TRANSCRIPT OF PROCEEDINGS

INQUIRY INTO THE COVID-19 HOTEL QUARANTINE PROGRAM

BOARD: THE HONOURABLE JENNIFER COATE AO

DAY 14

10.00 AM, TUESDAY, 8 SEPTEMBER 2020

MELBOURNE, VICTORIA

MR A. NEAL QC appears with MS R. ELLYARD, MR B. IHLE, MR S. BRNOVIC and MS J. MOIR as Counsel Assisting the Board of Inquiry

MS E. GARDNER appears for Alfred Health

MS J. FIRKIN QC appears with MS S. KEATING for the Department of Environment, Land, Water and Planning

MS C. HARRIS QC appears with MS P. KNOWLES and MR M. McLAY for the Department of Health and Human Services

MS J. CONDON QC appears with MS R. PRESTON and MR R. CHAILE for the Department of Jobs, Precincts and Regions

DR K. HANSCOMBE QC appears with MS H. TIPLADY for the Department of Justice and Community Safety

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MR R. ATTIWILL QC appears with MS C. MINTZ for the Department of Premier and Cabinet

MS A. ROBERTSON appears with MS E. GOLSHTEIN for MSS Security Pty Ltd

MR A. WOODS appears for Rydges Hotels Ltd

MR A. MOSES SC appears with MS J. ALDERSON for Unified Security Group (Australia) Pty Ltd

MR R. CRAIG SC appears with MR D. OLDFIELD for Wilson Security Pty Ltd

MS D. SIEMENSMA appears for Your Nursing Agency (Victoria) Pty Ltd

CHAIR: Good morning, Mr Ihle.

MR IHLE: Good morning, Madam Chair.

CHAIR: We're ready to proceed, Mr Ihle?

MR IHLE: We are. If the Board pleases, I appear again along with Ms Moir, to assist you for the next tranches of hearings, which will take an estimated three days, being today and Thursday and Friday of this week.

The first witness who will be called today is Ms Simone Alexander, the CEO of Alfred Health. I understand she is assisted by counsel so I will ask counsel to announce their appearance.

MS GARDNER: If the Board pleases, I appear for Alfred Health in this matter. My name is Erin Gardner.

CHAIR: Thanks, Ms Gardner. I couldn't actually see you, I'm not sure if your camera is operating, but I can certainly hear you. So I'll record your appearance and grant you leave to appear. That's better, thank you.

OPENING STATEMENT BY MR IHLE

MR IHLE: Madam Chair, there are a number of housekeeping matters that need to be attended to this morning. But before we do that, perhaps it's a convenient opportunity first to summarise the evidence you have heard over the preceding week or so and then outline the expected evidence over the coming days.

In respect of the evidence that the Board has heard most recently, over the course of six days of hearings the Board has received evidence from several witnesses in relation to the establishment, structure and operation of the Hotel Quarantine Program. That evidence was given by Departmental officers and representatives of hotels and security companies and formed both witness statements that were tendered to the Board but also viva voce evidence.

Witnesses that were called included those charged with the initial set-up of the Hotel Quarantine Program on 27 March 2020 and those who were responsible for the program's operation largely through May and into June of 2020. Those witnesses included people who were responsible for contracting with hotels and private security companies and those who performed duties pursuant to those contracts. The Board also heard evidence from a senior authorised officer and a senior member of Victoria Police.

Together, the evidence given was to the effect that the program was stood up, to use the term that the witnesses have used, from scratch and in an exceptionally tight

timeframe. It was a huge logistical operation, put into place over the course of the weekend starting 27 March, and was done so without warning or much time to plan. Much of the work in the initial weekend was done by staff from the Department of Jobs, Precincts and Regions, who began their work believing that they --- that is, that Department --- would be responsible for the running of the program. However, on Saturday, 28 March, they learnt that that would not be so. Precisely how and why that decision was made will be the subject of evidence next week.

Whatever the evidence is as to why that decision was made, its effect was that the Department of Health and Human Services became the control agency. It did so under the auspices of the emergency management framework.

The Department of Jobs, Precincts and Regions, or DJPR, retained the role in the program as a support agency, and the evidence was that in that role, it established a range of contractual relationships and the logistical structure to try and meet the needs of those who would be detained in quarantine.

The evidence has suggested that when work to establish the Hotel Quarantine Program began, the source of the power to detain returned travellers was not yet clear or crystallised. But by the time of the first arrivals on 29 March, a decision had been made to use emergency powers under the *Public Health and Wellbeing Act*. Those powers were largely exercisable by the Chief Health Officer and authorised officers as his delegate.

Further perspectives on the question of control and command may emerge in the hearings to come, but the evidence from the preceding six-day block has revealed that, overwhelmingly, those working within the program understood that whilst DJPR had a substantial role in managing logistics, the legal authority to detain returned travellers was a power vested in the authorised officers. It was they, therefore, who had authority over detention arrangements.

DJPR officers said that their work was to provide logistical support for the Department of Health and Human Services. Security guards understood that their role was to support the work of the authorised officers. Police understood that it was the authorised officers who were exercising the powers to detain, while the police role was really one limited to providing cordons when travellers were arriving and leaving quarantine, and to respond to calls for assistance via 000.

By contrast, however, the senior authorised officer who gave evidence saw the role of authorised officers in more confined terms. He described the involvement of multiple DHHS teams, including authorised officers, a DHHS team leader command structure and a public health team, a structure which was, in his words, not the usual pyramid structure. This theme of differing understandings of who was in charge was reflected in the evidence of changing and sometimes conflicting directions and protocols; a lack of consistency in decision-making and processes at different hotels; and different views about the role police and security contractors were to play.

The lack of common understanding and the lack of clear lines of command was mirrored in different perspectives and understandings of where responsibility for matters of infection control and training lay. The contracts entered into by DJPR on behalf of the State of Victoria placed those responsibilities with hotels and security providers. But there was evidence of an expectation that the Department of Health and Human Services would provide training and otherwise be the source of expert advice on matters of infection control and the use of personal protective equipment.

There was evidence of concern and frustration that those expectations were not met, as well as evidence that material was made available but the information in it was neither consistently understood nor applied in practice.

One consistent theme was how much work went into the establishment and running of the Hotel Quarantine Program. Long hours were the norm for the departmental workers and those who were subcontracting to work within it. The work of the first weekend in preparation for the midnight 28 March deadline involved a large number of departments and agencies. There is nothing to suggest any lack of good faith or effort on the part of anyone involved.

However, the evidence also tends to suggest that those tasked with the job were not always the people with the right skill set or resources. And the program was set up under extreme pressures of time. Both factors likely played a large role in the decisions that were made.

The structure that was so quickly created also had built-in complications which themselves were a source of confusion and lack of clarity. For instance, the DJPR contracted the hotels but the DHHS had the role of deciding which ones would be used. The DJPR contracted with security guards, but day to day those guards worked in accordance with arrangements over which the DHHS and its authorised officers had control. The hotels did not control the security guards, but did have some responsibility for cleaning arrangements.

The evidence suggests that the decision to engage private security guards was apparently not considered controversial at the time, at least not openly. Nothing has been revealed that suggests any person or body expressly or vehemently disagreed with it at the time those decisions were being made. But it has proved to be a contentious decision and there is a range of views about whose decision it actually was. More evidence will be called on that topic next week, including on what other options there might have been for security arrangements.

The evidence that has been led has shown that those involved believed the private security companies had the agility, flexibility and capacity to scale up quickly and provide a surge workforce of the hundreds of guards that were required. Those head contractors did that by subcontracting arrangements, relying in large part on a workforce of casual and part-time workers, many of whom had lost previous work because of the effects of restrictions on workplaces and on public events.

The evidence also demonstrates that ordinary Government procurement practices were not followed; that a substantial percentage of the security work went to a company that had previously sought but had been refused inclusion on the Government panel of preferred security contractors. That company was almost entirely reliant on subcontractors.

The evidence led before this Board also tends to demonstrate that security guards were called upon by the Department of Jobs, Precincts and Regions to perform tasks in addition to security-related tasks, and that willingness or resistance to undertake those additional tasks may have influenced those who were deciding which firm should be allocated which work.

The evidence led before the Board provides the basis for this Board to consider findings about the way in which the Hotel Quarantine Program was set up and to make recommendations as to the ways in which any future program might be conceived, structured and implemented. Such findings and the sequential recommendations touch upon the following themes:

1. The actual division of responsibilities and accountabilities between different Government departments;

2. Whether the distinction between logistical support and operational control embedded in a system from the outset is too abstract to be meaningful and whether it leads to an authority vacuum, such that inaction, ad hoc or even arbitrary decision-making are inevitable consequences;

3. Whether the Hotel Quarantine Program had a sufficiently clear command structure and, if not, what an appropriate structure would be for the future;

4. Whether those establishing and running the Hotel Quarantine Program were appropriately guided and supported by pre-existing Government structures, including procurement practices, and the reasons why such practices exist;

5. Whether the Hotel Quarantine Program struck an appropriate balance between the use of available Governmental personnel and expertise, including police, for example, and the use of private providers;

6. Whether responsibility for managing the risks of potential infection and security breaches was appropriately allocated as between Government departments and private providers;

7. Whether the contracting and management structure was fit for the purpose of the Hotel Quarantine Program;

8. Whether there was appropriate and proper training, supervision and support for those working in the program; and

9. Whether, given the multiplicity of parties, both private and Governmental, an effective infection control outcome could have been expected without an explicit, standardised regime supervised by those with the necessary authority and expertise for doing so.

These are the themes which, in our submission, arise from the evidence and to which further submissions will be advanced at the appropriate time.

In respect of that, may I foreshadow and outline the following timetable for the assistance of the Board and for the parties with leave to appear.

As stated earlier, it is currently envisaged that the Board will sit for public hearings today and Thursday and Friday of this week. Next week, it is expected that the Board will sit in public hearings every day from Tuesday until Friday; that is, from 15 to 18 September. Emergency management and the psychosocial impact of hotel quarantine will be among the topics to be explored in the evidence.

The following week, it is envisaged that the Board will sit in public hearings on Tuesday 22 and Wednesday 23 September, with Counsel Assisting delivering closing submissions on Friday 25 September. Those with leave to appear and anyone else given leave to make submissions may then do so in writing by the close of business on Friday 2 October.

It is likely that the Board will be invited by Counsel Assisting to make further orders about those submissions which, in the ordinary course, will be made public and posted on the Board's website.

Turning to the evidence of this week. Regardless of the setting, the primary objective of any quarantine program is a health objective: preventing the further spread of a disease. Professor Grayson's evidence was that quarantine is a public health measure by which people who have or may have an infectious disease are isolated to prevent the spread of that disease. That can be found in paragraph 51 of his statement.

We know from the uncontested evidence from Dr Alpren that the Hotel Quarantine Program failed to control the spread of COVID-19. There were outbreaks of COVID-19 from the Rydges Hotel in Carlton and from the Stamford Plaza Hotel in the city.

A second and equally important human objective of any quarantine program is to meet the health and wellbeing needs of people who are quarantined. By definition, quarantine limits freedoms, it separates people from others and it restricts their movement. That means that, through no fault of their own, those who are detained in the quarantine system, like the Hotel Quarantine Program, are unable to meet their own needs for food, for medical attention and for mental health care. All people in the Hotel Quarantine Program were thus vulnerable and at the mercy of the Government and its agencies to meet their basic health and human needs.

Based on the evidence of nurses and returned travellers, much of which was uncontested, it is open to the Board to find that there were shortcomings in meeting those needs. Infection control, outbreak management, healthcare, welfare and human services are the core work of the Department of Health and Human Services. Much of the evidence I will call this week will come from people within that department. Others to be called include those who provided services to the Department, either early on or later in the hotel quarantine piece, to assist in meeting those needs.

The first witness will be Ms Simone Alexander. Ms Alexander is the Chief Operating Officer of Alfred Health. You will hear that Alfred Health initially had limited involvement in the Hotel Quarantine Program but that, over time, the scope and span of its role in the program increased markedly. From mid-June, Alfred Health has provided clinical leadership and has overseen the provision of cleaning and security services at a health hotel; sometimes witnesses have referred to it as a COVID hotel.

Ms Alexander's evidence will provide an insight into the staffing and infection control arrangements that came into play late in the program.

The second witness I'll call today is Dr Simon Crouch. Dr Crouch is a public health physician employed by the Department of Health and Human Services. Dr Crouch is currently seconded to the role of Deputy Public Health Commander, Case, Contact and Outbreak Management. He will give evidence about the investigation of the outbreak at the Rydges Hotel and at the Stamford Hotel. At the time of the outbreak, the Board will note, the Rydges Hotel in Carlton was a designated hot hotel; the Stamford was not. You will hear about Dr Crouch's thoughts about the role of fomite transmission --- that is, transmission by inanimate surfaces or objects --- in the outbreak at Rydges Hotel and the steps that were taken to investigate the cause and limit the further spread.

Dr Sarah McGuinness will be the third witness for today. Dr McGuinness is an infectious diseases physician with an appointment at Monash University and at Alfred Health. she worked at the Department of Health and Human Services between mid-March and the end of July. During her time at the Department, Dr McGuinness led numerous outbreak investigations, including those at the Rydges Hotel and the Stamford Hotel. She will speak of the outbreak team's endeavours to deal with those outbreaks.

In the afternoon, I plan to call the final witness for today, time permitting. That is Professor Euan Wallace. Professor Wallace is the Chief Executive Officer of Safer Care Victoria. As you will hear, Safer Care Victoria is the peak State authority for quality and safety improvements in healthcare settings. Safer Care Victoria investigated two serious clinical incidents involving returned travellers in the Hotel Quarantine Program. You will hear about the findings and the recommendations in relation to those incidents, other issues that were identified as escalation points and how those matters have or have not been dealt with.

And the next two days. Another two days of evidence will follow today. We will hear from other staff from the Department of Health and Human Services, including senior decision-makers up to the level of Deputy Secretary. Deputy Secretary Skilbeck is to be a witness on Thursday. It is also envisaged that other high-ranking people within this Department --- that is, key decision-makers in the Hotel Quarantine Program --- will be called to give evidence about what they knew and why they made certain decisions.

The final list of witnesses and the time at which they will be called is yet to be settled, but once they provide written statements, those arrangements will be confirmed. However, for the benefit of the parties and the Board, I can indicate that it is anticipated the witnesses who may be called include Deputy Chief Health Officer Dr Annaliese van Diemen, State Controllers Jason Helps and Andrea Spiteri; Public Health Commander Dr Finn Romanes; and Commander of COVID-19 Enforcement and Compliance, Mr Murray Smith.

Finally, on Friday, we will hear from two people entrusted as other Commanders within the Department, Pam Williams and Merrin Bamert. We also intend to call another Deputy Secretary from the Department, Jacinda de Witts.

The evidence from this week is intended to help the Board understand whether decisions about infection control caused or contributed to the transmission of COVID-19 from returned travellers at the Rydges Hotel in Carlton and the Stamford Plaza; firstly, to people working within the Hotel Quarantine Program; and, secondly, the spread from those people to the wider community. The evidence that will be led this week will also help the Board to understand how decisions made by the Department's various controllers and commanders impacted upon the mental and physical health of people in the program. The evidence will be directed to who made those decisions, the reasons those decisions were made, and ultimately submissions will be put to you, Madam Chair, as to whether those decisions were sound.

If the Board pleases, before I call on Ms Alexander, there is a number of documents that need to be tendered. There, firstly, are some matters that are hangover matters from last week, and perhaps I'll call on Ms Harris for the Department of Health and Human Services firstly to address the Board on the documents she seeks to tender.

CHAIR: Good morning.

MS HARRIS QC: Mr Ihle, I might need to discuss with you --- I wasn't aware that I was going to be invited to tender a document this morning, so perhaps we could have a discussion and that could be addressed first thing after lunch.

CHAIR: All right. Yes.

MR IHLE: Perhaps that communication hasn't made its way to Ms Harris by her instructors. I'll then call on Ms Robertson, who has a document to tender, as

I understand it.

MS ROBERTSON: If the Board pleases, there's one document that we would seek to tender. It's a document which arose from pod 3 last week. It is the statement of the Operations Coordinator, Department of Jobs, Precincts and Regions. And the document number, for the benefit of the Board, is DJP.050.007.0001_ALIAS.

CHAIR: Thanks, Ms Robertson.

MS ROBERTSON: If the Board pleases.

CHAIR: I'll mark that document as Exhibit 84.

MS ROBERTSON: As the Board pleases.

EXHIBIT #084 - STATEMENT OF 'CCOC', THE OPERATIONS COORDINATOR, DEPARTMENT OF JOBS, PRECINCTS AND REGIONS

MR IHLE: There are a number of statements that the parties with leave to appear have had access to, and I've indicated to them as early as the middle of last week or towards the latter part of the middle of last week the statements that I intend to tender, along with the annexures and any other relevant documents. If now is a convenient time, I can go through that list, Madam Chair.

CHAIR: Yes, do that now, Mr Ihle.

MR IHLE: Yes. The first document that I tender is the statement of Jan Curtain. Does the Board require me to go through each of the document IDs in tendering?

CHAIR: No. I'm assuming --- I'll mark the statement as Exhibit 85.

EXHIBIT #085 - STATEMENT OF JAN CURTAIN

CHAIR: And I'm assuming you're going to tender bundles with respect to each statement; is that right, Mr Ihle?

MR IHLE: That's right, Madam Chair. So in addition to that statement, there are a number of annexures to Ms Curtain's statement. There's one matter that technically needs to be sorted out between the parties and those that are operating the IT. But suffice to say for now, I also propose to tender as one bundle the Exhibits JMC-4 and JMC-6 to that statement.

CHAIR: So I'll mark those as Exhibit 86.

EXHIBIT #086 - ANNEXURES JMC-4 AND JMC-6 TO STATEMENT OF JAN CURTAIN

MR IHLE: If the Board pleases. And there are three relevant documents that also relate to Ms Curtain and her nursing agency, YNA, that I seek to tender as a bundle. The numbers of those relevant documents it's perhaps convenient to mention: YNA.0001.0002.00028_R; same numbering, save for 52_R; and same numbering, 80_R. I'll provide a list, a further list confirming this to the Board and the interested parties.

CHAIR: Thank you. I'll mark that group of documents Exhibit 87.

EXHIBIT #087 - DOCUMENTS RELATED TO THE STATEMENT OF JAN CURTAIN

MR IHLE: As the Board pleases. The second statement that I tender is the statement of Dr Stuart Garrow from On Site Doctors Pty Ltd.

CHAIR: Exhibit 88.

EXHIBIT #088 - STATEMENT OF DR STUART GARROW

MR IHLE: As the Board pleases. And as a separate exhibit and as a bundle, I tender annexures 5, 6, 8 and 9 to that statement.

CHAIR: Exhibit 89.

EXHIBIT #089 - ANNEXURES TO STATEMENT OF DR STUART GARROW

MR IHLE: The next statement is the statement of Eric Smith from SwingShift.

CHAIR: Exhibit 90.

EXHIBIT #090 - STATEMENT OF ERIC SMITH

MR IHLE: And, as a bundle, annexures E and F to that statement.

CHAIR: Exhibit 91.

EXHIBIT #091 - ANNEXURES E AND F TO STATEMENT OF ERIC SMITH

MR IHLE: If the Board pleases. I tender the statement of Dr Julian Rait AO from the Australian Medical Association.

CHAIR: Exhibit 92.

EXHIBIT #092 - STATEMENT OF DR JULIAN RAIT

MR IHLE: And as a separate exhibit, but in a bundle, annexures 1 and 2 to that statement.

CHAIR: Exhibit 93.

EXHIBIT #093 - ANNEXURES TO STATEMENT OF DR JULIAN RAIT

MR IHLE: As the Board pleases. I also tender the statement of Alfred Nurse Manager.

CHAIR: Exhibit 94.

EXHIBIT #094 - STATEMENT OF ALFRED NURSE MANAGER

MR IHLE: As the Board pleases. I tender the statement of Dr Nathan Pinskier, the director of On Site Doctors Pty Ltd.

CHAIR: Exhibit 95.

EXHIBIT #095 - STATEMENT OF DR NATHAN PINSKIER

MR IHLE: And I tender annexure 10 to that statement.

CHAIR: Exhibit 96.

EXHIBIT #096 - ANNEXURE 10 TO STATEMENT OF DR NATHAN PINSKIER

MR IHLE: Finally, if the Board pleases, I tender the statement of Dr Clare Looker, Deputy Public Health Commander and Senior Medical Adviser at the Department of Health and Human Services.

CHAIR: Exhibit 97.

EXHIBIT #097 - STATEMENT OF DR CLARE LOOKER

MR IHLE: And I tender a relevant document to Dr Looker's evidence, being an email to Dr Looker and others from Dr McGuinness, dated 29 May this year. The document ID is DHHS.5000.0105.5936_R.

CHAIR: Exhibit 98.

EXHIBIT #098 - EMAIL TO DR LOOKER AND OTHERS FROM DR McGUINNESS, DATED 29 MAY 2020

MR IHLE: If the Board pleases. I see Ms Siemensma on screen. There has been some confusion about exhibits she wanted tendered. But if she is satisfied that confusion has been resolved, I am content for Ms Siemensma to make that application.

MS SIEMENSMA: Thank you. Madam Chair, just to indicate there has been quite a lot of communication in the last few days between myself, counsel instructing and instructing solicitors. I'm not sure that my learned friend's document range covers all of the documents that we agreed. But I'm content to look at that, if it's convenient, over the luncheon adjournment. We don't have any issue with the documents that he had foreshadowed, but there may well be others.

But if I could indicate as well, Madam Chair, I seek to tender some training and COVID information and instruction material that my client provided to its staff. That includes some extracts from its online learning program. The relevant code numbers have been foreshadowed with Counsel Assisting and I can provide those codes now, if it's convenient.

The reason we want those in --- paragraph 4 of the Board's Terms of Reference include that the Board is going to inquire into information, guidance and training

provided to staff and whether that was followed, and the material that we seek to tender is directed to that issue. It evidences the training advice and instruction given to staff and the fact that communication was continuous, it was dynamic. These matters aren't dealt with in the body of Ms Curtain's statement and they're matters that we wish to rely upon in our submissions.

My learned friend has indicated he wants to put in two pages of information out of a vast body of material that relates to training and instruction. Those pages are in or about mid-March and pre-date my client's involvement in the program. We say they are two pieces of a much larger mosaic and, with respect, it's inappropriate just to isolate those two pages because it leaves the Board with an incomplete picture at best, and runs the risk of being misleading at worst. So we wish --- we don't wish the Board to be left with an incomplete picture and, in short, we say the material is relevant and my client seeks to rely upon it.

As I said, I have the relevant coded code numbers, but it may be that --

CHAIR: All right. Well, Ms Siemensma, perhaps just to --- I don't wish to cut across you, but to deal with the issue in this way: if you can provide both the code numbers and copies of the documents that you wish to tender to Counsel Assisting, and in the event that it can't be resolved as between the two of you, you've got leave then to come back and readdress me about the material if you want to go in. Can we deal with it that way?

MS SIEMENSMA: Thank you, Madam Chair. Thank you.

CHAIR: Thank you. Ms Harris?

MS HARRIS QC: Madam Chair, I hadn't anticipated that only one of the documents that had been referred to in Dr Looker's statement would be tendered, and I would request leave to undertake the same process as Ms Siemensma, to identify all the documents that we say should also be referred to, to ensure that the statement is clearly understood in all of its contexts.

CHAIR: Yes.

MS HARRIS QC: And we'll deal with Counsel Assisting and Solicitors Assisting if the Board pleases on that issue.

CHAIR: Yes, Ms Harris, for exactly the same reasons and the same mechanism that I've directed Ms Siemensma's issues to be undertaken in that way, and I'll certainly allow you to do the same.

MS HARRIS QC: Thank you, Madam Chair.

CHAIR: Thank you.

MR IHLE: And we'd be grateful to receive that correspondence from the Department, Madam Chair. We foreshadowed that which would be tendered in respect of Dr Looker's statement upon receipt of the statement and hadn't heard anything back. So we would be grateful for that information.

CHAIR: Thank you.

MR IHLE: Unless there are any other issues in relation to those tendered documents, I propose to call the first witness. I might just pause for a moment.

CHAIR: You can proceed, Mr Ihle.

MR IHLE: Thank you, Madam Chair. In that case, I call Simone Alexander.

CHAIR: Ms Alexander, are you able to hear and see me? You've just got your microphone on mute at the moment, Ms Alexander.

MS ALEXANDER: Good morning, Madam Chair, yes, I can hear you clearly.

CHAIR: Thank you. I am sure you have had it explained to you that you need to take an affirmation for the purposes of giving your evidence, so to that end, I'll hand you over to my associate to administer the affirmation to you. Thank you, Madam Associate.

SIMONE ALEXANDER, AFFIRMED

CHAIR: Thank you, Ms Alexander. I'll hand you back now to Mr Ihle. Thanks, Mr Ihle.

MR IHLE: Thank you, Madam Chair.

EXAMINATION BY MR IHLE

MR IHLE: Ms Alexander, can you hear and see me okay?

A. Good morning, Mr Ihle. Yes.

Q. Good morning, Ms Alexander. Can you just formally introduce yourself to the Board. Firstly, your name is Simone Alexander; is that right?

