2020 outlining that all international travellers arriving at an airport in Victoria between 5.00pm on 18 March 2020 and midnight on 13 April 2020 must travel from the airport to a premises that is suitable for the person to reside in for a period of 14 days
Antigens	Molecules capable of stimulating an immune response
Asymptomatic	Someone who does not develop symptoms throughout the course of their disease
Authorised Officer	A person appointed under the *Public Health and Wellbeing Act 2008* (Vic) with power to enforce compliance with Detention Directions
Cases	Individuals who test positive to COVID-19
Charter	*Charter of Human Rights and Responsibilities Act 2006* (Vic)
Commonwealth Pandemic Plan	The Commonwealth Government's Australian Health Management Plan for Pandemic Influenza
Community transmission	Where a person is infected by the virus but they have not been overseas recently or been in recent contact with other confirmed cases
Contacts	Individuals who may have been exposed to COVID-19
Contact tracing	The identification, assessment and management of people who potentially have been exposed to disease (and so at higher risk of developing and spreading it) and working with them to interrupt the spread of the disease
Control agency	Agency with overall responsibility for all activities undertaken in response to an emergency
COVID-19	The coronavirus disease 2019 caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) strain of coronavirus
Crisis Council of Cabinet	The core decision making forum for the Victorian Government on all matters related to the coronavirus emergency, including implementing the outcomes of the National Cabinet.
Direction and Direction Notice	A direction issued by the Chief Health Officer or their delegate under the *Public Health and Wellbeing Act 2008* (Vic) mandating an individual into quarantine
Epidemiology	The study of the patterns and determinants of disease in specific populations
Facility-based model	A quarantine model for returning international arrivals that primarily takes place in a managed facility, such as a hotel or similar facility
Fogging	The use of chlorine-based chemical (that is, bleach) to fog the rooms
Fomites	Surfaces or objects (including hands) that may become contaminated and serve as an intermediary vehicle for transmission
Genome	An organism's complete set of genes or genetic material, comprising DNA or RNA
Genomic sequencing	A process by which the whole genetic signature of a pathogen is recovered
Genomic cluster	A group of samples with a condition or disease that have some similarity, suggesting that the condition or disease was acquired from one another or has a common source or common cause
Global Victoria	An agency within DJPR which focuses on trade facilitation. The CEO of Global Victoria is Ms Gönül Serbest
Green zone	A designated 'clean' area in a quarantine facility where no PPE is to be worn

Term	Meaning
Head Contracts	Contracts with security service providers (Wilson, MSS and Unified)
Home-based model	A quarantine model for returning international arrivals that primarily takes place in the home
Home Quarantine Direction	Direction to be made under the proposed Home Quarantine Model as outlined in Section 2 of the Interim Report
Home Quarantine Model	The proposed home-based model as outlined in Section 2 of the Interim Report.
Hot hotel	Certain premises that were used exclusively to accommodate returned travellers who had tested positive to COVID-19
Hotel Quarantine Program	The original Victorian Hotel Quarantine Program which ran from 29 March to 30 June 2020 and is the subject of this Inquiry
Incubation period	The time between being exposed to a disease and the onset of symptoms
Infection prevention and control	A scientific and risk management approach designed to prevent harm caused by infection to patients and health workers
Infectious period	The length of time an individual can transmit COVID-19
International arrivals	People who may visit Victoria and be required to quarantine under the new Quarantine Program
Interim Report	COVID-19 Hotel Quarantine Inquiry Interim Report and Recommendations (6 November 2020)
Isolate / quarantine	The terms 'isolate' and 'quarantine' are given distinct and separate meanings on DHHS' website: https://www.dhhs.vic.gov.au/self-quarantine-coronavirus-covid-19#when-do-i-isolate The term 'isolate' is used to describe the process of separating people with COVID-19 from people who do not have the virus. The term 'quarantine' is used describe the process of separating and restricting the movement of people who have been or may have been exposed to COVID-19. Notwithstanding this distinction, the terms 'isolate' and 'quarantine' were often used interchangeably throughout the evidence to this Inquiry. In this report, where witness evidence containing the terms 'isolate' or 'quarantine' is quoted or otherwise referred to, the terminology adopted by that witness is used. In all other contexts, the report adopts the distinction outlined above, and uses the terms 'isolate' and 'quarantine' accordingly
Issues Paper	Victoria's Private Security Industry — Issues Paper for Consultation
June Cleaning Advice	Hotel Quarantine Response — Advice for cleaning requirements for hotels who are accommodating quarantined, close contacts and confirmed COVID-19 Guests — Updated
March Cleaning Advice	Cleaning and disinfecting to reduce COVID-19 transmission: Tips for non-healthcare settings
National Cabinet	The Australian intergovernmental decision-making forum composed of the Prime Minister and state and territory Premiers and Chief Ministers
Operation Soteria	The alternative name for the Hotel Quarantine Program.
Pandemic	The worldwide spread of a new disease
Personal protective equipment (PPE)	PPE refers to anything used or worn to minimise risk to workers' health and safety. PPE for COVID-19 includes surgical masks, particulate filter respirators (such as P2 or N95), gloves, goggles, glasses, face shields, gowns and aprons. See Department of Health website for further information: https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-advice-for-the-healthand-disability-sector/personal-protective-equipment-ppe-for-the-health-workforceduring-covid-19
Procurement	The process of finding and agreeing to terms, and acquiring goods, services or works from an external source, often via a tendering or competitive bidding process

Term	Meaning
Purchase order contract	A commercial contract between a supplier and purchaser, which outlines the terms and obligations of each party in relation to the purchase of goods or services
Quarantine Governing Body	A body that consists of appropriate senior members of the governance structure, which meets regularly, is chaired by the Secretary to the responsible Minister, maintains records of its meetings including records of all decisions reached, and provides reports to the Minister from those meetings and in respect of decisions reached as proposed in Section 1 of the Interim Report
R_0	The average number of people who are likely to contract a contagious disease, from one other person with that disease, within a sample population
Red zone	A designated area in a quarantine facility where PPE must be worn
Returned travellers	People who returned to Victoria and quarantined in the initial Hotel Quarantine Program
Safer Care Victoria	A Victorian State authority that leads quality and safety improvements in healthcare settings
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
SCOVID	People who are suspected, but not yet proven to have COVID-19
Second wave	The increase in COVID-19 cases in Victoria in the wake of two outbreaks at the Rydges Carlton and Stamford Plaza hotels
Self-isolation Directions	Collective term to refer to both the Self-Quarantine following Overseas Travel Direction (issued 16 March 2020) and the Airport Arrivals Direction (issued 18 March 2020)
Self-Quarantine following Overseas Travel Direction	Direction issued 16 March 2020 requiring international travellers arriving at an airport in Victoria to travel from the airport to a premises that is suitable for the person to reside in for a period of 14 days
Specialised cleaning	Commercial cleaning services for rooms that have accommodated guests positive for COVID-19
State Controller — Health	The individual appointed in a Class 2 emergency to provide support to the State Control Centre and lead the emergency response in a public health emergency
State Control Centre	The Victorian operations centre for emergencies
State of Disaster	Declared if the Premier is satisfied an emergency "constitutes or is likely to constitute a significant and widespread danger to life or property in Victoria"
State of Emergency	Declared when there is a serious risk to public health
State Purchase Contract	Centralised contracts used by the Victorian Government to buy common goods and services
Super spreader	Individuals who infect a disproportionately large number of contacts
Support agency	An agency working under the direction of the department in control of the program
Swab testing	Swabbing of areas after they have undergone an infectious clean to verify the area is actually clean
Terms of Reference	The Terms of Reference of the Inquiry into the COVID-19 Hotel Quarantine Program established by the Order in Council dated 2 July 2020
Victorian Pandemic Plan	Victorian Health Management Plan for Pandemic Influenza 2014
Victorian Secretaries Board	A forum of all Department Secretaries, the Police Commissioner and the Victorian Public Sector Commissioner
Viral load	A measure of the number of virus particles in a given sample. For example, it may refer to the amount of virus present in a person's tissues or bodily fluids (such as respiratory droplets), or the amount of virus to which a person is exposed
Viral shedding	Occurs when a person who has the virus present in their body expels infectious fluid from their body; for example, by sneezing or coughing

Appendix C

Order in Council dated 2 July 2020

Inquiries Act 2014

APPOINTMENT OF A BOARD OF INQUIRY INTO THE COVID-19 HOTEL QUARANTINE PROGRAM

ORDER IN COUNCIL

The Governor in Council, on the recommendation of the Premier under section 53(1) of the **Inquiries Act 2014**, appoints the Honourable Jennifer Coate AO to constitute a Board of Inquiry to inquire into, report on and make any recommendations considered appropriate in relation to the terms of reference specified in paragraphs 1 to 6 of this Order.

This Order comes into effect on the date it is published in the Government Gazette.

BACKGROUND

Having regard to the global COVID-19 pandemic and the following:

a. Previous and current Directions on Detention, issued under section 200 of the **Public Health and Wellbeing Act 2008**, requiring returned overseas travellers to be quarantined for at least 14 days in certain hotels following their arrival in Australia as part of the Victorian government's COVID-19 hotel quarantine program (Quarantine Program);

b. The dynamic environment under which the Quarantine Program was established, including the concern at the time for the immediate safe return of Victorians from overseas areas impacted by the pandemic;

c. The use of certain hotels to facilitate the Quarantine Program;

d. The use of private sector providers, including security, transport, medical and food service providers (Private Service Providers) to administer the Quarantine Program;

e. Recent epidemiological material collected up to 15 July 2020 in relation to travellers quarantined as part of the Quarantine Program, potentially linking subsequent increases in the spreading of the COVID-19 virus from such quarantined travellers through to the broader Victorian community;

f. The Government's objective of effectively identifying, managing and containing the

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spread of COVID-19 from returned overseas travellers in the Quarantine Program into the community (COVID-19 Quarantine Containment); and

g. Subsequent efforts to diagnose and treat, and to contain case numbers and the community transmission of COVID-19, as a result of the Quarantine Program.

TERMS OF REFERENCE

You are required to inquire into, report and make any recommendations considered appropriate in relation to the following terms of reference:

1. The decisions and actions of Victorian government agencies, hotel operators and Private Service Providers, including their staff/contractors and any other relevant personnel involved in the Quarantine Program (each Relevant Personnel), relating to COVID-19 Quarantine Containment;
2. Communications between Victorian government agencies, hotel operators and Private Service Providers relating to COVID-19 Quarantine Containment;
3. The contractual arrangements in place across Victorian government agencies, hotel operators and Private Service Providers to the extent they relate to COVID-19 Quarantine Containment;
4. The information, guidance, training and equipment provided to Relevant Personnel for COVID-19 Quarantine Containment and whether such guidance or training was followed, and such equipment was properly used;
5. The policies, protocols and procedures applied by Relevant Personnel for COVID-19 Quarantine Containment; and
6. Any other matters necessary to satisfactorily resolve the matters set out in paragraphs 1 to 5.

REPORTING DATES

You must report your findings and any recommendations to the Governor as soon as possible, and not later than 25 September 2020.

CONDUCTING THE INQUIRY

1. You may:
   (a) conduct your inquiry as you consider appropriate, subject to the requirements of procedural fairness;
   (b) have regard to any research relevant to your inquiry;
   (c) consult with and engage experts as necessary to provide relevant advice and assistance;
   (d) engage Australian legal practitioners to assist you as counsel.
2. You must conduct your inquiry in accordance with this Order, the **Inquiries Act 2014**, and all other relevant laws.
3. It is anticipated that in conducting your inquiry, you will:
   (a) to the extent you think it appropriate, work co-operatively with, and seek not to prejudice, any ongoing response or recovery activities or investigations;
   (b) adopt informal and flexible procedures to ascertain the relevant facts as directly and effectively as possible;
   (c) avoid unnecessary duplication; and
   (d) avoid unnecessary cost or delay.

BUDGET

4. You may incur expenses and financial obligations to be met from the Consolidated Fund up to $3 million in conducting this Inquiry.

Dated: – 2 JUL 2020

Responsible Minister:

The Hon Daniel Andrews MP
Premier

C. Chisholm
Clerk of the Executive Council

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Amended Order in Council dated 5 August 2020

Inquiries Act 2014

AMENDED TERMS OF REFERENCE FOR THE BOARD OF INQUIRY INTO THE COVID-19 HOTEL QUARANTINE PROGRAM

ORDER IN COUNCIL

The Governor in Council, on the recommendation of the Premier under section 53 of the **Inquiries Act 2014**, amends the Order in Council dated 2 July 2020 establishing the Board of Inquiry into the COVID-19 Hotel Quarantine Program by:

1. For the words "25 September 2020" under the heading "Reporting Dates" **substituting** "6 November 2020".

This Order comes into effect on the date it is published in the Government Gazette.

Dated: 05 AUG 2020

Responsible Minister:

The Hon Daniel Andrews MP
Premier

C. Chisholm
Clerk of the Executive Council

Amended Order in Council dated 29 October 2020

Inquiries Act 2014

AMENDED TERMS OF REFERENCE FOR THE BOARD OF INQUIRY INTO THE COVID-19 HOTEL QUARANTINE PROGRAM

ORDER IN COUNCIL

The Governor in Council, on the recommendation of the Premier under section 53 of the **Inquiries Act 2014**, amends the Order in Council dated 2 July 2020 (as amended by a further Order in Council dated 5 August 2020) establishing the Board of Inquiry into the COVID-19 Hotel Quarantine Program by:

1. For the words "You must report your findings and any recommendations to the Governor as soon as possible, and not later than 6 November 2020" under the heading "Reporting Dates" **substituting** "You must report your interim findings and any recommendations to the Governor as soon as possible, and not later than 6 November 2020, and you must report your final findings and any recommendations to the Governor as soon as possible, and not later than 21 December 2020".

This Order comes into effect on the date it is published in the Government Gazette.

Dated: 29 OCT 2020

Responsible Minister:

The Hon Daniel Andrews MP
Premier

C. Chisholm
Clerk of the Executive Council

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Appendix D

Practice Direction 1

COVID-19
Hotel Quarantine Inquiry

PRACTICE DIRECTION NO. 1

SECTION 64 NOTICES AND DOCUMENT MANAGEMENT

RELEASED 15 JULY 2020

INTRODUCTION

1 This Practice Direction (**PD-1**) relates to notices issued pursuant to s 64 of the *Inquiries Act* 2014 (Vic) (**Act**) by the Board of Inquiry into the COVID-19 Hotel Quarantine Program (**Inquiry**) and provides the Protocol for the Electronic Management of Documents.

2 This Practice Direction is issued under s 63(1) of the Act. It should be read in conjunction with the Act and with the terms of reference contained in the Order establishing the Inquiry.

3 This Practice Direction sets out the way in which the Inquiry will:

(a) deal with claims of reasonable excuse in response to a Notice to Attend, Notice to Produce or Notice to Attend and Produce (as provided for by s 64 of the Act (**Notice**)); and

(b) receive materials in response to a Notice to Produce or an informal request for information.

4 In this Practice Direction, and for the purposes of PD-1 and the attached Protocol only, reference to a **Party** (or **Parties**) means:

(a) any entity, organisation or individual that has been served with, or is the subject of a Notice; and

(b) anyone who intends to provide documents, evidence or other material to the Inquiry, including in response to a request for information.

5 The intended audience of this Practice Direction includes a Party, as well as the legal representatives and IT professionals engaged to assist Parties in responding to Notices.

6 This Practice Direction may be varied, changed or amended by the Inquiry from time to time. The Inquiry may, at any time, depart from this Practice Direction if it considers it appropriate to do so.

CLAIMS OF 'REASONABLE EXCUSE' IN RESPONSE TO NOTICES

7 Any Party who asserts that they have a reasonable excuse for failing to comply with a Notice, in whole or in part, must have regard to sections 65 and 74(3) of the Act and any notes which accompany the Notice.

8 The Inquiry will set out in each Notice the date by which a claim of reasonable excuse must be made (**Objection Date**).

9 If a Party considers that any part of a Notice concerns evidence, material or document/s that are the subject of a claim of 'reasonable excuse' by that Party, it must, by the Objection Date:

(a) notify the Inquiry in accordance with the requirements of the Notice;

(b) provide the following information to assist the Inquiry to determine whether a reasonable excuse exists:

(1) a brief general description of the subject matter of the evidence, material or document(s) to which the reasonable excuse is claimed to apply;

(2) the basis on which the claim of reasonable excuse is made;

(3) brief reasons in support of the claim of reasonable excuse; and

additionally, for documents or materials:

(4) the nature of the document (date, type etc); and

(5) the author(s) and, where applicable, the addressee(s) of the document; and

(c) inform the Inquiry whether:

(1) it claims that the reasonable excuse applies to all of the evidence, material or document(s);

(2) it claims the evidence, material or document(s) should not be adduced and/or produced at all on the grounds of the identified reasonable excuse, or

(3) whether it consents to production of the evidence, material or document(s) on appropriate terms, and if so, what those proposed terms ought to be.

