TRANSCRIPT OF PROCEEDINGS

INQUIRY INTO THE COVID-19 HOTEL QUARANTINE PROGRAM

BOARD: THE HONOURABLE JENNIFER COATE AO

DAY 15

10.00 AM, THURSDAY, 10 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 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

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

Law in Order Pty Ltd
T: +61 02 9223 9200
W: www.lawinorder.com.au

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.

Madam Chair, before the first witness is called --- that witness is to be Professor Euan Wallace AM, and I see that he's already with us --- there are some documents that require tender. The Board may recall that from the sittings on Tuesday there were some documents in respect of the witness from Your Nursing Agency, that is, Jan Curtain, that needed to be tendered. Firstly, there is a document that I seek to be joined to Exhibit 86. The Board may recall that Exhibit 86 was a select number of the annexures to the statement of Ms Curtain. So I seek that document with ID YNA.0001.0001.0237_R be added to Exhibit 86, and those documents which Ms Siemensma sought be tendered are ready to be tendered as well, and I'll call on Ms Siemensma to tender those documents.

MS SIEMENSMA: Thank you, and thank you, Madam Chair. As foreshadowed earlier in the week, I have had some helpful discussions with Counsel Assisting. I understand he doesn't oppose the tender of these additional documents.

The first is a bundle of COVID information and instruction that YNA provided to its staff. Those documents are in folder C of the hearing book, the first page of which is YNA.0001.0001.0052, and the last page is 0152.

The second is some pages extracted from YNA's online learning module, and those documents are also in folder C, and they commence at YNA.0001.0001.0139_R. And just to indicate, Madam Chair, both of those bundles we say are relevant to paragraph 4 of the terms of reference in that they reference instructions and ongoing communications and guidance to our staff.

Finally, I seek to tender annexure JNC-14 to Ms Curtain's statement, and that has ID YNA.0001.0001.0249, and that is a table of concerns raised to or by YNA, and we wish to rely upon some of the content of that in our written submission.

CHAIR: Thank you, Ms Siemensma. Mr Ihle, is it intended that all of those documents that are sought to be tendered become part of Exhibit 86?

MR IHLE: Exhibit 86 was intended to cover only those documents that were exhibits, and I understand, notwithstanding the number that I have referred to was not the exhibit number, that they all are exhibited to Ms Curtain's statement. I'll be corrected by Ms Siemensma if I'm wrong. If they are all exhibits, then there's no reason not to combine them all in with Exhibit 86.

MS SIEMENSMA: Mr Ihle, I can indicate --

CHAIR: Some of those documents, they weren't part of the actual tender bundle, were they?

MS SIEMENSMA: Some of the documents, the first bundle I referred to, was not an existing exhibit.

CHAIR: So I think just for ease of reference, I'll mark those documents that you've now sought the tender of and I'll allow the tender, but I'll mark them as Exhibit 108.

MR IHLE: If the Board pleases.

EXHIBIT #108 - ANNEXURES TO STATEMENT OF JAN CURTAIN

CHAIR: Thank you.

MR IHLE: Thank you. There's a number of other statements and annexures that require tendering. The first is the statement of a person who will be known in this Board as Authorised Officer, Operations Support. That witness's statement has document ID WIT.0001.0032.0001_R, and I tender that document.

CHAIR: Exhibit 109.

EXHIBIT #109 - STATEMENT OF AUTHORISED OFFICER, OPERATIONS SUPPORT

MR IHLE: There are seven annexures to that statement, and I tender them as a bundle.

CHAIR: Those annexures in that bundle will be marked Exhibit 110.

MR IHLE: As the Board pleases.

EXHIBIT #110 - ANNEXURES TO STATEMENT OF AUTHORISED OFFICER, OPERATIONS SUPPORT

MR IHLE: I also tender the statement of Chief Conservation Chief Regulator from the DELWP, Ms Kate Gavens, G-A-V-E-N-S. Her statement is at DELW.5000.0001.0001.

CHAIR: Exhibit 111.

EXHIBIT #111 - STATEMENT OF KATE GAVENS

MR IHLE: I tender as a bundle those documents that are referred to in Ms Gavens' statement at footnotes 10, 11, 12 and 13, 21, 22, 28, and 30.

CHAIR: Exhibit 112.

EXHIBIT #112 - ANNEXURES TO STATEMENT OF KATE GAVENS

MR IHLE: I also tender, Madam Chair, the statement of Dr Finn Romanes. His statement is marked with document ID DHS.9999.0013.0001.

CHAIR: Exhibit 113.

EXHIBIT #113 - STATEMENT OF DR FINN ROMANES

MR IHLE: And I tender as a bundle all documents referred to in his statement.

CHAIR: Exhibit 114.

EXHIBIT #114 - ANNEXURES TO STATEMENT OF DR FINN ROMANES

MR IHLE: There is also a bundle of other documents that are relevant to Dr Romanes' evidence. I will provide a list separately, but indicate that I tender them as a bundle. There are six documents.

CHAIR: You are tendering those now, Mr Ihle?

MR IHLE: Yes, I will.

CHAIR: Yes. Exhibit 115.

EXHIBIT #115 - FURTHER ANNEXURES TO STATEMENT OF DR FINN ROMANES

MR IHLE: As the Board pleases. They are the documents to tender at this stage. Unless there are further matters, I will now call Professor Wallace.

CHAIR: Thank you. Professor Wallace, if I can get you to unmute yourself, please. You haven't quite managed that yet. Now, are you able to hear and see me,

Professor Wallace?

PROF WALLACE: I am, Madam Chair, good morning.

CHAIR: Thank you, good morning, I just apologise for the short delay in coming to you. I am sure you have had explained to you that for the purposes of giving evidence you will need to take a solemn promise, and I understand that you wish to do that by way of the affirmation?

PROF WALLACE: Thank you, yes.

CHAIR: So for that purpose, I'll hand you over to my associate who will take you through the affirmation. Thank you, Madam Associate.

PROFESSOR EUAN MORRISON WALLACE, AFFIRMED

CHAIR: Thank you. Professor Wallace, I'll hand you over to Mr Ihle now. Thanks, Mr Ihle.

PROF WALLACE: Thank you.

MR IHLE: Thanks, Madam Chair.

EXAMINATION BY MR IHLE

MR IHLE: Good morning, Professor Wallace. Thank you for making yourself available to give evidence before this Board of Inquiry. Can we start by you providing your full name to the board, please?

A. Thank you, good morning. My full name is Euan Morrison Wallace.

Q. Thank you. And you are a Professor of Medicine?

A. I'm a Professor of Obstetrics and Gynaecology.

Q. Yes, thank you. And you hold a number of roles and positions at the moment, but significantly for you, your purpose before the Board today, you are the Chief Executive Officer of Safer Care Victoria. Is that so?

A. That's correct. So my substantive role is the CEO of Safer Care Victoria.

Q. Yes, and you're also holding a role at the moment as the Deputy Secretary of the Department; if I understand that correctly?

A. Yes, so since late July, I've been on secondment to the Department as a Secretary in the COVID Public Health Command, and during that time my duties as CEO at Safer Care have been taken over by my Deputy CEO, so she's now acting.

Q. So that was from late July, Acting Deputy CEO at Safer Care whilst you've been performing the duties at the Department as a Deputy Secretary?

A. That's correct.

Q. Yes, thank you. Professor, there are two statements that you've provided to the Board of Inquiry; is that the case?

A. Yes, that's right.

Q. The first of those two statements is dated 2 September?

A. Correct.

MR IHLE: That's a statement, Madam Chair, which bears document ID SCV.9999.0001.0001. Professor Wallace, that's a 13-page statement?

A. It is.

Q. And there are a number of substantive paragraphs there. You have a copy of the statement with you?

A. I do.

Q. And have you recently read that statement?

A. I have.

Q. And are the contents of it true and correct?

A. They are.

MR IHLE: Yes, thank you. I tender the statement of Professor Wallace dated 2 September 2020.

CHAIR: Exhibit 116.

EXHIBIT #116 - STATEMENT OF PROFESSOR EUAN WALLACE

MR IHLE: In compiling that statement, Professor, did you have regard to and then

subsequently make reference within that statement to a number of other documents?

A. I did.

Q. And as far as you're aware, those documents are true and accurate?

A. Yes.

MR IHLE: I tender as a bundle the documents referred to in the statement of Professor Wallace dated 2 September 2020.

CHAIR: Exhibit 117.

EXHIBIT #117 - ANNEXURES TO STATEMENT OF PROFESSOR WALLACE

MR IHLE: If the Board pleases.

Your second statement, Professor Wallace, is a statement dated 7 September?

A. Yes.

Q. That is a briefer statement. It covers some three pages. Are the contents of that statement true and correct?

A. They are.

MR IHLE: Yes. I tender that statement, Madam Chair.

CHAIR: Exhibit 118.

EXHIBIT #118 - SECOND STATEMENT OF PROFESSOR EUAN WALLACE

MR IHLE: And, as with your first statement, in preparing that second statement, you had regard to and have referred to within that statement a number of documents?

A. I have.

Q. And as far as you're aware, they are truthful and accurate documents as well?

A. Yes.

MR IHLE: Yes. I tender as a bundle the documents referred to in the second statement of Professor Wallace.

CHAIR: Exhibit 119.

EXHIBIT #119 - ANNEXURES TO SECOND STATEMENT OF PROFESSOR EUAN WALLACE

MR IHLE: As the Board pleases.

Professor, can we start with you giving us an explanation of what Safer Care Victoria is?

A. Of course. So Safer Care Victoria is the State's lead quality and safety improvement agency for healthcare. We were established in January 2017 as an explicit response to one of 181 recommendations in the review of public --- safety of public hospitals across our State, led by Steven Duckett, the so-called Duckett Review, or Targeting Zero. So in that review, the recommendation to establish an explicit agency dedicated to the quality and safety of healthcare was made, and Safer Care is the response of Government to that recommendation.

Q. And where does Safer Care Victoria sit in relation to the Government structure?

A. So we are an administrative office, so under the *Public Administration Act*, we're an administrative office and aligned to the Department of Health and Human Services. So I'm an appointment of the Minister and the Premier, and my staff are employees of mine and Safer Care, but they're employed under the Victorian Public Service employment structures.

Q. Who does Safer Care Victoria report to?

A. I report to the Secretary for the Department of Health and Human Services and to the Minister.

Q. Although you report to the Secretary of the Department of Health and Human Services, you hold an appointment from the Government separate to the Department itself though; is that right? You're not employed by the Department?

A. No. So again, we're an administrative office aligned with the Department, and I sit as a member of the executive board of the Department, but my appointment is from Government.

Q. Yes. And you've annexed to your first statement a document which is part of now bundle Exhibit 117, a letter dated 2 October 2017 from then Minister for Health the Honourable Jill Hennessy MP, which you've described as a statement of expectation;

is that right?

A. That's right.

Q. And that letter provides, amongst other things, doesn't it, that Safer Care Victoria has a function to provide independent advice and support to public and private health services?

A. That's correct.

Q. And indeed on the second page of that letter, it provides as follows:

> *Consistent with the recommendations in Targeting Zero ....*

Just pausing there for a moment, Targeting Zero is the result of the Duckett review?

A. Targeting Zero is the colloquial name for the Duckett review, yes.

Q. Yes. It provides expressly --- this is the Minister's letter of expectation --- that:

> *.... Safer Care Victoria will perform its functions independently of the department and with a view to best practice.*

A. That's correct.

Q. So although there's the alignment, it was expressly envisaged both by the Duckett review and the establishment of Safer Care that Safer Care will be as independent as possible, notwithstanding its alignment with the Department?

A. That's correct.

Q. Do I understand also, when it comes to reviews that Safer Care Victoria might be asked to conduct from time to time, those reviews may be triggered by specific requests from certain people?

A. Yes, that's correct.

Q. Who are those people?

A. A variety of people. Our reviews can be triggered at the request of the Minister, or Ministers, and by the Secretary herself, by health services themselves, so on some occasions health services will pre-emptively or proactively seek our advice and review, or indeed by ourselves. So if --- when a matter comes to our attention, then we are able to trigger a review ourselves.

Q. And in those instances, to whom are the reports ultimately furnished?

A. It would depend on who commissioned the review in the first place, so if the Minister asked us to do a review, then we would provide --- ultimately we would provide the final report from that review to the Minister; likewise, if it was the Secretary, to the Secretary, AM, and so forth.

Q. So if the Secretary were to request a review, does that mean that the report would first of all go to the Secretary?

A. So the final report would go to the Secretary. So we have some very formal processes around our reviews, and the closing steps in those processes involve what we would summarise as fact-checking steps. So if we were doing a review, we would provide a draft review to the key stakeholders involved in the review. So if this was a hospital and we were undertaking a review of part of their service or all of their service, they've been commissioned, let's say, by the Secretary or the Minister, prior to providing it, the final review, to the commissioning person, the Secretary or the Minister, we would have a series of engagements with the health service just making sure the facts are correct. But the final report would go to the person or agency who commissioned it.

Q. Okay. So if the Secretary were to commission a report of Safer Care Victoria, in the ordinary course, would you expect that report to make its way to the Minister?

A. It would depend on the nature of the review. It wouldn't be uncommon for the Minister to receive a report, but it wouldn't be a necessity for the report to go to the Minister.

Q. And who would make that decision as to where the report was ultimately to go, if beyond the person or entity that commissioned it?

A. So in the example that you asked, that the Secretary commissioned the report, then it would be the Secretary.

Q. Thank you. With the reviews that are conducted from time to time, paragraph 16 of your first statement, you say that there are no guidelines "for the conduct of the reviews per se". And I just want to understand what you mean by "per se" in that context.

A. Yes, so the question that was asked of me by the Board was:

> *"Pursuant to which policy/policies, guidelines and/or directives are such reports .... prepared?"*

So there are no formal policies or guidelines by which we would prepare a report. It would be in response to an explicit request. So we don't have a policy framework that says, "We will only undertake a review in the following circumstances." Our reviews would be in response to incidents and/or requests to undertake reviews. Again, some of those are pre-emptive or proactive. Health services reach out to us

and say, "We would value your external thoughts on this aspect of our service with a view to improvement." So we don't have a policy guideline, as it were, that then dictates explicitly and constrains under what circumstances we might undertake a review.

Q. Yes. Perhaps we're at cross-purposes, Professor. Once the review is requested by whomever it is that requests it, are there any guidelines, policies or directions that guide how the reviews are to then be undertaken and the reports provided?

A. My apologies. So, as I've said in my response in paragraph 16, we use a range of methodologies. And again it would depend on what the review was for and what triggered the review. So sometimes the reviews are extraordinarily narrow in their scope and so the methodologies then are narrow, and sometimes they're much more broad-ranging and therefore we would bring into play much broader instruments, you know, methodologies. So again, we don't have a strict policy around, you know, one must use this method for this review. But rather when the review team is gathering at the beginning to scope the review, and we would issue terms of reference that were specific to an individual review under normal course of events, and as we scope those terms of reference, the review team would then decide which instruments or which method they were going to use for that particular review. And of course that can change in flight, because things come up during the review that were not anticipated and they then may need to call on other methodologies.