A. That's correct.

Q. What's your current role?

A. I'm the Chief Operating Officer of Alfred Health.

Q. And prior to that, I understand from your statement that you were the Clinical Services Director at Alfred Health?

A. Yes, for emergency and acute medicine.

Q. Yes, thank you. Ms Alexander, you've provided a statement to the Inquiry dated 1 September this year?

A. Yes.

Q. Do you have a copy of that statement there?

A. Yes.

Q. It's 24 pages long and has a single attachment to it?

A. Yes.

Q. Is that statement truthful?

A. Mr Ihle, I'd just like to direct you to page 10, paragraph 41. I'd like to note that the diagram in the statement represents the proposed future state.

CHAIR: Just say that last part again? Represents the proposed future --

A. State.

MR IHLE: Okay. So just to clarify on that, Ms Alexander, that diagram is provided, at least in part, to the answer to question 12, which is set out just above paragraph 41.

A. Yes.

Q. If I understand your evidence, you say that this is a proposal for things in the future rather, not what has been in place at the Brady Hotel?

A. It represents some of what has been in place at the Brady Hotel, but with an arm that would be added in the future based on requests for service provision.

Q. So what's the additional arm that would be added that hadn't previously been in respect of the Brady?

A. For Medical Workforce.

Q. Okay. That's in the --- if we dealt with it in four columns, in the third column, it's

the third entry down?

A. If you're looking at it, the far right column, the medical service provider, Medical Workforce, the two boxes.

Q. Thank you.

CHAIR: Third from the bottom in the far right column; is that right?

A. That's correct.

CHAIR: Yes.

MR IHLE: So if we were to remove that from that diagram, does that diagram then accurately represent the management and leadership structure that was in place or has been in place at the Brady Hotel?

A. Yes.

Q. Yes. Were there any other clarifications or amendments to your statement that you seek to make?

A. No, Mr Ihle.

Q. And with that one clarification, which we're grateful for, are the contents of that statement truthful?

A. Yes.

Q. And are the contents of that statement accurate?

A. Yes.

Q. Yes. Thank you, Madam Chair. I tender the statement of Ms Alexander with that clarification.

CHAIR: Exhibit 99.

EXHIBIT #099 - STATEMENT OF SIMONE ALEXANDER

MR IHLE: As the Board pleases.

Ms Alexander, just in relation to your role as the Chief Operating Officer, I should just foreshadow, the appendix to your statement we'll deal with as we go through your evidence, so that's not forgotten. But in your role as the Chief Operating

Officer of Alfred Health, can you just outline your primary responsibilities, specifically in relation to clinical operations?

A. So as the Chief Operating Officer, I'm responsible for the management and performance of Alfred Health clinical operations. So this includes medical and surgical services, psychiatry, sub-acute, and rehabilitation services.

Q. So that covers medical professionals, being doctors, nursing professionals, and allied health professionals?

A. All workforce.

Q. Dealing with the contents of your statement, can you just by way of brief outline describe for us how contact was first made with Alfred Health in relation to the Hotel Quarantine Program?

A. Alfred Health was first contacted on 15 April to supply a small number of staff to perform wellness checks.

Q. And do you know what those wellness checks were comprised of?

A. It was an already developed pro forma from the DHHS which really just went through a series of questions for the guests, so the guests were contacted each day and this was an opportunity just to sort of check in and identify any health concerns that needed to be addressed.

Q. And were they limited to physical health concerns or did it also touch upon issues about how people were coping emotionally?

A. It was a broad wellness check.

Q. And you say that you were contacted to provide staff. What was the cohort of staff specifically that was requested?

A. Nurses.

Q. Any particular qualifications that were sought?

A. A registered nurse, obviously with, you know, a level of experience that they could make the phone call, engage with the guest, and then, you know, fill out the pro forma and escalate accordingly.

Q. Yes. What was your understanding about whether any of the nurses that Alfred Health were to provide when you were first contacted, what was your understanding about whether they were to have any face-to-face engagement with the detainees?

A. No, there was no face-to-face engagement. This was very much like a boardroom

or separate-room exercise where it was phone contact only, so there was no face-to-face direct care requirements.

Q. You state in your statement, paragraph 27, that the nurses that you were providing were only working in designated green zones. Can you explain to us what you understood to be green zones and why they were working there and not elsewhere?

A. So the green zone is an area where it doesn't require any sort of, you know, PPE or special precautions from an infection prevention perspective. So it was just like working in the normal environment.

Q. How many staff was Alfred Health requested to provide?

A. Initially we were requested to provide two staff for the AM shift and two staff for the PM shift across a small number of hotels, I think it was five to begin with.

Q. And was it envisaged, at least at the outset, how long Alfred Health would be providing those nurses for?

A. The request was initially for two weeks.

Q. And did it remain two weeks?

A. No. It was extended beyond that. So after the, or nearing the end of the two weeks, there was a further request for another four-week service provision for wellness checks only, and with a view that this could be extended across other hotels that may become part of the quarantine program.

Q. But was it then extended across other hotels as well?

A. Yes.

Q. And after that four-week extension, was there a subsequent further extension?

A. Yes.

Q. Coming back to the question of the cohort that was requested, you said that it was registered nurses. Were you specifically requested to provide anyone with specialist mental health training or qualifications at this stage?

A. No.

Q. Does Alfred Health have within its employment mental health-trained nurses?

A. Yes.

Q. And I appreciate that this might be hypothetical, but had you been requested to

provide people with that type of qualification and training, as the Chief Operating Officer of Alfred Health, is that something you could have provided?

A. It could have been considered.

Q. I understand from your statement that you yourself have come originally from a trained nursing background. Have I understood that correctly?

A. I'm a nurse by trade, yes.

Q. Yes. So what would you say as a nurse by trade of the adequacy of remote calling for wellbeing checks?

A. In my experience with the wellness check process, there was a clear opportunity for escalation to those that provided direct care, so nurses on site that provided direct care, and also to medical staff should it be medically orientated, and my understanding was there's also mental health clinicians on site. So there was opportunities for escalation of any health concerns or any social concerns to other people on site.

Q. And who do you understand was providing that workforce, the other nurses on staff, the medical people?

A. I understood that that was under the auspices of the Department --- DHHS and various, you know --- through various agencies.

Q. Coming back to it, when it comes --- again, from a nursing background, and I appreciate that there are escalation opportunities there or avenues to escalate, but when it comes to checking in on someone's welfare, let's say we compare doing it via phone to doing it face-to-face, are there non-verbal cues that as a nurse through your training you've considered appropriate from time to time to pick up on things that might not be obvious over the phone?

A. In my experience as a nurse, obviously there is some visual cues that can give you a different picture from a verbal account from someone. But in regards to the Hotel Quarantine Program, I understand that there was also nurses on site that did provide the opportunity for face-to-face checking if required.

Q. Yes. Were Alfred Health staff asked during this initial phase, and I'll say "this initial phase" because we know from your statement there was a subsequent phase or subsequent phases, but were they ever involved in providing services in respect of triaging arrivals?

A. No.

Q. The nursing staff that you provided, I think you mentioned before had general particular expertise in respect of --- did you say emergency medicine or emergency

nursing?

A. No, they were just registered nurses, that we provided, from a --- you know, a variety of backgrounds. So I can't rule out that some of them hadn't worked in emergency, but it was probably unlikely that they were critical-care-trained nurses. They were of a general type nursing background.

Q. Was any infection prevention control training specifically provided to your nurses by the Department of Health and Human Services?

A. I'm not aware of any training provided to Alfred Health staff by the Department.

Q. Nevertheless, the staff that you provided, are they all employees of Alfred Health?

A. Yes.

Q. And as a consequence of that, are they required to maintain specific training?

A. Yes.

Q. And does that include training in infection prevention control?

A. Yes.

Q. Is that training one off or is it ongoing?

A. No, it's ongoing. I think when you're talking about infection prevention and control, it's really important that that is a continuous education and supervision and learning process. A lot of it is standard reminders and so that's ongoing.

Q. So again, during this initial phase where Alfred nursing staff were being provided to the program, was the Alfred at that stage providing any critical leadership or governance to the program or was it really people to man the phones?

A. It was just the phone, the wellness check. We were purely in a supportive role.

Q. You say in your statement at paragraphs 23 and 25 that you understood that the DHHS team leader on site was the person who had responsibility for all aspects of the hotel's operations.

A. Correct.

Q. Can I ask you how you came to that view?

A. It was clearly outlined to us from the Department that that Department person on site was the person in charge, and they had the capability to escalate internally at the Department should that be required.

Q. When you say "in charge on site", is it just in charge on site in relation to the work that your staff were doing, or was it generally in relation to all the operations that were taking place on site?

A. All the operations. They were the single point of contact.

Q. Okay. Could I ask you some general questions about Alfred Health as an organisation. Can you provide us a brief explanation about what Alfred Health is as a service, what types of facilities that it has, the services that it provides, the size of its workforce, things like that?

A. Yes. Alfred Health is a tertiary/quaternary service. We are a major provider, obviously, for healthcare within major metropolitan Melbourne, but more broadly we have state-wide service provision within trauma, burns, HIV, and many other services. We have approximately four --- we have four sites, major sites, and lots of community sites. And our workforce is around about 10,000.

Q. So you talk about four major sites and the number of community sites, if you can just describe those. Most of us would be familiar with the Alfred Hospital. I assume that's the major, major site, if I can put it that way, in Prahran. What are the other major facilities that fall under the ---

A. We have Caulfield Hospital, Sandringham Hospital, and we have Melbourne Sexual Health Centre, Carlton.

Q. And the community facilities that it also has, does that include things like rehab facilities?

A. Rehab is predominantly based at Caulfield Hospital. A lot of our community sites are within our mental and addiction health program, but spread across other programs as well.

CHAIR: Ms Alexander, the transcriber has just missed the --- when you gave the answer about the hospitals. They just missed the name of the first hospital that you named. Can you say that again?

A. So there was the Alfred, Caulfield Hospital --

CHAIR: Caulfield, thank you.

MR IHLE: And you say a workforce of about 10,000. So presumably there's a number of nurses within that workforce?

A. Yes.

Q. Qualified medical practitioners within that workforce?

A. Yes.

Q. People with mental health expertise?

A. Yes.

Q. Allied health professionals?

A. Yes.

Q. And within all of that as well, people with clinical leadership experience and healthcare governance experience?

A. Yes.

Q. Now, the Alfred Health Service is a pretty significant one within Victoria, but there's a number of other comparable health services, aren't there?

A. Yes.

Q. Could you name, say, another three that might be comparable in size and scope to Alfred Health?

A. Scope, probably the major hospital that you would call similar is, I suppose, the Royal Melbourne; again, you know, a major trauma service provider. There's other health services such as Monash Health, much larger size, and, you know, St Vincent's, again, a smaller size. But all public health services.

Q. And with your knowledge of the field, you would say they have similar types of facilities and similar size workforces and the constituents of those workforces too, I assume?

A. The constituents, yes. The size would be different. They're different size health services. And we all have slightly different service specialties, areas of expertise.

Q. Yes. So when it comes to Alfred Health, what would be your point of distinction as far as the area of expertise that Alfred can provide above and beyond perhaps the others?

A. I don't think it's above and beyond; I think it's different. So one particular service that is different is that we are the state-wide burns service provider. So we would take anyone that had a burn that was of greater than 20 per cent into our specialist service, which was different to any other health service in the State.

Q. Okay. Perhaps I'll focus my questioning a bit. When it comes to the services that Alfred Health were requested initially in April to provide to the Hotel Quarantine

Program, is there anything unique as far as Alfred Health is concerned in its ability to fulfil that role?

A. No.

Q. And indeed, when it came to the expanded role, which we're going to turn to shortly, which I understand came about by way of discussion late May, came to fruition mid-June, is there anything unique about Alfred Health in relation to assisting in that capacity?

A. No.

Q. Okay. Let's go to that expanded role. As I just indicated, from your statement, I understand there were discussions that commenced around late May; is that right?

A. Yes.

Q. Can you detail how those discussions came about?

A. Yes. There was discussions with the Department about what Alfred Health --- how Alfred Health could expand and potentially provide a complete, comprehensive clinical service to the program, and ideally, having all of the health-type clinical services under the one, you know, subcontractor in their view.

Q. Was it your understanding through those conversations that there had not, until that time, been a comprehensive clinical service?

A. That's correct.

Q. And did these discussions, as far as you're aware, commence prior to or after the incidents of staff working at the Rydges Hotel contracting COVID-19?

A. I don't know.

Q. Were you aware that the Rydges Hotel, prior to this expanded role discussion being enlivened, was being treated as and designated as a hot hotel or a COVID-positive hotel?

A. No.

Q. Given your role and overseeing the clinical operations at Alfred Health, and given what you've said before about there not being a comprehensive clinical service in the Hotel Quarantine Program, would you have formed a view about the appropriateness of a hot hotel or a COVID-positive hotel that didn't have a comprehensive clinical service involved?

A. At that point, I obviously didn't form a view. With the opportunity of hindsight

and our experience in --- our involvement in the Hotel Quarantine Program, I think it's, you know, definitely been good to separate out, I suppose, the clinical component and the infection prevention and control responsibilities. I think it was --- it's --- this was a really hard task. It was a very unwieldy program. It was incredibly dynamic. And so, you know, in my experience, breaking it up and putting it into smaller chunks and allowing, you know, the areas with the expertise, skills and resources to purely focus on that area and deliver that, you know, specific responsibility, you know, provided a more comprehensive and contained service.

I think that there's always challenges when you break it up. I think that you need to make sure that you've got very clear lines of responsibility and communication. You need to make sure that obviously people don't work in silos, because there needed to be a very team-based approach to this program, and, you know, lots of overlap in areas. And I think that it was obviously important there was clear escalation as well.

An example for us would be that, you know, our focus was absolutely in infection prevention and control, but we needed to work closely with the likes of the hotel staff who were delivering meals to the guests, because whilst the meals --- putting together the meals wasn't anything that we needed to do, the delivery of meals to a guest, and most importantly the pick-up of meal trays from guests, had certain requirements around infection prevention and control and systems and processes, and protections that we needed to put in place for everyone that was involved in that, and make sure that everyone was clear on that. So it was very much, you know, needed a team-based comprehensive approach.

Q. And, as you said, clear leadership in relation to that kind of clinical governance as well over all operations that are being undertaken, especially at a COVID-positive hotel?

A. Yes.

Q. So just drawing you back to my question for a moment, if I may. Given your responsibility for clinical operations over those four major sites, several minor sites, a workforce of 10,000 people --- and I appreciate you didn't know it at the time, but the evidence before the Board will indicate that a decision was made around 9, 10, 11 April to treat the Rydges Hotel in Carlton as a COVID-positive hotel, but one that didn't have a comprehensive clinical service in respect of it --- given your position, what would you say about the desirability or otherwise of a set-up like that?

A. I would say there's definite benefit of having a very comprehensive clinical-based level of expertise.

Q. And that's what you were asked to bring as of late May and implement it as of mid-June; is that right?

A. Yes.

Q. And your experience has been, notwithstanding the difficulties and complexities of it, the importance of clear lines of communication, clear governance, clear leadership, especially around clinical services, is absolutely imperative in that setting?

A. Yes.

Q. Let's go to what you've described as the health hotel model. I think....

[Announcement heard]

A. Sorry, I couldn't find my mute.

Q. No, that's okay. I take it you don't need to respond to that code?

A. No. Thank you, though.

Q. If you do, let us know.

So Alfred seems to describe the model of the COVID-positive hotel as a health hotel model; is that right?

A. That's correct.

Q. Perhaps outside that clinical perspective as described for hotels as red hotels or hot hotels, terms like that. Is the decision to call it a health hotel model a deliberate decision in the focus on health?

A. The decision to call it a health hotel, you know, from my understanding was to ensure that it wasn't called a COVID-positive hotel. We didn't think that was the appropriate way to brand it for anyone either working there or being there. So that was why that decision was made.

Q. Yes. You've taken us to that diagram under paragraph 41, and that shows the management and leadership structure. But if we can talk a little bit more about, on the ground, what Alfred Health were actually doing as of mid-June. So, first of all, I just want to clarify, 17 June, that health hotel opened.

A. Yes.

Q. And that's the Brady Hotel in the CBD?

A. Yes.

Q. Okay. So we've gone from the initial phase of Alfred Health's involvement, being the telephone calls with the nurses.

A. Wellness checks.

Q. Yes. And we're now going to the health hotel model mid-June. So this is the first stage of expansion beyond the original. So what were --- at that stage, 17 June, Brady Hotel opened its doors to detainees. What were Alfred Health providing?

A. So we were providing all of the clinical leadership and clinical nursing workforce, the cleaning, overarching infection prevention and control responsibility, and also some customer support officer type roles. We had a plan to also provide mental health, but in the initial phase, it was a staged roll-out/implementation at that point.

Q. So you were providing the clinical nursing staff, those that were actually assisting the guests with their health needs?

A. Face-to-face contact, yes.

Q. Okay. So that was the first time there was face-to-face contact by Alfred Health nursing staff in the Hotel Quarantine Program?

A. Yes.

Q. You also implemented nursing team leaders; is that right?

A. Clinical --- yes, clinical leaders.

Q. Yes. And who was designated, if anyone, on site for the responsibility for infection prevention and control?

A. So that was Alfred Health's responsibility as a whole. So the point of contact was the team leader, the Alfred Health team leader, or the Alfred Health clinical manager, depending on the time of day, as the key points.

Q. Okay. And that person, what type of qualifications would that person have to be designated as a clinical manager or a clinical team leader?

A. Quite senior nurses, either a nurse manager type background or, you know, some very senior experienced registered nurses, you know, that have had experience in leading shifts or leading teams.

Q. So how would they give effect to their responsibility for being in charge of infection prevention and control at the Brady Hotel?

A. They were clearly leading the education, the training, the supervision, coordinating all teams, Alfred Health specifically, but all teams. It was, you know, a team-based approach. And they would be responsible for coordinating audits, you know, environmental management, and escalation of issues as they arose, with also responsibility for rectification if they could, but escalation if they couldn't.

Q. What about the education of non-clinical people that were working within that setting? Did they have a role in respect of that?

A. As I said, it was a team-based approach so we didn't delineate. You know, there was lots of orientation, education, PPE donning and doffing training, that still exists shift to shift. There's a huddle, you know, each commencement of shift. There's opportunities for, you know, supervision and practice during the shift. It's everyone's responsibility to identify any issues. We set about having a very flat structure where everyone could feel like they had a voice and they could raise issues, they could ask questions and, you know, education and training in regards to PPE management or anything to do with infection control and prevention would be provided either in a structured way or an ad hoc way.

Q. And that was to all staff? Because you say that team-based approach, whether they be security, cleaning, hotel staff, whatever?

A. Didn't matter. Yes.

Q. I don't know whether you're aware, but the Inquiry has heard evidence from a security guard who worked at some hotels and concluded his work in the Hotel Quarantine Program at the Brady Hotel. He's referred to as Security Guard 2. Are you familiar with the evidence he gave to the hearing?

A. I think so.

Q. In a general sense, and I won't put too fine a point on it, but he described that team-based approach where people were sort of looking out for one another and saying, you know, if someone's doing something inappropriate from an infection prevention and control perspective, no matter who the other person was, everyone could speak up and look out for each other. "We had each other's backs," I think was the term he used. First of all, does that surprise you that that was his evidence?

A. No, that pleases me greatly, as certainly that was our intent, to create that environment where everyone, you know, felt that they were included and they could raise any issues. That's the culture that we would want.

Q. That was a deliberate choice, I take it, of Alfred Health to bring that culture into the program?

A. Well, I think it's reflective of Alfred Health's culture generally. So I think that we understood we were dealing with different levels of workers that had different, completely different, you know, backgrounds and experiences, and indeed some that had none in infection control or prevention. So, you know, we needed to tailor our approach and make sure that it was suitable for everyone that was going to be working in that environment, because it was our responsibility.

Q. So you've clearly articulated, both in your statement and today in evidence, the person --- the specific person on site responsible for infection prevention and control, being the clinical managers or clinical team leaders. Did you have any understanding about who was responsible for infection prevention and control at the sites where your nurses had worked prior to the Brady being stood up?

A. Those sites were governed by the lead agency, DHHS. So that was my understanding, that they were responsible for all service provision, including infection prevention and control.

Q. So you've got your nurses, going back to that first phase, your nurses that have had ongoing training in infection prevention and control; you've stressed the importance of that being continuing, ongoing, revised, supervised. Those nurses are embedded in these hotels in a boardroom, effectively, operating the phones; is that right?

A. That's correct.

Q. Were they ever asked to be involved in providing advice or assistance in infection prevention and control being used at those hotels?

A. Not to my knowledge.

Q. Was it ever identified to them, as far as you're aware, who they should speak to at the hotel if there was an issue with infection prevention and control?

A. It was identified to them who they should speak to if they had an issue with anything. Alfred Health put in, you know, a clinical manager to be a point of contact for Alfred Health staff at all times, but they also knew that the Department of Health lead was a contact for any issue that they should have during their time at work.

Q. Okay. So are you --- is the case --- and I'm certainly not being critical of you at all, Ms Alexander, and I appreciate the role you had versus the role that the nurses had at those hotels. But, other than the DHHS team leader who was installed at those hotels prior to the Brady, there was no one identifiable on the ground as the person in charge of infection prevention and control at each of the properties?

A. No.

Q. And then, by way of contrast, when we look at the Brady being stood up, there's a specific person nominated who is going to be there at every hour of the day, whether it be a team --- sorry, what were the roles? Clinical managers or clinical team leaders. There's going to be one of them there every hour of the day; is that right?

A. We were brought in as a specific agency to be responsible for infection prevention and control. So these team leaders and clinical managers were obviously responsible

for that, and any other, you know, workforce or issue that was occurring in that environment. We assumed our responsibility there to deal with any issue that arose, no matter what domain, and escalate it if it wasn't something that we could manage ourselves.

Q. Yes. Coming back to it, perhaps it was a compound question and that was unfair so I'll break it up. When it comes to Alfred Health clinical managers or clinical team leaders, first and foremost, they were the people identified as responsible for on-site infection prevention and control at the Brady Hotel?

A. Yes.

Q. And someone meeting one of those descriptions, either a clinical manager or team leader, was rostered on duty for each hour of the day?

A. Yes. 24/7.

Q. Yes. And the people who were rostered and assigned those roles were senior nurse practitioners?

A. Not nurse practitioners; senior nurses that were either of a nurse manager type level, so very experienced --

Q. Yes.

A. --- or had, you know, been a resource nurse or had managed shifts and had experience in coordinating a team on a shift-to-shift basis.

Q. Yes. In those discussions that took place between, say, late May and when the Brady was stood up in mid-June, did the Department share with you their views about infection prevention and control measures that had been employed at the other hotels prior to you having this increased role?

A. No.

Q. You mentioned earlier in your evidence about infection prevention and control, the concept of auditing. Can you tell us what you mean by that?

A. It's a standard process that we would undertake in a clinical environment like the hospital where we would conduct infection prevention audits on a regular basis to identify where there was issues or gaps, and we would complete that audit and outline what needed to be done to improve and put in a rectification plan that was addressed within a designated period of time, depending on the particular issue, in order to make sure that everything was compliant and the environment was safe and we were continually assessing this.

Q. So you talked about them being done on a regular basis. It might be "how long is

a piece of string", but how regular were those types of audits being conducted?

A. They were aiming to do them weekly. The first one was conducted the day after we opened Brady, and then we just sort of continued to do them weekly, as I recall. And then as the services continued to evolve, that schedule may have changed a little bit.

Q. And how would they be conducted? How would the audit --- is it a walk-around all of the floors of the hotel, is it interviewing staff? How are they conducted?

A. It's a pretty comprehensive tool. So we have a standard tool for the hospital environment, and with the expertise of our infection prevention team, we modified that to the hotel environment, and it's actually a physical walk-around by a person that's got that experience or a registered nurse that observes and checks off the various items, and they're either met, or generally not met, and then comments put beside what needs to be done, and then a rectification plan put in place.

Q. A statement has been tendered this morning from a person known as Alfred Health Nurse Manager. Are you familiar with the contents of that statement --- in a broad sense?

A. I think if you're referring to --

Q. I'll just stop you there. So there is a statement that has been provided by Alfred Health in response to some questions directed to a particular person. As that person doesn't sit in the executive of Alfred Health, that person has been provided the description "Alfred Nurse Manager".

A. Yes.

Q. So it's the only other statement that's been provided from Alfred Health.

A. Yes, I am aware.

Q. So are you generally aware of the contents of that statement?

A. Yes, I am.

Q. So that's been tendered this morning. I just want to read to you part of paragraph 69 of that statement to refresh your memory and see if this accords with your understanding of the IPC auditing process. Alfred Nurse Manager said:

> *The infection prevention nurse consultants undertook an audit which looked at the physical environment, hotel guidelines, staff education, competency training, staff screening and wellness checks, passenger screening and wellness checks, movement and transfer of passengers process, staffing for hotels, stock storage, PPE management, hand hygiene, room and facility*

environmental cleaning with assessment of cleaning, workstations cleaning and social distancing, waste management, kitchen management, housekeeping and soiled linen/laundry, clean supply room management and lift management.

You described the auditing as being "fairly comprehensive". Does that put a little bit more meat on the bones of "comprehensive"?

A. Yes, that's it.

Q. And is that your understanding of the things that were assessed on that weekly basis by people who were specialised in infection prevention and control?