10 Where a claim of reasonable excuse is made over documents or material, the Party making that claim must also comply with the requirements of the Protocol in respect of the production and coding of documents.

PROTOCOL FOR PRODUCING MATERIAL TO THE INQUIRY

11 Any material to be filed with the Inquiry should be in accessible electronic format consistent with the requirements of this Practice Direction and the Document Management Protocol (**Protocol**) attached to this Practice Direction. However, this does not preclude the Inquiry from accepting material, at its discretion, in a hard copy format or as objects.

12 All electronic material to be produced to the Inquiry must be prepared and provided in accordance with the Protocol.

PROTOCOL FOR DOCUMENTS WHERE AN ORDER IS SOUGHT FOR PROHIBITION OR RESTRICTION OF PUBLICATION

13 Any party who seeks an order prohibiting or restricting the publication of (or part of) a document must:

(a) have regard to section 73 of the Act and any notes which accompany the Notice; and

(b) comply with the requirements of the Protocol in respect of the production and coding of documents where an order is sought to prohibit or restrict publication of documents is made.

14 The Protocol provides a process for Parties to identify information as being personal identifying information. However, the existence of personal information is not, on its own, a basis on which the Inquiry will make an order prohibiting or restricting publication.

INQUIRY'S DOCUMENT MANAGEMENT SYSTEM

15 The Inquiry will maintain an electronic database using Lexel that will contain, among other things, copies of all material produced to the Inquiry including material produced in response to a Notice, informal request for information or otherwise.

QUESTIONS REGARDING THIS PRACTICE DIRECTION OR DOCUMENT MANAGEMENT PROTOCOL

16 The Inquiry accepts that some Parties producing documents to it may not be able to comply with the Protocol. These Parties should contact the person named on the Notice as the contact to discuss alternative arrangements for production.

17 Any person who has a technical question about producing material electronically to the Inquiry should also contact Solicitors Assisting at lawyers@quarantineinquiry.vic.gov.au or (03) 7017 3459.

Issue date: 15 July 2020

THE HONOURABLE JENNIFER COATE AO
Board of Inquiry into the COVID-19 Hotel Quarantine Program

COVID-19
Hotel Quarantine Inquiry

DOCUMENT MANAGEMENT PROTOCOL

RELEASED 15 JULY 2020

INTRODUCTION

1 This Document Management Protocol (Protocol) outlines the method by which documents are to be provided to the Inquiry, whether in response to a Notice to Produce (Notice) or otherwise.

2 The intended audience of this Protocol is the legal representatives and IT professionals engaged to assist Parties produce materials to the Inquiry.

3 All documents to be produced to the Inquiry must be prepared and provided in accordance with this Protocol.

4 This Protocol may be varied, changed or amended by the Inquiry from time to time. The Inquiry may, at any time, depart from this Protocol if it considers it appropriate to do so, including but not limited to circumstances where it is unreasonable or too onerous upon a party to comply with the technical specifications of this Protocol.

PRINCIPLES

1 Acceptable formats

1.1 The Inquiry will accept electronic documents in both Concordance/Relativity (.dat/.opt) and Ringtail (.mdb) formats, as outlined in Schedules 1A & 1B respectively.

1.2 Each electronic file must be produced in its native format or, alternatively, produced as a rendered PDF together with a (.txt) file containing the OCR contents of the PDF file.

2 Identification of documents

2.1 Each document must be identified with a Document ID and page numbers which are unique to each page and will be the primary means of identification of documents.

2.2 All Document IDs and page numbers are to be stamped in the top right hand corner of each page.

2.3 A Document ID must be in the following format:

PPP(P).BBBB.FFFF.NNNN_XXXX

(1) **PPP(P)** is a three (or four) letter party code that identifies a Party. A Party producing Documents should contact the Inquiry prior to production to confirm the Party codes available for use.

Party Code	Party
EHSP	Example Hotel Quarantine Services Pty Ltd
ABC	AB Corporation Pty Ltd
XYZ	XY Holdings Pty Ltd

(2) **BBBB** is a 4-digit 'box' number identifying separate collections of documents (for example in relation to a particular Notice to Produce or Summons), the number to be between 0001-9999.

(3) **FFFF** is a 4-digit 'container' number identifying further separate collections of documents, the number to be between 0001-9999.

(4) **NNNN** is a 4-digit number used to differentiate individual documents and/or individual pages. In some cases, NNNN operates as a document number rather than a page number because individual pages are not numbered (ie non-standard Native files not produced as searchable PDFs). This number is padded with zeros to consistently result in a 4 digit structure.

(5) **XXXX** is an optional 4-digit number used to identify suffix rendered PDF pages. It is only required where Parties may choose to review documents in native format in their document review platforms and render documents to PDF for the purpose of production. The suffix must be preceded by an underscore, padded with zeros to consistently result in a 4-digit number structure.

An example of the Document ID structure is set out below:

XYZ.0001.0001.0001

Where:

XYZ	Party code
0001	Unique 'box' number allocated by Party.
0001	Unique 'container' number allocated by Party.
0001	Sequential page number.

2.4 Document IDs assigned must be unique to each document and must not be re- assigned to subsequent documents produced.

2.5 If alternate numbering is required please contact the Inquiry to discuss.

2.6 It is understood and accepted that Document IDs may not be consecutive as a result of the removal of irrelevant documents during review. A Party must however identify host and attachment documents with consecutive Document IDs.

2.7 Upon production of a document, the document filename must be its Document ID.

2.8 If Parties wish to render a document at the time of production following a native file review and:

(a) the first Document ID is XYZ.0001.0001.0001; then

(b) the first page of that Document rendered PDF must be stamped with:

XYZ.0001.0001.0001 or XYZ.0001.0001.0001 _0001;

(c) the second page of that Document must be stamped with:

XYZ.0001.0001.0001_0002;

(d) the third page of that Document must be stamped with:

XYZ.0001.0001.0001_0003; and

(e) the next consecutive Document must be Document ID XYZ.0001.0001.0002.

3 Document Hosts and Attachments

3.1 Every document that is attached to or embedded within another document will be treated as an Attached Document. A document that contains at least one

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Attached Document will be called a Host Document. A document that is neither a Host or Attached Document will be called a Standalone Document.

3.2 Examples of Host Documents and Attached Documents include:

(a) An email, letter or fax (Host Document) and its attachments (Attached Documents).

(b) An electronic file (Host Document) that has other files embedded within it (Attached Documents)

3.3 If an Attached Document also contains attachments, those attachments will be treated as attachments to the Host Document.

3.4 A Party must ensure that false or unnecessary relationships between Host Documents and Attached Documents are not created by:

(a) taking reasonable steps to ensure that email footers, logos, and other repeated content are not separated as Attached Documents; and

(b) ensuring that physical or digital document containers, such as hard copy folders or electronic ZIP container files, are not identified as Host Documents, unless the identification of the container as a Host Document is necessary to the understanding of the documents within that container.

3.5 Unless required to provide documents in their native structure for technical reasons, documents should be extracted from their containers and the container itself should not be produced.

4 Indexes and Load Files of documents produced to the Inquiry

4.1 All documents to be produced to the Inquiry must be:

(a) included in an itemised electronic index of documents in Microsoft Excel format (**Index**) that is provided to the Inquiry; and

(b) provided in an electronic format that is in accordance with the applicable Production Load File Specification at Schedule 1A or 1B (**Load File**).

4.2 Both the Index and the Load File must contain the following information for each document, where available:

(a) Document ID
(b) Host Document ID
(c) Document Type
(d) Document Date
(e) Document Title
(f) Author (From)
(g) Recipient (To)
(h) Recipient (CC)
(i) Recipient (BCC)
(j) Notice to Produce or Summons No.
(k) Notice to Produce Tranche No.
(l) Notice to Produce Schedule Item
(m) Withheld
(n) Withheld Reason
(o) Restriction requested
(p) Reason for restriction request
(q) LPP
(r) Personal-identifying-information

5 Document metadata

5.1 Wherever possible, a Party is to rely on the automatically identified metadata of electronic documents. Automatically identified metadata should be used when:

(a) searching for documents;
(b) itemising documents in a list; and
(c) preparing a production of documents in accordance with the Production Specification at Schedules 1A or 1B.

5.2 A Party should take reasonable steps to ensure that all appropriate document metadata is not modified or corrupted during collection and preparation of electronic documents for review and production.

5.3 Document metadata is to be automatically extracted using UTC + 10 (Sydney, Melbourne, Canberra) as the time zone in the processing application.

5.4 The Inquiry accepts that complete document metadata may not be available for all electronic documents. A Party should attempt to provide complete metadata where practicable.

5.5 Hard copy documents must be produced as PDFs, together with extracted text files together with a load file as per Schedules 1A or 1B where possible.

5.6 A Party must provide information regarding the software and procedure used to automatically identify the metadata of their electronic documents if requested by the Inquiry.

5.7 Original versions of all documents must be retained by the Party producing them.

6 De-duplication of documents

6.1 A party must take reasonable steps to ensure that duplicate documents are removed from the produced material (**de-duplication**).

6.2 The Inquiry acknowledges that there may be circumstances where duplicates need to be identified and produced for evidentiary purposes.

6.3 Duplication must be considered at a document group level. That is, all documents within a group comprising a Host Document and its attachments, will be treated as duplicates only if the entire group of documents is duplicated elsewhere. An Attached Document must not be treated as a duplicate if it is merely duplicated elsewhere as an individual standalone document that is not associated with another group of documents.

6.4 A Party must apply electronic de-duplication using a MD5 algorithm.

6.5 A Party may also determine duplicate documents by way of manual review where appropriate

7 Exclusion of unusable file types

7.1 A NIST filter is to be applied to a Party's electronic documents to remove files with no user-generated content, such as system files and executable files, so that these are excluded from searches and disclosure (to the extent possible).

7.2 Temporary internet files and cookies are to be excluded from the disclosure process.

8 Treatment of email chain correspondence

8.1 Where an email is identified as relevant and it forms part of an email chain, the Party must disclose the entire email chain.

9 Use of advanced analytics technology

9.1 Parties may use advanced analytics technologies at their own discretion, but they must maintain the integrity and context of the documents, and provide entire document groups including all attachments.

9.2 Parties may use 'Email threading' technology to minimise document review. Where this technology has been used, Parties may provide only the relevant end point email with its attachments.

9.3 Parties may use technology commonly referred to as 'TAR / Assisted Review / Predictive coding' for document review at their discretion. Parties do not need to seek agreement to use such technology, but must disclose to the Inquiry that it has been used and implement processes to ensure that they are meeting their obligations under a Notice or otherwise by providing only material identified as relevant to the Notices issued, along with their document group.

10 Data security

10.1 A Party producing data must take all reasonable steps to ensure that the data is useable and is not infected by malicious software.

11 Errors in provided documents

11.1 If errors are found in any produced documents, the Party producing must provide a corrected version of the document to the Inquiry as soon as reasonably possible once that error is identified.

11.2 If errors are found in more than 25% of the produced documents in any one tranche, the Party who produced those documents must, if requested by the Inquiry, provide a correct version of all documents within the tranche.

11.3 A written explanation setting out the reasons for the errors in the documents and describing the data affected must be provided by the Party producing if errors are found in any produced documents.

12 Electronic provision of data for productions

12.1 Unless otherwise agreed or ordered by the Inquiry, the information provided and delivered to the Inquiry must be contained on agreed electronic media, being either:

(a) SFTP services of the Party providing the documents; or

(b) USB media.

In all cases Parties must apply encryption to the zip file uploaded to the SFTP or the USB media provided and the password must be shared with the Inquiry via a separate email, at the time of confirming the delivery.

13 Claims of a reasonable excuse for not complying with a Notice

13.1 Where a Party asserts that it has a reasonable excuse for failing to produce a **whole** document, the Party must:

(a) ensure that the document is identified in the Index and Load File;

(b) code the field 'Withheld=Yes' in the Index and Load File; and

(c) select the basis for the claim in the field 'Withheld Reason' in the Index and Load File.

13.2 Where a Party asserts that a reasonable excuse exists for failing to produce **part(s)** of a document, the Party must:

(a) redact the part(s) of the document that the Party asserts it has a reasonable excuse to withhold;

(b) ensure that the document is identified in the Index and Load File;

(c) code the field 'Withheld=Part' in the Index and Load File; and

(d) select the basis for the claim in the field 'Withheld Reason' in the Index and Load File.

14 Production of documents where an order is sought for restriction on publication of information

14.1 Where a Party seeks an order to prohibit or restrict publication of a **whole**

document, the Party must:

(a) produce the document;

(b) code the field 'Restricted=Yes' in the Index and Load File; and

(c) select the basis for the claim in the field 'Restricted Reason' in the Index and Load File.

14.2 Where a Party seeks an order to prohibit or restrict publication of **part(s)** of a document, the Party must:

(a) produce the document;

(b) highlight the part(s) of the document that are the subject of the claim as set out in paragraph 14.5 below;

(c) code the field 'Restricted=Part' in the Index and Load File; and

(d) select the basis for the claim in the field 'Restricted Reason' in the Index and Load File.

14.3 Where a Party seeks an order to prohibit or restrict publication over information that is personal identifying information, the Party may:

(a) highlight any personal identifying information as set out in paragraph 14.5;

(b) code the field 'Personal identifying information=Yes' in the Index and Load File; and

(c) code the fields 'Restricted' and 'Restricted Reason' in the Index and Load File as is appropriate.

14.4 The highlight colours to be applied are set out below:

Colour	Reason for highlighting
Light Blue	Personal identifying information.
Green	Claim for prohibition or restriction on publication provided for in s 73 of the Act.

14.5 If part of any document provided to the Inquiry is highlighted in accordance with this section 14, the Party producing that document must retain a non-highlighted version of the document which must be produced to the Inquiry on request.

Schedule 1A – Production Specification for .DAT/.OPT Load File (Concordance/Relativity Compliant)

1 Production format

1.1 Documents must be provided electronically, using a .DAT/.OPT data file format and in Microsoft Excel format.

(a) The first line of the .DAT file must be a header row identifying the field names.

(b) The .DAT file must use the following Concordance® default de-limiters:

(1) Pilcrow ¶ ASCII character

(2) Quote þ ASCII character

1.2 Date fields should be provided in the format: DD-MMM-YYYY or DD/mm/YYYY

1.3 If the production includes emails and attachments, the attachment fields must be included to preserve the parent/child relationship between an email and its attachments.

1.4 Productions must include an extracted text file for each document. An OCR PATH field must be included to provide the file path and name of the extracted text file on the produced storage media. The text file must be named after the Document ID. Do not include the text in the .DAT file.

1.5 For productions that contain PDF or Native documents, a LINK field must be included to provide the file path and name of the native file on the produced storage media. The native file must be named after the Document ID.

2 Preparation of documents

2.1 A Party should avoid converting native electronic documents to paper for production to the Inquiry and must instead produce them as searchable multi-page PDF documents. For non-standard documents, such as Microsoft Excel and Audio/Video files, native document production is required.

2.2 Documents produced as searchable multi-page PDFs must be stamped with sequential page numbers in the top right hand corner of each page. The number on the first page will be the Document ID. The format must be PPP.BBBB.FFFF.NNNN, eg XYZ.0000.0000.0001

2.3 Searchable electronic documents should be rendered directly to PDF to create searchable images. Documents should not be printed to paper and scanned or

rendered to Tagged Image File Format (**TIFF**) format and then converted to PDF, unless required for the purposes of highlighting within a document review platform.

2.4 Non-searchable or image only native files should be converted to searchable PDFs, and not image only or non-searchable PDFs.

2.5 Non-standard electronic documents that do not lend themselves to conversion to PDF (for example, complex spread-sheets, databases, etc.) must be produced to the Inquiry as native electronic documents or in another format agreed with the Inquiry.

2.6 Hard copy documents should be produced as searchable, stamped, multi-page PDF documents. The minimum requirement for scanned images is 300dpi text searchable multi-page PDF.

2.7 Colour versions of documents must be created if the presence of colour is necessary to the understanding of the document. Documents which have coloured annotations or highlighting, photos, graphs or images are to be captured in colour.

2.8 If documents are highlighted or redacted for the purposes identified in sections 13 and 14 of this Protocol, Parties must provide the Inquiry with an image set (as PDF files) with documents containing redactions or highlights burnt in, accompanied by a load file complying to this Schedule.

2.9 A Party may apply Document IDs to the following paper documents where they contain relevant content:

(a) folder covers, spines, separator sheets dividers;

(b) hanging file labels; and

(c) the reverse pages of any document.