Q. Yes. So, to put it in layman's terms just so I can make sure I understand that answer, you have a number of review tools in your kitbag and, once you are presented with the problem, you work out the best tool for that program?

A. Beautifully put, yes.

Q. So you talked about the scope of reviews and when the review team sits down, they work out, "What are we reviewing here? What's the scope? What's the terms of reference?" We know in relation to your statement you were directed to two reviews that were undertaken by Safer Care Victoria. Where on the spectrum, as far as scope of reviews that Safer Care Victoria undertakes, do these sit? Were these significant pieces of work looking at a broad range of factors or were they more targeted and focused?

A. I think when we do any review that is triggered by an incident, an adverse incident, then they're significant pieces of work. And one of these reviews, as the Board is aware, was in relation to a death of an individual. So that is a very significant piece of work. In terms of its breadth, they're quite narrow because the reviews were focused on care or services provided to an individual, to separate individuals, so those are quite narrow.

We would typically be involved --- so the equivalent of these reviews in a health service setting would be what would be broadly known as root cause analyses of serious adverse events. And we would oversee some 200 of those a year. That gives

you a sense of the frequency that this type of review would --- that Safer Care would have visibility of. Most of those root cause analyses are actually undertaken by health services themselves, albeit with our support in terms of quality checking, et cetera. But in terms of the methodologies, these two reviews were similar to that.

Q. Yes. Thank you for that. In your role as CEO, do you actually play a role in the review process at all?

A. Depends on the review. So much --- you know, very wide-ranging reviews, whole-of-system reviews, then it would not be uncommon for me to be involved. Reviews of this nature, I wouldn't be typically involved in the day-to-day running of the reviews, so not actually part of the incident review team. All of our reviews have an executive sponsor, so-called executive sponsor, so one of my directors, and the director would --- so has overarching day-to-day responsibilities for making sure the review team have the resources they need, that the timeframes are appropriate, and then they would be the first point of sign-off. And then reviews of this nature, I would also then sign off as the CEO before handing the review on, in this case to the Secretary.

Q. And --

A. So --- sorry, I'm not involved in the day-to-day running of the review and I'm not a member of the review team, but the report, once finalised, once those fact-checking steps had occurred, the final report comes to me for approval before release to the Secretary.

Q. So we take it then from that answer, I assume, that both of the reports with which we are concerned are ones that have been reviewed and approved by you?

A. Yes, definitely.

Q. And when we talk about the executive sponsor, that is, one of your directors, is that the person that we see who actually signs off the cover letter for each of those reviews?

A. It is.

Q. Thank you. We've already touched upon, in general terms, the first review. The first of those reviews concerns, as you said, a death that occurred by someone who was within the hotel quarantine system.

A. Yes.

Q. That was a person detained under the Hotel Quarantine Program. And the second review, as I read it, concerned what could generally be described as a delay in conveying an unwell detainee to hospital which may have resulted in that detainee's condition ultimately worsening and requiring admission to intensive care.

A. Yes. So the second review was a review of the circumstances that led to a detainee being transferred to hospital for further care, that's correct.

Q. And both of those reviews were commissioned by or requested by the Secretary for the Department of Health and Human Services, that is, Ms Kym Peake?

A. That's correct.

Q. And so, consistent with your previous answers, I assume the reports in their final version were furnished to Ms Peake?

A. They were.

Q. Along with the findings and the recommendations that are contained within those reports?

A. Yes.

Q. Are you aware whether either of these reviews were sent to Minister Mikakos?

A. I'm not aware.

Q. Thank you. The first of those reports concerned an event which occurred around 10 or 11 April.

A. Yes.

Q. And the report was finalised, as I understand it, on 10 June?

A. Yes.

Q. And that's the date upon which it was furnished to the Secretary, 10 June?

A. Yes. So the report was finalised some weeks earlier, but the actual final report was released to the Secretary on 10 June.

Q. Yes. Thank you. And the second report concerned events around 13 April?

A. Yes.

Q. And that was furnished to the Secretary on or about 17 June?

A. Yes, that's right.

Q. Now, each of those reports are documents referred to in your first statement, so they also form part of Exhibit 117. We'll go to aspects of those reports in a moment.

But just in a general sense, is it the usual course that a Safer Care Victoria report will not only make a number of findings but also proffer a number of recommendations?

A. Yes.

Q. And indeed with both of these reports, we see both of those things, findings and recommendations?

A. Yes.

Q. Does Safer Care Victoria play any role in following up what is being done, if anything, in relation to the implementation of recommendations?

A. Yes, we do. And again, the majority of our work, of course, is with health services, and again, the majority of reviews of this nature are actually undertaken by the health service themselves, so-called root cause analyses, using methodologies that we prescribe and have evolved in the three years since our establishment, and we provide training for health services in those methods.

One of the evolutions of the RCA methodologies that we have implemented over the last three years has been both the creation of an assessment template of the quality of the recommendations, because recommendations are only useful if they lead to future improvements that make the event less likely to occur in the future, and one of the challenges around the whole RCA methodology is there is a tendency to result in what we would classify as weak recommendations --- more training, more guidelines --- but the literature shows actually doesn't lead to any meaningful improvements and doesn't make it less likely for that incident to happen in the future. So we have constructed a rating system, if you like, for recommendations, and we'll score them, weak through strong.

One of the other evolutions of our methodologies is to have a check-in with health services, to agree with them a timeline for implementation, and then check in with them in a supportive manner, "How are you going with those recommendations?" and have them formally sign them off. So that would be our normal approaches to managing a list of recommendations and implementation.

And as was the case here, of course not dealing with the health service here but dealing with Operation Soteria, so a list of findings and what the reports call "learnings" --- it's not a word of my preference, I would much rather have "lessons" --- but a list of formal findings and learnings which are broader-scope insights into things that might not specifically relate to the incident but are important nonetheless in the eyes of the review team and the broader landscape of the environment in which this has occurred, and then a list of recommendations arising from both the findings and the lessons, and the recommendations are explicitly tagged to either those findings and/or lessons, and then a timeline is agreed with in this case Operation Soteria about their implementation, and Safer Care would check in.

I think in my statement I said of course the check-in date for implementation was subsequent to my secondment to the Department proper in my Deputy Secretary role at the moment. But, nonetheless, that check-in from Safer Care Victoria continues by Safer Care Victoria now by Associate Professor Keenan, who is the Acting CEO.

Q. Yes. Thank you, Professor. Can I just ask, so that I understand these reports, there is --- well, first of all, I assume the form of the reports is relatively standard, where you have an introduction, an analysis section and then the findings and the reasons for those findings. First of all, is that correct? Is the overall structure fairly similar from report to report?

A. They are. So this is very much a Safer Care report, and obviously health services have their own structures, but the broad structure is the same. I guess the other thing I should say early on in this discussion is that these two reviews are what we would call rapid reviews. So when the Secretary asked Safer Care to undertake these reviews, it was clearly an acknowledgment that, you know, having someone die under hotel quarantine and someone transferred as an emergency to a health service, those are very serious events. So she, the Secretary, asked Safer Care to really use our very formalised, robust, tried-and-tested methodologies, but could we do it quickly, because if there are lessons --- remember at this time, there were thousands of returning passengers coming in to the state --- so if there were important lessons, could we find those quickly without compromising our methods. So we would call these rapid reviews.

So if you were to compare these two reports with a more standard review report from Safer Care, the more standard review report might be more fulsome, but it would have taken us several more months to do it. And I agree with the Secretary that they actually wanted some rapid insights there because there might have been --- and obviously you don't know at the beginning of the review --- but there might be a need for rapid change. So these are what we would call rapid reviews.

Q. Yes. Thank you. When we come to the actual structure of the reports themselves --- and do you have them there with you, Professor?

A. I do.

Q. I just want you to turn, if you can, to, say, for example, page 20 of the first report. It's headed "Appendix 1: Recommendation Action Plan Template". Is that a part of these types of reports with which you're generally familiar?

A. Yes.

Q. Yes. What's the intention behind the action plan template, which is the appendix to the report?

A. So it's part of the toolbox that you referred to. When the review team is working on the review, they have this at their disposal so they can make notes in real time, as

it were, and then as they come together as a review team towards the end of the review and beginning to collate the findings, the insights and recommendations, they call upon these. So this is just part of our standard review toolbox which the review team used to begin to formulate draft recommendations which then feed in to the recommendations that are in the final report.

Q. And is it part of the living document prior to the document being finalised and sent to the Secretary?

A. Exactly.

Q. And --

A. And I think the fact --- sorry, apologies.

Q. No, please go on.

A. I was going to say, I think the fact they exist as an appendix is really a part of what's really an overarching philosophy of Safer Care, which is one of transparency. So we make visible to everyone involved in the review, not just the review team but the stakeholders involved in the review team, the tools that we are using. So they understand, they're involved and engaged in the review. Because, again, the literature will show that by involving those who have been involved in the incident in the review itself, they're much more likely to be engaged in the recommendations and their subsequent implementation and make it less likely for incidents like this to happen again.

Q. To buy into these lessons?

A. Yes.

Q. Another part of that appendix is table 2 which appears on page 22, "Recommendations Already Implemented". What's the purpose of that part of the document?

A. So again, as the review team are putting together their own thoughts, you know, firstly as individuals or as pairs, depending on how the review is done and then as a whole review team, they may raise things with stakeholders that they're interviewing as part of the review and saying --- I'm just going to make this up now --- so let's say there was a drug error in a health service, they'd say, "Well, why wouldn't you have that drug under lock and key, for example, or under a pass or access system?" "Actually, we've implemented that since the incident happened." Okay, so they would note that. Just so we're not making recommendations to health services, or in this case Operation Soteria, recommendations that are already implemented. So it's a means of cross-checking that we're not going to make recommendations that are futile because the action has already happened.

We would note in our review that there was this finding, but either subsequent to the incident or during the review process, that the health service had already responded so there is no merit in making a further recommendation on that finding. But it ensures that the finding is captured and the recommendation has already happened or a change or improvement has already happened that, had it not happened, would have resulted in an explicit recommendation.

Q. So given that, at least in relation to the first report, table 2 is left completely blank, and given that report was finalised and delivered to the Secretary on 10 June, do we take that to mean that as at 10 June, at least, none of the recommendations had been implemented?

A. No. No, I think that would be over-interpreting. Again, these are resources as part of the toolkit and as part of the standard report. Again, this is a rapid review that there wasn't time, nor did I ask for --- in fact, I may even have explicitly said, I can't recall, I may have explicitly asked the review team not to spend time on the normal cross-checking events that we would usually do. Because of the rapid nature, I wanted --- under the direction of the Secretary I wanted insights as fast as possible, again, not compromising the robust methodology. So I think the fact that these are blank, I wouldn't put any weight on that whatsoever. The review team just wasn't tasked with the normal cross-check processes.

I'm quite comfortable and, as actually was the case, I'm quite comfortable for the review team to have made findings and then for me to check in with Operation Soteria, with the Secretary and to have those findings or recommendations all ready and squared off by the hotel quarantine operation. My sole purpose of the reviews was to find important insights and lessons for improvement, and if those improvements had already happened, then fine. I don't think the fact these tables are blank has any meaning at all.

Q. Okay. And does that remain the case even though that sometime before 10 June for that so-called fact-checking process, the report, with the recommendations that were then drafted, had been sent to those people who were the key stakeholders in Operation Soteria and there had been no feedback that informed that table?

A. Yes, because I think the feedback actually was done through me. So I then took --- and there were a couple of so-called escalation points, several escalation points that I took to the Emergency Operations Centre --- in realtime again, not trying to slow up the process. So that did remain the case on 10 June.

Q. Yes, so it was a case of --- and again I am just trying to summarise that I understand what you are saying, Professor, correctly, we have these formalised, robust, tried-and-tested methods, and we're relying on those, but time is an imperative here because what we have going on is the system that's still in place, and if we can learn lessons right now, we will escalate them, as you did.

A. Yes, and that is always the case. I think the nuance here for these reviews,

compared to a normal review process with a health service, is that the step of checking off on, well, we've made a list of 10 recommendations, have any of these already been implemented, yes or no, let's record that, which now leaves us with seven recommendations because three are --- we would normally do that really out of respect for the health service, recognising that Health Services, thankfully, are all on a continuous improvement journey, so they're always changing their systems. Really, there wasn't a need for that here because we were able to feed back the recommendations, particularly those high-level escalation points, in real-time or near real-time, and if they had already been implemented, then great. And did we actually need to check off --- so, you know, here were 30 recommendations but actually a number had already been implemented. I didn't perceive really a need to do that in the way we would normally do with the Health Service, which would play out over months, again, partly because I didn't feel, under the direction of the Secretary that we necessarily had months and months to do this. We wanted to have the answers as fast as possible.

That check-off on, "Had this recommendation been implemented, yes or no?" actually has no material impact on the recommendation itself, and recording in the final report whether or not it had been implemented again has no material impact on the improvements and the likelihoods or decreased likelihoods of a similar event happening in the future.

Q. But it is an important aspect of governance, is it not, Professor, to be able to look back at these formalised documents that have been requested to be able to say, "Well, that was a point in time, and this is what we've done since"?

A. Oh, very much so. And I think the follow-up of the recommendation steps, those action plans, if you like, are to that exact point. So here are a list of recommendations at a point in time, here's a number of findings and lessons at a point in time, here are a number of recommendations derived from those, and here is where we are now, three months, six months, 12 months later, whatever. So, absolutely.

Q. Yes, and in relation to the agreement as to that monitoring of the implementation, those friendly and supportive check-ins, if we can call it that, what was agreed in relation to both of these reports, as I understand from your statement at paragraph 47, was a one-month, three-month and six-month check-in?

A. Yes.

Q. And indeed, in relation to your second statement, you identify a document which records those check-ins and the status of the recommendations as of, I think, 5 September?

A. Yes, so a number of recommendations had already been closed, and then another cluster of recommendations had implementation timelines of 14 and 28 August, which again was subsequent to my secondment, but wanted to --- so I didn't have

instant --- at the time of my first statement, didn't have immediate access to those outcomes and sought them, which came in after the time that the Board wanted my first statement, hence the supplementary report.

Q. Yes. Thank you, Professor.

Professor, I want to turn to the first report.

Madam Chair, can I just indicate that throughout the course of the last five or so minutes, I've received a message from Senior Counsel on behalf of the Department of Justice who has some concerns about the redactions of the version to which I was going to take the Professor. Perhaps, given this is all unfolding in real-time, I might just ask Dr Hanscombe to address the Board about that. There have, of course, been several correspondences with the interested parties about redactions and documents, but apparently there's a fresh issue.

CHAIR: Yes, Dr Hanscombe.

DR HANSCOMBE QC: Thank you. If the Board please. Thank you, Mr Ihle. I would like to be able to give you a little more detail than I presently can. I'm instructed that the additional redactions to the relevant document --- and for clarity, might I say the number of that document, it's the Operation Soteria version 3 plan, the document ID is DHS.0001.0001.1053. The application for some redactions or non-publication orders concern issues, I'm instructed, of national security which are around the interfaces between Victoria Police, the Australian Federal Police and the Australian Border Force operational procedures. And they, I infer from that, will be about the handover processes that occur when people arrive at the airport. I am further instructed that my instructors have sent a further version of this document with redactions, and I think they won't affect this witness. I would be surprised if this witness were examined on these topics.