A. Yes.

Q. And that's the service that Alfred Health brought to the Hotel Quarantine Program, but not until mid-June?

A. Yes.

Q. Alfred Nurse Manager goes on and says:

The purpose of the audit is to identify opportunities for improvement in infection prevention measures. Any risks/opportunities for improvement are then fed back to the relevant agency or contractor and improvements made to the site.

That's probably a more generic description of what you described earlier about how you would implement the changes?

A. Yes.

Q. At some point, Alfred Health engaged external staff to assist with the auditing process though, didn't they?

A. Yes, we did.

Q. Okay. When did that occur and why did that occur?

A. I can't recall the date exactly, but I think it was June. It occurred because there was just competing demands, and I recognised that there was a large amount of work at the health service, and obviously the Hotel Quarantine Program was a very large piece of work as well, and I recognised that my team really couldn't be stretched to provide the service well enough across all of those domains. So I had a conversation with the Department to talk about any opportunities for support in this particular area, and I was given a contact which I made contact with and then I employed some infection prevention consultants to support the work in the hotels, part of which was the auditing but part of which was training, supervision, and anything else, but under the au

spices of what Alfred Health already had in place, always open to feedback, but it wasn't a change in process or system.

Q. It was an augmentation of the resources that you had, if that's a fair description?

A. (Witness nods).

Q. Was there value in bringing external people in for the purposes of audit?

A. There's always value in bringing fresh eyes to any audit. So we had some really good feedback from these consultants who had experience in the New South Wales quarantine program. So we were pleased that the audit tool that we were using, you know, did provide a comprehensive overview, and continued to use that across all of the hotels.

Q. In your statement at paragraph 58(f), you say:

> *Alfred Health sought to engage an external consultancy to assist with this task. Alfred Health considered the appointment of a consultancy was consistent with best practice.*

Can you just expand on that and explain why appointment of a consultancy was consistent with best practice?

A. So obviously in order to --- in order for it to be best practice, we needed to have the appropriately trained and skilled staff in this particular area. So bringing in an external consultancy company supported our service provision and provided that completely independent overview which could be described as best practice.

Q. Yes. And, Ms Alexander, you mentioned before that the people that you brought in had experience in the Hotel Quarantine Program in New South Wales.

A. That's correct.

Q. Had they been performing a similar role in relation to the New South Wales Hotel Quarantine Program?

A. Yes.

Q. Audit and consultancy in relation to infection prevention and control?

A. Yes.

Q. Did you understand whether they had been involved in the Victorian program prior to your engagement of them?

A. They had not been involved.

Q. Yes. Just going on as to the further expanded role that Alfred Health had performed within the Hotel Quarantine Program, at paragraphs 50 and beyond of your statement, you talk about Alfred Health being involved in contact tracing.

A. Yes.

Q. Can you take us through the phases at which Alfred Health had been involved? We understand it started as one thing and has subsequently become something else.

A. So from the outset of our involvement, which goes right back to the wellness checks, Alfred Health were very clear that they maintained responsibility for contact tracing of all Alfred Health staff. It was --- as far as we were concerned, they were our employees and we wanted to look after them with regards to this and other aspects.

It was sometime in late May --- I can't recall the exact date --- there was a contact tracing progress, and there was some significant differences identified. So difference in timeframes, so difference in contacting people, you know, within agreed timeframes, and conflicting information. And this caused some concern for our staff. And I had then from feedback around that conversation --- it evolved that the Department asked us to put forth a proposal of how Alfred Health might support the Department in contact tracing. You know, it's like it's going down a rabbit warren. It's a very complex task. We felt we had good systems and already established sort of processes and indeed learnings from our experience that could support the Department in doing this for the workforce within the Hotel Quarantine Program, and when I talk about that, I talk about all of the agencies involved. And we thought that would allow us to align all of the challenges that we'd had before and provide an improved service provision.

Q. I just want to unpack that for a moment, if I can. You said that there were some concerns expressed within your staff because of differences in timeframe. What are the timeframe differences that you're talking about there?

A. So in the contact tracing process, some staff were not contacted for a number of days. So --

Q. By whom?

A. By the Department. So there's a --- because obviously we were doing Alfred Health staff, but there was other staff involved. So there was two approaches to contact tracing. So Alfred Health staff had the oversight of the Alfred Health contact tracing team, but it was identified that there was some other agencies who had staff that hadn't been contacted for a number of days or longer than what we would like in order to give them the information they need. And then there was some conflicting information that the various agencies were given.

Q. Okay. And again, just to be clear about this, as I understand what you're saying --- and please correct me if I'm wrong --- Alfred Health was taking a separate interest in its own staff, at least at the initial phases, because of the responsibility it has to its own staff in respect of contact tracing. And there were differences between the time which Alfred Health contact tracing would contact these people and then the time by which the Department would contact them. Is that a fair summary of what you've just said?

A. Yes.

Q. And in those differences, they were being contacted by the Alfred Health contact tracers earlier or later than the Department?

A. Earlier.

Q. And this was a problem that also presented in relation to other agencies, whether they be cleaners, security, things like that, working in the Hotel Quarantine Program, and that distinction between the time it took for them to be contacted was different to the earlier or shorter timeframe in which Alfred Health were making contact with their own employees?

A. So, not cleaners, because cleaners were part of Alfred Health staff through our subcontractor, Spotless.

Q. Yes, I apologise.

A. But, yes, you could describe hotel staff or Department staff contacted later.

Q. Okay. So the concern that was raised, not to put too fine a point on it, was that Alfred Health were contacted promptly but the Department was less prompt?

A. Yes.

Q. And a further concern was raised in that the information given to these people by Alfred Health contact tracers was not consistent necessarily with the information given to them by the Department?

A. Yes, there was differences.

Q. Concerns were therefore expressed up the chain, making their way to you, about those differences, both in respect of timing and in respect of the content of what they're being told?

A. Yes.

Q. And at that time, that issue was raised with the Department and you were invited to see how you might assist them in their endeavours?

A. Yes.

Q. So do you recall when your role --- when I say "your", Alfred Health's role --- in contact tracing expanded beyond its own workforce?

A. It was the end of July.

Q. And to what did it expand? What did you then cover?

A. So we covered all of the agencies working within the Hotel Quarantine Program. So if it was the hotel staff, Department staff, Victoria Police, whoever, we provided the contact tracing responsibilities for everyone that would be involved in an active contact trace from that date.

Q. Okay. So this again aligns, I suppose, with that clinical governance and management of the hotels, the Alfred Health is running point, if you will pardon the phrase, in respect of all of the health and medical concerns not only of those that are in the system as detainees but those that are working in the system as well. Is that a fair sort of overview?

A. That's a fair overview. We're not perfect, but we had experiences and systems in place.

Q. Yes. Again, Alfred Nurse Manager deals with this briefly at paragraph 25 of her statement. I'll just read that to you and see if you agree with that. This is in talking about the Alfred Health contact tracing:

> *In the event a positive COVID case is identified by DHHS within the Hotel Quarantine Program, Alfred Health is notified and our Unit identifies and contacts all potential close contacts of the COVID positive person. The Infection Prevention Unit provides employees with information regarding the need to isolate, the duration of isolation and testing required during isolation. Follow up at the end of the 14 day isolation period prior to staff returning to work is also provided to confirm they are asymptomatic and have received a negative swab result.*

Is that the services that Alfred Health were, first of all, providing to their own staff within the Hotel Quarantine Program, but then subsequently from late July to all of the staff working in the Hotel Quarantine Program?

A. Yes.

Q. Alfred Health also had a role, did they not, in providing security to, first of all, the Brady Hotel but then more broadly to other hotels when its role expanded?

A. Yes.

Q. Can you describe that set-up, how that worked and why Alfred Health --- first of all, was that asked of you or did you suggest that is what Alfred Health should be doing?

A. No, that was requested.

Q. Was it explained to you why that was requested?

A. Yes, it was to monitor floor-by-floor any noise or any potential discussions in rooms that were escalating, and to also make sure that there was no guests leaving their rooms.

Q. Sorry, perhaps my question was a bit obtuse. Did you understand there was security at hotel quarantine properties prior to Alfred Health standing up the Brady?

A. Yes.

Q. Who did you understand was providing those security services?

A. My understanding was under the Department.

Q. Okay. When Alfred came in to have the clinical management of the Brady, Alfred was also asked to bring in security providers; is that right?

A. Yes.

Q. Was it explained to you why that change in model, why other security agencies, those that had been working within the system previously, were then not going to be used?

A. No, it wasn't explained. But it was Alfred Health's proposal that we would provide the whole of the clinical service to the Brady, of which security was part of, as the same as cleaning or, you know --- and that was part of our subcontractor Spotless. We're familiar with security within that partnership. So it was, you know, our desire to provide that fully in the Brady Hotel, that service.

Q. Is it implicit in that answer, Ms Alexander, that from Alfred Health's perspective you considered security in this set-up as part of the clinical services being provided?

A. No.

Q. No? So why --- I'll be frank about it --- why not use the security that was already providing security in the Hotel Quarantine Program? What was important to the Alfred to bring in security with which it was familiar and had worked in the past?

A. So, firstly, the security role was identified as being required as part of a proposal.

So it wasn't a decision made by Alfred Health that we needed security in a clinical model. Again, it was Alfred Health's proposal to provide a complete service, and because we had capability and established relationships with Spotless to provide such a workforce, that was why we approached it in that way.

Q. Okay. So if I understand your answer, Alfred Health were asked by the Department to consider a more holistic service --- that is, the clinical service, the security service, the cleaning service --- and Alfred Health had those established relationships with trusted providers and said, "This is what we can provide." Is that --

A. Yes, I think there was a conversation that the Department would like to, where possible, work with one major sort of subcontractor, if you like, that provided the majority of those services to improve how they interacted.

Q. And so you mentioned Spotless on a number of occasions. They're the preferred security provider for Alfred?

A. Yes.

Q. And how long has Alfred worked with Spotless?

A. I don't know the actual timeframe, but a long time.

Q. Let's just say a long time. And they've provided security services at your major properties?

A. Yes. Cleaning, security, kitchen. They provide quite a broad service and, you know, we view the way we work with them as a partnership.

Q. You're aware, as you touch upon in your statement, that from time to time Spotless will engage a subcontractor to provide some security services. Do you have any knowledge about the extent to which their workforce is a full-time employed workforce or the extent to which they use workforce provided by their subcontractor Southern Cross Protection?

A. Predominantly their workforce is of some sort of a permanent nature, whether it's part-time or full-time. But I am aware that they do use subcontractors or agencies to, you know, top up where required, if there's any drop-off in EFT or if there's an increased need that they can't meet within their permanent workforce.

Q. In a not dissimilar way, I'd suggest, to the way in which Alfred Health might use agency nurses from time to time to top up. Is that a fair analogy?

A. Yes.

Q. So as part of the arrangements --- I don't need you to go into details --- that Alfred

Health have with Spotless, are there standards of expected behaviour that are contractually in place and enforced?

A. Yes.

Q. And are there standards in respect of particular training, if someone's going to be working in a security perspective, in an environment that might pose a risk of infection?

A. Yes.

Q. And so when Spotless provides security services to the Alfred Health, will there from time to time be the need to discriminate between those that are experienced in those infection risk environments versus those that are not?

A. There's not a distinction. There's a basic understanding, you know, required for any security-type person in the hospital environment, because with the nature of the place, you just don't know where you're going to need it. So there's always a need to have a basic or a baseline understanding of infection prevention.

Q. And for that long time that they've been providing those services to the Alfred Health, by and large Alfred, I assume, has been happy with those services and the quality of services being provided?

A. Yes.

Q. Including in those environments that might pose a risk of infection?

A. Yes.

Q. You've also told us that Spotless provides kitchen services, cleaning services. Did they provide any kitchen services at the Brady Hotel?

A. No.

Q. But cleaning? Did they provide cleaning?

A. Yes. Pathogen cleaning. So not standard cleaning. They would do --- and when I talk about pathogen cleaning, I'm talking about when a positive --- when a guest left the hotel, as in was discharged from the hotel, they would clean the room on the exit of that guest. They would do regular high touch-point cleaning in all of the sort of main thoroughfare areas, lifts, corridors, you know, general sort of areas of the hotel. But other cleaning, standard cleaning, I would refer to resetting of a room or cleaning a kitchen or standard vacuuming cleaning was provided by the hotel.

Q. Okay. So it was the specialised pathogen cleaning. That experience in pathogen cleaning, is that an experience they brought to this task from other jobs they've done

for you in the Alfred Health setting?

A. Yes, and there's also the Department guidelines that obviously have been released in regards to specific cleaning requirements for COVID-19 which they use.

Q. And I assume that you yourself at the Alfred Health, having a COVID ward, have specific cleaning requirements there too?

A. Yes.

Q. And are they consistent --- well, are they adherent to the Department's guidelines?

A. Yes.

Q. Do they go, as far as you're aware, above and beyond the Department guidelines, or are they just the same?

A. I think that we have employed I suppose a checking system where we use a UV light to validate cleaning has occurred in some areas, so whether it's, you know, the top of a patient tray, meal tray, we would do things like that. So we absolutely meet the requirements of the Department, but there's some things where we will do some further validation to assure ourselves that it is compliant.

Q. And are those further steps steps that were also employed, as far as you're aware, at the Brady and in the Hotel Quarantine Program?

A. That particular example, yes.

Q. Yes. You touch upon, at page 9 of your statement, services at the Alfred Health were providing in relation to customer service officers and bag screening. Can you just explain briefly what that's about?

A. So the customer service officer was again supplied by Spotless, and generally they had like an orderly or a sort of general hospital background or was certainly orientated with what the requirements of that role were. They were pretty much designed to support whatever was required in regards to guest movement, the support of, you know, luggage movement or anything like that. They were also --- the customer support officers also --- those that had a security licence --- so there was two particularly employed to be designated to look at the care packages. So the guests would have a lot of packages coming, whether they were care packages from their families or Uber Eats or whatever. And in order to maintain safety, so packages would be checked just for any dangerous items before being taken to the guests' rooms, and a customer service officer would perform that function.

Q. Yes. Thank you. As I understand it, in early July, in a general sense the services and the clinical model that the Alfred had employed at the Brady Hotel was expanded to a number of other hotels.

A. Yes.

Q. Is that right?

A. Yes. It was staged, but the first step was the clinical leadership and the clinical nursing role.

Q. So that would include those pieces that you've already discussed before about education, auditing, someone on site having responsibility for infection prevention and control and being the primary point of contact in relation to any issues on that?

A. Yes.

Q. It then expanded to include cleaning and security at those hotels as well?

A. At about the same time.

Q. Okay.

A. It was a package.

Q. Perhaps now is a convenient time to turn to that appendix to your statement that I referred to earlier. I'll ask if that might be brought up. I'm not sure whether it forms part of the statement as tendered or not, but it should be ALFH.0001.000 --- sorry, I'm just trying to gather these documents. Excuse me, Madam Chair.

CHAIR: Are you after the memorandum of understanding, Mr Ihle?

MR IHLE: No, I'm after the appendix to Ms Alexander's statement, which is numbered page 25. I'm not sure whether --

CHAIR: The Model of Care?

MR IHLE: No. We're having a --- there it is.

CHAIR: There it is, yes.

MR IHLE: I'm very grateful.

So, Ms Alexander, this appendix goes for --- you see it starts on page 25, the top right corner, and goes through to page 29. This is, by way of summary, as I understand it, the dates at which and the locations at which and the services that were provided by Alfred Health to the hotels in the Hotel Quarantine Program. Is that right?

A. Yes.

Q. So it's really a summary of when you started, where you started and what you were providing and when?

A. Yes, to the best of my knowledge. Yes.

Q. And so to the best of your knowledge, is that both truthful and accurate?

A. Yes.

MR IHLE: I tender the appendix, Madam Chair.

CHAIR: Exhibit 100.

EXHIBIT #100 - APPENDIX TO STATEMENT OF SIMONE ALEXANDER

MR IHLE: So we see there, Ms Alexander, the first entry, 17 June, the Brady Hotel; we've covered that in some detail this morning.

Then as of 1 July, there were three other hotels that came on board; that is, the Mercure Welcome in Melbourne, the Pullman on Swanston, and the Rydges on Swanston. We'll just have to scroll to the second page, Mr Operator.

A. Yes.

Q. Then expanded to the Sheraton Four Points there on 3 July, but only ran until 11 July.

A. Yes.

Q. And then scrolling to the next page, on 6 July, Alfred took clinical responsibility for Crown Metropol and the Grand Chancellor and Novotel on Collins; 7 July, Stamford Plaza; scrolling over to the next page, on 8, 9 and 10 July we've got Crown Promenade, Holiday Inn Airport, Holiday Inn Flinders Street; 10 July, Parkroyal Hotel; and we scroll all the way through to 1 August, Novotel South Wharf. Are they all of the properties at which Alfred Health has taken clinical control of for the purposes of Hotel Quarantine Program as detailed in that statement?

A. Yes.

Q. Do you understand there to be any hotels in the Hotel Quarantine Program at the moment for which Alfred Health does not have clinical responsibility?

A. No.

Q. So, put another way, Alfred Health has clinical responsibility for all hotels in the Hotel Quarantine Program, however that program might be described at the moment?

A. Yes.

Q. Thank you. I will ask now that the Alfred Health Model of Care document, which is DOJ.505.002.5445_P be brought up.

As that's happening, Ms Alexander, when I refer to the Alfred Health Model of Care document, specifically a document dated 14 July 2020, is that a document with which you're familiar?

A. Yes, Mr Ihle.

Q. And can you explain what that document is, who created that document, and the reason for its creation?

A. So this document was created by Alfred Health, and it was an internal sort of effort to describe what we were doing and also sort of outline what we intended to do, based on the requests. This document was used to prepare the MOU, so it was a precursor to that. It doesn't --- it's not current. It doesn't reflect the service that we're providing currently. It's evolved.

Q. Is it fair to describe it as sort of a point-in-time snapshot as of 14 July as to what Alfred Health was then offering and was proposing to offer in the future?

A. Yes.

Q. And this document, you will appreciate, has a document ID which begins DOJ. You can take it from me that that means this is a document provided to us by the Department of Justice and Community Safety. So do we take it from that that this document was provided to at least that Government department at some point in time?

A. I don't believe this document was provided to the Department of Justice by Alfred Health. I believe that this document was used by the Department of Health to commence the formalisation of an MOU process which then didn't progress any further, and I'm assuming that that's how the Department of Justice then received this document, in the transition to them assuming responsibility for the Hotel Quarantine Program.

Q. Okay. If we can turn to the third page of that document. I'm not sure whether you can see the screen or whether you have a hard copy, Ms Alexander. Just refer to whichever is more convenient for you. But you will see in the second paragraph under the heading "Background", we have by way of description the identification of Alfred Health's expansion to commence the provision of all nursing, security, cleaning and mental health services within the single COVID-19-positive hotel site at

the Brady.

A. Yes.

Q. It then goes on to talk about the expanded role from 6 July, which is reflected and perhaps provided in more detail in that appendix that we've referred to before, although I think in the appendix the first expansion was as of 1 July rather than of 6 July. Do you agree that that's what's being described there in that document?

A. Yes.

Q. If we turn to page 4, we see a table there. Now, the purpose of this table, I'd suggest, is to show the services that as of the date of this document --- that is, 14 July --- Alfred Health were providing to, on the one hand, the health hotels, COVID-19-positive, and on the other hand, the standard quarantine hotels.

A. Yes.

Q. Now, I note that it refers to health hotels plural in respect of the left-hand column. Was there a subsequent health hotel that was stood up?

A. Yes.

Q. Okay. So if we go through this table, we can, by way of comparison and contrast, see the responsibilities and workforce models that Alfred Health were employing at each of those two, by way of summary, the COVID-positive hotels versus the non-COVID-positive hotels.

A. Yes.

Q. Now, to my eye, and my eye is absolutely not perfect, but there is no material difference other than the row dealing with mental health clinicians --- sorry, and the security or residential support workers. I told you my eye wasn't perfect. Does that table accurately summarise, as of 14 July, the types of services that Alfred Health was providing in those two cohorts of hotels, on the one hand, health hotels; on the other hand, standard quarantine hotels?

A. Yes.

Q. And again, other than those two areas --- mental health clinicians, where it says in respect of COVID-positive hotels, "Second site yet to implement the AH MH model", that's Alfred Health Mental Health, and under "Standard Hotels", "Model yet to be agreed or implemented", and "Security or residential support workers", the services appear to otherwise be identical. Is that a fair summary?

A. Yes.

Q. If we turn to page 5 of that document, we see a clear identification of Alfred Health roles by title or description, and then a clear enunciation of their duties or responsibilities. Was that provided to the Department so as to clearly articulate Alfred Health's understanding of what it was required to do and what it would do within the Hotel Quarantine Program?

A. There was various iterations of this document provided to the Department that did have a description of the workforce roles and responsibilities, yes.

Q. But the purpose of that table, in whatever iteration it was, and this is the iteration as of 14 July, is to make clear to all of those that are going to be working in this environment and the partnership between Alfred Health and the Department, clearly as to who is where, who's doing what, who is responsible to whom?

A. Yes.

Q. And indeed, as we go over the page, at page 6, what you've provided there to the Department is a clear structure for governance of the program and the escalation --

A. Yes.

Q. --- of issues. And again, that's provided to the Department. And I appreciate there may have been several iterations over time, but just to be as concise and crisp as to who has what responsibilities, to whom do they report, how are issues raised, so that there can be no confusion in respect of those things?

A. Yes.

Q. Page 7 of that document, we see there a number of very important statements, I'd suggest, for example under the heading "Nursing":

> *Strong clinical site leadership and consistent staff is seen as an important component of maintaining the required high standard of governance.*

Now, that's a principle which guides Alfred Health through all of its health services, isn't it?

A. Yes.

Q. And indeed, even the final sentence there, where it's envisaged that there may be agency staff, it's clear that those staff will be under the supervision and governance of Alfred Health. It's a statement of responsibility and accountability even where outside staff are being brought in.

A. Yes.

Q. Is it the case too that in respect of responsible governance and risk identification

and mitigation that Alfred Health maintained risk registers in relation to the properties at which it was providing clinical services?

A. Alfred Health maintained a risk register that encompassed the entire Hotel Quarantine Program.

Q. And under the heading "Risk Management" on that page, we see that discussed, specifically the use of a RiskMan platform?

A. So there's two things to note here. One is that local risk identification was through the RiskMan platform, which is a standard platform for all --

[Announcement heard]

A. My apologies. Couldn't get my mute again.

So the RiskMan is a standard Victorian public health service platform where staff can enter any risk that they think is there and it would appropriately be dealt with. In addition to RiskMan platform or the ability for individual staff to identify risks, there was a risk register compiled by the leadership in encompassing the whole of the Hotel Quarantine Program.

Q. And both the RiskMan platform and the risk register, they're quite orthodox risk management strategies used in, first of all, the health setting in which you primarily operate; is that fair?

A. Yes.

Q. And the maintenance of a risk register itself is quite an orthodox management tool in relation to most --- you may or may not be able to comment on this --- but most governance structures within large organisations?

A. In my experience, yes.

Q. Yes. And the risk register itself is a document which can be accessed by those responsible for governance at any given time and is a living, breathing document which is updated as regularly as it needs to be?

A. Yes.

Q. It focuses the organisation's attention on risk and how to identify and mitigate those risks?

A. Yes.

Q. And that's something that you employed --- that is, Alfred Health has employed --- in its role in the Hotel Quarantine Program?

A. Yes.

Q. Just turning finally on this document to page 8, under "Priority 1 --- Embedding Workforce Model", the document talks about:

> *With the rapid expansion of [Alfred Health] HSS* --

What's HSS there?

A. Hotel support services.

Q. Thank you:

> *.... across 16 sites, our initial focus will be on embedding our team leadership & clinical and non clinical workforce.*

What do you mean about "embedding"?

A. Embedding was about really, you know, orientating, formalising, putting the team together on the ground, familiarising them with the environment and the day-to-day roles and responsibilities, making sure that they were seen as a key part of the entire team, that there wasn't silos based on different agencies, and ensuring that they were seen as a key point of contact should there be any issues that anyone wanted to raise.

Q. And again, under this heading of "Priority", you will see the final sentence there of the second paragraph:

> *This includes a strong focus on education and auditing of all staff and processes on site.*

First of all, when you talk about education there, what are you talking about?

A. I'm talking about education in regards to infection prevention, emergency procedures, standard sort of orientation to site.

Q. When you talk about emergency procedures there, you're talking about not only health procedures but I assume things like evacuation should it be necessary?

A. Yes.

Q. And were they part of that education piece when it came to staff working within hotels where the Alfred Health had clinical responsibility?

A. Yes.

MR IHLE: I tender --

CHAIR: Mr Ihle --- sorry, you're about to do a tender?

MR IHLE: I am about to tender that document. So, yes, I tender the document.

CHAIR: The Model of Care?

MR IHLE: Yes, Madam Chair.

CHAIR: Exhibit 101.

EXHIBIT #101 - ALFRED HEALTH MODEL OF CARE

MR IHLE: As the Board pleases. I anticipate that you may have been about to say something about time?

CHAIR: I was.

MR IHLE: Can I indicate that I think I will be in the order of 10 to 15 more minutes with Ms Alexander, and I have not had any approaches in respect of anyone that wants to ask questions of her, but there may have been issues that arose throughout the course of the examination thus far.