3 Document folder structure

3.1 The file name of each document must include the relevant file extension, e.g. 'DocumentID.xxx' where '.xxx' is the file extension.

3.2 The top level folder containing every document must be named '\Documents\'.

3.3 The documents folder must be structured in accordance with the Document ID hierarchy, e.g. 'Documents\ABC\."

4 Overview of metadata provided within the data (.DAT) load file

4.1 Required fields/metadata in a flat file format:

Field	Explanation – Document Types and Coding Method and possible values	
Document_ID	Document ID	
Host_Reference	If the document is an attachment, this field contains the Document ID of its host document. If a document does not have a host, this field is to be left blank\NULL.	
Document_Type	Paper Documents	Refer Document Types in Schedule 2.
	Electronic Documents (including email, email attachments, loose files etc)	Either native file type or Document Type in Schedule 2 as determined on the basis of the face of the document.
Document_Date	DD-MMM-YYYY or DD/mm/YYYY	
	Paper Documents	Determined on the basis of the date appearing on the face of the document.
	Undated Documents	Leave field blank\NULL.
	Incomplete Date (Year Only)	For example, 01-JAN-YYYY
	Incomplete Date (Month and Year Only, or Day and Month Only)	For example, 01-MMM-YYYY, DD-MMM-1900
	Emails	Email Sent Date
	Unsent Emails	Last Modified Date
	Other Electronic Documents	Last Modified Date; or Date appearing on the face of the document.
Document Date and Time	DD-MMM-YYYY HH:MM:SS (where HH is a 24 hour format)	
	Paper Documents	Determined on the basis of the date appearing on the face of the document .
	Undated Documents	Leave field blank\NULL.
	Incomplete Date (Year Only)	For example, 01-JAN-YYYY 00:00:00
	Incomplete Date (Month and Year Only, or Day and Month Only)	For example, 01-MMM-YYYY 00:00:00, DD-MMM-1900 00:00:00
	Emails	Email Sent Date and Time
	Unsent Emails	Last Modified Date and Time
	Other Electronic Documents	Last Modified Date and Time; or Date and time appearing on the face of the document.
Estimated	Yes OR No OR NULL	
	Default	No OR NULL
	Undated Documents	No OR NULL
	Incomplete Date	Yes
Title	Paper Documents	Determined on the basis of the title appearing on the face of the document .
	Email	Subject field from email metadata.
	Other Electronic Documents	Metadata file name or determined on the basis of the title appearing on the face of the document.

People and Organisations	Format 1: Person [Organisation] Format 2: Organisation Format 3: Person name or email address	
	Paper Documents	Name of person to be determined on the basis of the face of the document [Name of organisation that produced the document as determined on the basis of the face of the document]
	Emails	Electronic metadata – email addresses or email alias names.
	Other Electronic Documents	To be determined from the automatically identified metadata.
Organisations	Paper Documents	Name of organisation that produced the document as determined on the basis of the face of the document.
	Emails	Blank\NULL
	Other Electronic Documents	To be determined from the automatically identified metadata.
Persons	Paper Documents	To be determined on the basis of the face of the document.
	Emails	Electronic metadata – email addresses or email alias names.
	Other Electronic Documents	Author value to be determined from the automatically identified metadata.
Withheld	Yes OR Part OR No	
Withheld Reason	Legal professional privilege (65(2)(c)) Privilege against self-incrimination (offence) - (65(2)(a)); Privilege against self-incrimination (penalty) - (65(2)(a))); Parliamentary privilege (65(2)(b)); Public interest immunity (65(2)(d)); Prohibited by court order (65(2)(e)); Prohibited by enactment (65(2)(f)); Prohibited by enactment prescribed by regulations (65(2)(g)); or Other reason(65(1)(a))	
Restricted	Yes OR Part OR No	
Restricted Reason	Prejudice or hardship (73(2)(a)); Sensitive nature and subject matter (73(2)(b)); Possible prejudice to legal proceedings (73(2)(c)); Conduct of proceeding would be more efficient and effective (73(2)(d)); or Member should otherwise consider appropriate (73(2)(e))	
Personal-identifying information	Yes OR No	
Notice to Produce or Summons No.	Eg: NP002	Inquiry request number as identified on the Notice or Summons .
Notice to Produce Tranche No	NP002_TR01	Notice to Produce Tranche No in which the document is produced under
Notice to Produce Schedule Item	NP002-sch01	Notice to Produce Schedule item the document is relevant to

File Path	e.g. \\server\custodianname\	Source path of the original file, if available.
File Name	e.g, draft report.pdf	Source name of the original file, if available.
Date Created	DD-MMM-YYYY HH:MM:SS	Electronic metadata – created date, if available.
Date Last Modified	DD-MMM-YYYY HH:MM:SS	Electronic metadata – last modified date, if available.
MD5 Hash Value		MD5 hash value used for deduplication, if available.
File Extension	Eg: XLSX PDF	The file extension or original native file type is to be provided for all documents.
OCR TEXT file path	Documents\Text\Document_ID.TXT	Extracted text path.
Native\PDF file Path	Documents\Native\Document_ID.EXT	Native path for documents produced in native format.

4.2 Parties' information (To/From/CC/BCC) technical requirements:

(a) These fields hold the names of Parties associated with a particular document and their relationship to the document. It may also hold organisation information for these people.

(1) Describing people:

(i) A person's name may be referenced using:

A. email addresses (for example, jcitizen@xyz.com.au); or

B. Surname [space] first name initial (for example, Citizen J) where email addresses are not available; or

C. by reference to a position (for example, Private Service Provider) where email addresses or surname and first name initial are not available; or

D. by reference to an organisation associated with the person where email address, surname and first name initial and position are not available.

(2) Multiple recipients must be separated by a semicolon.

(3) Organisations must be placed into square brackets.

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Schedule 1B – Production Specification for Four-Table Microsoft Access Load File (Ringtail Compliant)

1 Production format

1.1 Documents must be produced electronically, in a cascading Windows folder structure, with the corresponding document metadata structured in a four-table Microsoft Access database format.

1.2 A Party should also include the index of documents in Microsoft Excel format.

2 Preparation of documents

2.1 A Party should avoid converting native electronic documents to paper for production to the Inquiry and must instead produce them as searchable multi-page PDF documents. For non-standard documents, such as Microsoft Excel and Audio/Video files, native document production is required.

2.2 Documents produced as searchable multi-page PDFs must be stamped with sequential page numbers in the top right hand corner of each page. The number on the first page must be the Document ID. The format must be PPP.BBBB.FFFF.NNNN, e.g. XYZ.0001.0001.0001.

2.3 Searchable electronic documents should be rendered directly to PDF to create searchable images. Documents should not be printed to paper and scanned or rendered to Tagged Image File Format (**TIFF**) format and then converted to PDF, unless required for the purposes of highlighting within a document review platform.

2.4 Non-searchable or image only native files should be converted to searchable PDFs, and not image only or non-searchable PDFs.

2.5 Non-standard electronic documents that do not lend themselves to conversion to PDF (for example, complex spread-sheets, databases, etc.) must be delivered to the Inquiry as native electronic documents or in another format agreed with the Inquiry.

2.6 Hard copy documents should be provided as searchable, stamped, multi-page PDF documents. The minimum requirement for scanned images is 300dpi text

searchable multi-page PDF.

2.7 Colour versions of documents must be created if the presence of colour is necessary to the understanding of the document. Documents which have coloured annotations or highlighting, photos, graphs or images are to be captured in colour.

2.8 If documents are highlighted for the purposes identified in section 18, 19 and 20 of this Protocol, Parties must provide the Inquiry with an image set (as PDF files) with documents containing highlights burnt in accompanied by a load file, complying to this Schedule.

2.9 A Party may apply Document IDs to the following paper documents where they contain relevant content:

(a) folder covers, spines, separator sheets dividers;

(b) hanging file labels; and

(c) the reverse pages of any document

3 Document folder structure

3.1 The file name of each document must include the relevant file extension, e.g. 'DocumentID.xxx' where '.xxx' is the file extension.

3.2 The top level folder containing every document must be named '\Documents\'

3.3 The documents folder must be structured in accordance with the Document ID hierarchy, ie "Documents\ABC\[subfolders if required]"

4 Overview of structure of four-tabled Microsoft Access database

4.1 The document metadata is to be structured into the following four Microsoft Access database tables:

Table Name	Table Description
Export	Main document information.
Parties	People and organisation information for each document.
Pages	Listing of electronic image filenames for each document. The Pages table must correspond to the files within the cascading document folder structure.
Export_Extras	Additional data fields for each document, including subjective fields populated by the Parties during review.

4.2 Export Table

Field	Data Type	Explanation – Document Types and Coding Method and possible values	
Document_ID	Text, 255	Document ID	
Host_Reference	Text, 255	If the document is an attachment, this field contains the Document ID of its host document. If a document does not have a host, this field is to be left blank\NULL.	
Document_Type	Text, 255	Paper Documents	Refer Document Types in Schedule 2.
		Electronic Documents (including email, email attachments, loose files etc)	Either native file type or Document Type in Schedule 2 as determined on the basis of the face of the document.
Document_Date	Date, 11	DD-MMM-YYYY or DD/mm/YYYY	
		Paper Documents	Determined on the basis of the date appearing on the face of the document.
		Undated Documents	Leave field blank\NULL.
		Incomplete Date (Year Only)	For example, 01-JAN-YYYY
		Incomplete Date (Month and Year Only; or Day and Month Only)	For example, 01-MMM-YYYY, DD-MMM-1900
		Emails	Email Sent Date
		Unsent Emails	Last Modified Date
		Other Electronic Documents	Last Modified Date; or Date appearing on the face of the document.
Estimated	Text, 3	Yes OR No OR NULL	
		Default	No OR NULL
		Undated Documents	No OR NULL
		Incomplete Date	Yes
Title	Text, 255	Paper Documents	Determined on the basis of the title appearing on the face of the document.
		Email	Subject field from email metadata.
		Other Electronic Documents	Metadata file name or determined on the basis of the title appearing on the face of the document.
Level_1		First subfolder level of where the document file is.	
Level_2		Second subfolder (if required) of where the document file is.	

4.3 Parties Table:

(a) This Table holds the names of people associated with a particular document and their relationship to the document. It may also hold organisation information for these people. There is a one-to-many relationship between the Export Table containing the primary document information and the Parties Table because multiple people could be associated with a single document.

Field	Data Type	Explanation	
Document_ID	Text, 255	Document ID	
Correspondence_Type	Text, 100	Paper Documents	AUTHOR, RECIPIENT BETWEEN, ATTENDEES, CC To be determined on the basis of the face of the document.
		Emails	FROM, TO, CC, BCC
		Other Electronic Documents	AUTHOR, RECIPIENT, CC To be determined from the automatically identified metadata.
Organisations	Text, 255	Paper Documents	Name of organisation that produced the document as determined on the basis of the face of the document.
		Emails	Blank\NULL
		Other Electronic Documents	To be determined from the automatically identified metadata.
Persons	Text, 255	Paper Documents	To be determined on the basis of the face of the document.
		Emails	Electronic metadata – email addresses or email alias names.
		Other Electronic Documents	Author value to be determined from the automatically identified metadata.

(b) Describing people in the Parties Table:

(1) A person's name may be referenced using:

(A) email addresses (for example, jcitizen@xyz.com.au); or

(B) Surname [space] first name initial (for example, Citizen J) where email addresses are not available; or

(C) by reference to a position (for example, Private Service Provider Manager) where email addresses or surname and first name initial are not available; or

(D) by reference to an organisation associated with the person where email address, surname, surname and first name initial and position are not available.

(2) Multiple recipients must be entered as separate rows in the Parties Table.

4.4 Pages Table

(a) There must be at least one entry in the Pages Table that relates to a single document in the Export Table. Concurrently, there must be an entry in the Pages Table for every file provided in the cascading document folder structure.

Field	Data Type	Explanation
Document_ID	Text, 255	Document ID
File_Name	Text, 128	Filename, including extension of each indexed document.
Page_Label	Text, 32	"PDF" for files produced as searchable multipage PDF documents. "Native" for documents produced as native electronic files. "Text" for the extracted text (OCR) contents of the file.
Page_Num	Number, Double	"1" for files produced as searchable multipage PDF documents. "2" for documents produced as native electronic files. "3" for the OCR text file.
Num_Pages	Number, Double	A number that represents the total number of pages of the document for files produced as searchable multipage PDF documents. "1" for documents produced as native electronic files.

4.5 Export Extras Table

(a) The Export Extras Table holds any additional metadata the Parties wish to produce that is not held in the other three Tables mentioned above. In addition to automatically identified document metadata, the Export Extras Table must also hold subjective coding information about documents that has been determined by the Parties.

Field	Data Type	Explanation
Document_ID	Text, 255	Unique Document Identifier (Document ID)
theCategory	Text, 50	Text OR Date OR Numb OR Bool OR Pick OR Memo
theLabel	Text, 255	Custom Field Name, from the List of Extras Fields below
theValue	Text, 255	Custom Field Contents from the List of Extras Fields below
Memovalue	MEMO	Custom Field Contents from the List of Extras Fields below for values more than 255 characters

(b) Required Extras Fields

Field	Data Type	Acceptable Values	Explanation
Document Date and Time	TEXT	DD-MMM-YYYY HH:MM:SS (where HH is a 24 hour format)	Document Date and Time electronically extracted using the respective processing tool (ie. Email Sent Date and Time OR Last Modified Date and Time). Where no time is electronically available the format value will be DD-MMM-YYYY 00:00:00
Withheld	PICK	Yes, Part	Only required for Documents being withheld in full or part. Single choice only
Withheld Reason	PICK	Legal professional privilege (65(2)(c)) Privilege against self-incrimination (offence) - (65(2)(a)); Privilege against self-incrimination (penalty) - (65(2)(a))); Parliamentary privilege (65(2)(b)); Public interest immunity (65(2)(d)); Prohibited by court order (65(2)(e)); Prohibited by enactment (65(2)(f)); Prohibited by enactment prescribed by regulations (65(2)(g)); or Other reason(65(1)(a))	Basis on which document is withheld. Only required for Documents marked as Withheld = Yes or Part
		(18(2)(d)); Prohibited by enactment (18(2)(e)); Prohibited by enactment prescribed by regulations (18(2)(f)) and (34(4)); or Other reason(18)(1)(a)	
Restricted	PICK	Yes, Part	Only required for documents with restrictions in full or part. Single choice only

Restriction Reason	PICK	Prejudice or hardship (73(2)(a)); Sensitive nature and subject matter (73(2)(b)); Possible prejudice to legal proceedings (73(2)(c)); Conduct of proceeding would be more efficient and effective (73(2)(d)); or Member should otherwise consider appropriate (26(2)(e))	Basis on which document is restricted. Only required for documents marked as Restricted = Yes or Part
Personal identifying information	PICK	Yes	Only required where information is highlighted as personal identifying information. Single choice only
Notice to Produce or Summons No.	PICK	Eg: N006/16	Inquiry request number as identified on the Notice or Summons.
Notice to Produce Tranche No	PICK	NP002_TR01	Notice to Produce Tranche No in which the document is produced under
Notice to Produce Schedule Item	PICK	NP002-sch01	Notice to Produce schedule item the document is relevant to
File Path	MEMO		Source path of the original file, if available.
File Name	TEXT		Source name of the original file, if available.
Date Created	TEXT	DD-MMM-YYYY HH:MM:SS	Electronic metadata – created date, if available.
Date Last Modified	TEXT	DD-MMM-YYYY HH:MM:SS	Electronic metadata – last modified date, if available.
MD5 Hash Value	TEXT		MD5 hash value used for deduplication, if available.
File Extension	TEXT	Eg: XLSX PDF	The file extension or original native file type is to be provided for all documents.

COVID-19
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Schedule 2 – Document Types

1 Document Types for electronic documents

Document Type	Description
Email	An email – usually contained within an email store (e.g. an email box) but may be extracted to reside within a directory or folder on a file system.
Email Attachment	An electronic document attached to an email.
Electronic File	An electronic file that is not attached to an email but rather resided in its original state in a directory on a file system.