So I'm sorry to hold you up. I gather there has been some correspondence with the solicitors instructing you and it appears that something might have slipped through a crack.

CHAIR: All right.

MR IHLE: Can I just address that very briefly, because I think this is not an issue. I'm not intending to take this witness to that document and I'm not sure where that's arisen from, but caution is a sign of prudence in relation to all of these things. But I can allay my learned friend's concerns: I'm certainly not intending to take this witness to the Operation Soteria plan with that document ID.

DR HANSCOMBE QC: I'm grateful to my learned friend for that indication. I apologise to the Board for interrupting the proceedings.

CHAIR: Thanks, Dr Hanscombe.

DR HANSCOMBE QC: If the Board please.

MR IHLE: I will ask that the first Safer Care Victoria report be brought up. That's document DHS.0001.0002.0058_R.

Are you able to see that document, Professor? I assume you have a copy of that with you, so if you need to follow in a hard copy and that's easier for you. But you will recall I asked you earlier about the identity of the executive sponsor and you agreed that that was the person who signed the cover letter. Do we have that person identified there on the document?

A. We do.

Q. Yes. And that's an executive member of Safer Care Victoria?

A. It is.

Q. And just to confirm, this is a report which you reviewed and authorised prior to it being provided to the Secretary?

A. Yes.

Q. Can I ask that we scroll to the 11th page of that report, the page which ends with document ID 68. Now, with this report, as with the other reviews with which Safer Care Victoria are concerned, it's the case, isn't it, that although the reviewers are looking through the prism of the particular adverse incident, they do, as a matter of course, almost find issues with systems that are in place that need to be addressed for the very reason you've described, to ensure that avoidable events can be avoided in the future and improvements made?

A. Yes.

Q. Yes. And so we see, in relation to this first review, which was a review triggered by the tragic death of one of the detainees, that a number of findings were made by the reviewers?

A. Yes, seven findings were made.

Q. And the first of those findings --- perhaps if we can just highlight the bold passage in the middle of the page with number 1, that's finding number 1. So in relation to the review that was undertaken, the reviewers --- and this is a finding which you've approved following your review --- that:

> *The welfare check team were unable to undertake welfare check calls to the planned schedule, as they did not have enough staff to match the required workload. As a result, initial welfare checks were often delayed, and*

subsequent checks were often infrequent.

That was the first finding that was made; is that right?

A. Yes.

Q. And that's a finding with which your --- sorry, that's a finding which, following your review of this report, you agreed with?

A. Yes. Perhaps it's worth just pausing to understand my role in reviewing the reports before formally approving their release and submission to the Secretary in this case. My role is not to question the facts and the findings of the review, my role is to ensure that the overarching standards of reviews are consistent with the quality of the reviews that Safer Care produces. Being mindful that I'm not a member of the review team, I do not have access to the insights and the material that the review team do, so I would not --- it would not be normal for me to challenge a finding, given I wasn't involved in the review team. But my role really is to ensure that the reviews have been undertaken with the methods and the quality, and described as such, that are consistent with the standards of Safer Care.

Having said that, I have no cause to question the findings of the review team. The team are led by members of our academy that we train in robust methods, et cetera, et cetera, so I have every confidence in the review team and I have confidence in their findings.

Q. Yes, thank you. Professor, do you understand that the Inquiry has sought statements from the review leaders and that the lawyers for the Department have actually indicated to the Board that you are the person who can speak to these reviews?

A. Yes, and I can speak to the reviews.

Q. Okay, excellent. So where we see a finding, notwithstanding you weren't intimately involved in the fact-finding exercise, you have at least implicitly endorsed those findings by approving the report for publication to the Secretary?

A. Yes.

Q. Thank you. If we can just take down that highlight and perhaps highlight the paragraph which is the second to the bottom on the page, it's the one that starts "Due to the backlog". Now, when you reviewed this report, I take it this is a paragraph you would have read?

A. Yes, I've read the entire report.

Q. Yes. And so this would have, given your role as the CEO of Safer Care, been a matter of some significance, given the events that triggered the report, I assume?

A. Yes, and I think, as we've commented already, you know, an incident that involves the death of an individual is profoundly significant and the findings, any findings that relate to a death, are also significant. So this is a significant finding.

Q. The significance of this finding is that someone who at least appeared to have taken their own life had received only one welfare check call during his first nine days of detainment.

A. Yes. So, as the Board is probably aware, there were a series of different calls made to detained passengers under Operation Soteria, under the Hotel Quarantine Program. They had a daily call from a nurse, and that was largely around symptom checks, short of breath, runny nose, et cetera. So because these were people clearly at higher risk of having COVID, so they got a daily call from a nurse. And then the initial plan was that on day 3 and day 9, I believe, they would get a so-called welfare check, which was a supplement to the daily symptom check. And the welfare check was intended as a broader check-in around wellbeing, not just symptoms related to COVID. So that first welfare check was scheduled to happen on day 3 and happened on day 5 in this individual. But on day 5, he'd had five daily phone calls by that stage by the nurse.

Q. So, just to clarify on that, do I understand that the daily nurse calls are questions about physical symptoms consistent with COVID --- sore throat, runny nose, cough, fever, those types of questions?

A. Principally.

Q. The welfare call was a call about broader aspects, "How are you coping, how are you feeling?", those types of things, that would touch upon someone's mental health and emotional position?

A. That was the intent, yes. And, again, on entry to the quarantine scheme there were health and mental health checks, sort of screening tools, as it were. But the intent of the welfare check, because they're happening on day 3 and 9, so just twice during the 14-day quarantine as opposed to a daily check by the nurses, was --- because of less frequency, there was --- the intent was that the welfare team, welfare check, you know, had more scope to how you --- you know, exactly as you said, "How are you going, how are you coping, are there other needs?", et cetera, et cetera. Whereas the daily nurse check was principally about symptoms of COVID. But of course, we've got nurses on the end of the phone, "How are you going?" is a standard entry question for that daily check, "How are things?", but the welfare check was specifically to be slightly broader ranging.

Q. Yes, thank you. Perhaps if we take that highlight down and scroll to the next page, which will show us the second finding made by the reviewers. That's at the top of the page and if that could be expanded so we might read it. Thank you. A finding made by the reviewers was again a finding which you at least implicitly endorsed

upon your review in authorising the report for publication by the Secretary. It's set out there:

> *Staff were often not able to access all detainee health and welfare information they needed to provide adequate care to detainees, due to a lack of comprehensive, central, accessible repository for such information.*

First of all, you're aware that is a finding that the review has made?

A. Yes.

Q. Secondly, it is not a finding that you thought was unreasonable, even given your relatively limited role in the review?

A. No. It reflects the findings of the review team, so very reasonable.

Q. So just reflecting back on what you said before about the daily calls being ones primarily directed to physical symptoms, where the welfare calls were broader and looking at emotional and psychological conditions, wasn't the fact that there was no central repository or comprehensive repository of all of that important information a significant matter, given that these people were being held in detention effectively against their will?

A. It is a significant matter. It's not to say that the records weren't there. I think the team found that there were nursing teams on site; there were general practice providers, so medical providers, on site; the welfare teams were off site at the end of a telephone. And at this time when the review was being done, the creation of a central system where all that information could be shared, almost like an electronic health record, wasn't in existence. Now, if we compare that to a health service where there is pathology information, information from imaging and an x-ray department, information on the ward and the ward rounds, nursing notes, medical notes, et cetera, increasingly the generation of electronic health records for hospitals is specifically with this intent of bringing everything together.

Now, we must remember that the operation was established --- I think it was announced on 28 March. By the time these events were happening in mid-April, there were some already 3,500 returning passengers in quarantine in Victoria under the scheme. And the department that was setting up the system, Department of Health and Human Services, setting up the systems for health and welfare, were setting up incredibly quickly.

I might reflect, in a past role I was head of Women's Health Service at Monash Health for nearly a dozen years, and we set up a home birthing service at Monash Health, which continues to look after about 60 or 70 women a year --- so 60 or 70 women a year. It took us about eight months to put in place all of the components that is needed for the provision of that service, which is essentially just moving birth out of the hospital into a woman's home.

Here was a system looking after 3,500 people by mid-April, set up extraordinarily quickly. And I think what my team, my review team were finding is that in order for the nurses and the welfare officers who were phoning in to fully discharge their duties, it would have helped them to have sight of each other's notes and at the time that the reviews were done, they didn't have that in place, because while they had their own systems, so the nurses had their own records, the GPs had their own records, the welfare officers had their own records, the system wasn't up and operational for them to share.

That's an important finding, but wholly understandable given the complexity and the rapidity with which this operation was established.

Q. Yes, we understand the heroic and extraordinary efforts that were taken to stand up this operation. But I take it, at least from your experience and that significant clinical experience, that if one were setting up this system from a clinical governance perspective, a single repository of all those notes such as is replicated in a hospital or a home birthing system should really have been something prioritised from very early on?

A. My understanding is it was prioritised, it just wasn't up and running by this stage. Under the normal course of events, it would be --- we would never ask a health service to set up a program like this in two days, a program of this complexity in two days. And I think what my team were finding were just the necessity of the individual teams needing to establish their bit, so, "We need to establish a nursing team to provide nursing checks, health checks. We need to establish --- what else do we need to do? We need to establish a welfare team to check on the welfare. Okay, let's establish a welfare team. We need to provide medical care for the small but significant number of people who we think will have COVID and who may fall unwell or for returning passengers who have their own health issues, pre-existing, who require medication," et cetera, et cetera, and all of the other bits, the compliance bits, the transport pieces. So all of these things were scoped and set up incredibly quickly.

I think what my review team was finding was by mid-April the connections and information-sharing infrastructure which will need to be provided hadn't actually been put in place by that time. I don't think we would be over-critical of that but it was an important observation because if it goes to the question --- and it's not for our review to say would this event have been prevented, but it would be made less likely into the future had nurses and welfare officers and GPs sort of all had a shared repository of information.

That's the importance of the finding. If you're going to improve this, then let's have an information-sharing platform where all that information can be visible to everybody who's involved in the holistic care of the detained passenger.

Q. Yes. Thank you, Professor. So this finding is directed to the lack of a central

note-keeping database, if we can call it that.

A. Yes.

Q. Can we move to the next finding which is later on down that page, in bold, number 3. This is a slightly different point but I think might be at least identifying potentially one of the causes for the previous finding. Do you agree with that classification?

A. Yes, I think so.

Q. That is ---

A. I think this is reflecting --

Q. Sorry, please go on.

A. I think it's reflecting that in this finding are both health and welfare information collected by different teams who yet don't have shared visibility of each other's findings in a systematic manner and it's a reflection of, you're quite right, it's a reflection of the lack of that shared system that finding 2 commented on.

Q. Yes. Can we just go over to the next page because I want to highlight one of the reasoning pieces behind that. The third paragraph starts:

> *The review team noted that day-to-day operations ....*

If that might be highlighted, please. Now, you will see, Professor, that this provides what the review team found:

> *.... that day-to-day operations were marked by a lack of communication and coordination regarding detainee information collected through these fragmented channels.*

This is saying, is it not, not only is there not a central repository and not only is there fragmentation of who is obtaining what information, there's a lack of communication between them above and beyond just record-keeping? Do you agree with that?

A. I do agree with that. And I think it was --- I think it's a reflection of the different locations of the teams providing the entirety of the, let's call it, care for the passengers, not just the healthcare but mental healthcare and welfare care. So again, as I commented before, there were teams on site, there were nursing teams and general practice teams on site, there were teams that were remote. And I think the Chief Operating Officer from the Alfred commented on that earlier in the week to the Board in her evidence, where she described the Alfred's role with nurses on the end of the phone. So there were nurses on site and there were nurses on the end of the phone and welfare officers on the end of the phone. And some of that remote team

things was necessary to reduce the risks of transmission to individuals.

So I think this finding of my review team reflects that, that not only was there not a unified information-sharing platform, but the teams providing the care holistically to returned passengers were actually in different locations also, some in the hotels and some remotely. Very difficult, very challenging.

Q. It results in effectively a siloing of that information, doesn't it?

A. Well, that's the risk, and I think that's what the review team was trying to call out, you know. There clearly is a need for better sharing of information through whatever means, whether it's an information-sharing platform or whether it's what we call in the health industry huddles, where a team comes together in the morning irrespective of where the teams are.

Q. Yes. Thank you. If we can highlight finding 4, which appears later on that page in bold, it starts "On a typical day". Finding number 4 was:

> *On a typical day, it was common for several detainees to not answer COVID symptom check calls, almost always for innocuous reasons. Therefore, unanswered calls alone did not trigger immediate escalation, beyond attempting follow-up calls.*

Now, we've already talked about, Professor, the fact that there were these daily symptom check calls and there was intended to be at day 3 and day 9 welfare check calls, but there were problems due to backlogs there. This is significant, is it not, as a finding because if there's no visibility of what's going on in the room from at least a symptoms perspective, you might also miss cues in relation to welfare concerns?

A. Yes. Look, I had hoped to --- well, I believe all of the findings are significant findings and the review team wouldn't have made them as findings had they not been significant --- but this is particularly significant because it goes to human factors in incidents. So people, you know, in the health industry, we have --- we have a workforce that get up in the morning to do good. The very purpose of their job is to care for other people, as it was for the nurses in this operation, they were there to ensure that the passengers' health was good.

So then when things don't go according to plan, understanding how has that happened. So here, the review team have found nurses who have made symptoms calls --- make a symptom call every day, but it wasn't uncommon or infrequent for the passenger in the hotel room not to answer for, as they've called it, innocuous reasons, and when they caught up with them later that day or the next day on the phone call, they're fine.

One of the challenges there is then that, of course, you get into a behaviour pattern and, "Okay, I called you this morning, you didn't pick up. Called you this afternoon." "Oh, yeah, I was in the shower. Sorry. I'm fine." So it is very easy to

see, without any mal-intent, how individual nurses can call into a pattern, "Well, he didn't pick up but, look, he didn't pick up yesterday morning and he was in the shower and he was fine, I'm sure he is fine." I think what the review team called out was there was no formal escalation process. What happens if you don't pick up at 9 o'clock in the morning when I call you? What is the formal escalation process? And they called that out because I think there was a need for such a formal escalation process.

Again, you know, where --- you know, is it, without being overly critical, mid-April or mid to late April that those weren't in place? No, because when these phone call structures were being designed by Public Health at the time, how could you foresee all of the eventualities that would come out of, "We need to call you every day. What happens if you don't pick up the phone? When do --- do I wait an hour, do I wait two hours, do I wait three hours?" et cetera, et cetera. But the review team I think are dutifully calling out that there is no formalised escalation process, and there should be, because if we repeatedly call someone and they don't pick up, should someone go and door-knock on them? So that's what this was calling out.