CHAIR: Can I just get an indication from any of the parties with leave to appear? I'm just conscious of the fact that we've been going for two hours in particular with respect to all of the staff supporting the hearings, to just give people a 15-minute break, Mr Ihle. It doesn't look like there is.

MR IHLE: It doesn't seem like there's anyone. I'm in the Board's hands, and certainly indebted to Ms Alexander and in her hands as to whether a break should be had now or whether we should proceed to the conclusion of it. I don't have a preferred view either way.

CHAIR: Are you okay to go on for about another 15 minutes, Ms Alexander? Mr Ihle is indicating that that will complete the questions he has for you, and at this stage, no one else appears to be indicating that they've got any other questions for you.

A. Yes, thank you, Madam Chair.

CHAIR: All right. Well, let's continue, Mr Ihle.

MR IHLE: Thank you, Madam Chair.

Ms Alexander, you've referred to a Memorandum of Understanding which

I understand is sort of the development of that last document to which we've referred. It is in a form which is more up to date, albeit --- and correct me if I'm wrong --- a document which has not been settled upon and executed. Is that fair?

A. That's correct.

Q. Do you know why that's the case, why a Memorandum of Understanding about the provision of hotel support services by the Alfred Health to the State of Victoria has not been concluded?

A. I understand that this document was almost ready for discussion between the parties, and then there was the change of leadership to the Department of Justice. The Department of Justice indicated to me that they will be providing a contract versus a Memorandum of Understanding, and are currently working on that.

Q. Okay. So has a draft of this Memorandum of Understanding made its way to the Department of Justice, as far as you're aware?

A. Not as far as I'm aware.

Q. Okay. And just in respect of that and the shift from the Department of Health and Human Services to the Department of Justice and Community Safety, Alfred Health was playing a very significant role in the Hotel Quarantine Program prior to that shift. Do you agree with that?

A. Yes.

Q. And indeed, when one considers, as we're about to, the services provided to the Hotel Quarantine Program, specifically to those within the Hotel Quarantine Program, Alfred Health was by far and away providing, in raw number, most of those services?

A. Yes.

Q. Was Alfred Health consulted at all in relation to its views as to moving the Governmental responsibility of this program from the Department of Health and Human Services to the Department of Justice?

A. No.

Q. Was it just told to you that that was happening, was it?

A. It was notified, yes.

Q. I'll ask that the Memorandum of Understanding be brought up. It's document ALF.9999.0002.0001_R. Now, this document that's been provided, Ms Alexander, is dated 27 July 2020.

To your understanding, is this the most recent iteration of the Memorandum of Understanding?

A. Yes.

Q. And we see that it has a number of comments tracked throughout it. I won't be going to those. But we're now on 8 September. You said this was close to being discussed with the Department in late July. Are there no other documents that have been generated as to the scope and location of services being provided by Alfred Health to the State of Victoria Hotel Quarantine Program between 27 July and 8 September?

A. There was the additional document in regards to contact tracing, that was submitted I think a little bit after that.

Q. Okay.

A. And obviously commenced on 30 July.

Q. Yes. Yes. So just within days of this document. But otherwise, Alfred Health has continued to provide services through all of August and the first week of September as you've described in appendix 1?

A. Yes.

Q. Okay. Just going to this document perhaps if we go to some of the salient features of it. First of all, page 3, table 1. We see there in that table, do we not, the different phases of Alfred Health's engagement in the Hotel Quarantine Program, phase 1, 2 and 3. Now, can I ask, which phase are we presently in?

A. We're in 3.5, in between 3 and 4.

Q. Okay. And we see that the reference, I suppose, in that final box under page 4 to the Department of Health and Human Services now needs to be considered as overtaken by the events of the Department of Justice and Community Safety being the responsible Government agency?

A. Yes.

Q. I want to go significantly to page 4, the Partnership Principles. Dealing with those, the first dot point there identifies that:

Person-centred care is the cornerstone of service delivery.

Why is that the case?

A. It was always intended that the care would be very much centred around the guests' needs and requirements alongside of what the clinical service provision that was required.

Q. A service delivery focused on those that are within the system and held within it?

A. Yes. It's a very hospital-based terminology, "person-centred care". It's very much, you know, our patients and our staff are very much the centre of how we build our care principles around that.

Q. And is it important as part of that person-centred care to actually take into account the circumstances of the individual?

A. Yes.

Q. The third dot point there:

> *The service delivery model will be continuously reviewed and improved.*

That's one of the principles which you've identified as underlying this partnership. We've talked about the audit processes. Are there other processes, formal or informal, which allow you to continuously review and improve?

A. Well, I think that, you know, we have a very reflective style at Alfred Health, so we're constantly sort of reviewing how things are going, is there any changes that need to be made. And clearly none of us have been through this before, so it was our view there was always going to be opportunities for improvement and learnings from wave to wave or from experience to experience, and that's why we would always consider the evolvement of the service.

Q. The second-last dot point there:

> *[Alfred Health] endeavour to provide dedicated workforce at each site meaning, where practical individual staff should only work at one hotel site (recognising that casual staff will be required on occasions....)*

Why is that important?

A. I think that's something we sort of started to learn, you know, early on. There had been issues identified --- from a health service perspective, there had been issues identified when staff worked at different health services that may have had outbreaks or in contact tracing, events, things identified where we had staff working at other sites that we didn't know about. So we had tried to understand our workforce and where else they actually worked in order to be able to, I suppose, respond in a more agile way to people working across different sites.

I think it was early July that we realised minimising the movement of staff across

sites helped to address any potential transmission, and so it was our request at that time that, where possible, staff would work at one site, whether it was one hotel site or one health service site.

Q. And you've articulated that really with a view to infection prevention and control there, if I understand that correctly. Is there also a governance issue which arises and is sought to be addressed by people working at the same site?

A. Well, I think it obviously adds familiarity to roles and responsibilities. So that is also important. However, I think that once a senior nurse manager was orientated to the role within the Hotel Quarantine Program, that those skills were transferable to another set of hotels and could be easily adapted if required.

Q. Thank you. Turning to page 6, and then I'll ask that it's scrolled through to pages 7 and 8, what we have there is a table called table 3, "Patient Journey", and it covers steps from bump in, receipt, health and welfare operations during patient quarantine, support services, bump out, and who is responsible for each of the items under each of those phases.

It appears to me, Ms Alexander --- and tell me if I'm wrong --- that really as far as Alfred Health's engagement in the Hotel Quarantine Program, it's involved in every single phase?

A. Yes.

Q. From before the arrival --- that is, bump in --- before the arrival of the guests into hotel quarantine, all the way through to bump out?

A. Yes.

Q. So an end-to-end delivery model?

A. Yes.

Q. And I don't know if we need to go to them on the screen, but I gather you have the document there. If you turn to page 11 of the document, Ms Alexander, again, we have the governance structure clearly delineated in a diagram, again for the reasons we discussed in respect of the Model of Care document. Do you agree with that?

A. Could I see that on the screen, please, Mr Ihle?

Q. Sorry, yes. Page 11. Yes. Again, clear lines of governance, who is responsible to whom, and how are issues escalated.

A. Yes.

Q. And then turning finally, and I think you said before --- to page 17, turning

finally, I think you said before that the roles and responsibilities as to who was responsible for what at the site was an evolving thing and an iterative process. We see there in all its detail specifically the roles and the descriptions of the responsibilities for each of those roles?

A. Yes.

Q. And again, the importance of that is to make it very clear to all who are involved in the program what is expected of them and what is expected of those around them?

A. Yes.

MR IHLE: Thank you. I tender that document, Madam Chair.

CHAIR: That will become Exhibit 102.

EXHIBIT #102 - ALFRED HEALTH MEMORANDUM OF UNDERSTANDING

MR IHLE: Ms Alexander, is it fair to summarise the role of Alfred Health in the Hotel Quarantine Program as adopting a clinical model of care?

A. Yes.

Q. That, in doing so, it has drawn on its considerable resources and organisational experience in being able to deliver these services from end to end?

A. Yes.

Q. It is hallmarked by strong and clear governance?

A. Yes.

Q. And strong and clear risk control measures?

A. Yes.

Q. Prior to late May, when there was discussion around standing up the Brady Hotel, had Alfred Health been approached by any Government department for its advice or services, other than the telephone welfare checks, in relation to the Hotel Quarantine Program?

A. Not to my knowledge.

Q. Presumably there would have been nothing to prevent you from responding, had

such a request been made, responding in the way that you clearly have responded since that request was first made in late May?

A. Yes.

Q. And you were able to, in just a couple of weeks, stand up a full COVID-positive hotel with a strong clinical governance model?

A. Yes.

Q. One final question, Ms Alexander: are you aware of any outbreaks --- that is, from detainees or guests to staff --- in any of the hotels that Alfred Health has been responsible for its clinical governance?

A. No, I'm not aware of any outbreaks. I'm aware of a couple of positive staff members, but I have no evidence to suggest that that's anything to do with any breakdown of processes or systems within any of the hotels, and I understand that it's as a result of community transmission/close contact.

Q. So, in other words, staff that are working within the hotels have acquired it in the community, not in the hotels?

A. That's to my knowledge, yes.

MR IHLE: Thank you, Ms Alexander. That covers my questions. Can I say that in the --- I said 15 minutes. I was a bit longer than that. I've had a request from your counsel to clarify two matters, and I'd invite Ms Gardner to make that application, Madam Chair.

MS GARDNER: There's just one matter, Chair, that I would seek to clarify. I've tried to put the video on, but the system is not permitting me.

CHAIR: That's all right, Ms Gardner, I can hear you and I assume Ms Alexander can hear you also.

MS GARDNER: Yes, Madam Chair. There's just one point of clarification in respect of the data that I seek leave to raise with Ms Alexander.

CHAIR: Yes.

CROSS-EXAMINATION BY MS GARDNER

MS GARDNER: Ms Alexander, Mr Ihle asked you some questions about Alfred Health's use of consultants, external consultants, who had had experience with the New South Wales quarantine system and the addition of that component of your

team in relation to auditing of infection control processes. Do you recall that?

A. I do.

Q. And when asked, you thought it was at the end of --- in about June of this year that that step was taken. If I could just take you to paragraph 37 of your statement, which is on page 6, there you've deposed that those consultants were engaged in or about --- or they commenced on or about 13 July 2020. Does that assist you with your recollection of when they actually commenced in their role?

A. Yes. Thank you.

Q. Yes.

MR IHLE: Sorry, Madam Chair, can I just take up that? Perhaps I misheard. But the events in paragraph 36 seem to be directed not to external consultants but rather to the provision of Victoria Police providing security services.

MS GARDNER: I was looking at paragraph 37.

MR IHLE: My apologies. I did mishear. Yes. Thank you, Ms Gardner.

MS GARDNER: Thank you. That's the only matter I sought to clarify, Madam Chair.

CHAIR: Thank you. Ms Alexander, just a couple of matters before I excuse you, and one of them was exactly that issue about the use of Victoria Police. I understand there was a change away from the security provider via Spotless to Victoria Police. Firstly, are you able to help me understand why that substitution happened?

A. Chair, I understand that there had been quite a bit of discussion about Victoria Police providing a security-type role in the health hotel, and this discussion had gone over a number of weeks. It wasn't until 13 July that I was contacted by the Department to cease all subcontracted security provision by security agencies with a view that there would be a Victoria Police model coming in.

CHAIR: And by "Department", I assume at that time you're talking about the Department of Health and Human Services?

A. That's correct, Madam Chair.

CHAIR: Yes. And have I understood your evidence correctly that that in fact did happen, that Victoria Police came into the role of security?

A. It did, Madam Chair. They provided a slightly different model to what was in place prior, and so there was a requirement that we used our customer support type officer to provide like a floor monitor type responsibility, because the Victoria Police

model was a roaming model that provided a mobile sort of security presence throughout the hotel.

CHAIR: So just to help me understand that, does that mean there was not or is not a full-time presence of Victoria Police at --- we're talking about the Brady, are we, rather than the range of hotels?

A. The Brady and --- the health hotels, Madam Chair. So the Brady and Grand Chancellor.

CHAIR: Yes.

A. So there is a full-time presence, but the presence is mobile and walks from floor to floor and around the major areas. There was concern raised within Alfred Health that without having someone stationed on each floor, sometimes we were unable to hear escalating behaviours in the rooms or to be able to stop anyone that might want to leave their room and then, you know, get a fair way down to, like, the foyer, because there wasn't that monitoring process. So we implemented a floor monitor type role in order to make sure that each floor had oversight 24/7, and that person was able to call Victoria Police or the Alfred Health team leader for assistance at any point.

CHAIR: This is the on-site presence of Victoria Police?

A. On site, yes, Madam Chair.

CHAIR: And at any given time, how many members of Victoria Police are on site?

A. I'm sorry, Madam Chair, I don't know that answer.

CHAIR: Okay. That's all right. Just one other matter, Ms Alexander. You have given some evidence about --- in the context of contact tracing, that there were significant differences between the way in which Alfred Health did their contact tracing and the system at that time being employed by the Department of Health and Human Services, and you spoke of --- you identified two differences, one with respect to the timeframes, and I understood your answer in the context of that being a difference of days between when individuals were being contacted with respect to possible exposure. But you also indicated that one of the other differences or concerns was the issue about conflicting information. Can I just ask you to clarify for me what you mean by that, the conflicting information, just to help me understand what that is?

A. The conflicting information, Madam Chair, was around how long they needed to furlough and at what point they needed to get a test and then the ability or the process for them to be able to return to work.

CHAIR: So by conflicting information, do you mean there was conflicting

information coming from individuals from inside the Department of Health and Human Services, or the information was conflicting with the view that Alfred Health took about how that should be done? Or both, potentially?

A. I think it was both, potentially. But I can't recall that. It was difference in the information that Alfred Health were giving their employees and the Department contact tracing team were giving Department employees.

CHAIR: And the nature of that difference was?

A. Was around when to get a test and the return-to-work process.

CHAIR: And can you be any more specific about those differences?

A. I can't recall the absolute detail, Madam Chair.

CHAIR: Okay.

A. I could certainly get that and provide that to you.

CHAIR: Thank you. Thank you, I will ask you to do that. Thank you.

Anything arising out of that, Mr Ihle, for you?

MR IHLE: No, there's not. We will follow up with counsel for Alfred Health in relation to that extra piece of information that the Board is interested in. And with our thanks, I ask that Ms Alexander be excused.

CHAIR: Yes. Thank you, Ms Alexander. Thank you for your attendance at the Board, and you are now excused so you can turn your camera and microphone off. Thank you.

A. Thank you.

THE WITNESS WITHDREW

CHAIR: So, Mr Ihle, perhaps before we get the next witness, we will give everyone a 10-minute break whilst the next witness is being arranged. Thank you.

MR IHLE: As the Board pleases.

ADJOURNED **[12.30 PM]**

RESUMED **[12.40 PM]**

CHAIR: Yes, Mr Ihle.

MR IHLE: Thank you, Madam Chair. I call Dr Simon Crouch, and I see that he is already with us, albeit on mute.

CHAIR: Thanks. Dr Crouch, are you able to see and hear us?

DR CROUCH: I can indeed.

CHAIR: Thank you. Dr Crouch, before I hand you back to Mr Ihle, you will need to take the affirmation. So for that purpose, I will ask my associate to administer the affirmation. Thank you, Madam Associate.

SIMON CROUCH, AFFIRMED

CHAIR: Thank you, Madam Associate. Thank you, Dr Crouch. I'll hand you back to Mr Ihle now.

MR IHLE: Thank you, Madam Chair.

EXAMINATION BY MR IHLE

MR IHLE: Dr Crouch, can you see and hear me?

A. I can indeed.

Q. Excellent. Just by way of formal introduction, can you please state your full name?

A. My name is Simon Robert Crouch.

Q. And you are a Senior Medical Adviser in the communicable diseases section of the Department of Health and Human Services?

A. That is correct.

Q. And at some point in the last few months --- we'll go to this in more detail later --- you became the Deputy Public Health Commander of Case, Contact and Outbreak Management; is that correct?

A. That is also correct.

Q. Thank you. Dr Crouch, you provided a statement in answer to a number of questions posed to you by those assisting the Board. Your statement is dated 21 August this year; is that right?

A. That is correct.

Q. It is a 19-page statement with 89 paragraphs.

A. Yes.

Q. And it appears that you have a copy of that there. Now, I understand before we tender that statement there's a couple of matters that you seek to clarify in respect of your statement; is that so?

A. That is.

Q. As I understand it, the first clarification that you seek to make is at paragraph 6 of the statement?

A. Yes.

Q. Can you take us to that?

A. Sure. So in the statement, it states that "The Public Health Incident Management Team ceased to exist in around June 2020", I just wanted to clarify that rather than ceasing to exist, there was a transition to a new structure that involved a dedicated COVID-19 division. The Public Health Incident Management Team did continue alongside that, and I have remained in the Deputy Public Health Commander role within that team at the time as taking on the role of Deputy Chief Officer, Case, Contact and Outbreak Management.

Q. Okay. So this is a all being transcribed, Dr Crouch, so if we were to take that explanation in lieu of what appears in paragraph 6 of your statement, you would be content with that approach, I assume?

A. Yes.

Q. Yes. The second point of clarification, I understand, relates to paragraph 8 of your statement; is that right?

A. Yes, that is correct.

Q. Can you please explain what you seek to add or clarify or amend there?

A. Yes, this is just a clarification. At the time of writing, the statement was true.

However, since the time of writing, the regular meetings that we held as a Public Health Incident Management Team three times a week have ceased in the form that they were being undertaken at the time of writing. So that is the clarification of that point.

Q. Are you able to explain why they've ceased?

A. Due to a transition to a broader operating structure within the Department of Health where there are now a number of dedicated COVID divisions that capture each of the different functions that were held under the Deputy Public Health Commanders within the incident management team, so it's a much broader structure, and there are different meetings happening at different times of the day, but the meetings I was referring to at paragraph 8 no longer occur in that format.

Q. Okay. Thank you for that clarification. I understand there's a final point that you want to raise and it's in respect of the roles of Public Health Commander and Chief Health Officer.

A. Correct, and again this is just a reflection changes since the time of writing my statement. At the time of writing my statement, the Public Health Commander role and the Chief Health Officer role were separate roles. It is probably worth noting that the Public Health Commander role is a delegated role from the Chief Health Officer in any event. However, they have now been recombined that the Chief Health Officer is currently functioning in the Public Health Commander role.

Q. When those roles were divided, who was performing those --- well, we know the Chief Health Officer is Professor Sutton.

A. Correct.

Q. Who was providing the services as the Public Health Commander? Who was that prior to those roles being rejoined?

A. That role has had a few people sitting in it at different times within the response. At the very, very early stages of the response, Dr Finn Romanes was the Public Health Commander, but fairly soon afterwards the Deputy Chief Officer Communicable Diseases Dr Annaliese van Diemen sat largely in that role of the Public Health Commander. However, other people would occasionally fill those roles on days when Dr van Diemen was not available.

Q. Okay. Thank you for that clarification. Are there any other matters in your statement that you would seek to add to, amend or clarify?

A. No.

Q. And taking on board those three matters which we've just discussed, are the content of your statement with those points of clarification or amendments truthful?

A. To the best of my knowledge, yes.

Q. Yes. And they're accurate to the best of your knowledge too, I assume?

A. Yes.

Q. Yes. Thank you. With those points of clarification, Madam Chair, I tender the statement of Dr Crouch dated 21 August.

CHAIR: That will be Exhibit 103.

EXHIBIT #103 - STATEMENT OF DR SIMON CROUCH

MR IHLE: As the Board pleases.

Now, Dr Crouch, just by way of understanding a little bit about your history with the Department, as I understand it, you joined the Department in mid-2016?

A. So I joined the Department in early 2015.

Q. My apologies.

A. Testing my memory now. However, I was in a different role at that time. I joined as a Public Health Medical Officer. I think from mid-2016 was the time when I stepped up into the role of a Senior Medical Adviser.

Q. Yes, thank you. And as we've already covered, at some point in the COVID-19 response from the State of Victoria's perspective, you have filled the role of Deputy Public Health Commander, Case, Contact and Outbreak Management?

A. That is correct. That is the role that I'm currently in.

Q. When did you first step into that role?

A. Again, it is a role that has evolved throughout the response. For the members of the Communicable Disease Section within the Department, we started working on this response in about January and fairly early on, with the formation of an Incident Management Team, I stepped into the role of Deputy Public Health Commander for Operations, overseeing a larger portfolio of operational responsibilities that did include Case, Contact and Outbreak Management within that. Around about 8 April, we established a slightly different structure within the Public Health Incident Management Team, noting the growing intensity of the work across many of the different areas and separated out some of the responsibilities, and that was at that point that the Case, Contact and Outbreak Management was the larger proportion of

the work I was doing as Deputy Public Health Commander.

Q. All right. So sometime in earlyish April?

A. Correct.

Q. Can I ask you, prior to you stepping into that role, as a Senior Medical Adviser, Communicable Diseases, have you been called upon or have you had any input into planning for pandemic or public, large-scale epidemics?

A. In my daily role in the Health Protection Branch I would have occasional involvement in conversations around pandemic planning. It wasn't a significant part of my portfolio of work. There were other people within the branch who really focused on that. But I would have occasional roles in providing input, insight, or supporting various exercises that may have been taking place.

Q. Is it a fair summary, based on that answer, to say that your involvement and input has been on really an informal, ad hoc basis rather than in a formal involvement in any development of pandemic planning?

A. I'd say in the large part, it was not part of my main responsibility. There were times when I would act as the Deputy Chief Health Officer, Communicable Disease, for a week or so, and I couldn't say right now whether in one of those periods I signed off on a particular document or made comments more formally on a particular document, but it wasn't a significant component of my daily responsibilities.

Q. Yes. Thank you, Doctor. Now, as I understand it from your statement in answer to the questions that have been posed to you, your involvement in the Hotel Quarantine Program really has been focused on the management of two outbreaks. Is that fair?

A. That is correct.

Q. And those outbreaks are a matter of some notoriety, of course. There's the outbreak from the Rydges Hotel which was first reported as a positive case in respect of a staff member from the Rydges on 26 May?

A. Yes.

Q. And then in relation to the Stamford Hotel, a security guard has tested positive which was reported to the Department on 16 June.

A. Yes.

Q. And your role in relation to the management of those outbreaks was, initially, at least, as the team leader of the Outbreak Management Team?

A. Yes, I took on that role for the first Outbreak Management Team meeting for both of those two outbreaks.

Q. You were asked some questions and you provided some answers in your statement about the difference between the Outbreak Management Team and the Outbreak Squad. Can you please explain those differences? What is the Outbreak Management Team, what is the Outbreak Squad, and how do they interact?

A. I can indeed. So the Outbreak Management Team as was functioning for both the Rydges and the Stamford outbreak was functioning under the Outbreak Management Plan which I have provided along with my witness statement. The Outbreak Management Team is a team that is brought together to respond to outbreaks as they are identified. Initially, upon assessment, a group is formed when there is a suggestion that there may be an outbreak or a case that could lead to an outbreak. The Problem Assessment Group can then identify whether an Outbreak Management Team is required and who would form part of that Outbreak Management Team. The Outbreak Management Team is led by the Outbreak Lead, usually a medical officer from within my team, one of the senior staff. It also has a case and contact lead, also somebody from my team who is one of the case officers who is responsible for the interviewing of cases and following up close contacts.

It also involves an intelligence representative to provide the epidemiological input to the team, as well as representatives from other areas of the Department and other areas of Government including the Joint Intelligence Unit at the State Control Centre, the DHHS Agency Commander, but also the Outbreak Squad coordinator. The Outbreak Squad coordinator is responsible for bringing together an Outbreak Squad if deemed necessary by the Outbreak Management Team. The Outbreak Squad is able to then go out to the particular site or setting of a given outbreak to provide further information back to the Outbreak Management Team and to provide advice on the ground to that outbreak setting. Usually that role involves providing information and advice around infection prevention and control, primarily around the use of personal protective equipment, but also around the cleaning that has undertaken or should be undertaken in that particular environment.

The Outbreak Squad can also be the eyes and ears on the ground to help follow up on providing rosters for the setting or site maps and other environmental aspects that are useful to inform the management of the outbreak by the Outbreak Management Team.

Q. Tell me if this is a wrong interpretation of the matters that you've covered in your statement, but as I understand it, the outbreak management squad reports up through a different chain of command to the Outbreak Management Team?

A. That is correct. So the outbreak management squads, when they were formed, it was decided that they would report through directly to the Deputy Secretary at that time, who was the same Deputy Secretary that I reported into, but they reported

directly, rather than through the Deputy Public Health Commander, Case, Contact and Outbreak Management.

Q. And who was that Deputy Secretary?

A. At that time it was Jacinda de Witts.

Q. So both you and the outbreak squads report separately to Jacinda de Witts?

A. That is correct. However, in the context of an outbreak, the direction for the outbreak squad within that particular outbreak comes from the Outbreak Management Team and they provide their report back to that Outbreak Management Team.

Q. Okay. And as I understand what you've just described as well, there's an Outbreak Management Team when there's an outbreak, and that team has a leader. And in relation to both of these outbreaks --- that is, Rydges and Stamford --- initially that leader was you?

A. Correct.

Q. The team that you lead includes the Outbreak Squad coordinator?

A. Correct.

Q. And that coordinator, presumably, directs the squad in how they fulfil their function?

A. That is correct.

Q. So in that instance where you were the leader of the team and one of your team was directing the squad, how is it that you have said in your statement at paragraph 34 that you're not aware of the precise manner in which the squad performs its functions and do not know, for example, the protocols under which they operate? Aren't they effectively under your direction?