2 Document Types for hard copy documents

2.1 Standard document types:

Document Type			
Agenda	Email	Minutes of Meeting	Transcript
Agreement/Contract/Deed	Facsimile	Notice	Web Page
Affidavit/Statement	Fax Transmission Report	Permit	
Annual Report	File Note	Photograph	
Article	Financial Document	Physical Media	
Authority	Form	Presentation	
Board Papers	Handwritten Note/Note	Receipt	
Brochure	Invoice/Statement	Report	
Certificate	Legislation/Act	RFI – RFO	
Cheque Remittance	Letter	Search/Company Search	
Court Document	List	Social Media/Messaging	
Curriculum Vitae/Identification	Manual/Guidelines	Specification	
Diary Entry	Map	Table/Spreadsheet	
Divider/File Cover	Media Article/Release	Submissions	
Diagram/Plan	Memorandum	Timesheet	

Practice Direction 2

COVID-19
Hotel Quarantine Inquiry

PRACTICE DIRECTION NO. 2

LEAVE TO APPEAR AT THE INQUIRY

15 JULY 2020

INTRODUCTION

1. This Practice Direction (**PD-2**) relates to participation in the evidentiary public hearings that will be held as part of the work of the Board of Inquiry into the COVID-19 Hotel Quarantine Program (**Inquiry**).

2. This Practice Direction is issued under s 63(1) of the *Inquiries Act 2014 (Vic)* (**Act**). It should be read in conjunction with the Act and with the terms of reference contained in the Order establishing the Inquiry.

3. This Practice Direction sets out general guidance about applications for leave to appear at the evidentiary public hearings of the Inquiry. Other information relevant to the work of the Inquiry can be found in Practice Direction 3 which relates to the taking of evidence at those public hearings.

WHEN LEAVE TO APPEAR MAY BE GRANTED

4. The Inquiry's power to grant leave to appear is contained in section 62 of the Act.

5. Having regard to the matters in that section and to the nature, purposes and timeframe of the Inquiry, it is anticipated that leave to appear may be granted to a person (including a body corporate or body politic) who has a direct or special interest in one or more of the subjects of the Inquiry. It will generally be granted where a person -

   (a) is a subject of consideration at the evidentiary public hearing;

   (b) is likely to be the subject of an adverse allegation; or

   (c) is able to demonstrate that their participation in the hearing will assist the Inquiry.

THE SCOPE OF ANY LEAVE GRANTED

6. It is unlikely that the Inquiry will grant any person unconditional leave to appear. Unless the Inquiry is otherwise persuaded in a particular case, any grant of leave will be -

   (a) limited to the particular issue or issues in which the person has the special or direct interest; and

   (b) subject to conditions.

7. A person granted leave to appear will be entitled to -

   (a) appear at and participate in the public hearing subject to the Inquiry's control and to any limitations and conditions imposed on the grant of leave;

   (b) be legally represented without the need for further or separate authorisation; and

   (c) seek leave to examine or cross examine witnesses in accordance with Practice Direction 3.

8. The Inquiry may at any time withdraw leave to appear or make a grant of leave subject to amended or additional limitations and conditions.

PROCESS FOR APPLICATIONS

9. The evidentiary public hearings will commence in August 2020 on dates to be fixed. The matters to be considered at the public hearings will be determined by the Inquiry and published on its website in advance of the hearing dates.

10. All applications for leave to appear at the evidentiary public hearings must be made -

    (a) as soon as the person becomes aware that they have a relevant interest in the matters to be considered at the public hearings;

    (b) wherever possible, no later than 3 days prior to the date of the evidentiary public hearing for which leave to appear is sought; and

    (c) on the form **attached** to this Practice Direction entitled "Application for Leave to Appear at the Public Hearings of the Inquiry".

11. The completed form must be accompanied by a short submission of no more than one page addressing the reasons why the applicant should be granted leave to appear at the evidentiary public hearing. Submissions should address:

(a) the matters referred to in section 62(2) of the Act; and

(b) the matters set out in this Practice Direction.

12. Applications for leave should be sent to Solicitors Assisting by email to: lawyers@quarantineinquiry.vic.gov.au or by post to: PO Box 24012, Melbourne VIC 3001.

13. The Inquiry will generally determine applications for leave to appear without any oral hearing and on the basis of the application and submissions provided.

14. The Inquiry will notify the applicant in writing of its determination.

CONTACTING THE INQUIRY

15. Any questions about any matters dealt with in this Practice Direction or other matters concerning the public hearings should be directed to Solicitors Assisting at: lawyers@quarantineinquiry.vic.gov.au.

Issue date: 15 July 2020

THE HONOURABLE JENNIFER COATE AO
Board of Inquiry into the COVID-19 Hotel Quarantine Program

Application for Leave to Appear at the Public Hearings of the Inquiry

Name of person or organisation seeking leave to appear	
Lawyer(s) representing the person or organisation (if any)	
Contact person(s)	
Contact address	**(State)** **(Postcode)**
Contact telephone number	**(Business)** **(Mobile)**
Contact email address(es)	

Please attach a short submission as to the reasons why the applicant should be granted leave to appear at the public hearings.

The submission must be no longer than one page and should address:

- the matters referred to in section 62(2) of the *Inquiries Act 2014* (Vic); and
- how granting leave to appear at the public hearings would assist the Inquiry in the conduct of the public hearings over and above any written submissions that the applicant may make

Please lodge this form with the attached submission by sending it via:

- email to: lawyers@quarantineinquiry.vic.gov.au; or
- post to: PO Box 24012, Melbourne VIC 3001.

Practice Direction 3

COVID-19
Hotel Quarantine Inquiry

PRACTICE DIRECTION NO. 3

CONDUCT OF PUBLIC HEARINGS

15 JULY 2020

As Amended on 20 August 2020

INTRODUCTION

1. This Practice Direction (**PD-3**) relates to the conduct of the public hearings that will be held as part of the work of the Board of Inquiry into the COVID-19 Hotel Quarantine Program (**Inquiry**).

2. This Practice Direction is issued under section 63(1) of the *Inquiries Act 2014 (Vic)* (**Act**). It should be read in conjunction with the Act and with the terms of reference contained in the Order establishing the Inquiry.

3. This Practice Direction sets out the way in which the evidentiary public hearings of the Inquiry will be conducted. Persons seeking to participate in the public hearings should consult Practice Direction 2 which relates to applications for leave to appear.

GENERAL MATTERS

4. The Inquiry will conduct evidentiary public hearings from August 2020 on dates to be fixed.

5. The Inquiry will endeavour to publish a list of the topics to be examined in the public hearings in advance. That list may be amended as the Inquiry proceeds. The Inquiry will also, from time to time, publish a list of the witnesses who will attend and give evidence at the hearings.

6. Subject to any contrary direction of the Inquiry pursuant to the Act, the public hearings will be open to the public via live streaming.

7. Subject to any changes in public heath directions made under the *Public Health and Wellbeing Act 2008*, or by leave granted by exception, only designated officers of the Inquiry, including Counsel Assisting the Inquiry (**Counsel Assisting**), will be physically

present during the public hearings. Persons granted leave to appear and their legal representatives will attend via online video platform.

WITNESSES

8. Subject to the control of the Inquiry, Counsel Assisting will determine -

   (a) who is to be called as a witness at the public hearings;

   (b) the order in which those witnesses are called; and

   (c) which documents are to be tendered.

9. The Inquiry will require witnesses to give evidence on oath or affirmation.

10. The Inquiry may require witnesses to give evidence concurrently with other witnesses.

11. All persons required to give evidence will be served with a notice under section 64 of the Act requiring their attendance to give evidence.

IDENTIFICATION AND PREPARATION OF WITNESSES

12. Counsel Assisting, with the assistance of the Solicitors Assisting the Inquiry, will:

   (a) identify and contact each individual they wish to give evidence as a witness before the Inquiry;

   (b) determine whether an individual in respect of whom a witness statement has been prepared or received will be called to give evidence at a hearing; and

   (c) obtain witness statements in accordance with this Practice Direction.

13. Unless the Inquiry otherwise determines, any witness called in the public hearings will give evidence by way of both written witness statement and oral evidence.

14. Where a proposed witness is not legally represented, Counsel Assisting and Solicitors Assisting the Inquiry will meet with the proposed witness for the purpose of preparing their witness statement.

15. Where a proposed witness is legally represented -

   (a) Counsel Assisting will prepare, and Solicitors Assisting will provide, an outline of the topics that should be addressed in a proposed witness statement;

   (b) the proposed witness will be assisted by their legal representative in the preparation of their witness statement;

   (c) the witness statement must follow, and address each topic in, the outline; and

(d) Solicitors Assisting will communicate with the witness's legal representatives about the time by which the statement will be required, and where relevant and appropriate, about conferring with the witness prior to the date on which the witness gives evidence.

EXAMINATION OF WITNESSES AT THE PUBLIC HEARING

Evidence in chief

16. All witnesses called to give evidence will be examined by Counsel Assisting who will -

(a) invite the witness to adopt their witness statement as their evidence in chief; and

(b) examine the witness on topics that are -

(A) not covered in their witness statement;

(B) the subject of different or contradictory information available to the Inquiry; or

(C) otherwise matters which the Inquiry will be assisted by being canvassed in oral evidence.

17. Where practicable, Counsel Assisting will notify witnesses in advance of the hearing of any topics on which questions will be asked of the witness that are not covered by their witness statement. Counsel Assisting may, however, ask questions of the witness irrespective of whether notice is given.

Cross examination

18. Examination or cross-examination of witnesses by any other party will be by leave only and no open-ended leave will be given.

19. Any person who has leave to appear and who wishes to examine or cross examine a witness should consult with Counsel Assisting, via email in the first instance, regarding topics to be canvassed and whether those matters are matters that can be dealt with by Counsel Assisting. Counsel Assisting can be contacted at:

Tony Neal QC – tony.neal@quarantineinquiry.vic.gov.au

Rachel Ellyard – rachel.ellyard@quarantineinquiry.vic.gov.au

Ben Ihle – ben.ihle@quarantineinquiry.vic.gov.au

Steven Brnovic - steven.brnovic@quarantineinquiry.vic.gov.au

Jess Moir - jess.moir@quarantineinquiry.vic.gov.au

20. A person who has leave to appear and who wishes to seek leave to examine or cross-examine a witness must notify Counsel Assisting in accordance with paragraph 19 at least 2 working days before the day on which the witness is scheduled to give evidence, in accordance with the timetable to be published by the Inquiry from time to time, and inform Counsel Assisting of the matters set out in paragraph 22 below.

21. If a person who has leave to appear wishes to seek leave to examine or cross examine a witness and has not given notice as required by paragraph 20, that person may nevertheless seek leave, and may be called upon to specify, in addition to the matters set out in paragraph 22, why notice was unable to be given in advance.

22. In determining whether a person has a sufficient interest to examine or cross-examine a witness, the Inquiry may call upon the party making the application to set out in writing or in oral submissions:

    (a) the purpose of the cross-examination;

    (b) the issues to be canvassed;

    (c) the proposed duration of the examination; and

    (d) details (with copies provided) of any documents to which they propose to take the witness.

23. Wherever possible the Inquiry will determine applications for leave in chambers and in advance of the date on which the witness is to be called.

24. Leave to cross examine will only be granted to the extent it will assist the Inquiry.

25. Where leave is granted -

    (a) that leave may specify the issue or issues about which questions may be asked;

    (b) questioning must be limited to matters within the scope of the Inquiry;

    (c) questioning which is repetitive of matters already raised by Counsel Assisting will not be permitted;

    (d) questions going only to credit will not be permitted;

    (e) parties with a common interest in the evidence of a witness will be expected to agree amongst themselves on the division of topics amongst them;

    (f) revisiting areas or subjects covered by earlier questioning by parties with a common interest will not be permitted; and

(g) in default of agreement the Inquiry will direct the order of questioning; and

(h) any leave granted to the legal representative of a witness to examine their client will be confined to matters not already in evidence.

26. After any questioning by other parties, Counsel Assisting may re-examine the witness.

DOCUMENTS

27. Counsel Assisting will determine, subject to the Inquiry's control, which and when documents are to be tendered.

28. Before the commencement of the public hearing, each person granted leave to appear at the hearing may at the discretion of Counsel Assisting or Solicitors Assisting be given confidential access to documents that are likely to be tendered as exhibits and which could affect that person's interests. The time at which such access will be granted is in the discretion of the Inquiry and may be granted in tranches subject to the order in which issues are to be addressed in the public hearing.

29. One purpose for which confidential access may be granted is to enable the identification of any application for a restricted publication order in relation to a document or part of a document.

30. Additional documents may be tendered by Counsel Assisting during the course of a public hearing. Copies of any such documents will be provided to persons granted leave to appear.

31. A copy of any document proposed to be put to a witness must be provided to the Solicitors Assisting the Inquiry as soon as the decision is made to use the document and in all cases prior to the date on which it is intended to be used.

32. If a person who has been granted leave to appear seeks to have a document tendered at a public hearing:

(a) that person must provide a copy of it to Solicitors Assisting the Inquiry as soon as the decision is made to place the document before the public hearing;

(b) the Inquiry may require the production of other documents to assist in determining whether the document in question should be received; and

(c) Counsel Assisting will decide whether or not the documents are to be tendered.

RESTRICTED PUBLICATION ORDERS

33. The Inquiry may restrict publication of information relating to the public hearings in accordance with section 73 of the Act.

34. Subject to section 73 and any other direction made by the Inquiry:

    (a) transcripts of the evidence at the public hearings will be uploaded onto the Inquiry's website as soon as they are available;

    (b) witness statements of witnesses called to give evidence at the public hearings will be available on the Inquiry's website as soon as practicable after the witness has given their evidence; and

    (c) documents tendered at the public hearings will be available on the Inquiry's website as soon as practicable after the document has been tendered.

35. A person who has been granted leave to appear at the public hearing and who wishes to apply for a restricted publication order in respect of any witness or any evidence to be given during a public hearing must -

    (a) give notice of the application to Solicitors Assisting as soon as the basis for the application is identified and in all cases prior to the date on which the witness or evidence is to be before the public hearing; and

    (b) in that notice set out the basis of the application in writing by reference to the matters in section 73.

36. Unless the Inquiry otherwise directs in a particular case, restricted publication order applications will be determined on the papers.

37. The Inquiry will give notice to media organisations of any application for a restricted publication order.

CONTACTING THE INQUIRY

38. Any questions about any matters dealt with in this Practice Direction or other matters concerning the public hearings should be directed to Solicitors Assisting at: lawyers@quarantineinquiry.vic.gov.au.

Issue date: 15 July 2020

THE HONOURABLE JENNIFER COATE AO
Board of Inquiry into the COVID-19 Hotel Quarantine Program

Practice Direction 4

COVID-19
Hotel Quarantine Inquiry

PRACTICE DIRECTION NO. 4

CONDUCT OF EVIDENTIARY PUBLIC HEARINGS IN A VIRTUAL ENVIRONMENT

6 August 2020

INTRODUCTION

1. This Practice Direction (**PD-4**) relates to the conduct of the evidentiary public hearings that will be held as part of the work of the Board of Inquiry into the COVID-19 Hotel Quarantine Program (**Inquiry**) in a virtual environment.

2. This Practice Direction is issued under s 63(1) of the *Inquiries Act 2014* (Vic) (**Act**). It should be read in conjunction with the Act, the terms of reference contained in the Order establishing the Inquiry, and the other Practice Directions available on the Inquiry's website (https://www.quarantineinquiry.vic.gov.au/lawyers).

3. This Practice Direction may be varied, changed or amended from time to time. The Inquiry may, at any time, depart from this Practice Direction if it considers it appropriate to do so.

VIRTUAL HEARING ROOM

4. The evidentiary public hearings will be conducted via a virtual hearing room (**Virtual Hearing Room**).

5. The software used to host the Virtual Hearing Room will be Zoom.

PARTICIPANTS

6. To maintain orderly proceedings, access to the Virtual Hearing Room will be limited to the following, subject to any contrary directions the Inquiry may make in exceptional circumstances:

   (a) Witnesses called to give evidence before the Inquiry;

   (b) The legal representatives of such witnesses, including their Counsel and/or

solicitors;

(c) The legal representatives of other parties with leave to appear, but only at such times as evidence is being given or submissions are being made to the Inquiry in respect of matters where that party has a direct or special interest in that evidence or those submissions; and

(d) If applicable, one other person representing witnesses and/or each party with leave to appear (e.g. 'clients').

(together, **Participants**).

7. All other parties or persons wishing to observe the evidentiary public hearings may do so via the livestream available on the Inquiry's website (www.quarantineinquiry.vic.gov.au).

TECHNOLOGICAL SPECIFICATIONS FOR VIRTUAL HEARING ROOM

8. Zoom is a video conferencing application that can be used on any device, including a computer, tablet or a smartphone. Zoom may be accessed through the dedicated application or through a web browser.

9. The Inquiry recommends that Participants:

(a) download the Zoom application (available free at https://zoom.us/download or in the app store for your device);

(b) familiarise themselves with Zoom using the videos and guides on the Zoom website;

(c) have their own device with Zoom installed;

(d) use a computer or tablet no smaller than an iPad (9.7"). Smartphones should not be used by Participants who will be addressing the Inquiry during the evidentiary public hearings;

(e) ensure that they access the Virtual Hearing Room from a location that has a reasonable internet speed, whether via Wi-Fi or a cellular network such as 4G;

(f) wear a headset when attending the Virtual Hearing Room to improve audio quality and reduce any audio feedback (noting that mobile phone in-ear headphones do not generally provide reliable audio).