Q. Yes, and --

A. And it just goes to the human factors, human behaviours that underpin so many things.

Q. Yes. And we'll come to the lack of formal escalation policy there. But that, combined with, as you've just touched upon, this finding here, is a matter of some significance, isn't it, because what ultimately results by reason of those human factors that you've described is a process which is necessarily ad hoc.

A. I think it's a mischaracterisation. I think, rather than ad hoc, I think it's the rapidity with which Public Health clearly had to set this operation up, there wasn't time to think through all of the eventualities. So I think, rather than ad hoc, they were individualised. Now, you could characterise them as ad hoc. I think --- and you get a sense from the individual clinician, in this case a nurse, making a phone call, and let's say this had been a phone call on the 10th day and every day the person had been extremely well and they didn't pick up, you might be less anxious about that than if it's someone on day 1 or day 2 or someone who had had some symptoms yesterday and didn't pick up today, and actually you'd want that individualised response because that's the nature of human biology; you want the clinician at the bedside, as it were, to make the decisions. And that's really important.

But I think what the review team were finding is that there wasn't the formal escalation policies lying behind the clinician to support her in her decisions. You could characterise it as ad hoc. I think it just hadn't been built yet.

Q. Yes. That was a finding that was of particular significance in relation to this case, though, wasn't it? Because if we turn over the very next page, please, Mr Operator, and if we can expand the second paragraph there, in the case of the deceased there

were at least five unanswered calls through that final day. And due to that lack of formal systems for documenting --- so it's not just escalation, it's actually identifying that there were missed calls --- the review team could not be certain if there were more. So it was at least five, as expressed by the review team. There was a delay of more than 24 hours from the last answered call to when the deceased was found in his room.

A. That's correct. So the team had spoken --- the nursing team had spoken to him in the afternoon of the day before and things were well, apparently, that day. And they had tried to call in the morning, and I think my review team found that there had been other fairly significant events going on in the hotel that night and still going on into the next day, as is summarised here. But he didn't pick up in the morning.

Now, the Board will be aware that this death is subject to review by the Coroner and it wasn't the task of my review team to make findings about avoidability or not. But there was 24 hours transpired between the last speaking with him and escalation. And the review team found there were at least five and there may have been more because of, as you've said, you know, whether every call was recorded or not in terms of an unsuccessful call. So there may have been more than five but there were at least five calls during the day.

Q. Yes. And if we then go to the next finding, which is finding 5 referred to in that passage there, finding 5 is later on that same page. And we've already touched upon this one, Professor. That is:

> *There was a lack of specific formal policy about the threshold for escalating concerns .... and a lack of formal procedure for tracking [unanswered calls].*

So that's really a twofold issue, is it not? One is in this otherwise fragmented world of recordkeeping, we don't actually have a record of how many times these detainees are being called and we are having shift changeovers as well. That's why notes are kept, isn't it, so that people can track what has happened and what hasn't happened?

A. Exactly.

Q. Then over to the next page, finding number 6, and I think you've touched on this, about other significant events that were occurring in the hotel:

> *Due to workload and delegation challenges .... AOs were sometimes required to prioritise multiple competing demands, resulting in delays in attending to detainee health and welfare concerns.*

That really was a consequence of the system that was stood up and how many people were in a hotel at any given time and under the purview of the particular Authorised Officer. Do you agree with that?

A. Yes, I do. I think clearly a very large number of returning passengers, clearly

a set-up of the operation, determining, you know, how many nurses, how many GPs, how many Authorised Officers would be required in any given hotel setting, et cetera, would have been very difficult. And I think what was reflected here was that that 24-hour window between checking in with him and everything was well, and then subsequently finding him, may have contributed by other events going on in the hotel at the time. My review team found during their interviews that there were other incidents or other events going on at the time that may have been distracting or using, you know, consuming the time of the Authorised Officers and police, et cetera, at the time.

Had that incident not gone on, would the escalation of no pick-up of the phone calls happened? We can't make that finding. That would be with hindsight bias. But it's possible, and I think that's what the team are trying to highlight. Could it have been different had there been different provision of staffing? That's what they're trying to raise with this finding.

Q. Yes, yes. And that's certainly the purpose of this report, isn't it: "Let's look at what we're doing and let's work out how we might do it better"?

A. Exactly.

Q. But those competing priorities, Professor, especially when they vest really on that person who is identified in that finding, the Authorised Officer, that calls for more rigorous note-taking and calls for more rigorous policies around escalation and documenting, don't you agree?

A. Yes. So remembering that --- again, it goes back to one of the previous findings, doesn't it, about the shared information. So we've got different teams here; we've got AOs, Authorised Officers, we've got nurses, we've got police, security and so on and so forth. But in principle you're right. Where there is an escalation of events, one would hope for, you know, a detailed recordkeeping of those events so one can track them. And, again, I go back to one of the earlier findings of the review team that the lack of shared information may have contributed here to a lack of visibility of, actually, do we have a problem, yes or no? Because ultimately that's the question: are we worried that we have a passenger who is not picking up the phone, yes or no?

Q. Yes. You referred to before sort of the holistic wellbeing of the person, that is, the detainee, that is the physical health concerns, mental health concerns. We can only really consider it as holistic if all of that information feeds into one place or at least is visible to one person making decisions in relation to that person. Do you agree?

A. I do agree.

Q. So in essence, what your reviewers are finding here is that, at least in mid-April and in fact when this report is published in mid-June, the system in place did not have that holistic perspective?

A. That is true. They didn't have the information-sharing that would be preferred when this review was done in mid to late April. That is true.

Q. Well, you say when the review was done. These are findings that are made and published in mid-June.

A. Well, the report is released to the Secretary in mid-June. The recommendations and the findings relate to a whole series of interviews that were done in mid to late April. And, again, the review team escalated and, again reflecting their instructions, escalated a number of priority findings that they felt shouldn't wait for the formal review, so we could check in whether any actions had already been implemented.

Q. Yes.

A. But to say --- but the findings, as far as the report was released on 10 June, they relate to interviews and findings that were collected in mid to late April.

Q. Just going to the last of the findings, that's on the next page, Professor Wallace. If we can go to the next page and highlight the finding which appears at the very top of the page:

> *The forms for collecting detainee information ....*

These are the intake forms that you were referring to earlier, wasn't it, when the person was received into detention:

> *.... were not well designed to readily elicit specific and detailed information regarding past or current mental health concerns, self-harm or suicidal ideation.*

That's clearly a finding that your review team made and has subsequently gone on to inform one of their recommendations. That's a matter that again was of some significance, was it not?

A. Oh, very significant. And I think what they found was --- so it's not that there was no mental health welfare check on admission, if you like, to the hotel scheme, but it wasn't substantial enough. It was essentially, "Do you have any past history, any history of mental health issues, any mental health problems?", rather than a more all-encompassing perspective. And I think the subsequent changes to the program, the involvement of mental health expertise and recrafting that triage tool or that entry questionnaire, perhaps I think is reflected --- is a response to this finding.

And again, the finding is not --- I mean, it's really important in our methods that these are not meant as criticisms. They're meant as, you know, "How could we do this better?" And, "Did it contribute to this event?" Who can say? But really what the team was saying was at the time, the questionnaire that was built, was written for

interview on entry to the program, actually didn't go into enough detail about mental health assessment. And a very clear opportunity to improve that as the quarantine program continued.

Q. Yes. Thank you, Professor. Can we just roll over to the next page, because we have there summarised in six points what the reviewers call learnings, but I understand, Professor, you prefer lessons?

A. I don't think learnings has ever been a proper word in our language, so I do prefer lessons.

Q. Let's call them lessons. They are clearly and succinctly stated and these are the take-home measures as far as the reviewers are concerned?

A. Yes. So these are softer. And, again, it goes to the precision with which the review teams do their work. So they will inevitably make findings --- they'll have insights into broader systems which may have contributed or may have a material influence on an outcome. But they don't have evidence for it. But, nonetheless, there's something in there that should be captured and relayed back to the Health Service or in this case the Hotel Quarantine Program. So you could say that perhaps you'd put less weight on these than you would the findings and, if you were addressing things, you would address the findings first. But don't want to lose the richness of the lessons that have broader implications, that actually, if you act on them, may prevent things that are quite different to the incidents you're addressing. I hope that makes sense to the Board. But it is quite an explicit separation of findings for which we have evidence and lessons or learnings which we don't really have evidence of, but actually we think they're important and we don't want them to be lost.

Q. Yes. So we see that articulated, I think, Professor, in the paragraph above those 1 to 6, and that is:

> *Learnings describe system issues for which there was insufficient evidence to demonstrate that they contributed substantially ....*

Now, that's a point of distinction from the findings; is that right?

A. Yes.

Q. Then:

> *.... but nonetheless provide important improvement opportunities.*

A. Yes.

Q. So these are in addition to, not to replace, the findings. But the findings are the key factors that fall specifically to the matter under review, and that they at least

contributed substantially to the precipitating event. The learnings are some ancillary matters that we've also observed but haven't specifically looked at?

A. Yes, and we think are important enough to bring to attention, because addressing them will lead to what we think will be useful improvements.

Q. Yes. Thank you. We won't go through them all seriatim, Professor, but if we turn to the next page, that is the recommendations, and the page thereafter, we have a number of recommendations listed A through M. And I think, as you identified earlier in your evidence, it's important to be somewhat prescriptive in respect of recommendations to ensure that there is implementation?

A. Yes, and we use this strength grading system --- weak, moderate, strong --- really as a reflection of, you know, how useful do we think they will be in changing future events.

Q. Yes.

A. So it's something that --- so a strong recommendation we think is very likely to lead to improvements that would make an event of this nature much less likely to happen in the future, whereas a weak one is much less likely to impact --- important, but less likely to impact on future events; and trying to, you know, increasingly reduce the number of weak recommendations and increase the number of strong recommendations.

Q. Yes. Thank you, Professor. You've discussed or explained to us that there was a real-time feed-in of the information that the reviewers were obtaining, via you, back to Operation Soteria about some of the things that could be addressed or needed to be addressed more quickly. Is that a fair summary of what you were describing earlier?

A. Yes. The review team again, partly reflecting the methodologies here, it was a rapid review. The review team understood the element of urgency around this. We wanted to know were there fundamental things wrong with the program that we should change today or tomorrow. So, as they did that, they identified some issues which they called escalation issues that they brought to my attention, not to be held up by the fact-checking and normal processes of the review which would take another month and a bit. You know, 10 June the final report was released. So the intent of that was to share that quickly. I think that was shared with me very late April, 1 May type of date, so I could then share that with the operations centre to say, "These things probably need to be addressed immediately."

Q. You're not saying though that that process rendered these recommendations or findings stale in any way though, are you?

A. Absolutely not.

Q. So these were still appropriate findings and recommendations to be reported formally to the Secretary as of 10 June?

A. Yes.

MR IHLE: Madam Chair, I'm about to move on to a separate topic. I'm aware that we've been going for some time this morning and I still have some time to go with Professor Wallace. So if that's a convenient time, may I suggest a short break.

CHAIR: We will take a short break.

Perhaps before we do that, it's appropriate, given the context of some of the evidence this morning, to just remind those the people watching who may have been impacted by some of the evidence that if they're concerned at all, the Lifeline number is 13 11 14. I'll just repeat that again: the number for Lifeline is 13 11 14.

So, Professor Wallace, we will take a mid-morning break now and give you the opportunity also to have a break. We will take 15 minutes. So we will be back at 11.50.

A. Thank you, Madam Chair.

MR IHLE: If the Board pleases.

ADJOURNED **[11.34 AM]**

RESUMED **[11.50 AM]**

CHAIR: Yes, Mr Ihle.

MR IHLE: Thank you, Madam Chair.

Professor Wallace, before the break, when you were giving evidence, you were talking about the real-time feedback that you were able to give to Operation Soteria as issues emerged during the review process. Do you remember that evidence you gave a moment ago?

A. Yes, I do.

Q. One of those issues that emerged relatively early in the piece was the issue of overall responsibility for the operation. Do you recall that arising as an issue?

A. I do. I think one of the feedbacks from my review team is when they spoke with the nurses and the GPs and the AOs and welfare people was that particularly I think

for the nurses on the ground in the hotels, was that they weren't quite clear if there were issues or problems with a particular script or whatever. They weren't quite clear to who they should refer that to seek improvements. And certainly one of the important findings from the review team was this, of on-the-ground-staff, a lack of clarity about who they should go to.

Q. And it was also a question about who was ultimately responsibility for those that were being detained, wasn't it?

A. No, I think --- so my recollection is I escalated this very question, actually, around who is responsible, to Melissa Skilbeck, who is the Deputy Secretary of Regulation and Health Protection at the time, and --- but the question was really related to --- from the review team, which was --- because they're interviewing them, the staff on the ground, the nurses, the security officers, the AOs, et cetera, et cetera, and what was coming to them were clearly --- and some of the issues we've shared already this morning around lack of shared information platform, et cetera, et cetera, and what they were expressing was an uncertainty about, "Who do I go to for this?" So that's what I was then escalating.

Q. And you escalated that in an email to Deputy Secretary Skilbeck, didn't you?

A. Yes, I did, I think on 1 May, I think.

Q. I'll ask that that be brought up, thanks, Professor. It's document with ID DHS.0001.0012.1031_R. If we can just zoom in. We see, first of all, Professor, that that's an email from yourself to Melissa Skilbeck, who was the Deputy Secretary, as you've just described her, on 1 May, as you've told us. The substance of that email or first paragraph:

> *We are working through reviews of some key incidents in the hotels. The reviews are throwing up a number of issues, not wholly unexpectedly, including the fundamental question regarding "overall responsibility".*

That's a bigger question than the one you just described to us, wasn't it, not just about escalation but who is in an overall sense responsible?

A. Yeah, no, so I think --- I can see how that interpretation comes around, and I think the key thing here was we were working through the reviews of the incident and what was coming from my review team was this narrative that the staff they were interviewing, whether they were hotel staff or nursing staff or medical staff, et cetera, were uncertain as to who was, you know, overall responsible, who should they go to, who has the final say on, you know, policies and procedures, how do we get things changed, et cetera. It wasn't --- the reviews weren't addressing high-level governance of the operation. That was not within the scope of the review, it was about the care and welfare of these two individuals. And what was coming --- what this email was reflecting, my question to Melissa was really, "This is a problem. If the staff don't know who to go to and who has the authority to change something, then we can't

change something quickly", and I was seeking clarity on that.

Q. I just want to press you on that interpretation, Professor, because if you read the balance of the email, I suggest it's actually a broader question that you're asking Deputy Secretary Skilbeck there. The very next sentence from the one we've just left was:

> *In essence, who is responsible for the quarantined detainees. There is not a consensus on this and lack of consensus/clarity fundamentally undermines governance and decisions.*

Not just a question about "Who do I go to with a problem?" This is, who is overall responsible for the quarantined detainees. Do you agree that is what the email says?

A. No. Again, what the email --- the origins of the question, the problem, the problem of the origins of this email were around the staff on the ground didn't know who to go to to answer key questions about provision of resources or platforms, information-sharing, et cetera, et cetera, and as the review team sensed, there were conflicting opinions. We had broadly two teams here, and I think in the second paragraph of the email, it goes to a bit of that. So two teams here, co-responsible for the care and welfare of the passengers. There was the Public Health Division who were writing the policies and the guidelines, and what became the Emergency Operations Centre who were responsible for the implementation, the operationalisation of those policies and guidelines.