A. So the protocols that were developed for the use by the Outbreak Squad are all pre-prepared protocols that were provided, developed in consultation with members of my team. However, the fine details of those protocols, of what they do on the ground, in relation particularly to infection prevention and control, were not under my remit as the Deputy Public Health Commander of the Case, Contact and Outbreak Management Team.

Q. If you're, as the team leader, responsible for managing the outbreak, isn't what the people who are doing the work on the ground by way of infection prevention and control --- that is, the squad --- an important part of managing the outbreak?

A. It is an important part of managing the outbreak, and they were following protocols that were developed in close consultation with Infection Prevention and Control Cell, which was a separate part again of the Public Health Incident Management Team. The Outbreak Squad performed functions that were both response functions as well as prevention functions, and so they had a range of documents that were compiled together across a number of different areas of the Public Health Incident Management structure.

Q. But nevertheless, you, as the Outbreak Management Team leader, were not aware, at least at the time of swearing your statement, of the precise manner in which the squad performs its functions and you do not know, for example, the protocols under which they operate?

A. I was not intimately familiar with them, no.

Q. Well, you don't say anything about intimate familiarity in your statement. You say, "I do not know", for example, "the protocols".

A. That is a correct representation.

Q. You don't even know what they are, let alone what they specifically provide?

A. I couldn't answer that question here, no.

Q. Okay. And you couldn't answer it when asked specifically the question in the time you had in which to prepare and provide your statement?

A. I did not have a --- I did not go back and revisit them at that time.

Q. Yes, okay. I want to ask you about the Rydges Hotel. You say that paragraph 42(a) that:

> *A hotel is not an unreasonable place for quarantining of returned travellers. Informally, I would have agreed with colleagues, if it came up, that having a hot hotel .... was also a good idea ....*

First of all, I just want to deal with that answer you provided. Do we take it from there that no one raised with you, as a Senior Medical Adviser in the Communicable Diseases Section of the Department, whether, at the time it was decided to establish a hot hotel, whether you had any input on that question?

A. It was not raised with me in any formal sense. I do recall a conversation with a colleague who was more involved in the processes around setting up the hotel quarantine procedure and providing public health input into that, mentioning that if we had to make a decision on whether it was an appropriate thing to have, a hot hotel, then I felt in my professional opinion that would be an appropriate thing to have, but it wasn't something that was ever asked of me in my function as the Deputy

Public Health Commander for Case, Contact and Outbreak Management.

Q. So just an informal chat with a colleague, "What do you think about this?"

A. Yes, it was a conversation. As peers within the Public Health Incident Management Team, we have our own areas of responsibility and our own areas we are responsible for, however we do draw on each other's public health experience and knowledge to have conversations, to canvass ideas at various different times, and that was one thing I do recall having a conversation about, saying actually, I think of all the different options, that doesn't seem to be an unreasonable option.

Q. Why is that the case? Can you explain to us from your professional perspective why the idea of a hot hotel is, in your words, not an unreasonable option?

A. Yes. Look, I think there were two key things that were informing my opinion on that. I think the first was that by making sure that the confirmed cases of coronavirus are in one hotel, you are providing added protection to those returned travellers in quarantine who are not yet cases and hopefully will not go on to become cases, so minimising the additional risks to them as well as to others, and also in terms of providing the best oversight and public health management of those cases, I think the staff working at the hotel being aware of that would be useful. Having said that, any returned traveller in quarantine should be managed as a suspected coronavirus case, so really all returned travellers in quarantine should be managed in the same way as any one of them could pose an infection risk.

Q. The question you were asked in respect of your statement was drawing your attention --- I appreciate it's difficult --- drawing your attention to a nominal date, being 1 May, and what you would have considered at 1 May. Are the answers that you've given equally applicable today, or has there been some development in your thinking about the idea of a hot hotel between 1 May and 8 September?

A. Look, I think I would say my opinion today is the same as it would have been on 1 May.

Q. Are there any assumptions that underlie the view that a hot hotel is not an unreasonable place in which to concentrate a COVID-positive cohort of quarantined detainees?

A. I think there is an underlying assumption there that the people involved with managing those quarantined --- the isolated, at that time, those isolated travellers, are trained appropriately to manage those confirmed cases and provided the appropriate knowledge and skills to be able to do that effectively.

Q. In another part of your statement, again when your attention is taken to that nominal date of 1 May, in respect of fomite transmission, that is, the transmission of the virus via an inanimate object or even via someone's hand, for example, that you did not consider it a significant source of transmission for local outbreaks. That was

as of 1 May. Is that still your position, Doctor?

A. I would say, and I think I do mention in my statement, that that was prior to the Rydges, and the experience of both the Rydges and the Stamford Hotel has changed my opinion on that more. I think it is fair to say that as of 1 May, I was aware that fomite transmission was a possibility, it is something that can occur, but we didn't have very much evidence from the outbreaks and cases we had seen up until that point in Victoria that it had played a significant role within any of the outbreaks we'd managed to that point. However, with the growing experience of the outbreaks we have managed since then and the various different transmissions that we have looked at, it does appear that fomite transmission plays a larger role than I would have given it credit at that point.

CHAIR: Mr Ihle, I'm going to stop you there and take the lunch break now. So you can return to that topic at 2.00.

MR IHLE: Certainly, Madam Chair.

CHAIR: Dr Crouch, we're going to take the lunch break now. I'll ask you to return at 2.00. Thank you.

A. Thank you very much.

ADJOURNED **[1:04 PM]**

RESUMED **[2.00 PM]**

CHAIR: Yes, Mr Ihle.

MR IHLE: Thank you, Madam Chair. Dr Crouch is back with us, but he's on mute again.

CHAIR: Dr Crouch, you will just need to unmute your microphone, please. Thank you.

MR IHLE: Dr Crouch, just before the lunch break, you gave evidence that, first of all, your opinion on whether the hot hotel model was a good idea, or not unreasonable, to use the term you've used today, would be the same today as it would have been as of 1 May, that it's still, that is, not unreasonable?

A. That is correct.

Q. Something that has substantially changed in your own mind, though, between 1 May and today is the role that fomite transmission can play in relation to outbreaks;

is that fair?

A. Yes, that is a fair representation.

Q. Now, as I understand it, you said that if we looked at 1 May as a point in time, you did not consider fomite transmission as a significant source of transmission for local outbreaks?

A. Correct.

Q. And in regards to fomite transmission there, do you include transmission from, say, someone's hand to their mouth or to someone else's hand to be a form of fomite transmission?

A. No, I'm really talking more about broader environmental contamination rather than contamination from person to person.

Q. Right. Because it would be difficult, would it not, to determine whether a transmission when two people were known to be linked from a COVID perspective, whether that had occurred from a direct droplet dispensing from someone's body to receipt by the other person, or whether it had in fact gone via touching or anything else?

A. Correct.

Q. And indeed when two people from an epidemiological or contact tracing perspective have shared a common space, it's impossible, isn't it, for you really to be able to determine whether the transmission event between them has been direct or via a third, inanimate object?

A. That is correct. It is not possible to determine what the cause was.

Q. So when we say that fomite transmission, at least in your mind, hadn't or was not considered a significant source of transmission for local outbreaks, that's really based on an assumption, is it not, that there's not the involvement of an inanimate object as between person 1 and person 2?

A. Correct. It is based on the observation that the types of interactions that we were seeing were much more of that close personal contact, as we've just discussed, and as I've just highlighted in my statement here, when I am talking about that fomite transmission, it is more a reflection on lingering environmental contamination and surfaces around a facility, for example a quarantine hotel. That wasn't something that I reflected on as being a particularly significant source. But you are correct in terms of that person-to-person interaction, whether it is a droplet from speaking or coughing or whatever, or whether it is contamination of a hand to a face, as you mentioned. That is not possible to determine.

Q. And indeed, that is probably what informed all the health advice that was disseminating well before 1 May about the importance of washing our hands when we've been out in public?

A. Absolutely.

Q. And washing our hands when we've been in close contact with anyone?

A. Correct.

Q. So knowing now what you do about fomite transmission or let's call it, say for example, environmental transmission rather than person-to-person transmission, if that's a phrase you're comfortable with to distinguish between the two, does that influence the level of comfort you have about the hot hotel being a not unreasonable idea?

A. It does not change my opinion. Again, as I mentioned, any of the hotels should be assumed to have potentially positive travellers in them, therefore the precautions being taken in those environments should be essentially the same. So 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.

Q. And indeed that's the case, isn't it, now, knowing what we do about environmental transmission as evidenced by the Rydges outbreak, the importance of cleaning, whether it be at a hot hotel or any quarantine facility, takes on or assumes an even greater mantle of significance?

A. You are correct, the cleaning is important. But I think, just for clarification, the implication of your question, I believe, is that we have made a conclusion that there was environmental transmission at the Rydges, and I just would like to be clear that that was not our conclusion, that there certainly was environmental transmission, the hypothesis was that it was a possibility, among other forms of transmission, that person-to-person spread, as I mentioned previously.

Q. Okay. We'll come to that in a bit more detail later. But focusing now on the question of the hot hotel, or even to adopt your line of thinking, which is the same, may I say, as Professor Grayson's, which is that the standards to be employed in a hot hotel are the same as the standards of any quarantine facility because you have to assume that everyone is infected. Is that fair?

A. That is fair. That is correct.

Q. So when it comes to those types of standards to be employed, you would expect, would you not, that the staff engaged at those facilities were not staff working across multiple sites?

A. It would be my opinion that it would be preferable to have staff that aren't working across multiple sites for the very reason if you do get an outbreak, you are not then spreading that outbreak to other settings, and that is generally our preference in most settings.

Q. You would expect the staff employed in those quarantine or hot hotel settings to be trained in respect of infection prevention control?

A. I would.

Q. You would expect those staff to be well aware of the types of symptoms which may present in the instance that they become infected?

A. Yes, I would, given that our advice at the time was, and still is, with any symptoms you should immediately cease working and go and get tested.

Q. And you would expect that to be part of any engagement of that staff as well, to be an express condition that if you are to be showing symptoms you must stop work immediately and go and get tested?

A. I would.

Q. And you would expect them to have a good understanding of the need for that?

A. Yes, I would.

Q. Yes. You would expect staff working in any quarantine facility, whether it be a hot hotel or otherwise, to be educated in the correct use of personal protective equipment?

A. That is correct. Any staff working in any of the quarantine hotels should be trained in the use of the personal protective equipment that they are being provided with.

Q. How to don and doff the personal protective equipment?

A. Correct.

Q. When it should be used and when it should be dispensed?

A. Yes.

Q. And how it should be dispensed?

A. Yes.

Q. You would not like to see in any of those facilities staff, for example, removing

personal protective equipment and putting it in their pocket when they go on break?

A. That would not be the appropriate way of managing your personal protective equipment.

Q. And, indeed, you would expect them to be educated as to the reasons why that is not be an appropriate way to handle their PPE?

A. Yes.

Q. And you would expect them to be educated as to understand why you don't reuse PPE?

A. Correct.

Q. You would expect staff working in that setting to practise social distancing both at work but also outside of work?

A. I'd expect staff in any setting to be practising social, physical distancing.

Q. Specifically in relation to working in the Hotel Quarantine Program, you would expect staff or you would want to see staff being educated as to the need for social distancing and practising it?

A. Yes.

Q. And you would expect when it comes to cleaning there be appropriate cleaning for a quarantine setting?

A. Yes, I would expect there to be appropriate cleaning appropriate to that setting.

Q. And so that means in respect of common areas where infected people will be passing through, that needs to be subject to pathogen cleaning?

A. Yes.

Q. You would not expect that cleaning to be done by staff who had other duties in the hotel?

A. That is slightly more challenging for me to answer. I think the arrangements about cleaning is, in my opinion, the appropriate person with the appropriate training should be doing the cleaning. If that person does have another duty within the hotel, that may be appropriate. But the person who is doing the cleaning should be trained and be doing that cleaning in the appropriate way.

Q. And the appropriate way includes the use of appropriate cleaners?

A. Using the appropriate disinfectant that would kill the virus, yes.

Q. In your role as part of the Outbreak Management Team in respect of the Rydges outbreak, were you ever able to identify a person or persons who were in charge of infection prevention and control at the Rydges Hotel?

A. I would say at the hotel, no.

Q. In your role as part of the Outbreak Management Team for the outbreak at the Stamford Hotel, were you ever able to identify a person in charge of infection prevention and control at the Stamford Hotel?

A. I was not, no.

Q. As part of the Outbreak Management Team in respect of the Rydges outbreak, it came to your attention that many of the staff there worked across different sites in the Hotel Quarantine Program.

A. That is correct.

Q. There were other staff who worked not only in the Hotel Quarantine Program but worked at other places of work during the time they were providing services to the Hotel Quarantine Program?

A. That is also correct.

Q. It came to your attention that there was inappropriate use of PPE?

A. That was reported to me via the Outbreak Squads.

Q. Was it reported to you that security staff were given one set of gloves and one mask for the whole shift that they were to work?

A. That is my recollection of that time, correct.

Q. And that they were instructed to remove PPE and then use that same PPE either side of taking a break?

A. So my recollection is not very clear of those specifics. However, on reading documents since that time, I'm aware that I received documents with that information in it.

Q. You're aware that security staff at the Rydges Hotel were observed not to practise social distancing whilst on duty?

A. Yes, I am aware of that.

Q. And not to practise social distancing whilst on break?

A. I am aware that that was also reported.

Q. You're aware that certain common areas, including those areas through which infected people would pass, were being cleaned by security staff and hotel staff?

A. Again, that was reported to me at that time.

Q. Now, in your role and in your professional experience, each of those matters I've just listed are factors that contribute to increased risk of transmission from detainees in the quarantine program through to the staff working in the hotel, aren't they?

A. So, many of those factors would increase the risk of transmission from a traveller within the hotel program to staff members. Some of those factors wouldn't increase that risk but would increase the risk of spread among staff members and security guards, so, for example, the security guards not socially distancing with each other doesn't increase their risk of being infected by a traveller but would increase their risk of infecting each other if one of them was unwell.

Q. Yes. All of those things that were reported to you as part of managing the outbreak team are the opposite of what you would expect in a good quarantine setting?

A. I don't know whether the word "opposite" is the one I would use, but they are not things that would be in line with the preferred practices.

Q. And all of these in a setting where you were unable to identify anyone in charge of infection prevention and control at the site?

A. That is correct. However, the engagement that we had with the site was via our colleagues within the Department who were responsible for the hotels, and it was my understanding at the time that they were working through their infection prevention and control teams to rectify the issues that we had identified.

Q. Rectify the issues you identified after the outbreak?

A. Correct. I wasn't involved prior to the outbreak, so this is all after the outbreak.

Q. You say in your statement at paragraph 39 that you formed an early view that environmental transmission --- sorry, I'll go to it. I don't want to misrepresent your words. As at 1 May, you answer that you didn't --- there was not significant evidence of environmental or fomite transmission contributing to the outbreak settings in Victoria prior to May but when you considered the Rydges outbreak in late May, it was the first time you considered fomite transmission as a likely source of transmission.

A. That is correct.

Q. And that's a view that you came to relatively early in the outbreak management process at Rydges, isn't it?

A. It is indeed.

Q. And part of that view was informed by the several and significant problems that we just went through about infection prevention and control practices by those that were working at the Rydges Hotel?

A. That is correct.

Q. And they are all problems, those that we've just gone through, that were identified to you in the morning of 27 May when an Outbreak Squad nurse emailed you at 26 minutes past 8 that morning.

A. I believe the contents were in that email. Given the large volumes of emails I receive on any given day, I can't guarantee I read it at that particular time of day, and I may actually have found out about it through a different mechanism prior to reading that email. But that issue was raised with me certainly on 27 May.

Q. So the first notification you had of one of the staff members being confirmed as a positive case came through to you on 26 May, and that's when the Outbreak Management Team for Rydges was first stood up?

A. That is correct.

Q. And the records will reflect --- we can go to the email if you like, but I appreciate you may not have read it precisely at that time --- that at 8.26 am, the Outbreak Squad nurse emailed a number of people, including yourself, and articulated those problems had been identified.

A. That's correct.

Q. So those problems were identified within 24 hours, even shorter than that, of the first positive test being confirmed; is that right?

A. Certainly within 24 hours of the Outbreak Management Team convening. I'm not sure in terms of in relation to when the first positive test was confirmed. Probably.

Q. Yes. Well, I think the records will indicate, and I'll stand corrected if I'm wrong, that the first positive test result was furnished on 26 May.

A. Yes. It was certainly on the 26th, but I don't know exactly what time. I believe it was on the afternoon of 26 May that that notification came through to the Department.

Q. Yes. And indeed by midday on 27 May, the Outbreak Management Team were aware that there was a second person who had worked at Rydges who had returned a positive test.

A. Around that time, yes.

Q. So within that very short space of time, you were aware of two positive cases of people who had worked at the Rydges Hotel, and you knew of those deficiencies in infection prevention and control as reported to you by the Outbreak Squad nurse?

A. Yes.

Q. And those factors led you to form that early view, did they not, about the possibility of environmental transmission?

A. Yes. Those factors, as well as the --- particularly with that first case, there was no clear interaction between that first case and any of the returned travellers, so the most likely hypothesis was that that first case that we identified had acquired their infection from one of the returned travellers by some mechanism, and so in lieu of the fact that they had had any direct close contact, we did have to give consideration to environmental spread. However, it doesn't negate the fact that there may have been at that point an unidentified and still unidentified additional member of staff who had had direct contact with a returned traveller and then transmitted it through person-to-person spread to that first indexed case. So while at that time on that day, as you have categorised, environmental transmission was relatively high on our list of mechanisms of transmission, we weren't able to rule out other methods of transmission, which is person-to-person spread through unidentified sources.

Q. That was at that stage. Would you say now, and appreciating we can never be certain about these things, certainly not scientifically certain, but even at that early stage, it presented as the most likely form of transmission, did it not?

A. Look, in my statement, I said at that early stage it was a likely consideration. I don't think I am able at this point to look back and say definitively either way, and we have to be open to the possibility that it could have been through environmental contamination, or, as I mentioned, it could have been through an intermediary, unidentified person-to-person mechanism.

Q. Just going back again to that period on 27 May, shortly after being aware of the second case, you were also seized of information around that time, were you not, that the first case, the index case, as you described it, was involved in cleaning at the Rydges Hotel, cleaning common areas to which infected people had been exposed.

A. I was made aware of that, yes.

Q. That was a factor again which leant in favour of the idea of environmental

transmission?

A. It does add to the possibility, noting that they are coming into contact with some of those settings. I think it is probably worth reflecting on, you know, some of the other components that we discussed around the use of personal protective equipment. That is less influential in leaning towards an environmental transmission mechanism, poor use of PPE would equally facilitate transmission person-to-person if not more, rather than environmental mechanisms. So that is the other reason why not all of the evidence points to environmental transmission.

Q. Okay. Perhaps I've overstated things and I don't want to get into a semantic argument. But if someone were to become infected via mishandled PPE, that would be a form of fomite transmission, would it not?

A. It would technically. It would technically, that is correct.

Q. Okay. So you were, as we've identified, the initial Outbreak Management Team leader in relation to the Rydges outbreak, and that outbreak team subsequently compiled an Outbreak Management Plan?

A. Correct.

Q. Is that right, that was ultimately published or concluded on 13 July?

A. I believe that is the date.

Q. So it says, the version I'm looking at, "Updated 14 June. EPI update, 13 July".

A. Yes, that would --- I believe that is the correct version, yes.

Q. Did you have any role in drafting that report?

A. The report is drafted by the teams that work for me, the outbreak leads on any given day. We did not --- I personally did not commence writing that report on the evening of 26 May when I took on the Outbreak Lead role, given that the Outbreak Management Team didn't convene until quite late in the evening and I spent the evening escalating the particular matters through the relevant chains, I believe the epidemiology, the intelligence component, did commence a first version of that report on that evening, as is part of their role, and then the intelligence function, along with the outbreak leads from that point for each of the given days, continued to update that report.

Q. Okay. Have you read the report?

A. I have.

Q. Do you endorse its content?

A. I do.

Q. Do you agree with its findings?

A. Yes.

MR IHLE: I tender that report, Madam Chair, and I ask that it be brought up on the screen. It's document DHHS.0001.0036.0145_R.

CHAIR: Exhibit 104.

EXHIBIT #104 – OUTBREAK MANAGEMENT PLAN – RYDGES SWANSTON DHHS.0001.0036.0145_R

MR IHLE: As the Board pleases.

As that document is being brought up, Doctor, you've indicated that you agree with the findings of the report. In effect, they include findings that, given the infection prevention and control practices at the Rydges Hotel prior to the outbreak, there was a high risk of transmission from COVID-positive cases to staff members working at the hotel. Do you agree that there was a high risk of transmission by reason of the infection prevention and control practices being what they were?

A. Can I request that we look at the particular wording in the report?

Q. Sure. Let's go to page 12. See under "Issues/risks"?

A. Yes.

Q. Perhaps that could be zoomed in on.

A. I actually believe that's in my statement, that section.

Q. Yes. The report, which you have endorsed and agreed with its findings, provides:

> *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.*

A. Correct.

Q. You agree with that?

A. Yes.

Q. The next sentence:

> *This is due to the inadequate education and cleaning procedures that are currently in place.*

A. That is correct.

Q. Then:

> *The cleaning duties of communal areas were the responsibility of the security staff; specifically, for the elevators used to transport COVID-positive cases.*

A. That is information that was reported to me, so I took it as read in the report.

Q. And indeed, going over the page, we'll start with the words here:

> *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.*

You would agree --

A. I would agree with that.

Q. Yes. And you agree with the next proposition:

> *At-risk populations include staff members from the hotel, DHHS staff, nurses, and various other HCWs [healthcare workers] that were on site to attend to the people in hotel detention.*

Do you agree with that?

A. That would be --- yes, I do.

Q. Yes. And dealing with that at-risk population, you came to know throughout your investigation that DHHS staff, nurses, and other various healthcare workers that were on site were working across a number of different quarantine facilities?

A. That is correct.

Q. And you also knew and would agree that an at-risk population included the security staff?

A. Correct.

Q. And they were working across a number of hotel quarantine properties?

A. Again, something I discovered during the course of the outbreak investigation.

Q. So, going back to the start of where we went on page 12. It was identified that the Rydges Hotel presented as a high risk of transmission from COVID-positive cases being detained in the hotel to the staff members in the hotel.

A. Correct.

Q. Specifically "a high risk". Furthermore, there was a high likelihood of fomite spread due to poor cleaning products being used.

A. That is correct.

Q. And the at-risk population that we've identified are a population of people who were working across a number of hotel quarantine facilities?

A. Correct.

Q. Some of them were working across and in other areas not associated with hotel quarantine?

A. That is correct.

Q. Given what we know now, Dr Crouch, it's the case, isn't it, that an outbreak from the Rydges Hotel was not only likely, it was almost inevitable?

A. I would say that given what we know now about the practices that were in place at the time that those initial transmission events occurred, as stated in this report, there was a high risk of transmission of coronavirus from returned travellers to people working in that setting.

Q. Then when we see there's a high risk, as you say, from returned travellers to people working within that setting, given the fact that those workers are working at a number of other facilities, there's a high risk of them passing it on, isn't there?

A. There is a lower risk, but there is still a risk.

Q. Well, the lower risk only arises if the people know what symptoms to be looking out for, when to get tested and when to leave work and furlough themselves. Do you agree with that?

A. That is correct. That is correct, and, you know, it is responsive in part to the isolation of cases as they arise.

Q. We knew as of late May that there was a period in which a person was infective or infectious prior to the onset of symptoms, didn't we?

A. That is correct, yes.

Q. So if symptom onset is the trigger to furlough oneself, if someone's already working in a high-risk environment, there is necessarily a window when they will be infective or infectious without knowing it.

A. Absolutely. The people who haven't been identified as a close contact or already being at risk for being a returned traveller, or for other reasons, prior to symptom onset there is absolutely a period of 48 hours where they are potentially infectious and can potentially infect other people.

Q. Those issues that were identified in relation to infection prevention and control measures --- that is, PPE not being used, who was cleaning what areas, what products were being used --- there was nothing to prevent that identification or identification of those things prior to the outbreak, was there?

A. I can't specifically comment on any barriers in preventing that prior to the outbreak as I was not involved with putting those measures in place, but they are general measures that were reasonably well known to be necessary to mitigate the risk of transmission.

Q. We can take that document down, please, Mr Operator.

When it comes to investigation of an outbreak, you were not just looking at how the staff that worked at the Rydges became infected, were you? You were also looking at how the virus had entered the broader community?

A. In relation to this particular outbreak, we looked at any onward spread into the community outside of the particular setting, that is correct.

Q. And, Doctor, are you familiar with the evidence that's been given to this Inquiry by Dr Alpren and Professor Howden in respect of the number of cases of COVID since the outbreak at the Rydges Hotel that can be linked back to the Rydges Hotel?

A. I'm generally familiar with it.

Q. Are you generally familiar that the effect of that evidence, as best as it's known, is that about 90 per cent of the cases in Victoria since late May are connected back to the outbreak at the Rydges Hotel?