ACCESSING THE VIRTUAL HEARING ROOM

10. In order to access the Virtual Hearing Room, Participants are required to:

(a) Prepare a list containing the names, email addresses and mobile phone numbers of each person requiring access to the Virtual Hearing Room; and

(b) Email the list at least 24 hours prior to the hearings they propose to attend to Solicitors Assisting at lawyers@quarantineinquiry.vic.gov.au using 'Proposed Participants for Virtual Hearings' as the subject line of the email.

11. Participants will then be provided with log-in details enabling them to access the Virtual Hearing Room.

DEVICE CHECKS

12. Device checks will be arranged with witnesses called to give evidence before the Inquiry, in the days before they are scheduled to give evidence, to confirm that their technology is operating effectively. Legal representatives for witnesses called to give evidence before the Inquiry are permitted to attend such device checks.

13. A final device check will be conducted immediately prior to the hearing. Witnesses and their Nominated Legal Representative (see paragraph 18, below) must log-in to Zoom using the details provided 30 minutes prior to their scheduled appearance time to complete the final device check.

ATTENDING THE VIRTUAL HEARING ROOM

14. In order to replicate the conditions of a physical hearing room, when attending the Virtual Hearing Room:

(a) all Participants must ensure that they are situated in a quiet physical location that complies with social distancing requirements in place at the time, and where they will avoid interruption; and

(b) save as may be necessary for the limited purpose of receiving technological support, and subject to any directions the Board may make from time to time, witnesses must ensure that there are no other persons present in that physical location while giving evidence before the Inquiry.

15. When logging-in to Zoom, Participants must enter '(LTA)' then their full name and the organisation they are representing (if applicable). E.g. '(LTA) John Smith – Sample Co Pty Ltd'.

16. Participants other than witnesses and their Nominated Legal Representative (see paragraph 18, below) must mute their microphones and ensure that their camera is turned off.

17. Witnesses and their Nominated Legal Representative must log-in 30 minutes prior to the scheduled commencement of the witness' evidence, with their microphone on mute and their camera turned on. Witnesses will be invited to unmute their microphone immediately prior to giving evidence, and their Nominated Legal Representative will be requested to switch off their cameras and leave their microphone on mute unless addressing the Inquiry as outlined below.

ADDRESSING THE INQUIRY

18. Only one legal representative for each witness and party who has been granted leave to appear (**the Nominated Legal Representative**) will be able to turn on their camera, unmute their microphone, and address the Inquiry during the public evidentiary hearings, subject to the following:

    (a) In accordance with standard Court etiquette, the Nominated Legal Representative must refrain from turning on their camera and unmuting their microphone while Counsel Assisting is examining a witness unless it is necessary to make an objection;

    (b) When considering the need to address the Inquiry, the Nominated Legal Representative should have regard to the following:

        (A) The need for the Inquiry to maintain orderly proceedings, and the added difficulty of maintaining orderly proceedings in a virtual environment;

        (B) Once the Nominated Legal Representative turns on their camera and unmutes their microphone, their image and voice will be broadcast within the Virtual Hearing Room and, unless the Inquiry otherwise directs, the public via the Inquiry's live-stream;

    (c) Applications for leave to re-examine or cross-examine a witness must be made in accordance with Practice Direction 3; and

    (d) The Inquiry maintains the right to conduct the evidentiary public hearings in any manner it considers appropriate in accordance with s 59 of the *Inquiries Act 2014*.

19. Witnesses will be permitted to address the Inquiry in the usual manner when responding to questions put to them.

20. Those persons who have been given access to the Virtual Hearing Room, other than the Nominated Legal representative and witnesses, will not be permitted to address the Inquiry, unless exceptional circumstances apply, and will have their camera and microphone settings disabled throughout the evidentiary public hearings accordingly.

GIVING EVIDENCE

21. Witnesses will be sworn in or affirmed by the Associate. Witnesses can choose to take an oath or affirmation via Zoom. Witnesses choosing to take an oath are not required to hold a religious text. In circumstances where a witness would like to swear an oath upon a religious text, it will be the responsibility of the witness and/or their legal representative(s) to ensure that text is available.

22. Where a witness wishes to show a document or video during the virtual hearing, the witness and/or their legal representative(s) must contact the Inquiry at least two days prior to the commencement of the hearing so that the Inquiry may make suitable arrangements for the document or video to be shown during the hearing.

ETIQUETTE

23. The Board of Inquiry is constituted by the Honourable Jennifer Coate AO. When addressing the Board of Inquiry, the appropriate terminology is 'the Board' (e.g. 'if the Board pleases').

24. Participants should remain seated when the Honourable Jennifer Coate AO enters and exits the hearings, and when addressing the Inquiry.

25. When attending the hearings, Participants are expected to be attired and behave in a manner appropriate for attendance at a Court.

26. For the avoidance of doubt, Counsel are not to be robed.

LIVE STREAM AND RECORDING

27. The evidentiary public hearings will be live streamed to the public on the Inquiry's website (www.quarantineinquiry.vic.gov.au), which will be closed-captioned and subject to a delay of five minutes.

28. All aspects of the public hearings will be audio and visually recorded.

CONTACTING THE INQUIRY

29. For any issues, including technological difficulties, that may arise during the course of the Board's hearings, please contact Solicitors Assisting, who will be monitoring emails in real-time to enable a timely response, at lawyers@quarantineinquiry.vic.gov.au.

30. Questions about any matters dealt with in this Practice Direction or other matters concerning the evidentiary public hearings should be directed to Solicitors Assisting at: lawyers@quarantineinquiry.vic.gov.au.

Issue date: 6 August 2020

THE HONOURABLE JENNIFER COATE AO
Board of Inquiry into the COVID-19 Hotel Quarantine Program

Practice Direction 5

COVID-19
Hotel Quarantine Inquiry

PRACTICE DIRECTION NO. 5

DOCUMENTARY EVIDENCE

31 August 2020

INTRODUCTION

1. This Practice Direction (**PD-5**) relates to the handling of documentary evidence produced to the Board of Inquiry into the COVID-19 Hotel Quarantine Program (**Inquiry**).

2. This Practice Direction is issued under s 63(1) of the *Inquiries Act 2014* (Vic) (**Act**). It should be read in conjunction with the Act, the terms of reference contained in the Order establishing the Inquiry, and the other Practice Directions available on the Inquiry's website (https://www.quarantineinquiry.vic.gov.au/lawyers).

3. This Practice Direction may be varied, changed or amended from time to time. The Inquiry may, at any time, depart from this Practice Direction if it considers it appropriate to do so.

ONLINE HEARING BOOK

4. The Inquiry's online Hearing Book (**Hearing Book**) is accessible to parties with Leave to Appear. Access is expressly subject to an undertaking given by the accessing party that information contained on the Hearing Book will not be published or otherwise disclosed unless and until it has been tendered at a public hearing of the Inquiry or otherwise made publicly available by the Inquiry.

5. The Inquiry's staff, including Solicitors Assisting and Counsel Assisting the Inquiry, will determine which materials provided to the Inquiry will be uploaded to the Hearing Book.

6. As a general guide, the Hearing Book will contain:

   (a) statements of witnesses;

   (b) any exhibits or attachments to the statements of witnesses;

   (c) other documents identified as being relevant to the evidence of witnesses; and

(d) transcripts of public hearings.

7. The Hearing Book folders are structured as follows:

[Hearing dates to which evidence relates]

01. Leave to Appear folder

[Name of witness to whom evidence relates]

a. Statement

b. Exhibits

c. Documents Relevant to Witness

Other relevant documents

02. Produced for Tendering folder

[Name of witness to whom evidence relates]

a. Statement

b. Exhibits

c. Documents Relevant to Witness

Other relevant documents.

03. Tendered Exhibits folder

04. Finalised Transcripts folder

HEARING BOOK PROCESS

8. Documents subject to a 'reasonable excuse' claim pursuant to s 65 of the Act will not be uploaded to the Hearing Book until such claims have been determined.

9. Documents will be uploaded by the Inquiry's staff to the Hearing Book as follows:

(a) As soon as practicable upon receipt of statements and their exhibits/attachments that are proposed to be tendered, and upon identification of any other documents relevant to witnesses, but following the resolution of any claims of 'reasonable excuse' over the documents, or parts of documents;

(b) Documents subject to an extant claim for an order pursuant to s 73 of the Act (**s 73 Order**) will be uploaded to the Leave to Appear folder along with documents that are not subject to claims;

(c) Where redacted copies of documents subject to a claim for a s 73 Order are not provided at the time the documents are produced, unredacted copies of

those documents will be uploaded to the Leave to Appear folder;

(d) Where redacted copies of documents subject to a claim for a s 73 Order are provided to the Inquiry, those documents will be uploaded in redacted and unredacted form while such claims are resolved;

(e) Where a party seeks any redaction to documents contained on the Inquiry's Hearing Book prior to them being tendered, that party is required to provide highlighted and redacted copies of the documents to Solicitors Assisting as soon as possible but at least three days prior to the hearing at which the documents are proposed to be tendered;

(f) The Inquiry's staff will endeavour to transfer documents from the Leave to Appear folder to the 'Produced for Tendering' folder at least two days prior to the hearing to which those documents relate;

(g) Once witness statements are tendered, they will be published on the Inquiry's website, generally the same day they are tendered;

(h) Once documents other than witness statements are tendered, they will be placed in the Tendered Exhibits folder. Should any further redactions to the documents be sought, the seeking party must provide the Inquiry with highlighted and redacted copies of the documents as soon as possible, but no more than two calendar days after their being uploaded to the 'Tendered Exhibits' folder;

(i) Documents contained in the 'Tendered Exhibits' folder will be published on the Inquiry's website in due course;

(j) Documents contained in the 'Produced for Tendering' folder may be publicly displayed during the Inquiry's hearings.

REDACTING DOCUMENTS

10. The Inquiry's staff are generally not in a position to make redactions on behalf of parties.

11. If a party seeks that a redaction be made, it is that party's responsibility to provide copies of:

(a) the document(s) with highlighting over those parts sought to be redacted; and

(b) the document(s) with the relevant parts redacted as sought, and

(c) an explanation in writing which justifies the redaction.

12. Failure to provide any one of (a) – (c) above will result in the application for redaction being considered void and the document may be tendered, referred to in public hearings and published on the Inquiry's website in accordance with the remaining paragraphs of this Practice Direction.

DOCUMENTS AVAILABLE TO WITNESSES

13. When giving evidence before the Inquiry, witnesses are required to have immediate access (whether in electronic or hard-copy format) to all documents contained in the 'Produced for Tendering' folder assigned to their name.

IDENTITIES OF NON-EXECUTIVE PERSONNEL

14. The Inquiry has determined that information tending to identify any non-executive personnel of a government or private agency is not generally relevant to its Terms of Reference.

15. Accordingly, unless otherwise directed by the Inquiry, parties producing documents in response to a Notice to Produce (including statements) may produce documents to the Inquiry in two forms:

    (a) an unredacted copy of the document which contains personal identifying information of non-executive personnel of government and/or private agencies; and

    (b) a form of the document where the personal identifying information is redacted from documents, and in which the redacted information may be replaced with text reflecting that person's job title or role.

16. In the instance that a party seeks to avail itself/themselves of the process afforded by paragraph 15 above, then:

    (a) only the redacted version of the statement will be placed in the 'Produced for Tendering' folder, tendered at any public hearing and placed on the Inquiry's website for public access; and

    (b) any person to whom such personal identifying information relates will be given a pseudonym by the Inquiry, and if referred to or called to give evidence at a public hearing, will give evidence under that pseudonym.

Issue date: 31 August 2020

THE HONOURABLE JENNIFER COATE AO
Board of Inquiry into the COVID-19 Hotel Quarantine Program

Appendix E

List of Parties with Leave to Appear

Alfred Health
Australian Nursing Agency
Crown Melbourne Ltd
Mr Christopher Eagle
Department of Environment, Land, Water and Planning (DELWP)
Department of Health and Human Services (DHHS)
Department of Jobs, Precincts and Regions (DJPR)
Department of Justice and Community Safety (DJCS)
Department of Premier and Cabinet (DPC)
Department of Treasury and Finance (DTF)
The Hon. Daniel Andrews MP
The Hon. Jenny Mikakos
The Hon. Lisa Neville MP
The Hon. Martin Pakula MP
Meteorite Land (Pearl River) Pty Ltd as trustee for the Meteorite Land (Pearl River) Unit Trust, trading as the Four Points by Sheraton
Melbourne Hotel Group Pty Ltd trading as Holiday Inn Melbourne Airport
Mr Michael Girgis, IKON Cleaning Services
MSS Security Pty Ltd
Onsite Doctors Pty Ltd
Professor Benjamin Howden
Rydges Hotels Ltd
Salter Brothers (Spencer Street) Hotel Pty Ltd
Chief Commissioner Shane Patton, Victoria Police
Stamford Plaza Melbourne Pty Ltd
Sterling Pixxel Pty Ltd trading as Sterling Security Group
Travelodge Hotel Docklands
Unified Security Group (Australia) Pty Ltd
United Risk Management Pty Ltd
Wilson Security Pty Ltd
Your Nursing Agency (Victoria) Pty Ltd (YNA)

Appendix F

Example letter and notice to produce documents

COVID-19
Hotel Quarantine Inquiry

[Date]

[Name of addressee]
[Position of addressee]
[Organisation]
[Organisation's address]

By email: [email address of addressee or their legal representative]

Dear [Name of addressee]

Board of Inquiry into the COVID-19 Hotel Quarantine Program – NTP-[number]

The COVID-19 Hotel Quarantine Program Inquiry was established on 2 July 2020 by Order in Council made under s 53(1) of the *Inquiries Act 2014* (Vic).

The Board of Inquiry's Terms of Reference (**Terms of Reference**) are enclosed at **Attachment 1**.

The purpose of this letter is to notify you that your organisation has been identified as an organisation of interest to the work of the Inquiry.

The Inquiry is conscious that many who will be asked to contribute to the work of the Inquiry are concurrently assisting with the ongoing efforts to respond to the COVID-19 pandemic. Whilst mindful of this, we are also conscious of the timeframes in which the Inquiry is required to undertake its task, and to furnish its report.

We now write to issue your organisation with a Notice to Produce requiring the production of documents.

Notice to Produce

Please find **enclosed** a Notice to Produce (**Notice**) issued pursuant to s 64 of the *Inquiries Act 2014* (Vic). A copy of s 64 is attached to this letter (**Attachment 2**).

The Notice is to be known as NTP-[number]. It contains important information about how the documents specified in the Schedule to the Notice are to be produced to the Inquiry and when.

The documents responsive to the Notice should be produced in accordance with Practice Direction 1: Production of Materials and Document Management Protocol, a copy of which is attached to this letter (**Attachment 3**).

When producing the documents responsive to the Notice, please include a covering letter that identifies whether the documents produced constitute complete or partial production in response to the Notice.

E lawyers@quarantineinquiry.vic.gov.au **quarantineinquiry.vic.gov.au**

OFFICIAL

Timeline

The Notice requires that you produce relevant documents to the Inquiry by **[time and date of deadline]**.

We appreciate your organisation may face difficulty in meeting this timeframe. We have factored that difficulty into the period in which production of documents is required pursuant to the Notice.

You will also note that the Inquiry is required to provide its final report to the Governor in approximately 13 weeks from now, on 6 November 2020. Accordingly, your compliance with the timeframe is required.

If you would like to discuss this, or any other matter regarding the Inquiry, please contact Solicitors Assisting at lawyers@quarantineinquiry.vic.gov.au or (03) 7017 3459.

Yours sincerely,

THE HONOURABLE JENNIFER COATE AO
Board of Inquiry into the COVID-19 Hotel Quarantine Program

NOTICE TO PRODUCE

DOCUMENTS TO A BOARD OF INQUIRY

Regulation 15

TO: [Name of addressee]
[Position title of addressee]
[Organisation]

AT: [Organisation address]

A Board of Inquiry is being held into the COVID-19 Hotel Quarantine Program, established by an Order in Council made under s 53(1) of the *Inquiries Act 2014* (Vic) (Act).

What you must do

You must produce the documents specified in the Schedule attached to this Notice (the **Schedule**). This Notice is identified as 'NTP-[number]'.

You should include with the documents a numbered index which includes:

- the document title and date; and
- any relevant commentary necessary to provide context to the document.

Where you must produce documents

The documents specified in the Schedule must be produced electronically in accordance with Practice Direction 1: Production of Materials and Document Management Protocol on or before **[time and date of deadline]**.