And there were times that the staff on the ground, and they were made visible through the review process of these two incidents; there were times that the staff on the ground would get a difference of opinion from one versus the other. So this was --- the governance that I'm referring to here is really around clinical governance. So, who has the ultimate decision-making around --- and some of these issues percolated through the escalation processes, the provision and usage of PPE, for example.

Critical to this was a position by Public Health that actually, these people are detained under us, and therefore we have accountabilities for them, and therefore responsibilities, and therefore the things that we decide as Public Health are important. And then on the other hand, what became the Emergency Operations Centre were trying to implement and operationalise those policies and guidelines.

So I think --- so what this is reflecting is --- again, following the discussions in sort of mid to late April, through the lens of those two reviews, is that the staff on the ground actually didn't know who was the final arbiter of, "What should we do?"

Let's stick with the example of PPE usage, for example. If someone says "We should use this PPE" and someone says "We should use different PPE", who is it? Who's right? That's what this --- I was really seeking clarity for the staff on the ground about, "Well, if this person says it, then that's what we do", and the Government's actually released clinical governance, because that's what Safer Care does, Safer Care

is a clinical governance expert. We're not an overarching business, you know, financial governance operation. We're focused solely on clinical governance.

Q. Professor, I just want to be clear about what you're saying there. Are you saying that this email is not a question that you're posing to Deputy Secretary Skilbeck about asking who has overall responsibility for quarantined detainees?

A. What I'm exploring with her is who is the final arbiter, who has responsibility for the decisions around the care and welfare component of the passengers or the detained passengers. Because that is, again, the focus of the two incidents. It's around care and welfare of the passengers.

Q. Okay. Thank you.

MR IHLE: I tender that email, Madam Chair.

CHAIR: Exhibit 120.

EXHIBIT #120 - EMAIL FROM PROFESSOR EUAN WALLACE TO DEPUTY SECRETARY MELISSA SKILBECK, DATED 1 MAY 2020

MR IHLE: As the Board pleases.

You've also referred earlier in your evidence today, Professor, to the escalation points that were brought to your attention, as I understand it, in late April, and you took them to the attention of Operation Soteria shortly thereafter. Perhaps if we bring up that document. It's SVC.0001.0002.0356_R. If we just zoom in on the first issue that's identified there, this is a document that was generated on or about 29 April, and I think you authorised it to be released to the Commander of Accommodation at Operation Soteria the following day, on 30 April.

A. That's right.

Q. So as at 29 April, your reviewers were reporting to you on daily checks --- just to be clear what we're talking about there, they're the symptom checks we were talking about earlier, "Do you have a cough, sneeze, sore throat", those types of checks, weren't they?

A. Yeah, so the first two points here, the daily checks and the welfare checks, and I think what they were calling out here, we've touched upon a wee bit already, was that there was confusion about who's doing what and when. But the first point, the daily checks here, was the nursing symptom checks.

Q. And they were primarily, if not entirely, done by phone?

A. Yes, so the review team were under the impression that the nurses on site were doing those checks, and they were being done mostly by telephone. So the nurse would phone, and we've talked about the five phone calls that day. So they would phone the room of the passenger.

Q. And as at 29 April your review team are telling you, "Look, Professor, this is an important thing because there's confusion as to who's even doing them."

A. That's right.

Q. And then the separate check, this was the one that was meant to be day 3 and day 9 by telephone, are the welfare checks. And your review team, as of late April, were telling you that they were concerned that they weren't being sufficiently done for two reasons, I suggest, as represented by this document: first of all, there's only two required across 14 days. That's the first concern they flag. Do you agree with that?

A. Yes. So there was --

Q. And --

A. So, apologies. And again, we've discussed this a wee bit already this morning, but my understanding is the original intent was the welfare checks would be done on day 3 and day 9, and the case we've been discussing, the gentleman we've been discussing, his welfare check was on day 5, not on day 3.

Q. And it was on day 9 that he was actually found deceased; is that right?

A. I'll have to check exactly ---

Q. We can come back to that.

A. Yes.

Q. But indeed, these welfare checks which the reviewers identified were insufficient by way of the questionnaires, they've also identified the second problem, not only that there was insufficient by number, but they're being conducted by non-clinical people, either at 50 Lonsdale Street or via Helloworld travel agency. Is it your understanding that as at 29 April, those welfare checks were being conducted by people at a travel agency?

A. So certainly the findings of the review team were that the welfare checks were being done invariably by a welfare check team in the Department of Health and Human Services, which is 50 Lonsdale Street, and by a call centre. And that, just to give the Board some broader awareness of that, so Helloworld has been engaged by the Department of Health and Human Services, trying to undertake a number of welfare checks, check-ins, with pre-approved scripts. And they do that very effectively.

Q. Except that it's identified in these escalation points, the final sentence in that box:

Often switch is overwhelmed and therefore welfare check not done at all.

A. So this was a really important finding, that the phone calls --- remember, we have two, broadly two discrete teams, one on site and one remote, whether it's Helloworld or in Lonsdale Street, and they're both remote. The teams on site could lift a phone in the lobby and dial direct into the detained passenger's room. The teams remote had to come in through the switchboard and the reception deck of the hotel, and reception desk is doing other things. Any of us who have tried to phone a loved one in a hotel and going through a switchboard going through reception will be familiar with that. Often --- you know, sometimes your phone isn't taken. So this is a really important finding, because actually we had --- while the process was set up with good intent, and we can see why that makes rational sense, the other complexity to this, we touched very briefly on this morning, is, actually we want as few people as possible in the hotel because you increase risks of transmission the more traffic there is through the hotel. So if the welfare checks are being done just by phone, they didn't require an in-person, face-to-face, then could that phone call welfare check be made by a team that's not present in the hotel? That is good design. Except what my review team then uncovered is it's good design except that the phone call has to go through the reception desk, and there's another blockage. And so there is another reason that interferes with the efficient delivery of that welfare check, if that makes sense.

Q. Yes, there's a bottleneck through the switchboard.

A. Yes.

Q. Yes. I just want to give you an opportunity, Professor --- you're familiar with this document. It's a document you were sent on the 29th and authorised its dissemination to Operation Soteria on the 30th. Are there any other comments that you want to make about these other escalation point here?

A. Not particularly. I think just for the Board's awareness, I used this document --- so obviously it's a distillation of more, you know, urgent issues that could and should be addressed immediately and not wait for the final report. I sent it to the Emergency Operations Centre, then I used this as the basis of a phone call with the lead of EOC to talk through them, and many of them actually had already been solved or had solutions in flight, and some of them hadn't. And so those that hadn't were then further discussed by a working group and brought all their sort of health and welfare teams together each day to say, "Can we talk through these issues, because my review team has identified them, and as I understand from discussions with EOC, they haven't yet been solved. Can we solve them?"

Q. Thank you, that document can come down.

Madam Chair, that's part of the bundle of attachments to Professor Wallace's first statement.

As part of the implementation of those recommendations, and I just want to understand this precisely from you, Doctor, in your first statement, in response to a question about recommendations that were raised prior to finalisation of the report, you identified a number of issues that were discussed, and specifically at paragraph 39(b), which is on page 11, discussing the issue around PPE usage, which you saw in that escalation point before, that:

> *[Safer Care had] suggested nursing staff in hotels be allowed to use P2/N95 masks for swabbing ....*

You go on to say:

> *The Deputy Chief Health Officer advised that the state PPE guidance did not require P2/N95 masks for swab-taking and that the nursing staff at the hotels should therefore not use P2/N95 masks.*

I just want to correlate that with your second statement, where when you were asked specifically to provide the dates on when those issues addressed in paragraph 39 --- so if you look at paragraph 7 of your second statement, you say:

> *With regards to the improvements I note in paragraph 39 of my first statement....*

You will recall that that was paragraph 39(b):

> *.... a record of discussion and action in the working group action include....*

And then at (b):

> *PPE usage by nursing staff --- no change to practice required.*

I'm trying to correlate or reconcile those two statements. Can you explain that for us, please?

A. Yes, thank you. And PPE usage and recommendations is something that's vexed, not just the hotel quarantine but the whole of the State and indeed the whole of the nation and other nations as understandings around this virus have evolved and changed since January. So in essence, what was happening here was that my review team, speaking with nurses, and it goes to those issues that are not directly related to the incidents themselves, but the nurses were saying, you know, understandably, "We are anxious. We're concerned. We're working in these hotels with quarantined passengers. Some of the passengers may be COVID-positive. We don't know. We're taking swabs. We've got surgical masks, but we should really have N95 masks." So that was raised in that escalation table that you had up earlier. I then

discussed that with the leader of the EOC, the Emergency Operations Centre, and it was an unresolved issues.

So we had nurses on the ground saying "We want to use N95 masks", and a state-wide policy that was tied to a Commonwealth policy, through the HPPC, that did not require N95 masks for swabs, for swabbing. So it was then taken to the working group, that daily informal group that was really trying to work through issues very quickly, to say, "What do we do here?" And there was clear direction from Public Health that was responsible for detaining these passengers and for writing the policies and procedures that the state policy at the time was that an N95 mask was not required for taking a swab, and so it would have been extraordinarily difficult and unusual to then have a policy for nurses working in a hotel quarantine environment to be using an N95 mask where our nurses in our EDs were not using N95 masks at that time. Now, they are today, but our understanding of the virus and aerosol transmission, today it is completely different to how it was in mid-April where we thought it was droplet transmission primarily, and I don't pretend --- it's not my area of expertise and I don't pretend to understand the nuances of those, but I am guided by the experts in the field, both locally and in our own the public health division, but also HPPC nationally.

And remember that the usage --- the other complexity to this issue is that there is a Commonwealth, a national stockpile of masks, of PPE. But access to that stockpile by jurisdictions, is related to the jurisdictions, not unreasonably, using PPE in accordance with nationally agreed guidelines. You couldn't have a situation where there was a Commonwealth Government stockpile of PPE and then one jurisdiction, one State, deciding to give N95 masks to everybody, burning up their own supply and therefore accessing the Commonwealth supply, leaving all other jurisdictions without any PPE.

So access to the Commonwealth stockpile was contingent upon everyone using the Commonwealth-agreed, the nationally agreed guidelines. And the state guideline, and the guideline that was used at the quarantine, the public health said this is the guideline --- this is when N95 masks should be used and should not be used or not required, and that's what was playing out here. We had nurses saying, "Can we use N95 masks?" Not unreasonably. Not unreasonably. Safer Care, we are a very --- Safer Care is a very clinician- and patient-facing organisation. So we were really asking the question, "Hey, guys. We've got a few nurses in a dozen or so hotels. Why don't we just let them use N95 masks? They're worried". And it was also the time we were wanting them to test. There's no requirement for the detained passengers to have testing, and we were wanting the nurses to sell testing to the passengers, because we wanted to know who was positive and who wasn't.

So here we had a workforce that we were dependent on to encourage people to be tested, who were asking for N95 masks, and Safer Care, very clinician- and patient-facing organisation, said, "Guys, why don't we just let them use N95 masks", and then public health saying, "Actually, that's not in accordance with both our State and national guidelines that we've signed up to, and also would compromise our

access to a national stockpile if we needed it, and what messages does that send to our nurses in ED and ICU and so on, who were saying to them 'You don't need an N95 mask'?"

So, quite a complex issue. The outcome of that issue is that the experts in the field were and are our public health clinicians, so let's take their advice, and again, there, it's under their directions that the passengers are detained, and so that's what we did, we took their advice and said actually no change was needed, there is no requirement for the nurses to use an N95 mask. That's rather long-winded, but it's important to bring in all the things that were going on at that time, and the discussions were live at the time, how is this virus transmitted.

Q. Can I try and summarise that, just to make sure that I understand. You had nurses saying, "Can we have these masks to conduct the swabs?"

A. Yes.

Q. Safer Care saying, with a view to safety, "If you can, let them have it"?

A. Yes.

Q. But public health saying, "No, that's not in compliance with the national guidelines"?

A. And the guidelines in use by our own hospitals at the time, and I think Safer Care, we were comfortable with that advice, so --- we were comfortable with the resolution that the nurses didn't need to wear masks, N95 masks. But you've encapsulated it, yes.

Q. Thanks. Were you aware that a draft policy around the use of PPE, specifically P2 or N95 masks, was prepared and disseminated amongst a number of people involved in public health operations and Operation Soteria as early as 17 April?

A. Who prepared that policy?

Q. Well, I can take you to it, you might be able to assist me on all of that, but perhaps first to follow it through, I'll take you to a chain of emails. It's an email chain which starts at document ID DHS.5000.0027.5106_R. I just want to ask you whether you were privy to any of these communications.

Now, if we actually scroll to the last page, which ends 5114, it's the first email in time. If we can perhaps zoom in to the first email which is at the bottom. This is --- I don't know why, but the role has been redacted. It says:

> *Hello,*
> *I'm working at the Mercure Welcome as one of the [team leaders].*

So that's just to put it into context for you. You will see that it says there:

> *We currently have P2 masks --- the nurses are requesting N-95 masks to protect themselves from patients.*

So this is an enquiry that comes through on 7 April, and without going through it chapter and verse, unless you want to, Professor, we can scroll up to what would be the fourth page. You see at the bottom there of the fourth page there's an email from Finn Romanes, who was the Commander of Public Health at the time. Is that right?

A. Yes.

Q. To Merrin Bamert, who was the accommodation commander for Operation Soteria. Is that so?

A. Yes. I can't recall exactly what Merrin's role was at that time, but broadly, she was the leader of what became the EOC. I don't think the EOC had formally stood up on the --- what date is that? That's the 10th, on the 10th ---

Q. 10 April.

A. Yes, but you have accommodation --- whatever her --- I can't remember her explicit role at that time. But essentially she was leading the operation.

Q. Yes, and if we just scroll over to the next page, you see at the top, this is the substance of the email sent by the Public Health Commander:

> *It's challenging --- thanks for your good work here.*
> *I think a conversation between the nursing agency and [there is a name redacted there but someone from Operation Soteria] might .... be of considerable value.*
> *Let's engage authoritative people to advise.*

Are these emails that you've ever seen before?

A. I've seen them in preparation for coming to the Board and as a witness, but at the time, I wasn't party to them in April. But I think the go-to, just this issue that we've been discussing and that my review team made visible, that we had a workforce, nurses in the hotels, that were asking for N95 --- so P2 and N95 is essentially the same thing, distinct from just the normal surgical masks that we're now wearing as we go about our daily business. So here is a workforce --- so these emails go to the same issue, exactly the same issue, so perhaps it's no surprise that a week or so later, when my review team were interviewing these nurses, that the issue then was made visible to them and became an escalation point for me.

Q. You see that sentence I was reading to you finishes:

.... you may need to consider alternative recruitment.

When you were looking at that document for the purposes of preparing for your evidence, did you take note of that reference there?