A. I agree that I am aware of that from a genomics perspective, yes, I am.

Q. And are you aware of the number of deaths?

A. I don't have the actual number of deaths to date at hand.

Q. Are you aware, Doctor, that an infection prevention and control consultant was

tasked by the Department to visit a number of hotels, including the Rydges Hotel, in early May?

A. At that time, I was not aware of that. Since then, I have seen some documentary evidence, I believe, that refer to that.

Q. Are you aware that one of the recommendations made by that consultant to the Department was a request that the nursing agency provider ensure that the same staff are rostered at the same hotel for a minimum of the 14 days to cover the entire quarantine period?

A. I was not aware of that specific recommendation.

Q. That would make good sense to you though, wouldn't it?

A. It would make sense to have the same staff rostered at the same hotel for the duration of their time in that program.

Q. Yes. Not just the nursing staff, but all of the staff?

A. Yes, it would make sense to have staff focused on a particular location, yes.

Q. Yes. Do you know if that recommendation was implemented or followed?

A. I do not know for sure whether that was recommended. That was specifically in relation to nursing staff, I recall, from what you just said.

Q. Yes, it was.

A. I'm less --- while I'm clear that security staff were working in a number of different settings, I'm less sure on my knowledge whether nursing staff were working across different hotels. I expect they probably were. I know there were a lot of rostering challenges in terms of getting staff across the whole program.

Q. You're aware, aren't you, that one of the cases from the Rydges Hotel was a nurse?

A. I am aware of that, yes.

Q. Case 6, as referred to in the Outbreak Management Plan?

A. I believed it was Case 6.

Q. And you knew from trying to stem the outbreak or deal with the outbreak that Case 6, that nurse, worked at the Rydges on 24 May? We can go to the plan if you want to see that. But I just put to you that they worked at the Rydges on 24 May and then subsequently worked at the Marriott on 25 and 26 May.

A. Now that you bring it to my attention, yes, I do recall that.

Q. That case, at least, is an anecdotal example of a nurse not being rostered to work at the one hotel in the relevant period.

A. That is correct.

Q. And we know, don't we, from the investigation that your team performed, that that nurse actually ended up being admitted into intensive care?

A. We do.

Q. I think you agreed with me earlier that at least by late morning, if not the middle of the day on 27 May --- that is, the day after the index case was reported from the Rydges Hotel --- that environmental transmission was already presenting fairly highly on the list of potential reasons for that positive test?

A. Yes.

Q. And indeed by that stage, you knew that there was a second positive test?

A. Correct.

Q. You say in your statement at paragraph 61 that when it comes to close contacts, that they all get the same information and guidance which is based on their specific exposure date.

A. Correct.

Q. And in fact, in that same paragraph, you talk about outbreak management being relatively standardised.

A. There are many components of it that are standardised, particularly in relation to the interviews that we conduct with the cases, the identification of the close contacts, and the information that we then provide. In terms of the actual case interviews, they are quite an intensive effort and do require some nuance and skill from the people conducting those interviews to gather the relevant information, build trust and, you know, work through sometimes an hour-long interview. So, yes, they are relatively standardised but it does require some skill to do them effectively.

Q. But significantly, you say that all close contacts are given the same information.

A. That is correct.

Q. Now, by 27 May, you've got environmental transmission rising in your list of --- I'm going to use a term from another area of medicine --- differential diagnoses. It's

getting up there. But you knew at that time, didn't you, that the Rydges continued to be used as a hotel in the Hotel Quarantine Program?

A. I did. I was aware of that, yes.

Q. You were also aware that there was a number of staff coming and going in and out of the Rydges Hotel because the shifts were changing over two or three times a day depending on whether you're looking at nursing or security.

A. Yes.

Q. So every day there's a big influx of staff, and there's also a large number of staff leaving that hotel?

A. I couldn't comment on the numbers, but yes, there is movement of staff.

Q. And they're coming in and out of an environment that you have identified as potentially being contaminated with COVID-19.

A. And as part of the initial Outbreak Management Team meeting, we identified that as a potential risk, and because of that, our initial control measures, as communicated on the evening of the 26th, was to immediate undertake, or as soon as possible undertake, a thorough clean of the setting to mitigate the risk of any environmental contamination that there may have been in that setting.

Q. So that was decided on the afternoon or the evening of 26 May?

A. Correct, on the evening of 26 May, we directed the cleaning to be undertaken.

Q. When was it undertaken?

A. I don't believe it was thoroughly and satisfactorily undertaken until --- I want to say the 28th was when it was finally agreed that it had been done to our fullest satisfaction.

Q. Okay. So you've got environmental transmission rising in your list of probable bases for these positive tests that you're seeing. You have the hotel continually being used, staff coming in, staff leaving, and at least for that two-day period between the 26th, when you said it must be cleaned, and the 28th when you said it was cleaned, that cleaning was not done.

A. That is correct. Well, the cleaning had been done, but not to our full satisfaction.

Q. Was there consideration given at that point, given the high --- well, given environmental transmission rising in the list of probabilities, to actually furloughing all the staff that had been exposed to that environment?

A. So we considered all the different options and at that time, we focused primarily on identifying those who were the likely close contacts. I think it's fair to say that while there was a risk of environmental contamination, it isn't fair to suggest that that environmental contamination was there constantly and ongoing through that entire period, given the clustering of the vast majority of the cases around --- with a symptom onset, a significant number of cases with a similar symptom onset, it is quite possible, if not likely, that there was a contamination event at some place in the hotel, either an environmental contamination, or, as I said, potentially an interaction with an individual person on a date sometime preceding the events of the 26th and 27th. Looking at the rosters of the staff and when people had overlapped on shifts, there is a suggestion that that may have been more around the time of 21 or 23 May.

So, to characterise that there was a constant and ongoing environmental risk and exposure is not really accurate. It doesn't mean it wasn't potentially there. But our key priority was to ensure that confirmed cases were furloughed and their close contacts were identified and also quarantined.

Q. Yes, but you've also got people who are coming and going from that hotel and to other hotels who had worked in that period, that 21st to 23rd window that you were referring to, who were not stood down.

A. Yes, and we were only able to really draw our attention to that 21st to 23rd period as more cases emerged and we were able to gain a clearer picture of the likely time course from the incubation period for those cases. So just with a single case, we weren't able to pinpoint to a specific time.

Q. Well, even that specific time that couldn't be pinpointed but the general time, you could identify people that had worked at the Rydges Hotel, even if the environmental risk had evaporated, notwithstanding no proper cleaning in that time, you were in a position to be able to identify people who had worked and tell them to isolate, weren't you?

A. That is something that we potentially could have done. Again, looking back at that time, how we manage outbreaks today is different. There is greater understanding of the potential for spread of the virus and the need to close settings and furlough staff is a much more common process today across many countries, as well as Australia. At that time, it was not standard practice to have a single case, as it was initially, or two cases, and furlough the entire workforce. It was much more common practice to focus on the close contacts of those people who have been identified as being exposed to the confirmed cases.

Q. And notwithstanding that the risk of environmental transmission was rising in your mind as a potential explanation here, you continued to look at close contacts of people who were confirmed positive cases?

A. We continued to do that but also continued to consider the other components and as the Outbreak Management Plan shows, we moved towards widespread --- we

engaged in widespread testing very early on to see what else was going on and move to furloughing and quarantining a large proportion of staff as more information became available.

Q. Did you consider the concept of close contact with the environment?

A. When we moved to the definition of close contact being an exposure site contact, that is what we are talking about in terms of an exposure site contact being a close contact. It's because there is something at that site, possibly environmental exposure, that we are unclear of or unsure of and so therefore we move to a definition that involved 30 minutes' exposure to that site over a given period of time.

Q. And are you familiar with the statement of Dr Looker?

A. Not really.

Q. Okay. That statement has been tendered this morning. It's marked Exhibit 97. And perhaps if that statement might be brought up, Madam Chair.

CHAIR: I don't know if it helps to give a document ID. Oh, here it comes.

MR IHLE: Specifically, Dr Crouch, we were talking about decisions that were being made with the information available as of 27 May. We just introduced that concept of close contact with the environment being 30 minutes or more. And I wonder if we might bring up page 7 of that statement. Paragraph 34. And if we can hone in on subparagraph (c). Now, just to put this into context, Dr Crouch, and we can go back and check this if you want, but paragraph 33, which commences at the bottom of the previous page, is under the heading "Wednesday, 27 May 2020". Dr Looker says:

> *I worked alongside Dr Crouch on 27 May, who was in the role of DPHC-CCOM.*

And then we see paragraph 34 at the top of page 37. Do you see there at (c):

> *All staff who had been on site for 30 minutes or more from 11 May 2020 (14 days prior to symptom onset of cases 1 and 2) were notified and asked to undergo testing (i.e. such staff did not meet the definition of close contact but we considered it appropriate to include them acquisition testing)....*

First of all, do you agree that that accurately reflects a decision that the Outbreak Management Team made on 27 May?

A. I presume it is a decision that was made on that date. I wasn't in the Outbreak Management Team meeting. I do know there was a step-wise, I do recall there was a step-wise movement from initial testing of only close contacts to a broader spread of testing, and my recollection was this would probably represent an accurate representation of the decision on that date.

Q. And this decision reflects, does it not, the concern held by the Outbreak Management Team as at 27 May that environmental transmission from 11 May to 25 May might be the reason we were seeing cases 1 and 2, at least at that stage?

A. It does reflect that as a possibility, but it does also capture the possibility that during that period, there was an unidentified case that these people had been exposed to. So it does reflect both of those two components.

Q. Why were the staff that had been on site for 30 minutes or more not told to go into isolation at that point?

A. So at that point, there wasn't sufficient evidence to deem them as clearly close contacts of a confirmed case, and while we have discussed and characterised the environmental risks, it was rising in likelihood, but it wasn't our only source of investigation. So I don't think at that time, there was enough evidence to require all of these staff over that period to go into quarantine.

Q. Well, not at least until they got the results of that testing?

A. So quarantine would be while they were waiting for the testing. So if they got the results and became a case, then they'd be going into isolation. I'm sorry, I'm not sure I grasped that question.

Q. Well, I'm really trying to understand, Dr Crouch, why, given the risk, appreciable risk, let's not even say high risk but the appreciable risk that people had been exposed to COVID-19 between 11 and 25 May, working in the Hotel Quarantine Program, going home to their families and loved ones, working in other sites within the program and other places, were not told, "There is a risk, an appreciable risk you've been exposed; you need to now isolate." Why were they not told that?

A. So, I think it's important to reflect on the decisions as they have been made at the time, rather than necessarily with the lens of all the information we have now, and the conclusion as we worked through --- in the Outbreak Management Plan of that high risk was a conclusion which was drawn with all the facts at the end of that outbreak, having been through the evolution of all of the cases at that time. At this stage in the response, where there were two cases who may have shared a similar contact with an exposed --- with a case, I don't believe at that time there was sufficient evidence to strongly say environmental exposure was the cause and that everybody who had worked over a given period of time would have to go into quarantine.

Q. Faced with that decision, and I appreciate you weren't making this decision, from your evidence earlier, but faced with that decision again, with that same information available, do you expect that the Outbreak Management Team would have made that same decision?

A. The decisions that the Outbreak Management Team would make today would likely be different based on our experiences across a number of outbreaks and a number of situations and a number of settings, including the Rydges outbreak but also other outbreaks since then.

Q. Yes. Thank you. If we can jump ahead now --- if we can leave Dr Looker's statement there, because we'll go to it again. But we can jump ahead to 29 May, so some two days later. By that stage a third case had emerged from Rydges, had it not?

A. That is correct.

Q. And if we turn to page 8 of Dr Looker's statement paragraph 39, you will see that Dr Looker identifies three agreed actions of the meeting on that day.

A. I can see those, yes.

Q. Were you part of that meeting?

A. I believe not. I'm sure I was not.

Q. Okay. If we can scroll down to paragraph 41, now, that same day, a fourth COVID-positive case emerged from Rydges.

A. Yes.

Q. Were you aware that a fourth COVID-19-positive case had emerged from Rydges on the 29th?

A. No, I think I should clarify, and we didn't get to this in the opening remarks. The role that I fill is a role that I share with Dr Clare Looker to cover the full span of the week, and generally I work on a Sunday-through-Wednesday roster with Dr Looker and crossing over on a Wednesday, and Dr Looker covering the Thursday, Friday, Saturday period, and I believe this was all happening on a Friday, which was a day I was not rostered to work.

Q. Okay. You're aware, though, from when you did come back to work that there was a fourth case that emerged on 29 May?

A. Correct.

Q. And if we scroll to paragraph 47 of Dr Looker's statement, indeed, there was a fifth and a sixth case that emerged on that same day.

A. That's correct.

Q. Now, surely by that stage, if not earlier, the risk of an environmental source of the

transmission is becoming even more likely. Do you agree with that?

A. No, I don't agree with that. No, I don't agree with that assessment. We will commonly see a rapid increase in case numbers with exposure to a single case. It doesn't negate the fact that environmental exposure may have been the cause. However, it is just as feasible with an increasing number of cases on a given date that those people were all exposed to a similar source case on a similar previous date, and that's actually the much more likely pattern that we see with outbreaks, is a similar exposure to a previous case rather than a similar exposure to an environmental setting.

Q. We knew, though, by that time, did we not, that some of the positive cases had not even worked at the same time at the Rydges?

A. My understanding --

Q. Perhaps if I take --

A. Sorry?

Q. Go on, I'm sorry. Sorry, I spoke over you.

A. That's okay. Again, revisiting my notes, my recollection is that of these first six cases, I believe they did all share similar shifts either --- on 21 and/or 23 May, is my recollection.

Q. When you say "similar shifts", are you saying that they worked concurrently, they worked at the same time?

A. I believe --- my recollection is I believe they all worked on a night shift over that period, or perhaps overlapping with that night shift.

Q. Okay. Perhaps if we just scroll back up to paragraph 43 of Dr Looker's statement then. In fairness I just want to put this to you and see if it refreshes your memory. So dealing at the point in time where there were only three positive cases, again, that was early on the day of 29 May:

> *We also learnt that the three positive COVID-19 staff cases had all worked on 23 May.... but on different shifts.*

A. Okay.

Q. Now, that would tend --

A. So, as I say --

Q. That would tend, would it not, in favour of an environmental source?

A. Again, potentially, but not necessarily. My memory was --- again, I wasn't there for this particular decision-making process or these particular meetings, but having reviewed the notes, I thought that I had reviewed that they had worked on similar shifts. However, we were aware of there being shift cross-overs and handover times. I can't comment right now without going and revisiting the documentation, as to whether these different shifts did have any overlap. But if there is any one person who does overlap with these shifts, then that is quite possible that that one person is someone who is transmitting. Likewise, they may have been exposed to the same resident within that quarantine setting, albeit across different shifts, so again, a person exposed to it. Because I believe at this time we were not yet aware of the links to a specific resident within the quarantine hotel.

Q. But you had been provided advice that in respect of those three positive cases, they each denied direct contact with any quarantine guests?

A. I believe that was their information at the time.

Q. If not earlier, wasn't that the point then, to stand down all the staff that had worked at least on the 23rd?

A. I think we had already put in place measures to do a significant amount of testing. Whether that was sufficient to be stepping down all of the staff from the 23rd, I am not sure. As I said, I wasn't there at that time and across all the information that they had at that point to be able to make the decisions that were being made.

Q. Doctor, do you accept that there was a lost opportunity to try and stem the further outbreak of the virus that had come from the Rydges Hotel to the community at large over the course of that four-day period from the 26th through to the 29th?

A. If the --- sorry, can you repeat those dates? The 20 --

Q. The 26th, being the date on which you first --- sorry, I'll just ask that the document come down.

A. Yes.

Q. The 26th is when you're first notified of the positive case at Rydges. The 27th, second positive case. By the 28th, 29th, you know of a third case. And by the end of the 29th, you know of six cases.

A. Yes.

Q. You know at that time that not all of them have worked at exactly the same time. Isn't that the point, if not earlier, to say, "Hang on, this is too risky"?

A. So, yes, I would agree in retrospect, looking at what we know now in relation to

those cases, and as I said, I wasn't there with the information at that time that was to hand, it would make sense, with what we know now, to quarantine the staff working across that period.

Q. And not only quarantine them from the Rydges Hotel, but quarantine them from working at other hotels?

A. Yes, if we were to quarantine them, we would quarantine them, and that would be from any setting, as required for anybody in quarantine.

Q. Including from interacting with their family?

A. Yes, when people are in quarantine, they are quarantined from their families.

Q. Including telling them not to travel on public transport to and from work?

A. Correct.

Q. And not attending social gatherings and the like?

A. Correct. When people are in quarantine, they are quarantined within self-isolation protocols.

Q. So, coming back to the question that I asked before, that was a lost opportunity in that window, wasn't it, between the 26th and the 29th, to make more decisive and definitive decisions about limiting the spread of COVID-19 from the Rydges into the community?

A. So if there were a broader group of staff who were quarantined at that time, that may have helped prevent wider spread of the virus. However, noting that a number of the people who were isolated and quarantined among this group were somewhat less than forthcoming in terms of the information they provided to us in relation to other close contacts, and so a lot of what was undertaken was hampered by the information that we were able to get from those cases and other close contacts.

Q. I understand what you say about that, but if you order these people into quarantine, that's it. You don't need to worry about close contacts thereonwards, because they're in quarantine.

A. When people are in quarantine, that is correct. However, we are aware that a number of the cases, and as you've highlighted yourself earlier, those cases would have been infectious for 48 hours prior to their symptom onset, had already exposed a number of close contacts, and we were very keen to make sure that they were being quarantined to try and stem that broader community spread, as you have indicated, and that is where we faced a lot of challenges in terms of getting that accurate information.

Q. Doctor, going back through what we now know, as per the Outbreak Management Report, there was, to use the language of the Outbreak Management Report, 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, and a high risk of transmission from COVID-positive cases being detained in the hotel to the staff members working at the hotel. Given that fact, given the fact that environmental virus particles, if there were any, were around at the hotel probably between 21 and 23 May, given that the hotel did not undergo pathogen cleaning until 28 May, and that there was a daily influx and deflux of a large number of staff, do you agree that once COVID-19 got from the detainees into the staff, it was inevitable that it would spread into the community?

A. I would agree that there would likely be further spread, at least among close household contacts of those staff. I would not necessarily agree that we would have --- it was inevitable --- I would not necessarily agree that it was inevitable that it would then spread into the broader community.

Q. No? What do you say about the suggestion that the best way to stem that flow of COVID-19 once it's made its way into the staff cohort is to quarantine that staff cohort?

A. I think there is a point where quarantining the staff cohort becomes appropriate.

Q. And do you say that that point was not reached between 26 and 29 May?

A. I think on 29 May, I think there was sufficient evidence to be doing broader quarantining of staff.

Q. Doctor, to your knowledge, were the staff that worked through that window --- that is, 21 to 23 May --- were they ever put into quarantine?

A. I cannot --- I don't think I can answer that question now. I might have to take that on notice.

Q. Okay. Well, please do and let us know the answer.

Madam Chair, that concludes the questions that I have for Dr Crouch. Can I indicate that I have been contacted by counsel on behalf of MSS Security who I understand have some questions, and I have also been contacted, albeit not until just before court this morning, by counsel for Unified Security. So perhaps if I first call upon Ms Robertson to make her application on behalf of MSS.

CHAIR: You're on mute, Ms Robertson.

MS ROBERTSON: My apologies, Madam Chair. If the Court pleases, I don't propose to persist with the application that I foreshadowed to Counsel Assisting.

CHAIR: Thank you.

MR IHLE: That being the case, perhaps Ms Alderson on behalf of Unified.

MS ALDERSON: Thank you, Counsel Assisting. Madam Chair, we're in the same position and no longer press our application.

CHAIR: Thank you. Thanks, Ms Alderson.

MR IHLE: Sorry, I should indicate that Mr Woods did contact me late last night about this matter as well, and I think there's a matter that he seeks to clarify if it requires clarification.

MR WOODS: It's only a brief issue, Madam Chair, and it just is a matter of clarification about staff members or others on behalf of my client, obviously the owner of the hotel. I just want to clarify paragraph 51 of the witness' statement briefly, if I may.

CHAIR: Yes, I'll grant you that leave, Mr Woods.

MR WOODS: Thank you, Madam Chair.

CROSS-EXAMINATION BY MR WOODS

MR WOODS: Dr Crouch, at paragraph 51 of your statement, you set out some evidence regarding transmission from the returned traveller family to people who were working at the hotel. You're familiar with that evidence?

A. Yes.

Q. Now, you say it's not known whether or not it was Case 1 or others who were the first person to become infected. Is that still the situation?

A. That is still the situation. We haven't identified an additional person who may have been infected prior to the person named as Case 1, but it doesn't mean that there wasn't an asymptomatic case or other person.

Q. I understand. And at paragraph 51, and indeed on a number of occasions during your evidence today, you've used the term "staff members" when describing those early cases at Rydges. When one looks at the Outbreak Management Plan and some other documents that are before the Board, it's clear that one of the cases was technically a staff member of Rydges; the others were either security guards or a nurse of those first six. You accept that only one of them was a staff member?

A. I do, and apologies if I inferred otherwise.

Q. No, that's quite all right. I think you were using the term broadly. I just wanted to clarify.

That's all I had. Thank you, Madam Chair.

CHAIR: Thanks, Mr Woods.

MR IHLE: Yes, Madam Chair. There's nothing arising from any of that for me. Unless the Board has any questions for Dr Crouch --

CHAIR: No.

MR IHLE: --- may we thank him for his time and excuse him?

CHAIR: Yes. Thank you, Dr Crouch. Thank you --- oh. Ms Harris?

MS HARRIS QC: Madam Chair, I'm sorry. My learned junior, Ms Knowles and I are going to both seek to tender all of the documents that were referred to in the statement of Dr Crouch and also had perhaps a question in re-examination.

CHAIR: Yes, Ms Knowles?

MS KNOWLES: [Indistinct].

CHAIR: Yes. We are having difficulties hearing you, Ms Knowles.

MS KNOWLES: Is that better?

CHAIR: Yes.

MS KNOWLES: Thank you, if the Board pleases, I appear on behalf of the Department of Health and Human Services.

CROSS-EXAMINATION BY MS KNOWLES

MS KNOWLES: Dr Crouch, you were asked whether or not, given what you know now, whether there was a difference in getting all the information. Did you --- and you were also asked about the period on the 28th and 29th. Firstly, who was making the decisions on behalf of the Outbreak Management Team on the 28th and the 29th?

A. I was not working on that day, so my understanding is that the Outbreak Management Team lead was Dr Sarah McGuinness reporting in to the Deputy Public Health Commander on that day, who was Dr Clare Looker, but again, would have been working --- I expect would have been working closely with the Public Health

Commander on those days and I don't have the roster in front of me to know who the Public Health Commander was on those days.

Q. And you were also asked about the cleaning, and that cleaning occurred on the evening of the 28th. What relevance is that in terms of determining what controls apply prior to the 28th or after the 28th in relation to staff who might have worked prior to the 28th?

A. Yes. When we were making decisions around --- when the team was making decisions around the measures in relation to the staff, that period of the 28th was taken into account as the definitive control measure, so the testing recommendations and quarantining and further recommendations used that as one of the time points to guide those decisions.

Q. You were also asked about overlapping shifts. Are you aware of the table at the end of the Outbreak Management Report that includes the shifts that worked for the first six cases?

A. I am aware of that table, and that was the one I was referring to in my memory, but I haven't got it in front of me right now.

Q. And to your knowledge, the shift information for 23 May is accurate, isn't it, in terms of the fact that those shifts indicate an overlapping shift for the first six cases? I think you weren't sure if it was the 21st or the 23rd. There's shift information in that table in relation to those first six cases for the 21st, working in some shifts, but certainly for the 23rd, that that was in fact, as you said, an overlapping shift. Is that consistent with your knowledge?

A. That is consistent with my knowledge and that was information as it was provided to us by the relevant parties.

Q. And you were also asked in relation to what is otherwise referred to as cohorting. Did you have an opportunity to look at Dr Looker's statement when it was up in relation to paragraphs 44 and 47, and I might ask if the operator can bring it up. It's DHHS.9999.0011.0001.

Were you involved in this decision as to whether to require staff to not in fact work at other premises if they had worked at the Rydges from 11 May?

A. Not on that particular date, I don't believe I was involved with that specific decision. I do recall one of our very early directions to staff was to cease working across different sites. I believe that was even reported in an email that was --- I believe it was an email communication on 26 May as one of our key actions out of the first OMT for staff to immediately stop working at other sites.

Q. And in relation to any staff that did work in the relevant period, being from 11 May, is it the case that all of those staff were tested?

A. My understanding is that they were all retested. It was a requirement for them to test negative to be able to return to work.

Q. So does the table at the end of the Outbreak Management Report include all of the staff that worked at the Rydges Hotel that in fact returned a positive test for Rydges, being eight people?

A. Sorry, just to clarify the question, are you asking out of all of the staff who had worked at the Rydges Hotel, be it Rydges staff or other staff, that only eight of them tested positive? Is that your question?

Q. Yes.

A. Yes, that is --- that is true.

Q. Just one moment, please.

They are my questions, if it pleases the Board.

CHAIR: Thank you. Perhaps if that document could be taken down now, please.

MS HARRIS QC: Madam Chair, there's an issue with that witness and also with respect to the statement of Dr Looker, that because those statements were prepared referring to a number of documents as an integral part of the statement, we tender all of the documents that were referred to in each of the statements. Those documents have been provided to the Board like the statements of other witnesses, in exhibit folders on the online hearing book so they can be readily tendered in a similar way to those of other witnesses, and it may be just convenient to do that with Dr Crouch now.