Objecting to this notice

You may object to this notice if you have (or will have) a reasonable excuse for failing to comply with the notice. For example, it is a reasonable excuse to fail to comply with the notice if you are prohibited from disclosing the document(s) by a court order. See section 65 of the *Inquiries Act 2014* (the **Act**) for further examples of what constitutes a reasonable excuse.

You may also object to the notice by claiming that the document(s) specified in the notice are not relevant to the subject matter of the inquiry.

If you wish to object to this notice, you must do so in writing:

To: lawyers@quarantineinquiry.vic.gov.au

By: [time and date of deadline].

Your written objection must outline your reasons for objecting and include a relevant contact person with which to liaise. If the Board of Inquiry is satisfied that your claim is made out, the Board of Inquiry may vary or revoke this notice.

Failure to comply with this notice without a reasonable excuse may constitute a criminal offence. The maximum penalty for this offence is 240 penalty units or imprisonment for two years. See section 86 of the Act.

Failure to comply with this notice without a reasonable excuse may also result in the Board of Inquiry making an application to the Supreme Court of Victoria. The Court may then order you to comply with the notice within a specified period. See section 70 of the Act.

THE HONOURABLE JENNIFER COATE AO
Board of Inquiry into the COVID-19 Hotel Quarantine Program

Date: [Date]

SCHEDULE TO NOTICE TO PRODUCE

DOCUMENTS TO A BOARD OF INQUIRY (NTP-[number])

The documents described below are required to be produced to the Board of Inquiry pursuant to s 64 of the *Inquiries Act* (Vic):

[Insert numbered list of types or categories of documents to be provided]

DEFINITIONS

For the purposes of this Notice to Produce:

[Insert definitions relevant to this notice]

Example letter and notice to produce witness statement

COVID-19
Hotel Quarantine Inquiry

[Date]

[Name of addressee]
[Position of addressee]
[Organisation]
[Organisation's address]

By email: [email address of addressee or their legal representative]

Dear [Name of addressee],

Board of Inquiry into the COVID-19 Hotel Quarantine Program

The Board of Inquiry (**Inquiry**) is inquiring into certain matters relating to the Hotel Quarantine Program and has identified you as a person with relevant evidence to give regarding one or more of those matters.

This letter is a request for a witness statement from you to assist the Inquiry with its work.

Attached to this letter are:

- A list of questions to be answered in your witness statement; and
- A Notice to Produce the statement **by [time and date of deadline]**. (**NTP-[number]**).

Powers of the Inquiry

Under the *Inquiries Act 2014* (Vic) (**Inquiries Act**) the Inquiry has the power to compel a person to attend to give evidence before a sitting of the Inquiry and to produce any document or thing. Persons who give evidence to the Inquiry enjoy certain protections under the Inquiries Act. In certain circumstances, a person may offer a reasonable excuse why they ought not be compelled to give evidence. More information can be found on the Inquiry's website and in the Inquiries Act.

Your witness statement will be your evidence in chief

The nature of the matters being inquired into and the timeframe within which the Inquiry must complete its work means that the Inquiry has determined to receive evidence in chief from all witnesses by means of a written witness statement. We are seeking your assistance in the preparation of a statement in advance of the hearings so as to enable the timely and effective receipt of relevant evidence. If you are not willing to prepare a written statement you should advise us as soon as possible so that arrangements can be made for your attendance before the Inquiry to have your evidence taken in another way.

E lawyers@quarantineinquiry.vic.gov.au **quarantineinquiry.vic.gov.au**

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Not all witnesses who provide statements will also be called to give oral evidence at the public hearings. You will receive notice in advance of the public hearings if your oral evidence is required

You can get help with writing your witness statement

If you have a legal representative, you may seek their assistance in preparing your witness statement.

If you are not legally represented, you may choose to -

- seek legal representation for the purposes of preparing your witness statement; or
- prepare the statement yourself in accordance with the questions and guidance contained in this letter and attachment; or
- meet with someone from the team of Counsel Assisting the Inquiry who will assist you in the preparation of your statement. If you wish to take up this option, you should contact us immediately.

Approach to witness statement

The Inquiry requests that you take the following approach when preparing your witness statement:

1. Answer the Inquiry's questions in the order in which they are listed in the attached document;
2. List each question as a heading and answer the relevant question under that heading;
3. Draft the statement in your own words and in plain English without the use of acronyms or jargon;
4. Only include additional evidence which you consider necessary, *having regard to the terms of reference of this Inquiry*, to give context or completeness to the questions you have been asked after you have answered the Inquiry's questions;
5. Where it is necessary to refer in your statement to a document which you or your organisation have already produced to the Inquiry under a Notice to Produce, refer to the document both by its title or description and by the number assigned to it when it was produced to the Inquiry;
6. Where it is necessary to refer in your statement to a document which you have not yet produced to the Inquiry, assign it a number in accordance with Practice Direction 1, refer to the document both by its title or description and by the number it has been assigned, and produce the document or documents to the Inquiry at the same time that you produce your statement; and
7. Once completed, assign your statement its own number in accordance with Practice Direction 1.

You can find Practice Directions relating to documents and your witness statement at the Inquiry's website, www.quarantineinquiry.vic.gov.au.

Timeline for production

The Notice requests that you produce all relevant documents to the Inquiry by **[time and date of deadline]**. However, we would gratefully receive any material produced prior to that date, if it is practicable for you to do so.

If you have any questions, please contact Solicitors Assisting at lawyers@quarantineinquiry.vic.gov.au or (03) 7017 3459.

Yours sincerely,

THE HONOURABLE JENNIFER COATE AO
Board of Inquiry into the COVID-19 Hotel Quarantine Program

COVID-19
Hotel Quarantine Inquiry

IN THE MATTER OF the *Inquiries Act 2014*

AND IN THE MATTER OF a Board of Inquiry into the COVID-19 Hotel Quarantine Program

LIST OF QUESTIONS FOR [NAME OF WITNESS]

[Please include these questions in your witness statement as headings, with your answer to each question immediately beneath the relevant heading]

[Insert sample questions for Witness]

E lawyers@quarantineinquiry.vic.gov.au quarantineinquiry.vic.gov.au

NOTICE TO PRODUCE

DOCUMENTS TO A BOARD OF INQUIRY

Regulation 15

TO: [Name of addressee]
[Position title of addressee]
[Organisation]

AT: [Organisation address]

A Board of Inquiry is being held into the COVID-19 Hotel Quarantine Program, established by an Order in Council made under s 53(1) of the *Inquiries Act 2014* (Vic) (**Act**).

What you must do

You must produce the documents specified in the Schedule attached to this Notice (the **Schedule**). This Notice is identified as 'NTP-[number]'.

You should include with the documents a numbered index which includes:

- the document title and date;
- whether the document is subject to a claim for reasonable excuse; and
- any relevant commentary necessary to provide context to the document.

Where you must produce documents

The documents specified in the Schedule must be produced electronically on or before **[time and date of deadline]** in accordance with Practice Direction 1: Production of Materials and Document Management Protocol.

Objecting to this notice

You may object to this notice if you have (or will have) a reasonable excuse for failing to comply with the notice. For example, it is a reasonable excuse to fail to comply with the notice if you are prohibited from disclosing the document(s) by a court order. See section 65 of the *Inquiries Act 2014* (the **Act**) for further examples of what constitutes a reasonable excuse.

You may also object to the notice by claiming that the document(s) specified in the notice are not relevant to the subject matter of the inquiry.

If you wish to object to this notice, you must do so in writing:

To: lawyers@quarantineinquiry.vic.gov.au

By: [time and date of deadline]

Your written objection must outline your reasons for objecting and include a relevant contact person with whom to liaise. If the Board of Inquiry is satisfied that your claim is made out, the Board of Inquiry may vary or revoke this notice.

Failure to comply with this notice without a reasonable excuse may constitute a criminal offence. The maximum penalty for this offence is 240 penalty units or imprisonment for two years. See section 86 of the Act.

Failure to comply with this notice without a reasonable excuse may also result in the Board of Inquiry making an application to the Supreme Court of Victoria. The Court may then order you to comply with the notice within a specified period. See section 70 of the Act.

THE HONOURABLE JENNIFER COATE AO
Board of Inquiry into the COVID-19 Hotel Quarantine Program

Date: [Date]

SCHEDULE TO NOTICE TO PRODUCE

DOCUMENTS TO A BOARD OF INQUIRY (NTP-[number])

The documents described below are required to be produced to the Board of Inquiry into the COVID-19 Hotel Quarantine Program (**Board**) pursuant to s 64 of the *Inquiries Act 2014* (Vic):

1. The statement, along with any supporting documents annexed thereto and an index of the supporting documents, prepared or gathered in response to the list of questions in the Board's letter addressed to [name of witness] dated [day / month] 2020.

Example letter and notice to attend

COVID-19
Hotel Quarantine Inquiry

[Date]

[Name of addressee]
[Title of addressee]
[Organisation]
[Organisation's address]

By email: [email address of addressee or their legal representative]

Dear [Name of addressee],

Board of Inquiry into the COVID-19 Hotel Quarantine Program: Notice to Attend

We write further to our recent correspondence, in which you were requested to provide a written statement to the Board of Inquiry into the COVID-19 Hotel Quarantine Program (**Board**).

Notice to Attend

As foreshadowed in that letter, please find **attached** a Notice to Attend the evidentiary hearings being conducted by the Board on [date of hearing].

[Include the following two sentences only if date of hearing is not yet decided:] We expect that you will be called in the period between **[first possible hearing date] and [last possible hearing date]**. We will contact to you in the coming week providing further details in this regard.

Conduct of hearings

The evidentiary hearings will be conducted via video-link. You will not be required to physically attend the hearings, but rather, will be able to attend remotely using Zoom using log-in details that will be provided to you in advance of the hearing at which you will be called to give evidence.

In you have legal representatives, they will also be permitted to attend the hearings remotely via Zoom. Further information regarding the conduct of the evidentiary hearings is available on the Board's website in Practice Direction 4.

Publication of your statement

Consistent with its usual procedures, the Board intends to make your statement and any documents annexed thereto available on the Board's Hearing Book in advance of the hearing at which you will be called to give evidence. The Board will also make any other documents likely to be raised during your evidence available on the Hearing Book.

The Board's Hearing Book is available to parties with leave to appear before the Board, and is regularly updated with relevant documents, such as your statement and any documents annexed thereto, to ensure that parties with leave to appear have notice of the matters likely to be raised at the Board's hearings.

E lawyers@quarantineinquiry.vic.gov.au **quarantineinquiry.vic.gov.au**

Subject to any contrary orders you may seek from the Board, once your statement and any other relevant documents relating to your evidence are tendered during the Board's hearings, those documents will be published on the Board's website. Again, this is consistent with the Board's usual procedures, and ensures that the public has access to relevant evidence forming part of the Board's Inquiry.

Application for Leave to Appear

If you have not done so already, and would like access to the Board's Hearing Book or to have legal representatives attend the hearings, we ask that you apply for leave to appear in accordance with Practice Direction No.2, which is contained on the Board's website by [time and date of deadline] (https://www.quarantineinquiry.vic.gov.au/lawyers).

If you have any questions, please contact Solicitors Assisting at lawyers@quarantineinquiry.vic.gov.au or (03) 7017 3459.

Yours sincerely,

THE HONOURABLE JENNIFER COATE AO
Board of Inquiry into the COVID-19 Hotel Quarantine Program

COVID-19
Hotel Quarantine Inquiry

NOTICE TO ATTEND TO A BOARD OF INQUIRY

Regulation 15

TO: [Name of addressee]
[Title of addressee]

AT: [Organisation of addressee]
[Address]

A Board of Inquiry is being held into the COVID-19 Hotel Quarantine Program, established by an Order in Council made under s 53(1) of the *Inquiries Act 2014* (Vic) (**Act**).

What you must do

You must attend the Board of Inquiry to give evidence until excused.

Where you must attend

Where: The Board of Inquiry's hearings will be conducted by video-link using Zoom. You will be provided with login details and required to attend the hearing remotely using those details.

When: [date of hearing] at [time of hearing].

Note: You should bring this notice with you when attending the Board of Inquiry.

Objecting to this notice

You may object to this notice if you have (or will have) a reasonable excuse for failing to comply with the notice. For example, it is a reasonable excuse to fail to comply with the notice if you are prohibited from disclosing the document(s) by a court order. See section 65 of the Act for further examples of what constitutes a reasonable excuse.

You may also object to the notice by claiming that the document(s) specified in the notice are not relevant to the subject matter of the inquiry.

If you wish to object to this notice, you must do so in writing:

To: lawyers@quarantineinquiry.vic.gov.au

By: [time and date of deadline].

Your written objection must outline your reasons for objecting and include a relevant contact person with whom to liaise. If the Board of Inquiry is satisfied that your claim is made out, the Board of Inquiry may vary or revoke this notice.

Failure to comply with this notice without a reasonable excuse may constitute a criminal offence. The maximum penalty for this offence is 240 penalty units or imprisonment for two years. See section 86 of the Act.

Failure to comply with this notice without a reasonable excuse may also result in the Board of Inquiry making an application to the Supreme Court of Victoria. The Court may then order you to comply with the notice within a specified period. See section 70 of the Act.

THE HONOURABLE JENNIFER COATE AO
Board of Inquiry into the COVID-19 Hotel Quarantine Program

Date: [date]

E lawyers@quarantineinquiry.vic.gov.au quarantineinquiry.vic.gov.au

OFFICIAL

Appendix G

List of witnesses and statements received

Last name, first name	Title	Role	Date of Appearance(s)
Adams, Jamie	Mr	General Manager (Victoria and Tasmania), MSS Security Pty Ltd	3 September 2020
Aggarwal, Sorav 'Sam'	Mr	Chief Executive Officer, Sterling Services Group	2 September 2020
Alexander, Simone	Ms	Chief Operating Officer, Alfred Health	8 September 2020
Alpren, Charles	Dr	Epidemiologist	18 August 2020
Andrews, Daniel	The Hon.	Premier of Victoria	25 September 2020
Arundel, Craig	Mr	Security guard	24 August 2020
Ashford, Luke	Mr	Authorised officer	21 August 2020
Ashton, Graham	Mr	Former Chief Commissioner of Victoria Police	17 September 2020
Attalah, Mina	Mr	Managing Director, United Risk Management	2 September 2020
Bamert, Merrin	Ms	Director, Emergency Management and Health Protection, Department of Health and Human Services	11 September 2020
Banks, Dan	Mr	Director, Signal88 Security Australasia	Statement tendered[1]
Baxter, Hayley	Ms	Acting Executive Director of Strategic Sourcing, Department of Treasury and Finance	Statement tendered
Bedford, Rebecca	Ms	Partner, MinterEllison	Statement tendered
Chakik, Eddie	Mr	Business/Operations Manager, Ultimate Protective Services	Statement tendered
Chekaik, Samir	Mr	Director, Australian Protection Services Pty Ltd	Statement received[2]
Cleaves, Noel	Mr	Manager, Environmental Health Regulation and Compliance, Department of Health and Human Services	4 September 2020
Coppick, Nigel	Mr	National Operations Manager, Unified Security Group	3 September 2020
Crisp, Andrew	Comm'r	Emergency Management Commissioner, Emergency Management Victoria	15 September 2020
Crouch, Simon	Dr	Senior Medical Advisor, Department of Health and Human Services	8 September 2020
'Crowne Plaza Melbourne Executive Assistant Manager'		Executive Assistant Manager, Crowne Plaza Melbourne	Statement received

1. 'Statement tendered' denotes that a statement was formally tendered in evidence before the Board. The makers of such statements, and those who appeared before the Board's hearings, are defined as 'witnesses' throughout this Report.
2. 'Statement received' denotes that a statement was produced to the Inquiry and not tendered in evidence. As indicated in 'About this Report', the fact that a statement was not tendered does not mean that regard was not had to it by the Board for the purposes of its Inquiry.