A. I read it. I'm not sure I understand your question.

Q. Well, you read it. How did you construe it? What did you understand that to be saying?

A. Well, I think I --- it's not proper for me to speak ---

MS HARRIS QC: Madam Chair, I was going to object to that question, Madam Chair, on the basis that it's not really relevant what Professor Wallace might interpret an email that he was not party to, that was sent sometime ago, and has only recently seen. The question has been partly progressed upon, but I don't think it adds to the Board's understanding of these matters, in my respectful submission.

MR IHLE: I'm trying, amongst other things, to contextualise the draft to which I referred the Professor Earlier, and the to'ing and froing that the Professor had indicated had occurred between nursing staff on the ground and with which Safer Care Victoria then threw their support behind in respect of the use of these masks. But if it's not of assistance, I can certainly move on.

CHAIR: Yes, I think the point has been made, Mr Ihle, with the use of PPE and the various constraints that have been now explained by Professor Wallace.

MR IHLE: As the Board pleases.

Professor, the first email in that chain, the last in time, is dated Friday, 17 April, and attaches to it "COVID Hotel HCW Quarantine Advice v0.1", and I'll ask that that document be brought up, because that's where we started upon this. It's document ID DHS.5000.0027.5115_R. So you see the note at the top of that page, it says:

P2 or N95 masks are only recommended when aerosol generating procedures are being undertaken or will occur.

then if we scroll down to the bottom of that page, you see there "Client/s room, Entering the client/s room" in the left-hand column:

Examples of aerosol generating procedures include:
- Collecting nasopharyngeal swabs.

Now, they're the swabs that are taken for COVID testing, aren't they?

A. They are.

Q. An

d you see in the right-hand column, "Respirator N95/P2 standard". Is that a document you have seen before?

A. It is, again, in preparation for today it was made available.

Q. Yes, thank you. I tender that document, Madam Chair.

CHAIR: Exhibit 121.

EXHIBIT #121 - COVID HOTEL HCW QUARANTINE ADVICE V0.1, DATED 17 APRIL 2020

A. I think one of the --

CHAIR: Go on, Professor Wallace.

A. I think this document may have been attached to an email on 17 April, as you said, but the author of that email just two days prior, on the 15th, had advised that N95/P2 mask was not required for collecting a nasopharyngeal swab. And I think that just gives visibility of the very hotly debated and discussed issues around what are aerosol-generating procedures and what require N95 masks or not. So the author of this document two days prior in an email had said N95 masks wasn't required by the nurses in the hotels. It's not in any way undermine this document but rather just to make visible just how hotly debated this was, and at the same time and in parallel, debate and discussion was going on in what was the PPE taskforce, in the Department of Health and Human Services that Safer Care established for the Department, to determine policies around PPE usage in our hospitals by healthcare workers. And it remains a very hotly debated topic today, many, many months later.

But I wouldn't want this document to be left as this was the gospel on 17 April. It wasn't. And I think that the most expert advice at that time, including all the way up to HPPC was that an N95 mask wasn't required, and the public health guidelines for Victoria, in usage of the quarantine, reflected that. And while Safer Care said, you know, "In essence, why don't just we let them have masks? It will help them encourage passengers to have testing," because we wanted that, we were sensitive to, well, actually there's very formal State and national guidelines and guidelines for our healthcare workers. We were sensitive to that, we agreed that actually a mask wasn't required.

Q. Thank you, Professor. We're going to go not as slowly through, but I want to take you to the second Safer Care report, and I ask that that be brought up, it is DHS.0001.0002.0032_R. I'll ask that we go straight to page 24, Mr Operator, please, which is document ID ending in 0055. If we can just zoom in on the first paragraph under the heading, which is "Below is a summary" is at the top of the page as shown.

Now, Professor, you will recall when you reviewed this document prior to it being published to the Secretary that one of the things that it did is the collated common themes that emerged through the first report process and the second report process, and to use your term, called them out as consistent themes across those issues.

A. Yes.

Q. And those themes, as we see, as we go down the page --- we can take the highlight off, please --- concerned firstly the selection of staff --

A. Yes.

Q. --- including an observation that some staff were assigned to roles for which they did not have appropriate knowledge base, skillset or relevant experience. And did you --

A. Yes.

Q. --- understand that to be an issue that presented both in respect of the incident that triggered the first report, and the incident that triggered the second report?

A. Yes. So what the review teams, two review teams have done here --- so again, we had two separate review teams undertake the two reviews independently. Again, probably not normally what we would do. If we'd had two incidents, say, like these, two different but related incidents in our health service, we would have commissioned a review, what we would call a cluster review, where we would have reviewed the two incidents with the same team collectively. But again, reflecting the desire to do this quickly, to get --- if there were important insights and lessons to learn and make improvements quickly, then let's get them done quickly, and the fastest way to do that is to have two independent reviews.

So what we then did here was to bring essentially the reviews together, high-level themes, six themes identified, trying to pool from the two incidents are there common themes, factors, that we should make visible for future improvement. So, slightly unusual. Normally the reviews would be done by the same team in sequence, and then collated in the same way. So we would still come up with high-level themes that require some addressing, but because we wanted to do this, we wanted the results quickly, we operationalised two review teams in parallel that then came together and shared the themes. So that's what this high-level --- these six themes highlight.

Q. Just to be clear, the two incidents that triggered the report actually occurred at two separate hotels, didn't they?

A. Yes, they did. They did.

Q. So these are themes that emerge from the reviews from staff at each of those

hotels?

A. Yes.

Q. Yes.

A. And not called out here about, you know, whether was there a particular incident, a particular hotel that related to a particular theme. I think again, this is really a collation of themes as opposed to precise findings.

Q. Yes. And so we see those themes listed, don't we, the selection of staff that was dealt with, problems with onboarding and training being insufficient, problems arising because staff are rostered at different hotels, problems that we covered in the first report about the collection, storage and access to information about return travellers, and then over the page, difficulties arising because policies and procedures were under-developed or not readily available, and again, as we've discussed, problems with escalation and leadership responsibilities, who had what responsibilities were not understood or appreciable.

A. Yes.

Q. Yes. Just finally, you will be pleased to know, at least from me, Professor Wallace, we've recently been served --- thank you. That can come down.

The Inquiry has recently been served with a statement from the State Controller, Andrea Spiteri, whom I assume you're familiar with?

A. I am.

Q. In her statement at paragraph 54, she says that the health and wellbeing arrangements for Operation Soteria were reviewed by Safer Care Victoria on 12 April 2020.

Now, first of all, are you aware of that review of the wellbeing arrangements?

A. So Safer Care Victoria, through the evolution of, you know, the development of the operation, because we have lots of clinicians at our disposal, and Safer Care Victoria offered to review --- so the original --- the starting documents of health and welfare policies were written by Public Health, and Safer Care offered to have them looked at by clinicians to offer advice about changes, and actually we made recommendations about changes in escalation pathways, for example, categorisations of three --- categorisations about urgency and escalation. So Safer Care Victoria offered advice around --- sort of, you know, let me take your starting documents and we'll get clinicians to look at it and offer you advice. So I think that's what Andrea is referring to.

Q. Were you yourself involved in that process of review?

A. I didn't review the documents myself. My role was simply to resource clinicians through Safer Care to do that review for us.

Q. And was anyone who was involved in the review of the two incidents involved in the review of the health and wellbeing arrangements?

A. Sorry --- are you asking was anyone, any member of the review team involved in the review of the health and welfare policies, the guidelines?

Q. Yes.

A. No. No.

Q. Okay. So is it more the case that really what Safer Care Victoria did by way of the reviewing of those health and wellbeing arrangements, as described by Ms Spiteri, was to facilitate others to review them and feed back?

A. Yes, so Safer Care has 11 clinical networks servicing, you know, emergency care, ICU, maternity, et cetera, et cetera, et cetera, and so we have literally hundreds of clinicians doing work with us out in sector, and so if we require a clinical expertise around health escalation pathways, so specifically we --- I remember we asked three emergency physicians, "Can you look at the escalation pathways for passengers who might become unwell in the Hotel Quarantine Scheme, and are those escalation pathways right?" And they then made comment on those escalation pathways which we then fed back, which then was reflected in changes and evolution in the operation plan for Soteria, so a very --- you know, very much a live document. And I think what Andrea is probably referring to is that live document being commented on by clinical access, which public health doesn't have immediate access to, which we do have immediate access to.

Q. I just want to ask about this role of Safer Care in reviewing the arrangements on 12 April concurrently with conducting reviews into incidents about those precise arrangements and whether, in your opinion, the statement of expectations about independence both from the Department structurally but also fundamentally were adequately observed.

A. I think they were. I mean, the reviews were being done by my incident review team in the patient safety and experience branch. The clinicians who we'd asked to look at the health escalation pathways would have had no visibility in the fact that we were doing reviews at the time. And actually I think it reflects --- this is the precise need for an agency like Safer Care, not to blow my agency's own trumpet, but this was exactly what Duckett called out. We want an agency that is sitting alongside the Health Department and health services, working in partnership with them, but when required, reviewing independently, providing expertise on quality and safety.

So here we had two things going on. We had safety reviews going on, and then we

had a look at the quality of the escalation, the care escalation pathways that had been drafted really quickly, been written very quickly. And fundamentally I think the escalation pathways were fine, but we got emergency doctors, physicians, experts, to look at the review pathways and make suggestions on them and change them. And that is actually the core function of Safer Care. That's the gem that we are to the state's health system.

So I don't see any conflict in us improving things in flight for an operation that's being stood up, a complex operation that's being stood up so quickly, and at the same time providing frank and fearless advice on reviews of serious incidents to the Secretary.

That almost encapsulates what Safer Care Victoria does for the state.

Q. I just want to ask one further question on that, and as I understand it, during the period these reviews were being undertaken, you were the CEO of Safer Care, but you were also concurrently the State Health Coordinator for COVID-19 Pandemic Response as appointed by the Secretary for the Department. Did that give rise to issues of independence, given that you were effectively wearing those two hats, one was a Departmental hat, one was a Safer Care hat?

A. No, I don't think so. The State Health Coordinator role, as the Board is aware, is in the emergency command structures of our state health response, and it's important that that role is a senior clinician, I think. Actually, reflecting Safer Care's core functions and quality and safety, under "business as usual" events, but also, even more importantly, under the conditions of a pandemic that is challenging our health services --- remember, back in April we were expecting 4,000 Victorians to be ventilated at any given time in a sector that at that time we had about 450 ventilators.

So, sitting as the State Health Coordinator allowed me a breadth of vision across our health system, because under SHERP, under the Emergency Response Plan, the State Health Coordinator is responsible for health provision in both acute sector and primary care. So it gave me visibility of some of the issues we've talked about this morning. PPE provision and usage, I wouldn't have had, in my role in trying to escalate some of those points, the PPE issue from the reviews; I wouldn't have had the breadth of vision of the complexity of PPE provision and usage, not just across the State but across the nation, had I not had that State Health Coordinator role.

So, I don't think so. I think we were able to execute our functions in undertaking these reviews quickly but with robust methodologies and accuracy and precision, without any influence from a State Health Coordinator. I mean, the State Health Coordinator's role is to escalate issues, to identify issues that are going to challenge our health system under a pandemic, in collaboration with the Public Health Commander and all others in the state emergency response command structures, ultimately to our Emergency Commissioner.

So I actually think having that role gave me a breadth or a horizon that fed in to

making implementation of some of the recommendations much richer than they might have otherwise been.

Q. Again, just so I understand your answer, do I assume that your answer to my question therefore is, no, you don't see that that in any way compromised the independence of the Safer Care processes in conducting the reviews of the two incidents?

A. Yes, that is my answer, I don't think it compromised at all. Again, going back to some of our very first conversations, the reviews were undertaken by my review teams and overseen by my director, and I didn't influence the content of the reviews at the end of the day.

MR IHLE: Yes. Thank you, Professor. I have no further questions for you.

As things stand, Madam Chair, I haven't been notified that anyone in particular has questions by way of cross-examination, but I assume that Ms Harris seeks to lead some further evidence from the Professor.

MS HARRIS QC: Madam Chair, what I do seek to do is to clarify two short points of evidence given by Professor Wallace. One relates to the escalation points and the discussion in the escalation points about welfare checks being undertaken by non-clinical staff, and that's a very brief question. And then the other relates to the difference between findings and learnings in the first report of Safer Care Victoria.

CHAIR: Yes, I will grant you that leave, Ms Harris.

MS HARRIS QC: Thank you.

CROSS-EXAMINATION BY MS HARRIS QC

MS HARRIS QC: Professor Wallace, as I understand it, your evidence was that the first report, in fact both reports, really, were based on findings and interviews based on your staff's interactions and investigations in mid to late April. Is that a correct understanding of your evidence?

A. Yes, it is.

Q. So in the escalation points that you were taken to, I don't think I need to bring this up, but it does say at the top:

Operation Soteria incident review, escalation points, 29 April 2020.

And there was an observation there about welfare checks being done by non-clinical people. The people who had been doing those interviews in mid-April may not have

been aware that on 15 April, the Department had entered into arrangements with Alfred Health to engage nurses to undertake welfare checks by telephone. Would that be right?

A. Very possible. It probably goes to the point that we discussed earlier with Counsel Assisting, that while the reports were provided to the Secretary 10 June, they reflected findings back in mid to late April. So this is the same issue, I think.

Q. Thank you. Professor, Simone Alexander from Alfred Health gave evidence that in fact Alfred Health began providing nurses for the telephone welfare checks at five quarantine hotels on 16 April. So that may, depending on when interviews were had, not have been something to which the people within Safer Care Victoria who did the reports were made aware; is that right?

A. It's possible.

Q. The other matter, Professor Wallace, relates to the difference between that difficult word, "learnings", and "findings" in the Safer Care Victoria report. I don't think I need to bring up the report, Professor Wallace, but first, the report describes the method on page 5 of the first report, and it says that in a case like this one:

> *The review team cannot determine for certain whether changes to the events and factors surrounding the death would have ultimately contributed to a different outcome. For this reason, the review focuses on addressing whether the management of this person's quarantine correspondence were to an adequate standard of care based on the information available about that person to those involved at the time. Therefore, in producing this report, the team do not purport to make any conclusions about fault or blame, nor whether any changes to the circumstances outlined would have prevented the incident.*

Is that an approach that informs the entirety of the review in an incident like this?

A. Yes, it does. I mean, the AcciMap tool that we used in this case, which is essentially a graphical structured tool to assist the interview team or the review team to go through all the potential elements that might contribute to an incident, when applied to health, it's an instrument that is evolved and taken from other high-reliability organisations. So it's the same instrument that's used in the Columbia Space Shuttle investigation way back in 2003, I think. Deepwater Horizon uses the same instrument.

But here, it's applied to health. And in essence what the distillation of the AcciMap and so-called protocol seeks to do is to answer the question, "Was the standard of care provided appropriate, yes or no?" Rather than, "Did this contribute or cause, in this case, the death of an individual?" Does that answer the question?

Q. It does, thank you. And I think in a much more summary term, on page 11 of the report, under the heading "Findings", it says:

Findings describe contributing factors identified through the review and AcciMap process that directly related to or arose from the sequence of events under review.