CHAIR: Any objection to that, Mr Ihle?

MR IHLE: I do query the utility of it. I don't object per se. It's a matter really for the Board as to whether it would be of assistance to the Board to receive the number of documents that are referred to in every statement. Of course, with those statements that have been tendered this morning, only those documents that were to be seen as significant and relevant to the Board's work have been tendered, and that's been on a discriminating or discerning basis. I note that, for example, if one just looks at Dr Crouch's statement, there are some 32 footnotes. The last of those references 10 separate documents. And by way of another observation, Dr Crouch cites at footnote 27 minutes to a meeting that he didn't even attend. I do query the utility of that process being adopted, also considering how much material is already before the Board. If there's something specific, then the witness ought be taken to it, in my respectful submission.

MS HARRIS QC: Madam Chair --

CHAIR: Ms Harris, are there particular documents that you're concerned to bring to my attention in that bundle?

MS HARRIS QC: Really, Madam Chair, it's all of them. With other witnesses, they've been given an opportunity to say, "Did you prepare your statement in conjunction with a number of documents that really need to be read to understand the statement fully?" That opportunity hasn't been given with respect to Dr Crouch. We say that all of the documents that are referred to are responsive to the questions that were asked by the Board of the witnesses, and, for example, to take the example given by Counsel Assisting of the last footnote where there is a series of references to minutes, that's directly responsive to the question:

> *In respect of meetings concerning the outbreak at Rydges .... Carlton conducted by the Outbreak Squad, were notes or minutes taken? If so, please identify when such meetings occurred and who was present at them. In addition, please provide copies of any notes or minutes of that meeting.*

Now, that's one specific example, Madam Chair, but each of the things that are referred to have been carefully considered by the witness in the course of preparing their statement, and we submit that, as with other witnesses, this witness should be given the opportunity to tender the statement, along with the documents that have been annexed to that statement, to make quite clear to the Board the full context of the evidence in his statement. And if we were put to the task of having to demonstrate the relevance of each individual document, unlike the practice that has been adopted in other cases, that would be a very time-consuming exercise.

CHAIR: So I assume, Ms Harris, that you, for the purposes of final submissions, want the opportunity to be able to refer to those documents as part of the tender?

MS HARRIS QC: We certainly do, Madam Chair. We want to refer to the totality of the witness' statement. For that reason, we will be making the same application with respect to the exhibits to Dr Looker's statement, and with any other witnesses that are called that have been preparing witness statements in response to the notices to produce statements from the Board which have specific questions that are answered by reference both to the content of the statement and the documents that are provided with them.

CHAIR: All right. I will mark those --

MR IHLE: In that regard, Madam Chair, can I just make one other observation.

CHAIR: Yes.

MR IHLE: There will be a huge amount of duplication if this is the process to be adopted. For example, footnote 15 to Dr Looker's statement are the minutes of the Outbreak Management Team meeting on 28 May, with a specific document

reference. That is the first document referred to at footnote 32 of Dr Crouch's statement. So we're, of course, in the hands of the Board and whatever the Board would consider to be of most assistance, but there will be a large overlap if this wholesale approach is to be adopted. I understand there is already 10,000 pages in the hearing book for these three days of evidence. That's what we're looking at if this approach is to be adopted.

MS HARRIS QC: Madam Chair, if I can, the potential overlap is necessarily in many cases a response to the fact that the questions that have been asked of some witnesses are overlapping questions, and there would, in my respectful submission, be a very significant unfairness to the DHHS witnesses if this approach were now taken, when it has not been taken to other witnesses who have been permitted to have their statement tendered along with all of the exhibits and documents that they refer to as an integral part of that statement. So we do press that.

CHAIR: Yes. No, I accept that, Ms Harris, and I understand how it's being put, that whilst there will be some duplication, that the way in which the documents have been attached is to make sense of the particular statement attached to the particular witness in the context in which the evidence is given. So with respect to Dr Crouch's statement, I'll mark as Exhibit 105 the bundle of documents attached to that statement.

EXHIBIT #105 - ANNEXURES TO STATEMENT OF DR SIMON CROUCH

MS HARRIS QC: Thank you, Madam Chair. Do you require us to make a separate application of any sort with respect to exhibits to the statement of Dr Looker that was tendered this morning? We do make the same application, that all documents referred to can be a separate exhibit to that statement.

CHAIR: Yes. Perhaps for my own benefit, so that I don't lose track of the attachments to Dr Looker's statement, I might mark that bundle as Exhibit 98A. At the moment, Exhibit 98 is an email to Dr Looker of 29 May. So 98A will be the bundle of documents that form the attachments to her statement.

EXHIBIT #98A - ANNEXURES TO STATEMENT OF DR CLARE LOOKER

MS HARRIS QC: Thank you, Madam Chair.

MR IHLE: If the Board pleases.

CHAIR: Sorry, Dr Crouch. You are actually now formally excused, so thank you for your attendance at the Board and you can turn off your camera and your microphone.

A. Thank you.

CHAIR: Thank you.

THE WITNESS WITHDREW

MR IHLE: Madam Chair, the next scheduled witness is Dr Sarah McGuinness. I do note the time, but it might be convenient in the circumstances just to take a very short break because arrangements will need to be made in respect of the witness scheduled after Dr McGuinness, who looks unlikely to be called today.

CHAIR: Yes, all right. We will take a short break whilst arrangements are being made. Thanks, Mr Ihle.

MR IHLE: If the Board pleases.

ADJOURNED **[3.25 PM]**

RESUMED **[3.33 PM]**

CHAIR: Mr Ihle.

MR IHLE: Thank you, Madam Chair. The next witness is Dr Sarah McGuinness. As Dr McGuinness is making herself available, can I just perhaps state that which is obvious. The witness that was to be called after Dr McGuinness, being Professor Wallace, will be unable to be accommodated today. I understand there's a number of enquiries being made as to his availability over the balance of the week and hopefully by the end of today we will be in a position to land on a time and date on which he will be called. But it obviously will not be today.

CHAIR: All right. Thanks.

MR IHLE: I call Dr Sarah McGuinness.

CHAIR: Dr McGuinness, you are actually on mute at the moment. Thank you. Are you able to hear and see me?

DR McGUINNESS: Yes, Madam Chair.

CHAIR: Thank you. Dr McGuinness, I understand that you wish to take the affirmation for the purposes of giving your evidence?

DR McGUINNESS: That's correct, Madam Chair.

CHAIR: All right. To that end, I'll just hand you over to my associate whilst that's done.

DR McGUINNESS: Thank you.

SARAH McGUINNESS, AFFIRMED

CHAIR: Thank you, Dr McGuinness. I will hand you now to Mr Ihle. Thanks, Mr Ihle.

MR IHLE: Thank you.

EXAMINATION BY MR IHLE

MR IHLE: Dr McGuinness, can you see and hear me?

A. I can.

Q. Just by way of formal introduction, can you please tell us your full name?

A. My name is Sarah Louise McGuinness.

Q. And your current occupation?

A. I am a medical practitioner.

Q. Thank you. You've provided a statement in relation to a list of questions that were posed to you by those assisting the Board of Inquiry; is that right?

A. Yes, that's correct.

Q. That's a 29-page statement dated 21 August this year?

A. Yes.

Q. Do you have a copy of that statement there with you?

A. I do, yes.

Q. Excellent. Are the contents of that statement truthful?

A. To the best of my knowledge, yes.

Q. And are they accurate?

A. Yes.

MR IHLE: I tender the statement, Madam Chair.

CHAIR: Exhibit 106.

EXHIBIT #106 - STATEMENT OF DR SARAH MCGUINNESS

MR IHLE: In preparation of that statement, did you have regard to a number of documents that you have referred to throughout your statement?

A. Yes.

Q. And do you seek that those documents be incorporated so as to be read with your statement or at least your statement read in light of the contents of those documents?

A. Yes, that was my intent.

MR IHLE: Madam Chair, that being the case, I would tender all documents referred to in the statement of Dr McGuinness dated 21 August.

CHAIR: And that bundle of documents will be Exhibit 107.

EXHIBIT #107 - ANNEXURES TO STATEMENT OF DR SARAH McGUINNESS

MR IHLE: As the Board pleases.

Dr McGuinness, you identified yourself as a medical practitioner. What's your usual place of practice?

A. So my usual appointments are at Monash University as a lecturer in clinical epidemiologically and researcher, and at Alfred Health as a visiting medical officer in the Department of Infectious Diseases.

Q. Thank you. I understand at some point you were seconded as a Senior Medical Adviser to the Department of Health and Human Services?

A. Correct. That was on 15 March 2020.

Q. And in that role you were employed in the Case, Contact and Outbreak Management Team?

A. That's correct. Initially, as Dr Crouch earlier explained, I was part of the operations team within the Public Health Incident Management Team, but when the Public Health Incident Management Team structure was revised on around about 8 April, then I was part of the Case, Contact and Outbreak Management team.

Q. Thank you. So you worked in that team both in respect of the Rydges outbreak but also in respect of the Stamford outbreak; is that fair?

A. Yes, that's fair.

Q. And that was the extent, and I don't mean that pejoratively or critically, but that was your involvement in the Hotel Quarantine Program: looking at the outbreaks from the quarantine program?

A. Correct. I was not in any way involved in hotel quarantine prior to being involved in the outbreak [indistinct].

Q. And not since?

A. And not since.

Q. Yes. Thank you. Do you still have any engagement with the Department of Health and Human Services?

A. I completed my agreed contract term on 31 July 2020, and I don't have any current role in the Department.

Q. Yes. Thank you. Dr McGuinness, have you been shown or are you familiar with Dr Looker's statement that she's provided to the Inquiry?

A. I have only had a chance to briefly look at it today, but yes, I am briefly familiar with it.

Q. I just want to read to you part of it, and we can bring it up, if necessary, but at page 18, paragraph 85, Dr Looker states as follows, and she's referring both to Stamford and Rydges:

> *For both outbreaks, there were various household and social contacts that became infected. The genomic evidence that is presently available indicates a broader spread of the virus most likely through unidentified infected cases from household or social contacts of cases.*

You see that there in paragraph 85?

A. Yes.

Q. I appreciate that you're no longer working in that role in the Department, but does that accord with your understanding of the outbreaks and how we saw the virus go from detained person to staff in the Hotel Quarantine Program to household and social contacts and then to the broader community?

A. Yes. My recollection is that primarily, it was household contacts that became infected. But I am aware of at least one social contact.

Q. Yes. And then that the broader spread of the virus most likely occurred through unidentified infected cases from those household or social contacts but then to the community?

A. Yes, there is genomic evidence to support that.

Q. So in essence, you agree with that statement from Dr Looker?

A. Yes.

Q. Yes. Thank you. And if we could, whilst we have Dr Looker's statement up, go then through to paragraph 86, which has quite a bit of material in it. But I want to ask you --- perhaps I'll put the emphasis on it:

> *In both the Rydges and Stamford Plaza outbreaks we know that there was further transmission from hotel staff to their household and social contacts. Many of these household cases had previously been identified by the staff member as close contacts, however [and this is the part I want you to focus on] it is likely that there were additional unrecognised transmission events from the staff cases to unidentified contacts or from these household and social contacts to other individuals.*

Is that consistent with your understanding of the case contact tracing that has been undertaken?

A. Yes, I believe there were instances where contacts were not identified to us by the cases.

Q. Yes. And just going on down two further lines:

> *A key limitation that arises in outbreak management is that the information relied on to inform actions depends on both the quality of information gathered from cases and the information about contacts that is available from other sources such as staff rosters.*

Do you agree with that statement?

A. Yes, I agree with that statement.

Q. Okay. And going about eight or nine lines from the bottom:

> *In a number of the households associated with these outbreaks, household members were not well known to each other and/or undertook shift work at different times of the day to each other.*

Was that your understanding of the evidence that was yielded from the epidemiological data that was being obtained?

A. Yes, I am aware of specific instances where that was the case.

Q. Yes. And that makes case contact tracing much more difficult, doesn't it?

A. It does.

Q. When you have people that are living in the same household but are not well known to one another?

A. It does, yes.

Q. Perhaps if we can just go ahead to page 21. Dr Looker starts paragraph 95:

> *With the benefit of hindsight, it is apparent that the use of private security guards may have contributed to the outbreaks.*

Do you agree with that statement?

A. Yes, I would agree to the extent that there were attributes of that group of guards that made it --- or perhaps meant that they were less health-literate, and there were potential language barriers to them fully understanding and comprehending the level of infection control required, the need to physically distance and so on.

Q. And there were other factors, were there not, such as those that Dr Looker refers to in the very next sentence:

> *In both outbreaks, the IPC outbreak nurses observed PPE and hand hygiene practices below the appropriate standard.*

A. Yes.

Q. And:

> *In addition, the contact tracing efforts were impeded by a workforce [that is,*

the security workforce] that often worked in multiple jobs and many cases lived in large or dense housing.

A. Yes.

Q. That made outbreak management considerably more difficult, didn't it, the fact that they were working multiple jobs and that many of the cases lived in large or dense housing?

A. Yes.

Q. Dr Looker goes on:

Social and health vulnerabilities in the security guard cohort meant that many of our usual outbreak control measures were more difficult to implement and have success with.

Was that your experience?

A. Yes, I would agree with that statement.

Q. And just jumping ahead past the example that Dr Looker gives:

The workforce was also largely casual and so many had and were required to have more than one job to sustain themselves and their families. They were also a young, fit and socially active cohort and tended not to seek testing even if symptomatic....

That was your experience as well?

A. Yes.

Q. From an outbreak management perspective, it was probably the very worst cohort of people to have to try and identify close contacts and then contain them, wasn't it?

A. I wouldn't agree that it was the very worst. I would perhaps characterise it by saying it was a particularly vulnerable cohort.

Q. Yes. Sorry, that's a much more erudite and accurate way of saying it than I did.

The fact that these people --- that is, that vulnerable group --- were employed as the frontline supervisors, if you like, to ensure that people stayed in quarantine, presented itself as a considerable difficulty once the outbreak occurred. Would you agree with that?

A. I would certainly agree that it made it more difficult to contain the outbreak.

Q. Ye

s. And that's something that, from an outbreak management perspective, even if you were standing at the very start of this Hotel Quarantine Program and looking forward, you would identify that cohort of workers as one that would make case contact and outbreak management very difficult by reason of all of those things that we've just gone through?

A. It was never my role to consider or I should say that my responsibilities at the Department didn't involve considering how the quarantine hotel should be set up. I think it's easy to say in retrospect that this was a very vulnerable cohort that potentially precipitated the spread of COVID and inhibited control of this outbreak. It's difficult for me to say that, you know, without the benefit of hindsight, that would have been identified as an issue at the outset.

Q. That's fair enough. Let's move to paragraph 97 then, if we may. Let's move away from the characteristics of that cohort of the workforce. Let's look at the structural influences that were at play:

> *The use of multiple contractors for functions also created a complicated environment for contract tracers.*

Was that your experience?

A. Yes.

Q. Then:

> *Usually, there is a single source of information relating to a site, typically a workplace, it is the employer.*

Were you involved in the outbreak management at Cedar Meats?

A. To some extent, yes.

Q. So that was a case, was it not, of a single employer and you could identify all of those people by reason of contacting that employer?

A. For the most part, yes, although even in the setting of Cedar Meats, there were additional people who would be on site at any given time, for instance meat inspectors, who would belong to other organisations.

Q. Going back to what Dr Looker says:

> *However, in the hotel quarantine there were a number of stakeholders including the hotels, security companies, contracted nurses and doctors, guests and multiple Government departments.*

First of all, as a statement of fact, you wouldn't quibble with that, I assume?

A. No, it was certainly the case where there was not one single source of information available for all of those work groups, so the team needed to interact individually with each of those staff and contractor groups to get the information required for the investigation.

Q. Yes. Did I hear correctly earlier that you say you have an appointment at the Alfred Hospital?

A. Correct.

Q. Were you able to observe the evidence from Ms Alexander this morning?

A. Most of it, yes.

Q. Yes. And so do you understand the effect of her evidence to be that at least in relation to what she considered the clinical services, but broadened that, I suppose, to include security, cleaning and the like, that all really funnelled through from a single point, being Alfred Health? Did you understand that to be the part of the evidence that you heard, at least?

A. Yes. However, my understanding was that that all funnelled through Alfred Health at a point after these outbreaks occurred.

Q. Yes. From a contact tracing perspective --- before I finish that question, I'll ask that the document be taken down. From a contact tracing perspective, and the management of any outbreak, that is a scenario which makes your job as an outbreak management practitioner much more --- easy is probably the wrong word, but much less complicated, doesn't it?

A. When there is a single source of information, yes, that does make our work easier.

Q. Can we turn to the Stamford outbreak. As I understand from Dr Crouch earlier today, he was the original outbreak lead, but at some point you and another were the leads for that outbreak management?

A. Yes, that's correct.

Q. He also explained to us the difference perhaps between Outbreak Squads and Outbreak Management Teams, and that is that the Outbreak Squads, although directed by a coordinator in the Outbreak Management Team, ultimately reported through a different chain of command?

A. Yes, that's correct.

Q. The Outbreak Management Report, which has now been included in the bundle of those documents that have been tendered as Exhibit 107, that's a report with which

you're familiar, I assume? That is, the Stamford Plaza outbreak management plan.

A. Yes.

Q. Were you one of the authors of that report?

A. Yes, I was. So the outbreak management plan, I guess the bespoke outbreak management plan for an individual outbreak is a living document that's updated daily and eventually becomes the written Outbreak Management Report for that outbreak.

Q. Yes.

A. So it's the responsibility of both the Outbreak Lead, which is the role that I was employed in, as well as the Epidemiology Lead within the Outbreak Management Team to ensure that that report is updated regularly as information comes to light. So the version that you would be looking at is the complete version with all of the evidence from the investigation, but there were previous versions of that document which contained the information that had come to light at that point in time.

Q. Thank you, that's helpful. So the version that I'm looking at says on the cover page "OMT Lead updated, 25 June; EPI updated, 19 July".

A. Yes. My understanding is that's the latest version of that document.

Q. Fantastic. So we are looking at the latest and greatest. Do I assume then that you, much like your statement, agree that its contents are truthful?

A. Yes, to the best of my ability.

Q. And you agree with those contents?

A. Yes.

Q. And you endorse its conclusion?

A. Yes.

MR IHLE: I'm not sure whether there's any value in tendering that separately, Madam Chair. I'm content to adopt whichever approach you prefer.

CHAIR: It's not necessary to tender it separately, Mr Ihle. It's already in.

MR IHLE: As the Board pleases.

Much like the outbreak management at Rydges, upon being notified that a security guard who had worked at the Stamford Plaza had returned a positive test for the virus, the Outbreak Squad were sent in very quickly; is that right?

A. That is correct.

Q. And very early on --- first of all, the notification in relation to the positive test was received by the Department and the Outbreak Management Team stood up late in the afternoon or late in the day on 16 June?

A. Yes, that is my understanding.

Q. Yes. And perhaps I'll ask that the document be brought up. It's referred to at footnote 21 of your statement. It's DHHS.5000.0076.5215_R. We might have to zoom in on that a little bit. That's an email dated 17 June at a few seconds before 2 pm, and you're one of the addressees on that email.

A. Correct.

Q. Do you recall receiving this email?

A. I recall reading this email. I couldn't say for sure what time I read it, as I received many emails a day during my work at the Department.

Q. This is, in effect, the immediate report of the Outbreak Squad back up the chain to you in the Outbreak Management Team and to others about the key concerns that had been identified that day.

A. That is correct.

Q. Those concerns included, at point 1:

> *The staff of this hotel and MSS Security staff are not adequately educated in hand hygiene and PPE.*

A. Yes.

Q. Then:

> *Their work is not visibly readily zoned for safe containment of COVID-19 cases, suspected cases and quarantined close contacts.*

A. Yes.

Q. And then we see below the paragraph that has redacted parts to it:

> *Security guards who all attended a gathering of 70 people including now confirmed cases need to be assessed for possible exposure and quarantined and all be instructed in PPE and hand hygiene.*

A. Yes.

Q. This is sort of the first information you're receiving from those tasked to investigate what's going on at the ground at the Stamford?

A. That is correct.

Q. Now, that would have echoed, would it not, about the poor infection prevention and control practices, at least some of them, that you had observed at the Rydges Hotel some weeks earlier?

A. That's true.

Q. Was that, from an outbreak management perspective or even just from a general medical perspective, a matter of some concern, that the lessons from the Rydges were not being heeded at the Stamford?

A. Yes, given that the investigation at the Rydges had identified those issues and had attempted to put in place actions to mitigate those risks, it was disappointing that these issues were still ongoing in the hotel quarantine environment.

Q. And these issues were not only disappointing; they were actually concerning, given that the reason for this visit was the fact that one of the people who worked at that venue, a venue that was not a COVID-positive hotel, had returned a positive test for COVID-19?

A. Yes. Although I would point out --

Q. And going down --

A. Sorry, I would point out --

Q. No, go on.

A. --- that in any quarantine hotel, there is the potential for anyone to be a case of COVID-19, and in fact at all quarantine hotels, cases of COVID were identified. It was just that at the time when they were identified as positive cases, they were then transferred to the COVID-positive hotel.

Q. Indeed. And that echoes the evidence from Dr Crouch but also from Professor Grayson about the need to treat all quarantine environments just the same as you would a positive hotel or a COVID hotel, because you just don't know who's got it.

A. Correct.

Q. Just going down on that email before we move away from it. See "Problem: Risk

of fomite and person-to-person cross-contamination: security guard room to room housing, nursing, PCA & DHHS staff". What did you take that to mean? First of all, can we break it down, "security guard room to room housing, nursing, PCA & DHHS staff".

A. So I believe it's all part of the same sentence, so there is a risk of both fomite transmission, so transmission through inanimate objects such as surfaces and door handles, lift buttons, et cetera, but also person-to-person transmission, and I believe the cross-contamination refers to the fact that the security guards may move from room to room, including to the rooms that house the nursing, PCA and DHHS staff.

Q. And the reference perhaps earlier to "not visibly readily zoned for safe containment", et cetera, et cetera, that's one of those needs, to have designated green areas, red areas, places where you can go with PPE, places where you ought not go. Is that what that's talking about there?

A. So I think the concept of zoning is as you've said, having clean and dirty zones where certain areas are designated as clean and things like, for instance, rubbish or meal trays that had come from a quarantined person's room should not be in the same space as, you know, freshly prepared meals and clean sheets, for instance.

Q. Going to the next paragraph where a name is redacted and on the second line, a specific role is redacted, the Outbreak Squad nurse is reporting back to you:

> *Today I saw [a DHHS officer] inside security guard room handling paperwork with [and there's a role described there] before returning to the room with nursing PCA and DHHS staff.*

What did you take that sentence to mean and why was that important information for an Outbreak Squad nurse to be relaying to you and others?

A. I took that to be an example of the potential for cross-contamination between the different employee groups working at the hotel, so the hotel staff and contractors. So the potential for there to be person-to-person and fomite transmission between those different staff groups.

Q. And the person who's being identified there as potentially posing that risk from that one area to the other is the DHHS officer?

A. Yes.

MR IHLE: That statement is already tendered as part of the bundle --- sorry, that email, so I won't tender that, but we can move away from that for the moment. That can come down.

Dr McGuinness, in your statement, you provided an answer to a specific question about, "Did you have any reservations about any aspects of the Hotel Quarantine

Program generally or as administered at the Rydges Hotel Carlton or as administered at the Stamford Plaza Hotel at any time? If you did, what were your reservations and to whom, if anyone, did you express them?"

At paragraph 94, you've said:

> *My main concern related to inadequate cleaning and infection control processes. I expressed my concerns to Operation Soteria.*

When did you form that main concern?

A. I'm not sure that I can pinpoint an exact date. It was certainly a concern that developed over time as more evidence came to light about how the hotels were operated and the cleaning and infection control practices that were happening within that environment.

Q. You say that you sent Operation Soteria recommendations about cleaning and guidelines for cleaning and disinfection, and you've cited there an email that you sent on 29 May.

A. Yes, that is correct.

Q. So in answer to the question about when you formed those concerns, does that suggest that you formed them on or before 29 May?

A. I would suggest that I thought that it was important that cleaning was addressed on 29 May. Whether I was aware of the extent to which cleaning was a concern at that time, I cannot say.

Q. Okay. But in any event, there's that record which is an email that you sent on 29 May, and that was a time at which you were dealing most significantly with the Rydges outbreak.

A. Correct.

Q. And that was some 2.5 weeks before the outbreak at the Stamford had emerged?

A. Correct.

Q. Excuse me for a moment.

You were asked a question about your knowledge about transmission of COVID-19 as at 1 May. And in answer to that question, you've deferred to the WHO guidance from late March.

A. Yes.

Q. That's at paragraph 27.

A. Throughout the pandemic, it was my practice to be familiar with the most up-to-date guidance released by public health bodies, and that would include the guidance of the WHO; guidance of the Communicable Diseases Network of Australia, which releases national guidelines for public health units; and also the DHHS Case and Contact Management Guidelines for Health Services and General Practitioners.

Q. You've set out, though, in answer to that question a quote from the WHO Guidance dated 29 March:

> *Transmission may also occur through fomites in the immediate environments 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.*

Now, that's advice from the WHO identified from 29 March.