Last name, first name	Title	Role	Date of Appearance(s)
Currie, Katrina	Ms	Executive Director, Employment Delivery, Working for Victoria; Executive Director, Department of Jobs, Precincts and Regions	27 August 2020
Curtain, Janette	Ms	Manager, Your Nursing Agency (Victoria) Pty Ltd	Statement tendered
D'Cruz, Shaun	Mr	Executive General Manager, Crown Melbourne Hotels	28 August 2020
de Kretser, Hugh	Mr	Returned traveller and Executive Director of the Human Rights Law Centre	20 August 2020
de Witts, Jacinda	Ms	Deputy Secretary, Legal and Executive Services, Department of Health and Human Services	Statement tendered
'DHHS Infection Control Consultant'		Infection Control Consultant, Department of Health and Human Services	Statement tendered
'DHHS Learning Consultant'		Learning Consultant, Department of Health and Human Services	Statement tendered
'DHHS Manager'		Manager, Department of Health and Human Services	Statement tendered
'DHHS senior project officer'		Senior project officer, Department of Health and Human Services	Statement tendered
'DJPR Administrative Officer'		Administrative Officer, Department of Jobs, Precincts and Regions	Statement received
'DJPR Operational Safety Advisor'		Operational Safety Advisor, Department of Jobs, Precincts and Regions	Statement received
'DJPR Program Manager'		Program Manager, Department of Jobs, Precincts and Regions	Statement received
Eagle, Christopher	Mr	Deputy State Controller, Health	15 September 2020
Eccles, Christopher	Mr	Former Secretary, Department of Premier and Cabinet	21 September 2020
Erasmus, Ron	Mr	Returned traveller	21 August 2020
Erasmus, Sue	Ms	Returned traveller	21 August 2020
Febey, Claire	Ms	Executive Director of the Priority Projects Unit, Department of Jobs, Precincts and Regions	27 August 2020
Ferrigno, Stephen	Mr	General Manager, Four Points by Sheraton Melbourne	28 August 2020
Garrow, Stuart	Mr	Clinical Lead Medical Practitioner, Onsite Doctor Pty Ltd	Statement tendered
Gavens, Kate	Ms	Chief Conservation Regulator, Department of Environment, Land, Water and Planning	Statement tendered
Girgis, Michael	Mr	General Manager, IKON Services Australia Pty Ltd	11 September 2020
Gordon, Rob	Dr	Psychologist	18 September 2020
Grayson, Lindsay	Prof.	Infectious diseases expert	17 August 2020
Gupta, Ishu	Mr	Managing Director, The Security Hub	2 September 2020

Last name, first name	Title	Role	Date of Appearance(s)
Helps, Jason	Mr	State Controller; Deputy Director of Emergency Operations and Capability Health, Department of Health and Human Services	17 September 2020
Henderson, Nick	Mr	General Manager, Holiday Inn Melbourne Airport	Statement tendered
'Hi8 Security Duty Manager'		Duty Manager, Hi8 Security	Statement received
Hogan, Braeden	Mr	Deputy Director, Strategy and Policy, Emergency Management Branch, Department of Health and Human Services	Statement tendered
Hogan, Shaun	Mr	National Manager, Corporate Risk, Wilson Security Pty Ltd	Statement tendered
Howden, Ben	Prof.	Medical microbiologist	17 August 2020
Hyslop, Kate	Ms	Returned traveller	20 August 2020
Krikelis, Sam	Mr	Business Manager, Event Services, MSS Security Pty Ltd	3 September 2020
Lapsley, Craig	Mr	Former Emergency Management Commissioner, Emergency Management Victoria	Statement tendered
Looker, Clare	Dr	Senior Medical Advisor, Department of Health and Human Services	Statement tendered
Loughnan, Matthew	Mr	Airport Services Manager, Melbourne, Dnata Airport Services Pty Ltd	Statement tendered
Lombardo, Matthew	Mr	Director, ACOST Security Services	Statement received
Mandyam, Ram	Mr	Hotel General Manager, Travelodge Hotel Melbourne Docklands	28 August 2020
May, Rachaele	Ms	Executive Director, Emergency Coordination and Resilience, Department of Jobs, Precincts and Regions	4 September 2020
McGuinness, Sarah	Dr	Outbreaks Lead, Outbreak Management Team, Department of Health and Human Services	8 September 2020
McLean, Andrew	Mr	Director, Elite Protection Services (Australia) Pty Ltd	Statement received
Mead, Cameron	Mr	Hotel Manager, Park Royal Hotel	Statement tendered
Menezes, Rosswyn	Mr	General Manager, Rydges on Swaston	28 August 2020
Menon, Unni	Mr	Executive Director, Aviation Strategy and Services, Department of Jobs, Precincts and Regions	31 August 2020
'Mercure Welcome Melbourne CEO'		Chief Executive Officer, Mercure Welcome Melbourne	Statement received
Mikakos, Jenny	The Hon.	Former Minister for the Coordination of Health and Human Services: COVID-19, Former Minister for Health, Former Minister for Ambulance Services	24 September
Millward, David	Mr	Director of National Operations, Unified Security Pty Ltd	Statement tendered

Last name, first name	Title	Role	Date of Appearance(s)
Murphy, Richard	Mr	Partner, MinterEllison	Statement tendered
Nagi, Mo	Mr	Victorian Operations Manager, Unified Security Pty Ltd	3 September 2020
Neville, Lisa	The Hon.	Minister for Police and Emergency Services Minister for Water Former Minister for the Coordination of Environment, Land, Water and Planning	23 September 2020
'Nurse Jen'		Nurse, Your Nursing Agency	20 August 2020
'Nurse Manager'		Nurse Manager, Alfred Health	Statement tendered
Ofli, Kaan	Mr	Returned traveller	24 August 2020
'DJPR Operations Coordinator'		Operations Coordinator, Department of Jobs, Precincts and Regions	Statement tendered
Paccioco, Rob	Mr	Director, BlackTie Security Pty Ltd	2 September 2020
Pakula, Martin	The Hon.	Minister for Racing Minister for Tourism, Sports and Major Events Minister for Industry Support and Recovery Minister for Trade Minister for Business Precincts Former Minister for the Coordination of Jobs, Precincts and Regions: COVID-19	23 September 2020
Patton, Shane	Chief Commissioner	Chief Commissioner, Victoria Police	17 September 2020
Peake, Kym	Ms	Former Secretary of Department of Health and Human Services	22, 23 September 2020
Phemister, Simon	Mr	Secretary of Department of Jobs, Precincts and Regions	22 September 2020
Pinskier, Nathan	Dr	Director, On Site Doctor Pty Ltd	Statement tendered
'Principal Policy Officer'		Principal Policy Officer, Employment, Inclusion, Department of Jobs, Precincts and Regions	Statement tendered
Rait, Julian	Dr	Associate Professor, AMA Victoria President	Statement tendered
Ratcliff, Liliana	Ms	Returned traveller	21 August 2020
'Returned traveller 1'		Returned traveller	20 August 2020
Romanes, Finn	Dr	Deputy Public Health Commander — Planning, Department of Health and Human Services. On various occasions, Dr Romanes also performed the role of Public Health Commander	Statement tendered
'Security 1'		Security guard	21 August 2020
'Security 16'		Security guard	24 August 2020
'DHHS Senior authorised officer'		Senior authorised officer, Department of Health and Human Services	Statement tendered

Last name, first name	Title	Role	Date of Appearance(s)
Serbest, Gönül	Ms	Chief Executive Officer of Global Victoria, Department of Jobs, Precincts and Regions	27 August 2020
Sinadinov, Darko	Mr	Director, Hospitality Performance Leaders Pty Ltd (T/A Nu Force Security Group)	Statement tendered
Singh, Ricky	Mr	Returned traveller	20 August 2020
Skilbeck, Melissa	Ms	Deputy Secretary, Regulation, Health Protection and Emergency Management, Department of Health and Human Services	10 September 2020
Smith, Eric	Mr	Managing Director, SwingShift Nurses	Statement tendered
Smith, Murray	Mr	Commander, COVID-19 Enforcement and Compliance, Department of Health and Human Services	10 September 2020
Spiteri, Andrea	Ms	State Controller; Health; Executive Director of Emergency Management, Department of Health and Human Services	17 September 2020
Sutton, Brett	Prof.	Chief Health Officer, Department of Health and Human Services	16 September 2020
Symonds, Terry	Mr	Deputy Secretary, Health and Wellbeing, Department of Health and Human Services	Statement tendered
Tait, Michael	Mr	Nurse, Your Nursing Agency	20 August 2020
Tully, Timothy	Cdr	Commander, Victoria Police	4 September 2020
Unterfrauner, Karl	Mr	General Manager, Stamford Plaza Melbourne	28 August 2020
van Diemen, Annaliese	Dr	Deputy Chief Health Officer, Department of Health and Human Services	16 September 2020
Verosaari, Mika	Mr	General Manager, Victoria and Tasmania, AHS Hospitality Pty Ltd	Statement tendered
'Victoria Police Superintendent'		Superintendent, Victoria Police	Statement tendered
'Victoria Police Superintendent 2'		Superintendent, Victoria Police	Statement received
'Victoria Police Inspector'		Inspector, Victoria Police	Statement received
'QSS Security Executive Manager'		Executive Manager, QSS Security	Statement received
Wallace, Euan	Prof.	Former Chief Executive Officer, Safer Care Victoria; Secretary, Department of Health and Human Services	10 September 2020
Watson, Greg	Mr	General Manager, Regional Operations (Victoria and Tasmania), Wilson Security Pty Ltd	2 September 2020
Williams, Pam	Ms	Commander, Operation Soteria, Department of Health and Human Services	11 September 2020

Appendix H

Exhibit list

Exhibit	Document Title
1	Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson
2	Exhibit HQI0002_RP Curriculum vitae of Prof. Michael Lindsay Grayson
3	Exhibit HQI0003_P Dept Health training on how to protect yourself and others from COVID-19
4	Exhibit HQI0004_P Operation Soteria PPE advice for hotel security staff and AOs in contact with quarantined individuals (Grayson)
5	Exhibit HQI0005_P Witness statement of Prof. Benjamin Howden
6	Exhibit HQI0006_P Curriculum vitae of Prof. Benjamin Howden
7	Exhibit HQI0007_P Genomic clustering graph
8	Exhibit HQI0008_RP Witness statement of Dr Charles Alpren
9	Exhibit HQI0009_RP Witness statement of 'Nurse Jen'
10	Exhibit HQI0010_RP Induction and learning modules completed by 'Nurse Jen'
11	Exhibit HQI0011_P YNA COVID-19 Staff Update re infection control training module ('Nurse Jen')
12	Exhibit HQI0012_RP Email to 'Nurse Jen' re Dept of Health infection control training
13	Exhibit HQI0013_RP Witness statement of 'Returned Traveller 1'
14	Exhibit HQI0014_RP Witness statement of Mr Michael Tait
15	Exhibit HQI0015_RP Email from Mr Michael Tait asking for assistance
16	Exhibit HQI0016_P Witness statement of Mr Hugh de Kretser
17	Exhibit HQI0017_P Hotel room photos taken by Mr Hugh de Kretser
18	Exhibit HQI0018_P Joint witness statement of Ms Kate Hyslop and Mr Ricky Singh
19	Exhibit HQI0019_P Joint witness statement of Ms Sue and Mr Ron Erasmus
20	Exhibit HQI0020_P Witness statement of Ms Liliana Ratcliff
21	Exhibit HQI0021_RP Annexures to witness statement of Ms Liliana Ratcliff
22	Exhibit HQI0022_RP Annexure to witness statement of Ms Liliana Ratcliff
23	Exhibit HQI0023_RP Witness statement of Mr Luke Ashford
24	Exhibit HQI0024_RP Witness statement of 'Security 1'
25	Exhibit HQI0025_P Wilson Security Duties and Action On ('Security 1')
26	Exhibit HQI0026_P Wilson Security Toolbox Talk re hotel quarantine work ('Security 1')
27	Exhibit HQI0027_P Witness statement of Mr Kaan Ofli
28	Exhibit HQI0028_RP Meal order information for people with food allergies (Ofli)
29	Exhibit HQI0029_P Witness statement of Mr Craig Arundel
30	Exhibit HQI0030_P Wilson Security Core duties at the hotel (Arundel)
31	Exhibit HQI0031_RP Witness statement of 'Security 16'
32	Exhibit HQI0032_P Witness statement of Ms Claire Febey

Exhibit	Document Title
33	Exhibit HQI0033(1)_RP Annexures to witness statement of Ms Claire Febey
	Exhibit HQI0033(2)_RP Audio recording of SCC Operation Soteria meeting 27 March 2020
	Exhibit HQI0033(3)_RP Audio recording of SCC Operation Soteria meeting 10.00am 28 March 2020
	Exhibit HQI0033(4)_RP Audio recording of Operation Soteria meeting 6.00pm 28 March 2020
34	Exhibit HQI0034_RP Victoria enforced quarantine planning process (Febey)
35	Exhibit HQI0035_RP Operation Soteria Operations Plan (Febey)
36	Exhibit HQI0036_RP Witness statement of Ms Katrina Currie
37	Exhibit HQI0037_RP Annexures to witness statement of Ms Katrina Currie
38	Exhibit HQI0038_RP Witness statement of Ms Gönül Serbest
39	Exhibit HQI0039_RP Annexures to witness statement of Ms Gönül Serbest
40	Exhibit HQI0040_RP Witness statement of Mr Ram Mandyam
41	Exhibit HQI0041_RP Witness statement of Mr Shaun D'Cruz
42	Exhibit HQI0042_RP Witness statement of Mr Stephen Ferrigno
43	Exhibit HQI0043_RP Witness statement of Mr Nick Henderson
44	Exhibit HQI0044_RP Witness statement of Mr Cameron Mead
45	Exhibit HQI0045_RP Witness Statement of Mr Rosswyn Menezes
46	Exhibit HQI0046_RP Annexures to witness statement of Mr Rosswyn Menezes
47	Exhibit HQI0047_RP Witness statement of Mr Karl Unterfrauner
48	Exhibit HQI0048_RP Annexures to witness statement of Mr Karl Unterfrauner
49	Exhibit HQI0049_RP Witness statement of Mr Unni Menon
50	Exhibit HQI0050_RP Annexures to witness statement of Mr Unni Menon
51	Exhibit HQI0051_RP Witness statement of Mr Sorav 'Sam' Aggarwal
52	Exhibit HQI0052_RP Witness Statement of Mr Mina Attalah
53	Exhibit HQI0053_RP Witness Statement of Mr Ishu Gupta
54	Exhibit HQI0054_RP Witness Statement of Mr Rob Paciocco
55	Exhibit HQI0055_RP Subcontract agreement between Wilson Security and Black Tie Security (Paciocco)
56	Exhibit HQI0056_RP Witness statement of Mr Darko Sinadinov
57	Exhibit HQI0057_RP Witness statement of Mr Dan Banks
58	Exhibit HQI0058_P Witness statement of Mr Eddie Chakik
59	Exhibit HQI0059_RP Witness statement of 'Principal Policy Officer'
60	Exhibit HQI0060(1)_RP Annexures to witness statement of 'Principal Policy Officer'
61	Exhibit HQI0061_RP Witness statement of Mr Gregory Watson
62	Exhibit HQI0062_RP Annexures to witness statement of Mr Gregory Watson
63	Exhibit HQI0063_RP Witness statement of Mr Shaun Hogan
64	Exhibit HQI0064_RP Annexures to witness statement of Mr Shaun Hogan
65	Exhibit HQI0065_RP Witness statement of Mr Jamie Adams
66	Exhibit HQI0066_RP Annexures to witness statement of Mr Jamie Adams
67	Exhibit HQI0067_RP Witness statement of Mr Sam Krikelis

Exhibit	Document Title
68	Exhibit HQI0068_RP Annexures to witness statement of Mr Sam Krikelis
69	Exhibit HQI0069_RP Witness statement of Mr David Millward adopted by Mr Nigel Coppick
70	Exhibit HQI0070_RP Annexures to witness statement of Mr David Millward
71	Exhibit HQI0071_RP Witness statement of Mr Mo Nagi
72	Exhibit HQI0072_RP Annexures to witness statement of Mr Mo Nagi
73	Exhibit HQI0073_P Witness statement of Ms Hayley Baxter
74	Exhibit HQI0074_RP Witness statement of Mr Matthew Loughnan
75	Exhibit HQI0075_P Witness statement of Mr Noel Cleaves
76	Exhibit HQI0076_RP Annexures to witness statement of Mr Noel Cleaves
77	Exhibit HQI0077_RP Witness statement of 'Senior AO 1'
	Exhibit HQI0077(1)_RP Annexures to witness statement of 'Senior AO 1'
78	Exhibit HQI0078_RP Witness statement of Commander Timothy Tully
79	Exhibit HQI0079_RP Annexures to witness statement of Commander Timothy Tully
80	Exhibit HQI0080_RP First witness statement of Ms Rachaele May
81	Exhibit HQI0081_RP Annexures to first witness statement of Ms Rachaele May
82	Exhibit HQI0082_RP Second witness statement of Ms Rachaele May
83	Exhibit HQI0083_RP Annexures to second witness statement of Ms Rachaele May
84	Exhibit HQI0084_RP Witness statement of 'Operations Coordinator'
85	Exhibit HQI0085_RP Witness statement of Ms Janette Curtain
86	Exhibit HQI0086_RP Annexures to witness statement of Ms Janette Curtain
87	Exhibit HQI0087_RP Annexures to witness statement of Ms Janette Curtain
88	Exhibit HQI0088_RP Witness statement of Dr Stuart Garrow
89	Exhibit HQI0089_RP Annexures to witness statement of Dr Stuart Garrow
90	Exhibit HQI0090_RP Witness statement of Mr Eric Smith
91	Exhibit HQI0091_RP Annexures to witness statement of Mr Eric Smith
92	Exhibit HQI0092_RP Witness Statement of Dr Julian Rait
93	Exhibit HQI0093_RP Annexures to the witness statement of Dr Julian Rait
94	Exhibit HQI0094_RP Witness statement of 'Nurse Manager'
95	Exhibit HQI0095_RP Witness statement of Dr Nathan Pinskier
96	Exhibit HQI0096_RP Annexures to witness statement of Dr Nathan Pinskier
97	Exhibit HQI0097_RP Witness statement of Dr Clare Looker
98	Exhibit HQI0098_RP Annexures to witness statement of Dr Clare Looker
99	Exhibit HQI0099_RP Witness statement of Ms Simone Alexander
100	Exhibit HQI0100_RP Annexures to the witness statement of Ms Simone Alexander
101	Exhibit HQI0101_P Alfred Health Model of Care COVID-19 Hotel Support Services (Alexander)
102	Exhibit HQI0102_RP MOU between DHHS and Alfred Health (Alexander)
103	Exhibit HQI0103_RP Witness statement of Dr Simon Crouch
104	Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston (Crouch)