Is that the broad process that you were talking about?

A. Yes. Yes. So I think --

Q. And then --

A. Yes.

Q. Sorry. So with respect to "Findings", that's that description. Then "Learnings", you were taken to those as well. And "Learnings" on page 17, the statement there describing it is:

Learnings describe system issues for which there was insufficient evidence to demonstrate that they contributed substantially and specifically to the incident under review but nevertheless provide important improvement opportunities.

Now, the fact that that describes learnings in that way doesn't mean that anything described as a finding is the reverse of that and that it was found that they contributed substantially, is it?

A. No, I think the distinction is made because --- I guess the broader backdrop to this is, of course, we're involved not infrequently in reviews where the participants in the reviews don't really want to participate. That actually wasn't the case here, but you can imagine if we're working with the health service where major incidents happened and the care providers who have been involved in incidents don't really want to participate, and sometimes the health services themselves might be reluctant. So when we make findings, we actually link it to the evidence: "We've made this finding because of this." Whereas learnings, lessons, are much softer. You know, "In the course of the review, these other things or these other things came up." And we think, as I was explaining to Counsel Assisting earlier, "These other things, we think they're important and we shouldn't let them go. Just because we can't pin evidence to support them, we shouldn't let them go as an opportunity for learning," and the hope would be in the health service context, that health service would embrace that and say, "Yes, we understand that and we know that you can't point to the evidence but we nonetheless accept it and we would look to work to make improvements to correct it." Does that --- so they are softer. And I guess the essential difference in your profession is there isn't evidence to support them.

Q. And going to the language that's used in the "Learnings" description, that there is insufficient evidence to demonstrate that they contributed substantially, they were asked a question by Mr Ihle that was in terms of --- it had two parts to it, and this is the reason I wish to clarify. Mr Ihle said that the learnings are in addition to --- not

to replace the findings, but the findings are the key factors that fall specifically to the matter under review, and that they at least contributed substantially to the precipitating event. And then he says that "The learnings are some ancillary matters that we've also observed but haven't specifically looked at?" And you said, "Yes, and we think are important enough to bring to attention, because addressing them will lead to what we think will be useful improvements." Now, in that answer, were you intending to say what might possibly be understood --- that findings necessarily are to the effect that matters at least contributed substantially to the precipitating event?

A. I think the findings, and it's captured by our sort of definition sentence on "Findings", which is on page 11, I think, of that report, which is essentially findings describe contributing factors identified through the review processes. So is it direct cause and effect, and the outcome happened because of this? No. But these are factors that may have contributed. And if you --- because the intent is improvement, isn't it. The intent is not, "Oh, that's the cause." Actually, I know I mentioned Columbia before in the context of the AcciMap, but actually the findings of the Columbia Shuttle disaster encapsulates the whole thing. Complex systems fail in complex ways. So the purpose of health service incident reviews is not to say, "That was the cause," and point a finger, but rather to identify very complex contributing factors that all together, when you bring them all together, the so-called Swiss cheese model, make an event possible. Not that they caused it, but it made it possible. And if you correct these contributing factors or those factors that may have contributed, then you make the event much less possible to happen in the future.

So it's not that the findings say, "This caused the event. But rather, "If we corrected these things, it's possible we would make a future event less likely to happen. Does that --- it is complex, this, and --- yes, it is the world of systems, safety systems review.

MS HARRIS QC: Thank you, Professor Wallace. That does clarify that matter. Madam Chair, I have no further questions.

CHAIR: Thank you, Ms Harris.

MR IHLE: There's just one matter arising, Madam Chair.

RE-EXAMINATION BY MR ILHE

MR IHLE: Professor Wallace, Ms Harris just took you to some of the evidence given by Ms Alexander on Monday by way of abbreviated summary. At page 1018, in talking about this change to nurses from the Alfred who were providing the phone call service, she identified that specifically registered nurses had been requested. Can I ask you, when it comes to those non-clinical people who were working out of the offices of DHHS at 50 Lonsdale Street, and if in any way different, the travel

agents at the call centre at Helloworld, what qualifications did they have?

A. Look, I don't know, and I think it's out with the scope of Safer Care to make comment on what the required qualifications would be for people providing those services. That wasn't the scope for the review. But I don't know what the qualifications for the staff either here or elsewhere, in Lonsdale Street or elsewhere, had for those welfare check calls.

MR IHLE: Thank you, Professor. Unless there are further questions, Madam Chair, can we thank the Professor for his time and his work and otherwise excuse him.

CHAIR: Yes, indeed.

Thank you, Professor Wallace. Thank you for your attendance at the Board today, and you are now excused, which means you're able to turn off your camera and your microphone. Thank you.

A. Thank you, Madam Chair. Thank you.

THE WITNESS WITHDREW

CHAIR: Mr Ihle, the next witness --- I've just noticed the time, 12.55. It makes sense, doesn't it, to start with the next witness at 2.00?

MR IHLE: Indeed.

CHAIR: And that next witness is?

MR IHLE: Murray Smith, the Commander of COVID-19 Enforcement and Compliance at the Department of Health and Human Services.

CHAIR: Thank you. So we will start with Mr Smith at 2.00.

MR IHLE: As the Board pleases.

CHAIR: Thank you.

ADJOURNED **[12.55 PM]**

RESUMED **[2.00 PM]**

CHAIR: Yes, Mr Ihle.

MR IHLE: Madam Chair, we have now the Commander of COVID-19 Enforcement and Compliance in the Department of Health and Human Services, so I call Mr Smith.

CHAIR: Mr Smith, you're on mute, so you will need to unmute your microphone. You're still on mute. I don't think --- whatever's happening, Mr Smith, it's not unmuting you.

Are you able to see and hear me now?

MR SMITH: Yes, I am.

CHAIR: Thank you. Mr Smith, I understand you wish to take the oath for the purposes of giving your evidence?

MR SMITH: Yes, that's right.

CHAIR: All right. I'll hand that to my Associate while that's being done. Thank you.

MR MURRAY SMITH, SWORN

CHAIR: Thank you, Mr Smith. I'll hand you over to Mr Ihle now.

Thanks, Mr Ihle.

EXAMINATION BY MR IHLE

Q. Thank you, Mr Smith. Good afternoon.

A. Good afternoon.

Q. I take it you're able to at least hear me. Can you see me as well?

A. Yes, I can. I can hear you and see you.

Q. Thank you. Your full name, Mr Smith, what's that?

A. Murray Douglas Smith.

Q. Thank you. And your current position is Commander of COVID-19 Enforcement and Compliance at the Department of Health and Human Services?

A. Yes.

Q. That's a position that you have held since 7 May this year?

A. Yes.

Q. Prior to holding that position, what was your role?

A. I didn't have a role with the Department of Health and Human Services prior to that, I was an external appointment.

Q. Okay. Mr Smith, you've provided a statement to the Inquiry in response to a notice to produce. Is that the case?

A. Yes.

Q. That's a statement dated 1 September of this year?

A. Yes.

Q. It comprises 31 pages?

A. I'll take your word for that. I haven't checked the number of pages recently.

Q. That's all right. You have the statement there with you though?

A. Yes.

Q. And have you recently read through it?

A. Yes.

Q. And are the contents of that statement both true and correct?

A. Yes.

MR IHLE: I tender the statement of Murray Smith dated 1 September.

CHAIR: Exhibit 122.

EXHIBIT #122 - STATEMENT OF MURRAY SMITH

MR IHLE: As the Board pleases.

Mr Smith, I think there were two annexures with that statement, annexure MS-1, which is a copy of your CV, and annexure MS-2?

A. Yes.

Q. Are the contents of those two annexures true and correct?

A. Yes.

MR IHLE: I tender the annexures as a bundle, Madam Chair.

CHAIR: Exhibit 123.

EXHIBIT #123 - ANNEXURES TO STATEMENT OF MURRAY SMITH

MR IHLE: As the Board pleases.

And finally, Mr Smith, in preparing your statement, you had regard to and made subsequent reference in your statement to a number of documents. Is that the case?

A. Yes.

Q. And you seek that your statement be read in light of the content of these documents?

A. Yes.

MR IHLE: I tender each of the documents referred to in the statement of Mr Smith.

CHAIR: Exhibit 124.

EXHIBIT #124 - DOCUMENTS REFERRED TO IN STATEMENT OF MURRAY SMITH

MR IHLE: As the Board pleases.

Mr Smith, to understand your role, being that role that you've held since 7 May of this year, effectively being one that's primarily directed to supervising Authorised Officers, team leaders and senior Authorised Officers?

A. Yes, that was my role and is my role.

Q. And that includes Authorised Officers that were working within the Hotel

Quarantine Program from at least your appointment, 7 May?

A. Yes.

Q. You also had reporting to you from time to time Deputy Commanders in relation to COVID-19 Enforcement and Compliance?

A. No, I didn't have them from time to time. They were reporting at all times to me. And the ---

(Simultaneous speakers - unclear)

Q. How many Deputy Commanders have there been since your appointment on 7 May?

A. You mean in numerical number or as in the roles themselves?

Q. Let's start with the roles themselves.

A. Okay. So there was a Deputy Commander that was responsible for the Authorised Officers, and there was a Deputy Commander role responsible for undertaking the work for determinations and policy work. So there was two roles that were reporting to the Commander role.

Q. Both of those roles have been in place since 7 May, have they?

A. Prior to 7 May.

Q. Do I understand your statement correctly that in essence, the role of the Authorised Officers generally is to exercise powers under section 200(1) of the *Public Health and Wellbeing Act*?

A. If you're referring to undertaking their work in the regulatory framework for Detention Notices, yes.

Q. Yes, we're focusing, so the questions I'm going to ask you for the remainder of the afternoon relate to the Hotel Quarantine Program, so if we look at it through that prism, just assume that the questions are about the Hotel Quarantine Program and if I'm going to step outside that, I'll expressly say so. Okay?

A. Thank you.

Q. So in the Hotel Quarantine Program, that is the function of the AOs, that is, they're the delegates of the Chief Health Officer to exercise powers under section 200(1) of the *Public Health and Wellbeing Act*?

A. Yes.

Q. And as you've identified at paragraph 11, they fulfil that function essentially in three broad ways. One, they serve a notice upon those returning at the airport. That's the first?

A. I'm sorry? The question is, is that what they do as part of --

Q. The question is --- yes.

A. Yes.

Q. So they ensure compliance and manage permission and exemptions?

A. Yes.

Q. Including authorising fresh air walks for people that are in hotel quarantine?

A. Yes.

Q. And ultimately it falls to the Authorised Officers to approve a person's release at the end of detention.

A. Yes, in accordance with the regulatory framework.

Q. Yes, and I understand from your statement that the Authorised Officers had no role in overseeing infection control and prevention at the hotel?

A. That's right.

Q. Nor did they oversee the use or assignment of personal protective equipment of the other people working in the hotel?

A. That's correct.

Q. Who, to your knowledge, if anyone, was responsible on the site at each hotel for infection prevention and control?

A. Well, that would be in accordance with the emergency management structures that were in place for the Commander of Operation Soteria, which was the COVID-19 Commander in charge of accommodation.

Q. Okay. Those Commanders of accommodation were not on site at the hotels though, were they?

A. No.

Q. So who, if anyone, on site was responsible for infection prevention and control?

A. There was a DHHS team leader that was responsible for the coordination for those sort of services.

Q. Okay, and does that also include oversight or responsibility for personal protective equipment for those working in the hotels?

A. Yes.

Q. Were those people --- that is, the DHHS team leaders --- also the ones on site responsible to ensure that cleaning was adequately done?

A. I'm not sure. I can't answer that question.

Q. Okay. You say at paragraph 14 of your statement that the Authorised Officers had no responsibility for any of the other staff at the hotels. Is that right?

A. Yes.

Q. To your mind, given that you're responsible for the AOs, who was relevantly in charge of the hotels?

A. So the DHHS team leader was the port of call for services provided by DHHS in terms of outside of the activities of detention, of the regulatory framework.

Q. Okay. So if there were functions that weren't falling to DHHS, was there any nominated person who was in charge on site for the hotels, as far as you're concerned?

A. I understand that other Departments had site managers at hotels.

Q. Coming to the questions you were asked and have answered in your statement about Authorised Officers, I understand that there was a need to obtain a number of Authorised Officers, including from originally outside the Department, when this operation came into effect. Is that your understanding?

A. Yes.

Q. And you were asked about any particular qualifications or training that people were required to have to be considered, and you've identified a number of things at paragraph 34. But in essence, I want to go to the types of people that were brought into the Department. Did you understand that that included officers from the DELWP?

A. Yes.

Q. From local councils and city councils?

A. Yes.

Q. And that included people like park rangers; is that right?

A. Yes.

Q. Ticket inspectors?

A. I'm not sure how you define "ticket inspectors".

Q. Well, parking inspectors?

A. Yes.

Q. And health and sanitation inspectors?

A. Yes.

Q. Now, given your understanding of Authorised Officers exercising powers pursuant to section 200(1), it's the case, isn't it, Mr Smith, that pursuant to that understanding, it was the authority that the AOs were using to detain people in hotel quarantine, they were exercising the detention power?

A. Yes.

Q. So in essence, those detained in hotel quarantine were in the custody of the Authorised Officers?

A. In terms of the regulatory framework, yes.

Q. So you would agree then, wouldn't you, that it was the responsibility of the AOs as custodians for those people within the regulatory framework, to ensure that the safety and welfare concerns of those detainees is looked after?

MS HARRIS QC: Could I just make an objection to the use of "custodian"? I don't think the witness agreed to that terminology.

MR IHLE: He agreed that they were in the custody of the Authorised Officers.

MS HARRIS QC: For that regulatory framework.

MR IHLE: Yes.

MS HARRIS QC: I won't pursue the objection, but it just needs to be understood with that qualification.

CHAIR: Yes.

MR IHLE: So, given that the detainees were in the custody of the Authorised Officers within the regulatory framework, it was the responsibility of the Authorised Afficers, was it not, Mr Smith, to ensure that the safety and the welfare of the detainees was looked after?

A. In terms of the regulatory framework, yes.

Q. And those roles that we covered just examples of, people that were chosen from outside the DHHS to come in --- park rangers, parking ticket inspectors, sanitation inspectors --- they're not people that you would expect, would you, Mr Smith, to have had experience in detaining people?

A. Well, I don't know what their experience had been. I can't comment on their experience, professional, experience, irrespective of what position they might hold.

Q. Let me ask you this then, Mr Smith. Are you aware of any incident that you can think of where a park ranger has had to take someone into their custody?

A. I can't answer that question. I don't know.

Q. What about a parking ticket inspector?

A. I can't answer that question. I don't know.

Q. Okay. So if I put to you the suggestion that those three examples that we've discussed are not roles that would usually involve taking someone into your custody and being responsible for their health and welfare, you can't answer that question, I assume?

A. No, I don't believe that's what you asked me. You asked me whether or not people that have held those roles previously have held anyone in custody, and I don't know.

Q. Okay.

A. I haven't worked in those roles, I'm not --- I can't help you with that, unfortunately.

Q. No, I appreciate that. But notwithstanding, that's really the primary role of the Authorised Officer, isn't it, to hold these detainees in their custody?