A. Yes.

Q. When the --- well, first of all, you're asked about 1 May. That was your source material as at 1 May, amongst others.

A. Yes.

Q. And then so when the outbreak at the Rydges occurred, that was one of the possibilities you were entertaining as part of the Outbreak Management Team, and that is fomite transmission?

A. Correct.

Q. Did you watch all of Dr Crouch's evidence from today?

A. Yes, I did.

Q. He seemed to be suggesting, and if you disagree with my summary of it, he seemed to be suggesting that the evidence around fomite transmission, which I call environmental transmission, was not so strongly indicated --- again, I'm making a meal of his evidence --- but it was something he came to appreciate more readily in the wake of the Rydges outbreak. Was that how you understood his evidence?

A. I believe what Dr Crouch was trying to portray is that in previous outbreak investigations that had been run through the Department of Health, fomite transmission had not been thought to play a large role in transmission as primarily the outbreaks we had managed to that point had occurred within household settings,

you know, gatherings of people, some small workplace settings, and generally I think fomite transmission was something that was recognised to be more of an issue in healthcare settings and settings where common equipment or, you know, common devices might be used across different people.

Q. Okay. So when we look at the Rydges, you identified in your statement at paragraph 60 that the first four contacts denied close contact with one another and with any guests.

A. Yes, that is correct.

Q. That, amongst other information, led you to a view, did it not, that fomite transmission was very possible?

A. Certainly fomite transmission was possible in that context, but it was also possible that person-to-person transmission was occurring, because it is entirely possible that people don't recall interactions of close contact with others and/or don't disclose those periods of interaction. And it's also possible that people are exposed outside of the workplace, and we have to consider all of those possibilities when investigating an outbreak such as this.

Q. At the conclusion of your involvement in the Rydges outbreak, though, you regarded, did you not, that person-to-person transmission was less likely than an environmental source?

A. I think certainly for the initial group of cases that an environmental source seemed likely. But I couldn't definitively state that that was the cause of all the forms of transmission.

Q. Madam, I appreciate that, and lawyers always want someone to speak in definites, and I appreciate that that's not something a responsible doctor or scientist can do. But if we were to compare the probability --- I'm not putting a figure on it, but if we were to compare the probability of person-to-person transmission versus environmental at the Rydges, environmental is more likely, is it not?

A. It's really very difficult to say. Part of the problem is that COVID is a disease for which people may be infectious before they develop symptoms, and the disease is often minimally symptomatic and in some people is not symptomatic at all. So there is always the possibility that there was an undetected case that was the source of transmission that we never, you know, were able to identify. But I think the likelihood of an environmental source, there is certainly a likelihood that there is an environmental source, given what we knew about the circumstances in terms of infection prevention and control, and also given several of the staff members had similar symptom onset dates, which might suggest a common source of exposure, although it is possible that that was a person rather than the environment.

Q. Yes. Look, I apologise if it seems I'm trying to trip you up or push you into

a position you're not comfortable with. Let me read to you from your statement and see if you stand by it:

> *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.*

Do you stand by that comment?

A. Yes, I stand by that comment.

Q. So what you're saying there is person-to-person, less likely than environmental?

A. In the case of the Rydges outbreak, I stand by that statement.

Q. Yes, thank you. And then when we go to look at the Stamford outbreak, there are two potential opportunities for the outbreak to have occurred there: person-to-person or environmental. But that's one which ultimately you can't say one is more or less likely?

A. Yes, and I think in the context of the Stamford outbreak, there are a few things that made person-to-person transmission more of a possibility than perhaps we saw in the Rydges outbreak. For instance, we did have documentation as you showed just before of large gatherings of security guards in a single room where up to 70 people were in a room not appropriately physically distanced. So that provided the opportunity for that sort of person-to-person transmission to occur.

Additionally, there were reports of people car-pooling and several people who car-pooled were detected as positive cases. So there were possible person-to-person transmission events identified there that weren't identified in the Rydges context.

Q. Yes. Coming back to Rydges and this idea about it being environmental, that likelihood, person-to-person versus environmental, and environmental ultimately being more likely, that's something which was directly connected to your concern around cleaning, was it not?

A. I would say that cleaning is only one component or one consideration when it comes to environmental transmission. I think, you know, it's important to get a history from each of the cases, and the fact that none of the cases were able to recall an incident where they'd had close contact with a case also weighed in on the possibility that it was environmental. The clustering of symptom onset dates in the cases also potentially supported that hypothesis. So I think there were several factors.

Q. You yourself and the Outbreak Management Team were pushing quite strongly in relation to there being a thorough clean, a bioclean, indeed, of the Rydges from the 26th?

A. Yes, that is correct.

Q. And for reasons that were beyond your control, it was not undertaken until late in the day on 28 May?

A. Yes, and I would qualify that by saying, as Dr Crouch did earlier, that it was not that no cleaning was conducted until that time; it's just that cleaning wasn't conducted to our satisfaction with an appropriate level of cleaning and disinfection until that time.

Q. And indeed as part of the outbreak management investigation, not only was the cleaning not adequate, it was actually itself posing a risk of spreading fomites around the hotel?

A. Yes, that's fair.

Q. And that's why, in your statement at paragraph 49, you say that that delay rendered the site an uncontrolled site for longer than it may have otherwise been and ultimately required a greater number of people to self-isolate.

A. So, yes, what I meant by that statement was that the cleaning and disinfection was designed to mitigate the risk of environmental transmission, and as per the evidence Dr Crouch gave, we can't definitively say when that environmental risk occurred and whether it was persistent. But by, you know --- it wasn't until the hotel had been cleaned and disinfected that we could be confident that the environment did not pose an ongoing transmission risk to staff.

Q. So you could only be confident that the environment did not pose an ongoing transmission risk after it was cleaned on 28 May in the afternoon or evening?

A. Yes.

Q. And, in fact, you, as I said before, were quite insistent, sending emails including, through 27 May, that this happen "ASAP, tonight"; that is, the clean?

A. Yes, and I believe I followed up some of those emails with phone calls.

Q. On 29 May --- so we've got 26 May, where it's notified --- 26, you say it needs to be cleaned. Not cleaned. Followed it up on the 27th on the email and follow-up phone calls. Subsequently cleaned on the 28th. You identified in an email of 29 May that you --- that is, when I say "you", you the plural --- "We are concerned that environmental transmission may be happening at Rydges." And you go on to recommend that there be at least daily cleans of the common areas.

A. Yes.

Q. Do you recall those emails? We can bring them up if it would remind you.

A. No, I can recall those emails.

Q. You said that the cleaning has to occur in consultation with IPC, so Infection Prevention Control?

A. Yes.

Q. At least daily?

A. Yes.

Q. Now, this is the email that we referred to earlier where you notified Operation Soteria of your concerns and the cleaning. Do you recall we referred to that earlier in your evidence?

A. Yes, I do.

Q. And you were trying quite insistently at that point to emphasise the need for cleaning, especially given that the Rydges Hotel was a hot hotel?

A. Yes. I think my insistence for cleaning would have applied to any quarantine hotel environment, but yes.

Q. And in that email, you were trying to be as helpful as possible, and indeed you actually attached cleaning guidelines to the email. Do you recall that?

A. Yes.

Q. And they're cleaning guidelines that you had been provided with on infection prevention and control from the Department?

A. Yes, they're cleaning guidelines that had been prepared by the infection control team within the Department.

Q. Yes. Can we please bring up the attachment to that email. It's DHHS.5000.0105.5942_R. Dr McGuinness, just to put this again in context, you're dealing with the outbreak at the Rydges Hotel. You're insisting on the importance of daily cleaning. You're sending an email to Operation Soteria saying it needs to be at least daily. And infection prevention and control give you this document so you can be as helpful as possible to Operation Soteria. Is that right?

A. Yes, that's correct.

Q. Okay. If we can just turn over to the second page. There's discussion here about "Routine cleaning and disinfection". Were you providing this to give guidance as to

routine cleaning and disinfection being that daily clean?

A. Yes, that was the intent.

Q. If we can go to "Routine cleaning and disinfection":

> *Workplaces should routinely (at least daily) clean frequently touched surfaces ....*

That's what you wanted Operation Soteria to do?

A. Yes.

Q. See the final line there:

> *Where available, a disinfectant may be used following thorough cleaning.*

That's not particularly insistent, is it, "a disinfectant may be used"?

A. No, that's not particularly insistent.

Q. If and if we then go down the page. Zoom out, if we can, from there. Under the heading of "Use of personal protective equipment (PPE) when cleaning":

> *Gloves are recommended when cleaning and disinfecting. Use of eye protection, masks and gowns is not required when undertaking routine cleaning.*

That's below the standard that you would have expected to be provided to you by infection prevention and control at the Department in respect of the cleaning you were talking about, wouldn't it?

A. So perhaps I should qualify here that this was provided as an example of guidelines on cleaning and disinfection. It's since come to my attention that an alternative cleaning and disinfection guideline specifically developed for the Hotel Quarantine Program had been actually given to Operation Soteria and DJPR at an earlier time point.

Q. So in your email, though, the covering email, you say "Attached are the current DHHS guidelines for cleaning and disinfection".

A. Yes. So these are the current DHHS guidelines for cleaning and disinfection in, I believe, workplaces and construction sites. But it has since come to my attention that separate advice was prepared specifically for the hotel quarantine environment, and that that advice had been provided to the appropriate people prior to this email being sent.

Q. I did want to ask you about that. Because if we go back to page 1, this document, which you say you were provided by infection prevention and control at the Department for the purposes of this helpful email you were sending to Operation Soteria, is one that provides it's for building and construction sites. Is that the document you were given by infection prevention and control to forward on to Operation Soteria?

A. I cannot specifically say that I was given the document. I believe I was referred to the website and told that the information was there, and I selected the link.

Q. Okay. And perhaps there may have been other links that were not selected?

A. That's entirely possible.

Q. Thank you. That document can come down. Going to the Stamford outbreak, the first case was notified on the evening of 16 June.

A. Yes.

Q. And it was resolved that there would be, and indeed there was done, a full clean of the hotel the following day.

A. Yes.

Q. Upon Outbreak Management Team being stood up on 16 June, all staff from the Stamford Hotel, whether that be hotel staff, nursing staff, security staff, were all stood down with immediate effect, were they not?

A. I believe that was not put into effect until 17 June.

Q. Well, you recall a letter from Dr Crouch dated 16 June which went to all staff?

A. Yes, and I believe that was to ask all staff to undergo testing.

Q. We can go to the letter if you want to. I'll read it to you:

> *A thorough clean will take place at the hotel at 17 June. Once complete, any staff who have worked since 1 June will not be allowed to work at the hotel while the Department undertakes its investigation.*

A. Yes, but that does not mean that they will be quarantined. I'd have to make that distinction. So asking staff not to work at a hotel is not the same as asking staff to quarantine.

Q. So are you saying that it was at least implicit in his direction that the staff who had been at the hotel since 1 June were free to go and work anywhere else?

A. No, I'm not saying that. I'm just saying that the direction given is that the staff should not work at the hotel. It doesn't give the direction that the staff should quarantine.

Q. Well, you know that at least the GPs that had worked at the hotel were all ordered into immediate quarantine, don't you?

A. I would have to check my records of that.

Q. Okay. We'll go to that in a moment. But I just want to go to it. If you want, it's in Dr Looker's statement and we can pull it up if you need to, but paragraph 57 on page 12. Dr Looker provides that the meeting was convened that evening, being 16 June. Number 1:

> *Full clean of the hotel as soon as possible tomorrow. All staff who have worked since 7 June will be stood down in the first instance and only new staff will be allowed to staff the hotel.*

A. Yes.

Q. And I appreciate you say being stood down from the hotel is not quarantined.

A. Yes.

Q. Then:

> *All staff to be tested that have worked since 1 June.*

A. Yes.

Q. Now, that's a significant point of distinction, isn't it, in the way in which the Stamford outbreak was handled compared with the way in which the Rydges outbreak was handled?

A. Yes, I would agree.

Q. And indeed, we know, don't we, that in relation to the Stamford outbreak, there was a much greater number of staff that worked at the hotel who were infected as a result of whatever transmission event that they were exposed to?

A. There was certainly a larger number of cases amongst staff, yes.

Q. There were 26 security guards from the Stamford who became infected?

A. Yes.

Q. Including security and nursing staff at the Rydges, there were seven?

A. I believe there were eight at the Rydges, including hotel security and nursing.

Q. Eight? Okay. Well, what I want to suggest is that the swift and decisive action that was taken at the Stamford, notwithstanding that there were many, many more workers that were infected as a result of that outbreak, was much more effective in limiting the on-spread of the disease into the community. Would you agree with that as a proposition?

A. Look, I would qualify that by saying that every outbreak offers opportunity for learning and improvement, and the Rydges outbreak was the first hotel quarantine outbreak that we had dealt with in Victoria, and indeed it was one of the first hotel quarantine outbreaks in a global sense, and there was not a great deal of knowledge or evidence to support the public health management actions to be taken in that setting. I think what we did for the Rydges outbreak, you know, really responded to the evidence that we had at the time and our knowledge of transmission of COVID at the time. And because of our learnings from the Rydges outbreak, we took faster and more decisive measures in the Stamford outbreak.

Q. Okay. So let's just go through the facts, then. Eight staff, on your count, at Rydges tested positive to COVID?

A. Yes.

Q. From the on-spread from those staff, we have 90 per cent of the cases since June in Victoria?

A. The genomic evidence supports that 90 per cent of them are linked, yes.

Q. Since 24 June, there have been 655 people die in Victoria as a result of COVID infection.

A. Yes.

Q. The Stamford, by contrast, 26. More than three times the number of staff were infected.

A. Yes.

Q. Less than 10 per cent of the current cases in Victoria can be linked to that outbreak.

A. Yes.

Q. You must agree with the proposition that the management of the outbreak at Stamford was much more effective in stemming the community transmission of COVID-19 than was the Rydges, for whatever reason.

A. It appears that way, yes.

Q. Just finally, Dr McGuinness, I asked you before about the quarantining of staff from the Stamford Hotel. Now, you're aware that the staff from Stamford Hotel were quarantined, aren't you?

A. Yes, and I believe that decision was made on 17 June, to quarantine --- to tell staff that they needed to quarantine for a period of 14 days.

Q. Yes. Within less than 24 hours of the notification of the first positive test?

A. Yes.

Q. That direction was never given to any of the staff at Rydges unless they were considered a close contact?

A. That is incorrect.

Q. That's incorrect? So all of the staff at Rydges were told to quarantine, were they?

A. Yes. On 30 May we made a decision to quarantine all staff who had attended the site of the Rydges for 30 minutes or more who worked between 18 and 28 May.

Q. Okay. Thank you. So on the 30th?

A. On 30 May, yes.

Q. Okay. So there we have it, the point of distinction, do we not?

A. It is one --

Q. There we have it.

A. --- point of distinction, yes. But I would argue that the information we had at the time that the Rydges Hotel outbreak happened --- you know, it's very easy to say in retrospect with all of the information in black and white in front of you and the benefit of time and knowledge of how the outbreak has progressed, but at the time, I think we made a decision that balanced the public health risk with the potential impact of the measures that were being taken, and in the case of the Rydges, to quarantine all staff would have resulted in the hotel no longer being able to operate and the need to rapidly relocate a large number of hotel guests, and in fact after the staff were quarantined, they did actually need to relocate those --

Q. They did.

A. --- guests to another hotel.

Q. On 1 June.

A. So there were potential consequences and impacts to those measures that needed to be balanced against what we understood about the public health risks. And so, you know, eventually a decision was made to quarantine the staff, and I think that was appropriate, but we acted on the information that we had at the time.

Q. Yes, I understand that.

A. And we learned from the experience of the Rydges Hotel and what we understood about the spread by acting much more quickly and decisively in the case of the Stamford outbreak.

Q. So the case is, I suppose you're saying, that "We learned where we didn't do things as well as we might have with Rydges, and we employed those to good effect at the Stamford"?

A. Look, I think we have to acknowledge and understand that this is a new disease that we are still learning about, and that there wasn't one cookie-cutter approach that we could apply to every setting that was always going to work effectively. And we had not had a hotel quarantine outbreak before this outbreak at the Rydges happened. So we were doing our best to draw the lessons from outbreaks that had happened in other settings and apply them in this setting. And with what we know now, I think we might have acted more quickly and decisively in that context, but at the time, we did the best we could with the knowledge that we had.

Q. No one is suggesting that you were not acting in good faith, Doctor, and I want to make that very, very clear. But I'll ask you the same question that I asked Dr Crouch. That delay between 27 May and 30 May in deciding to quarantine the staff that had worked at Rydges, do you agree that that was an opportunity now appreciable as being lost to more effectively control the outbreak that occurred at that hotel?

A. I agree that if we had implemented quarantine of those staff earlier, it may have had an impact. I wouldn't agree that it necessarily would have had an impact, but it may have had an impact. But I think that would have been one of only many measures that could potentially have been looked at, and in particular looking at the spread within household environments which we saw there was onward spread to households, would also have been an important aspect.

Q. Yes. I just want to ask you, you were sent an email on 21 June by Dr Garrow. Do you know who Dr Garrow is?

A. Yes, I do.

Q. And he attached to that email a document that had been prepared by one of his

GPs who was then in quarantine because they had worked at the Stamford Hotel. Do you recall that email?

A. I do recall that email.

Q. And that email, the attachment provided a number of suggestions from a doctor who had been on the ground at the Stamford Hotel.

A. Yes.

Q. Suggestions included the need for PPE induction of staff working at the hotel, enforced sanitation, and protocols for the recognition and proper testing of people who might be infected.

A. Yes. And I believe all of those things reflected the comments that were made by the infection control nurses who visited on site as well.

Q. Yes, so when you received that email from Dr Garrow which attached to it those suggestions from a medical practitioner who had been on the ground, did you pass them on?

A. I certainly passed on the intent, and the suggestions I guess were bundled up with the considerations from the infection prevention and control team as part of the ---

Q. So the document itself may not have been passed on, but you say the sentiments were?

A. Yes.

MR IHLE: Thank you, Madam Chair. That concludes the questions that I have for Dr McGuinness. I have heard from --- I see counsel for DHHS there. Perhaps prior to hearing from Ms Knowles, we hear from the other counsel who have indicated they seek to ask questions. The first is counsel for Unified Security.

MS ALDERSON: No, thank you, Madam Chair. No questions.

CHAIR: Thank you, Ms Alderson.

MR IHLE: I think by my reckoning, that's all, but perhaps I'll just wait a moment to see if anyone else.... No. Perhaps then counsel for the Department.

CHAIR: Just bear with us, Dr McGuinness, and this will be the last round of questions for you.

A. Thank you, Madam Chair.

MS KNOWLES: Thank you. Madam Chair, I just had a few questions that arose

from the evidence in relation to the directions that were given in relation to transmission between household contacts and also the questions about cleaning that were put to Dr McGuinness.

CHAIR: Thank you. I'll let you go on.

CROSS-EXAMINATION BY MS KNOWLES

MS KNOWLES: Dr McGuinness, you were asked about whether or not there was transmission between household contacts, and at 46(b) of your statement you refer to a follow-up that you had made with a security company in relation to directions that were made to workers. Can you explain what directions were given to staff that had worked at the Rydges Hotel since 11 May in relation to quarantining, and whether this differed before or after 29 May?

A. Can you please just refer to what aspect of my statement that was again, which paragraph?

Q. It's paragraph 46(b). And you state that you took an active role in responding to the outbreak, including by liaising with contractors and hotel management to obtain information. And then you say:

> *An example of this occurred on 30 May 2020, when I emailed [a security company] and asked that staff attending .... between [a particular period] were being asked to quarantine for a period of 14 days ....*

A. Mmm'hmm.

Q. My question is, what directions were given to staff that worked at the hotel in relation to quarantining, i.e. isolating at home in a suitable premises, before and after 29 May?

A. So my understanding is that on 30 May, we advised all staff that had been on site at the Rydges for 30 minutes or more between 18 and 28 May that they needed to quarantine for a period of 14 days from the last shift worked at the hotel within that risk period, and that quarantining meant that they needed to isolate themselves from their family and other household members in a single room, preferably with their own bathroom where it was available. And we provided all of those staff with the quarantine facts sheet or the facts sheet for close contacts, which actually describes what quarantine is and what things you are allowed to do while you're in quarantine.

Prior to 29 May, I do not believe that there were any security guards who we had advised to quarantine unless they had been identified as close contacts of a case, and I think at that stage it was just the initial two cases perhaps. Yes.

Q. And that part of your evidence refers to 18 May. Was that the date relevant for all, or was there another date having regard to the first symptom onset date of 25 May? Was 11 May the date that was also used for other staff?

A. So, no, the date range that was given to all staff was 18 to 28 May. 11 May was a date that was used to select which staff should be tested, and that was on the basis that 11 May was 14 days prior to the onset of symptoms in the first case, and that signifies the maximum or the likely maximum incubation period of the disease, and the reason that we had selected 11 May as the starting date for the staff who needed to be tested is to see if there were any staff who were perhaps asymptomatic, undetected cases that may have been the exposure source for the staff members who became infected. And 18 May was chosen for the period of risk because we did know that there were shift overlaps on 21 and 23 May that may have been the exposure events. It was also approximately sort of seven days prior to the symptom onset in the first case. So we thought that was the most likely period of risk. And it persisted up until 28 May because that was when the definitive clean was performed where we were confident that a clean and disinfection of the hotel had happened and that the environmental risk had therefore been mitigated.

Q. And are you aware of any measures that were taken for contacts that couldn't quarantine at home in terms of whether or not alternative accommodation was provided for those contacts?

A. So contacts who couldn't safely quarantine at home away from their household members were offered accommodation, and so that would usually be accommodation in a hotel environment where they could safely isolate away from their family and household contacts.

Q. And did this require, this offer, that they identify that they couldn't, or that you identify that they couldn't isolate at home?

A. Yes, the accommodation was offered in the event that someone identified or that we identified that they couldn't safely isolate. So, for instance, if they were in a large sharehouse where they shared a room or where there were a small number of bathrooms for a large number of people and we thought it wouldn't be possible for them to safely isolate away from people.

Q. You were asked about the anterior decision about whether to cohort all staff earlier, and you indicated that you had to balance the risk of moving the hotel. Did that consideration include the fact that at that time, the hotel obviously accommodated people who were in fact COVID-positive?

A. If I could clarify what is meant by "cohorting"? Cohorting usually means restricting the movements of a group of people. And so in the case of the hotel, I think that was the instruction, that they shouldn't work elsewhere. My understanding is for the Rydges we advised on 29 May that staff working at the Rydges should not work at any other quarantine hotel environment.

Q. My question is, in deciding whether or not to limit, or require, sorry, staff that had been working on the dates immediately prior to the outbreak to no longer work and thus close the hotel, was one of the considerations and the impact of that decision the fact that the hotel would then have to relocate a number of guests who were COVID-positive?

A. Yes. I mean, I think the fact that they were COVID-positive was one consideration, but it would have been the case for any hotel quarantine environment where the staff in that hotel environment are responsible for the health and wellbeing of those quarantined guests, and so it needed to be taken into consideration that those people needed to be safely cared for and that quarantining a large proportion of staff may limit the hotel's capacity to operate and care for those people.

Q. And my final few questions, Dr McGuinness, is you were asked about the cleaning advice and that you had a few phone calls. Can you tell the Board who you telephoned in relation to cleaning immediately following the 26th and on the 27th?

A. My recollection is that I had phone discussions with Merrin Bamert and Pam Williams from Operation Soteria, possibly also [Redacted], and also Rachaele May from DJPR.

Q. And were you aware that Ms May has given evidence to the Board that she had received some cleaning advice from the Department that was a March 2020 document described as "Cleaning Tips"?

A. Yes, I am aware of that.

Q. And are you aware of whether that document directs that a clean should also include disinfection?

A. My understanding is that it does.

MS KNOWLES: Those are the questions for the Department, if the Board pleases.

CHAIR: Thank you, Ms Knowles. Nothing arising out of that for you, Mr Ihle?

MR IHLE: No, there's not, Madam Chair. May we thank Dr McGuinness for her time and endeavours and have her excused.

CHAIR: Yes. Thank you, Dr McGuinness. Thank you for your attendance at the Board, and you are now excused, so you're able to turn off your camera and your microphone.

A. Thank you.

CHAIR: Thank you.

THE WITNESS WITHDREW

MR IHLE: Thank you, Madam Chair. That concludes what has been a lengthy day of evidence. Unfortunately we haven't gotten through as much as we had planned, and as I indicated, Professor Wallace, who was intended to be called today, will be called later this week. It has been relayed to me that he is available to give evidence on Thursday, so we will commence on Thursday morning with the calling of Professor Wallace. Other witnesses who are currently confirmed as witnesses for Thursday are Mr Murray Smith, a DHHS Commander, and Melissa Skilbeck, a Deputy Secretary of the Department. Pending the arrival of their statements and consideration of the issues arising from them, other witnesses might include Deputy Chief Health Officer Annaliese van Diemen, and Dr Finn Romanes, who of course has been referred to in evidence today.

CHAIR: All right. Thank you, Mr Ihle. So we will adjourn now until 10.00 on Thursday morning.

MR IHLE: As the Board pleases.

HEARING ADJOURNED AT 4.46 PM UNTIL 10.00 AM ON THURSDAY, 10 SEPTEMBER 2020

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