Exhibit	Document Title
105	Exhibit HQI0105_RP Annexures to witness statement of Dr Simon Crouch
106	Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness
107	Exhibit HQI0107_RP Annexures to witness statement of Dr Sarah McGuinness
108	Exhibit HQI0108_RP Annexures to witness statement of Ms Jannette Curtain
109	Exhibit HQI0109_RP Witness statement of 'DHHS Manager'
110	Exhibit HQI0110_RP Annexures to witness statement of 'DHHS Manager'
111	Exhibit HQI0111_RP Witness statement of Ms Kate Gavens
112	Exhibit HQI0112_RP Annexures to witness statement of Ms Kate Gavens
113	Exhibit HQI0113_P Witness statement of Dr Finn Romanes
114	Exhibit HQI0114_RP Annexures to witness statement of Dr Finn Romanes
115	Exhibit HQI0115_RP Annexures to witness statement of Dr Finn Romanes
116	Exhibit HQI0116_RP First witness statement of Prof. Euan Wallace AM
117	Exhibit HQI0117_RP Annexures to first witness statement of Prof. Euan Wallace AM
118	Exhibit HQI0118_RP Second witness statement of Prof. Euan Wallace AM
119	Exhibit HQI0119_RP Annexures to second witness statement of Dr Euan Wallace AM
120	Exhibit HQI0120_RP Email from Prof. Euan Wallace AM to Ms Melissa Skilbeck
121	Exhibit HQI0121_RP PPE advice for hotel based healthcare worker
122	Exhibit HQI0122_RP Witness statement of Mr Murray Smith
123	Exhibit HQI0123_RP Annexures to witness statement of Mr Murray Smith
124	Exhibit HQI0124(1)_RP Annexures to witness statement of Mr Murray Smith
125	Exhibit HQI0125_RP Witness statement of Ms Melissa Skilbeck
126	Exhibit HQI0126(1)_RP Annexures to witness statement of Ms Melissa Skilbeck
127	Exhibit HQI0127_RP Witness statement of Mr Mika Verosaari
128	Exhibit HQI0128_RP Witness statement of Mr Michael Girgis
129	Exhibit HQI0129_RP Annexures to witness statement of Mr Michael Girgis
130	Exhibit HQI0130_RP Witness statement of Ms Pam Williams
131	Exhibit HQI0131(1)_RP Annexures to witness statement of Ms Pam Williams
132	Exhibit HQI0132_RP Email from Ms Rachaele May to Ms Pam Williams
133	Exhibit HQI0133_RP Minutes of Operation Soteria meeting 10 April 2020
134	Exhibit HQI0134_RP Operation Soteria Positive diagnosis guidance
135	Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert
136	Exhibit HQI0136_RP Annexures to witness statement of Ms Merrin Bamert
137	Exhibit HQI0137_RP Email from Ms Merrin Bamert to DHHS and Safer Care Victoria
138	Exhibit HQI0138_RP DHHS emails re hotel accommodation for COVID positive passengers
139	Exhibit HQI0139_RP Email from DHHS Team Leader at Stamford Hotel to DHHS Operation Soteria
140	Exhibit HQI0140_P Witness statement of Mr Craig Lapsley
141	Exhibit HQI0141_RP Letter from the Commonwealth of Australia to the Board of Inquiry
142	Exhibit HQI0142_RP Voluntary submission from the Commonwealth of Australia

Exhibit	Document Title
143	Exhibit HQI0143(1)_RP Audio recording of SCC Operation Soteria meeting 27 March 2020
	Exhibit HQI0143(1)_RP Transcript of audio recording of SCC Operation Soteria meeting 27 March 2020
	Exhibit HQI0143(2)_RP Audio recording of SCC Operation Soteria meeting 10.00am 28 March 2020
	Exhibit HQI0143(2)_RP Transcript of audio recording of SCC Operation Soteria meeting 10.00am 28 March 2020
	Exhibit HQI0143(3)_RP Audio recording of Operation Soteria meeting 6.00pm 28 March 2020
	Exhibit HQI0143(3)_RP Transcript of audio recording of Operation Soteria meeting 6.00pm 28 March 2020
144	Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp
145	Exhibit HQI0145(1)_RP Annexures to first witness statement of Commissioner Andrew Crisp
146	Exhibit HQI0146_RP Second witness statement of Commissioner Andrew Crisp
147	Exhibit HQI0147_P Third witness statement of Commissioner Andrew Crisp
148	Exhibit HQI148(1)_RP Annexures to third witness statement of Commissioner Andrew Crisp
	Exhibit HQI0148(2)_RP Audio recording of SCC Operation Soteria Meeting 27 March 2020
149	Exhibit HQI0149_RP Witness statement of Mr Christopher Eagle
150	Exhibit HQI0150_RP Annexures to witness statement of Mr Christopher Eagle
151	Exhibit HQI0151_P Witness statement of Ms Jacinda de Witts
152	Exhibit HQI0152(1)_RP Annexures to witness statement of Ms Jacinda de Witts
153	Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton
154	Exhibit HQI0154_P Annexures to witness statement of Prof. Brett Sutton
155	Exhibit HQI0155_RP Annexures to witness statement of Prof. Brett Sutton
156	Exhibit HQI0156_P Review of Australia's Health Sector Response to Pandemic (H1N1) 2009
157	Exhibit HQI0157_P Transcript of Prime Minister's Press Conference 27 March 2020
158	Exhibit HQI0158_RP Email from Dr Finn Romanes to Ms Andrea Spiteri and Mr Christopher Eagle
159	Exhibit HQI0159_RP Emails between DHHS Commanders and Prof. Brett Sutton
160	Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen
161	Exhibit HQI0161(1)_RP Annexures to witness statement of Dr Annaliese van Diemen
162	Exhibit HQI0162_P Witness statement of Ms Andrea Spiteri
163	Exhibit HQI0163(1)_RP Annexures to witness statement of Ms Andrea Spiteri
164	Exhibit HQI0164_RP Witness statement of Mr Jason Helps
165	Exhibit HQI0165(1)_RP Annexures to witness statement of Mr Jason Helps
166	Exhibit HQI0166_P Class 2 State Controller responsibilities
167	Exhibit HQI0167_RP EMV State Operational Arrangements COVID-19
168	Exhibit HQI0168_RP Emails between Ms Claire Febey and Mr Christopher Eagle
169	Exhibit HQI0169_RP Witness statement of Chief Commissioner Shane Patton APM
170	Exhibit HQI0170_RP Annexures to witness statement of Chief Commissioner Shane Patton APM
171	Exhibit HQI0171_RP Victoria Police safety officer instructions
172	Exhibit HQI0172_RP Witness statement of 'Victoria Police Superintendent'
173	Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM

Exhibit	Document Title
174	Exhibit HQI0174_RP Annexures to first witness statement of former Chief Commissioner Graham Ashton AM APM
175	Exhibit HQI0175_RP Second witness statement of former Chief Commissioner Graham Ashton AM APM
176	Exhibit HQI0176_P Witness statement of Dr Rob Gordon
177	Exhibit HQI0177_RP First witness statement of Mr Christopher Eccles
178	Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles
179	Exhibit HQI0179_RP Second witness statement of Mr Christopher Eccles
180	Exhibit HQI0180_RP Annexures to second witness statement of Mr Christopher Eccles
181	Exhibit HQI0181_RP Texts between Commissioner Andrew Crisp and Kate Houghton
182	Exhibit HQI0182_RP Working with Vic messages re good security companies
183	Exhibit HQI0183_RP Buying for Victoria webpage re security services
184	Exhibit HQI0184_RP Witness statement of Mr Simon Phemister
185	Exhibit HQI0185(1)_RP Annexures to witness statement of Mr Simon Phemister
186	Exhibit HQI0186_RP First witness statement of Ms Kym Peake
187	Exhibit HQI0187_RP Annexures to first witness statement of Ms Kym Peake
188	Exhibit HQI0188_RP Second witness statement of Ms Kym Peake
189	Exhibit HQI0189_RP Annexures to second witness statement of Ms Kym Peake
190	Exhibit HQI0190_RP Annexures to second witness statement of Ms Kym Peake
191	Exhibit HQI0191_RP Initial response to the Board of Inquiry from DHHS
192	Exhibit HQI0192_RP DHHS draft advice to National Cabinet
192	Exhibit HQI0192_RP DHHS draft advice to National Cabinet
193	Exhibit HQI0193_P Letter from the Hon. Daniel Andrews MP to Ms Kym Peake
194	Exhibit HQI0194_RP Mission Implementation Plan
195	Exhibit HQI0195_RP Witness statement of the Hon. Martin Pakula MP
196	Exhibit HQI0196_P Witness statement of the Hon. Lisa Neville MP
197	Exhibit HQI0197_RP Appointment of Ms Andrea Spiteri as a Class 2 State Controller
198	Exhibit HQI0198_RP Appointment of DHHS Class 2 Controllers
199	Exhibit HQI0199_RP DHHS emails re returning passengers from Greg Mortimer cruise
200	Exhibit HQI0200_P Protecting our Healthcare Workers
201	Exhibit HQI0201_RP Witness statement of 'DHHS Learning Consultant'
202	Exhibit HQI0202_RP Annexures to witness statement of 'DHHS Learning Consultant'
203	Exhibit HQI0203_RP Witness statement of 'DHHS Infection Control Consultant'
204	Exhibit HQI0204_RP Annexures to witness statement of 'DHHS Infection Control Consultant'
205	Exhibit HQI0205_RP Witness statement of 'DHHS Senior Project Officer'
206	Exhibit HQI0206_RP Annexures to witness statement of 'DHHS Senior Project Officer'
207	Exhibit HQI0207_P Witness statement of Mr Terry Symonds
208	Exhibit HQI0208_RP Annexures to witness statement of Mr Terry Symonds
209	Exhibit HQI0209_RP Texts between Assistant Commissioner Mick Grainger and Ms Claire Febey

Exhibit	Document Title
210	Exhibit HQI0210_P Video of press conference by the Hon. Daniel Andrews MP 27 March 2020
	Exhibit HQI0210_P Transcript of press conference by the Hon. Daniel Andrews MP on 27 March 2020
211	Exhibit HQI0211_P First witness statement of the Hon. Jenny Mikakos, former MP
212	Exhibit HQI0212_RP Annexures to the first witness statement of the Hon. Jenny Mikakos, former MP
213	Exhibit HQI0213_RP Bundle of government emails across departments
214	Exhibit HQI0214_RP Texts between Assistant Commissioner Mick Grainger and Commissioner Andrew Crisp
215	Exhibit HQI0215_RP Initial responses from parties
216	Exhibit HQI0216_P Index of initial responses
217	Exhibit HQI0217_RP Request for assistance register
218	Exhibit HQI0218_P Witness statement of the Hon. Daniel Andrews MP
219	Exhibit HQI0219_RP Annexures to witness statement of the Hon. Daniel Andrews MP
220	Exhibit HQI0220_P Video of press conference by the Hon. Daniel Andrews MP
	Exhibit HQI0220_P Transcript of press conference by the Hon. Daniel Andrews MP
221	Exhibit HQI0221_P Video of press conference by former Chief Commissioner Graham Ashton
	Exhibit HQI0221_P Transcript of press conference by former Chief Commissioner Graham Ashton
222	Exhibit HQI0222_P Second witness statement of the Hon. Jenny Mikakos, former MP
223	Exhibit HQI0223_RP Bundle of documents tendered by DHHS
224	Exhibit HQI0224_RP Annexures to witness statement of 'Operations Coordinator'
225	Exhibit HQI0225_RP Annexures to witness statement of Mr Shaun D'Cruz
226	Exhibit HQI0226_RP Bundle of notices and advices tendered by DHHS
227	Exhibit HQI0227_RP Bundle of documents tendered by DJPR
228	Exhibit HQI0228_RP Letter from MinterEllison dated 25 September 2020, responsive to questions posed to Ms Kym Peake
229	Exhibit HQI0229_RP DHHS email chain re 'Information — Chain of Command — people in detention' and 'Smoking policy — Operation Soteria' ending 2 July 2020
230	Exhibit HQI0230_RP DHHS emails re VIC Hotel Quarantine arrangements
231	Exhibit HQI0231_P Letter from Solicitors Assisting to Solicitors for DHHS dated 16 October 2020
232	Exhibit HQI0232_P Letter from Solicitors for DHHS to Solicitors Assisting dated 19 October 2020
233	Exhibit HQI0233_RP DHHS email chain re 'Information — Chain of Command — people in detention' and 'Smoking policy' — Operation Soteria' ending 1 April 2020
234	Exhibit HQI0234_RP DHHS email chain re 'Smoking policy — Operation Soteria'
235	Exhibit HQI0235_RP DHHS email chain re 'Governance of mandatory detention implementation'
236	Exhibit HQI0236_RP DHHS email chain re 'Passengers under detention having Covi swabs at hospitals'
237	Exhibit HQI0237_P Affidavit of Mr Christopher Eccles
238	Exhibit HQI0238_RP Further DPC document
239	Exhibit HQI0239_RP Affidavit of the Hon. Daniel Andrews MP
240	Exhibit HQI0240_RP Exhibit to Affidavit of the Hon. Daniel Andrews MP
241	Exhibit HQI0241_RP Text exchange between the Hon. Daniel Andrews MP and Lissie Ratcliff dated 27 March 2020

Exhibit	Document Title
242	Exhibit HQI0242_RP Premier's Private Office (PPO) Document
243	Exhibit HQI0243_P Affidavit of Mr Simon Phemister
244	Exhibit HQI0244_P Affidavit of former Chief Commissioner Graham Ashton AM APM
245	Exhibit HQI0245_RP Further Victoria Police document
246	Exhibit HQI0246_P Affidavit of the Hon. Lisa Neville MP
247	Exhibit HQI0247_RP Bundle of documents produced by DHHS in response to Notice to Produce 163
248	Exhibit HQI0248_RP Bundle of documents produced by DHHS in response to Notice to Produce 165
249	Exhibit HQI0249_RP First affidavit of Prof. Brett Sutton
250	Exhibit HQI0250_RP Exhibit to First affidavit of Prof. Brett Sutton
251	Exhibit HQI0251_RP Document referred to in the first affidavit of Prof. Brett Sutton
252	Exhibit HQI0252_P Second affidavit of Prof. Brett Sutton
253	Exhibit HQI0253_RP Exhibit to second affidavit of Prof. Brett Sutton
254	Exhibit HQI0254_RP Further document pertaining to Prof. Brett Sutton
255	Exhibit HQI0255_RP Affidavit of Mr Jason Helps
256	Exhibit HQI0256_RP Document referred to in affidavit of Mr Jason Helps
257	Exhibit HQI0257_RP Affidavit of Mr Braedan Hogan
258	Exhibit HQI0258_RP Document referred to in affidavit of Mr Braedan Hogan
259	Exhibit HQI0259_RP Affidavit of Dr Finn Romanes
260	Exhibit HQI0260_RP Document referred to in affidavit of Dr Finn Romanes
261	Exhibit HQI0261_P Letter from Solicitors for DHHS to Solicitors Assisting dated 11 November 2020
262	Exhibit HQI0262_P Affidavit of Mr Richard Murphy
263	Exhibit HQI0263_P Affidavit of Ms Rebecca Bedford

COVID-19
Hotel Quarantine Inquiry

COVID-19
Hotel Quarantine Inquiry

COVID-19
Hotel Quarantine Inquiry
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