A. For the purposes of hotel quarantine, their primary role is to issue Detention Notices and maintain integrity of the Detention Notice throughout the life of it.

Q. And to exercise those powers delegated to them under section 200(1) of the

Public Health and Wellbeing Act?

A. Yes.

Q. We've talked a little bit about the types of people that were brought in to be Authorised Officers. Let's talk about the training they were provided initially. As I understand it, there was induction training that was held by teleconference? Is that right?

A. Yes.

Q. That was induction training that went for one hour?

A. Yes.

Q. They were also provided with copies of the documents that you've listed at paragraph 40 of your statement?

A. Can I look at paragraph 40 of my statement?

Q. Please do. Please do.

A. Thank you. Yes, that's right.

Q. And then thereafter, they were from time to time provided with different policies, instructions and guidelines, being those that you've outlined at paragraph 57.

A. Yes, that's correct.

Q. So other than the one-hour teleconference training and those documents you've listed at paragraph 40, before Authorised Officers began their duty on the ground, there was no other formal program-specific training; is that right?

A. I wouldn't agree with that, no. You will note that in paragraph 41, there was part B of the training that was undertaken for workplace orientation, and it goes on to explain that in that paragraph.

Q. I'm referring to paragraph 36, Mr Smith, where you say:

> *.... no specific additional qualifications were required to be appointed as an AO for the purposes of Hotel Quarantine Program. For the first two weeks of the program following rapid establishment AOs did not receive formal program-specific training before commencing work on the ground at hotels ....*

A. And I note that it says:

.... but received instruction and supervision from senior AOs (who were on the ground at hotels or on call 24 hours a day 7 days a week) and members of the Enforcement and Compliance team.

Is also included in that.

Q. So what you're talking about there is on-the-job training?

A. Well, that and appropriate supervision and leadership.

Q. Yes. And from time to time, when the AOs attended, they were the only AO at a specific hotel, weren't they?

A. That's right.

Q. You discuss at paragraph 68 and following in answer to question 13 the process of daily reviews that were required under the *Public Health and Wellbeing Act*.

A. Yes.

Q. And you say at paragraph 68 there was one criterion. That is, you say:

Given that the Hotel Quarantine Program was instituted in the context of a national requirement that all returned travellers spend a period of 14 days quarantine in a suitable facility such as a hotel, the criterion for identifying the elimination or reduction of a serious risk to public health was whether the person had completed the required 14 day period of quarantine.

What you're suggesting there is that there is one factor which goes into consideration of those daily reviews?

A. I'm not suggesting it; I'm actually saying it.

Q. Yes, you're saying that there is one factor, and that's just a question of where in the 14 days they sit?

A. Yes.

Q. And that process of the daily reviews, you go on to identify, sat with a single person who was a senior AO?

A. Yes.

Q. So in effect, are we to understand that daily reviews were done en masse by simply looking at where in the 14-day period a person sat?

A. Yes.

Q. Going back to the general responsibilities of the AOs, and this includes senior AOs, at paragraph 16, you identify a number of general responsibilities that Authorised Officers had.

A. Yes.

Q. And amongst those, you will see at subparagraph (i) that their general responsibilities included considering the *Charter of Human Rights and Responsibilities Act* when making decisions?

A. Yes, there was a number of general responsibilities, that was one, yes.

Q. Yes, that was one of them. And the decisions that AOs were making, were those decisions to exercise the powers under section 200(1) of the *Public Health and Wellbeing Act*?

A. I'm sorry, I've lost you. Could you just repeat the question?

Q. Yes. So the decisions --- because you say that they have to consider the *Charter* when making decisions --- the decisions that they were making related to the exercise of their powers under section 200(1) of the *Public Health and Wellbeing Act*?

A. Yes.

Q. Yes. We've covered briefly the training. The teleconference that AOs had, that did not touch upon issues to do with the *Charter*, did it?

A. I'm not aware of that, no.

Q. And the documents that you've listed at paragraph 40 that were provided to the AOs are not documents that dealt with the *Charter* at all, are they?

A. No.

Q. And of the documents that you've listed at paragraph 57, it's only the document at 57(c) that has any mention of the *Charter*, isn't it?

A. Which document are you referring to again, please?

Q. 57(c):

> *Guidelines for Authorised Officers - Ensuring physical and mental welfare of international arrivals in individual detention (unaccompanied minors), Charter considerations ....*

A. No, I disagree with that.

Q. So you say that there's another document amongst that list in 57 which deals with the *Charter*?

A. There should be a document that's listed here with respect to the protocols that are sometimes referred to as annex 1, and there they are. In 57(a), you will see overarching documents, "Annex 1 COVID-19 Compliance Policy and Procedures --- Detention Authorisation", version 1, 2, and then there's a subsection (v) there that talks about that. The *Charter of Human Rights* and the decisions to be made are also incorporated in that document.

Q. Yes, so do you say that those documents give AOs any guidance as to how they are to have regard to *Charter* rights?

A. Yes, they do.

Q. And if they do, that that will be obvious on the face of those documents, I assume?

A. Yes.

Q. Thank you. Given the significance of the decisions that were being exercised by Authorised Officers from time to time pursuant to the powers vested in them under section 200(1) of the *Public Health and Wellbeing Act*, do you consider that the training and instructions Authorised officers had received was sufficient for them to discharge their legal obligations to make lawful decisions under the *Charter*?

A. Yes.

Q. Can you explain your answer, please?

A. Well, they were equally --- if you're talking about the length of the program, and as it --- there were opportunities to improve upon that, of course, and they were taken. So I am very confident that the Authorised Officers had the appropriate skills and capabilities to undertake their job ---

Q. Yes, and specifically say that that --- sorry, go on?

A. --- and appropriately supported with the relevant policies and procedures to do so.

Q. And those policies and procedures are those that you've directed us to, those at 57(a)(iii) through to (v) which would be described as annexes?

A. Well, there's a number of policies and procedures listed that clearly demonstrate there was a number of documentations given to Authorised Officers throughout the program.

Q. I'm specifically asking about the Charter, because you would appreciate,

Mr Smith, that the failure to have regard to *Charter* rights by a person exercising public powers could render that decision or the exercise of that power unlawful. You appreciate that, don't you?

A. Of course.

Q. So what I'm asking you --

A. Your question was --

Q. What I'm asking you was whether you felt, given that you were responsible and are responsible for all the Authorised Officers exercising these powers, whether the training was sufficient to guide them in ensuring that they had proper regard for Charter rights?

A. Well, I would agree with that question, yes.

Q. You say they do, okay. And that's based on --- you've identified those three documents, being the annexes which you say on their face will show the guidance that the Authorised Officers were given in respect of consideration of Charter rights when making their own decisions?

A. That and the other documents that you identified, yes.

Q. The other document that I identified was one that's directed to a particular circumstance, being the circumstance of unaccompanied minors. Do you agree with that?

A. Yes.

Q. Yes. Mr Smith, in your statement at paragraph 97, you discussed or identified in respect of a question that was asked of you:

> *Do you have any reservations about any aspects of the hotel quarantine at any time? If you did, what were your reservations, and to whom, if anyone, did you express them?"*

You say at paragraph (a) that:

> *.... I raised with the Deputy Commander --- Accommodation (Hotels), the issue of providing evacuation plans for each hotel to Authorised Officers so they would be familiar with their accountability should an evacuation be required.*

Do we take that part of your statement to at least imply that, prior to late May 2020, evacuation plans for the hotels had not been provided to Authorised Officers?

A. No, that is correct. What was provided was a flowchart of how to respond to any

emergency situation, but there wasn't evacuation plans for each individual hotel readily available to the Authorised Officers.

Q. Do you know whether there were evacuation plans at all?

A. There were evacuation plans with respect to what you would expect for any hotel. However, I was seeking further clarity about roles and responsibilities should something occur in those hotels for the overlay of the Hotel Quarantine Program.

Q. Yes. Thank you. I want to ask you about complaints, and you were asked about this in relation to your statement, and indeed the second annexure to your statement is a summary of the complaints that came to your attention, isn't it?

A. Yes.

Q. I want to ask you specifically about the last of the entries that you've made there, which concerns a complaint that came to your attention which had been raised by someone on behalf all of the DELWP-based Authorised Officers; okay?

The Inquiry, the Board has before it now, as Exhibit 111, a statement of Ms Gavens from the DELWP. Are you familiar with whom Ms Gavens is?

A. Yes.

Q. Ms Gavens details at paragraph 31 of her statement --- first of all, have you read Ms Gavens' statement?

A. Yes.

Q. Okay. So you will recall that at paragraph 31, she says on 24 June, she spoke with someone at the Department in relation to the issues identified by Parks Victoria Authorised Officers, and she, that is Ms Gavens, told the DHHS representative that she would send her an email, and she sent an email setting out those issues. Do you know the email that that part of the statement is referring to?

A. I can assume, but I would hate to do so, so I'm happy for you to tell me exactly which email.

Q. We can bring it up. That's okay. Ms Gavens describes the purpose of the email to be to prompt a conversation with the Department about whether the issues were reasonable and what could be done to resolve them.

I'll ask that the email be brought up, Madam Chair. It's document ID DELW.0001.0001.0652_R. If we just scroll to the second page there, and perhaps if we can zoom in where the dot points start to emerge.

Is this the email that you were assuming we were talking about, Mr Smith?

A. Yes.

Q. Yes. Ms Gavens describes in her statement that this is an email that is sent not only after conversation with the Department, but after a number of issues have been sent through in different tables and emails over time, and you will see that what she's provided here, you will see the second line that's on the screen:

Here is the consolidated list.

And she describes:

Lack of adjustment to systems after Rydges contamination ....
Fatigue management....
Lack of job-specific onboarding and briefing ....
Lack of operationally focused processes and procedures ....
Lack of incident management team structure and operational command and control....
Lack of oversight of .... staff.... Inconsistencies between hotels ....
Testing of detainees not compulsory but [people] .... being allowed to go for walks ....
Lack of mitigation plans in place ....

Which is over the page. We can turn to it if you like.

When did the contents of that email come to your attention?

A. I think I was carbon-copied into an email of that description at some point. I couldn't give you the exact date without --- I'm sure it would have been supplied in my exhibits that were submitted to the Inquiry. So I couldn't give an exact date, but I'm sure we can identify it.

Q. All the issues that are being identified there by Ms Gavens on behalf of the workforce for which she has usual responsibility, they're significant issues, are they not?

A. Well, they're not written by me. I'm not sure what you're asking in terms of the --

Q. Well, you're the person with primary responsibility for the oversight and supervision of Authorised Officers working within the Hotel Quarantine Program. Here you have a member of another Government Department saying, "Here is a consolidated list of the issues that are coming to our attention, and we want to bring them to your attention."

As the person responsible for the Authorised Officers, when this came to your attention, you would have appreciated the significance of those issues, would you not?

A. I would appreciate that they're an interpretation of someone's experience. It doesn't make them that they're correct.

Q. Okay. Well, you're aware that, not receiving a satisfactory response to that email, Ms Gavens sent a following email on 10 July after a number of attempts to get follow-up response to that, and she withdrew all DELWP officers from the Authorised Officers program. You're aware of that, aren't you?

A. No, I'm not aware of --- if you'd take me through the circumstances of events, I'm sure we could work that out, but jumping to that conclusion, I'm not aware of what you're talking --- certainly I've read her statement, but I haven't read it recently enough to be able to be sure about what you're saying.

Q. Okay. Well, we can go through it piece by piece if you like, but first of all let's start at the end. Were you aware that all DELWP officers were withdrawn from the Authorised Officer program on 10 July?

A. No. I was aware that we didn't have DELWP officers --- I wasn't aware of the circumstances of how they came to not be in the program. I'm aware they weren't in the program.

Q. My question was, and I'll come back to it precisely: were you aware that all DELWP officers were withdrawn from the Authorised Officer program on 10 July?

A. No.

Q. So, notwithstanding that you were the Commander responsible for all Authorised Officers, it didn't come to your attention, either on 10 July or afterwards, that they had been withdrawn from the program by DELWP?

A. No.

Q. Can we please bring up document DELW.0001.0034.0008. Mr Smith, you've read Ms Gavens' statement and this was one of the emails referred to in it. You will see that that's an email from a person that's redacted, dated 10 July, sent to the COVID-19 Authorised Officer Rostering email address, and it says:

> *Hi Rostering team,*
> *Following on from [something] email below, can I please also request the immediate removal of [a particular person] from the roster as well?*
> *Until further notice, no other DELWP staff members are available for rostering in [Operation] Soteria.*

Were you aware that that email had been conveyed through to COVID-19 Authorised Officer Rostering Services on 10 July?

A. No.

Q. When did you first become aware?

A. Of what?

Q. Of the existence of that email on 10 July.

A. Well, I wasn't aware of it on 10 July.

Q. When did you first become aware of it? Was it only in reading Ms Gavens' statement recently?

A. Yes, I wasn't aware of this email.

Q. Did you read in Ms Gavens' statement her explanation for the removal of DELWP Authorised Officers?

A. Recently, yes.

Q. And was that the first time, are you saying, Mr Smith, that you understood why DELWP had made the decision to remove its Authorised Officers?

A. If you could direct me to the statement. It's hard for me to put context around a statement that I certainly have read, but I don't have in --- I may have in my documents somewhere, but I don't have it at hand at the moment.

Q. Okay. Mr Smith, I'm trying to understand, is your evidence that you were not aware that DELWP had withdrawn its Authorised Officers from the Authorised Officers program? Is that your evidence?

A. Yes. In terms of --- I said earlier --- I said earlier that I was aware they weren't working in the program. I wasn't aware of why they weren't working in the program.

Q. Okay. And have you consequently become aware as to why they're not working in the program?

A. Yes.

Q. And why is that, to your understanding, that they're no longer working in the program?

A. They had an interpretation that I didn't agree with, but it was their interpretation.

Q. And that interpretation is the one evidenced by the previous email that we looked at, which is that there are a number of issues outstanding that were not being addressed. Is that your understanding as to their interpretation?

A. That's --- yes, that's their interpretation, that is correct.

Q. Is that your understanding of their interpretation?

A. I can only talk for what I know. I can't talk for others, of course. And what I can say is, we've seen the email where there was a number of issues that they raised based on their interpretations, and that's a matter for them.

Q. Yes. And you also understand that after they sent that email, they had to spend some time following up Department of Health and Human Services, specifically your department, COVID Enforcement and Compliance, to try and get a response, and it was the lack of response that caused them to make the withdrawal?

A. Again, I can't comment on their decision-making process. I can comment on that there's an email in front of this screen now that talks about that, but it's not a matter I can take further in terms of the question you're asking.

Q. Okay. Are you aware, Mr Smith, of the evidence given to this Inquiry by a Parks Victoria employee who performed duties as an Authorised Officer by the name of Luke Ashford?

A. I'm aware that he gave evidence, yes.

Q. And are you aware that he gave evidence that he sent an email to a person at the Department who was responsible for onboarding him as an Authorised Officer on 18 June whereby he had claimed to have raised safety concerns which hadn't been addressed? Are you aware of that aspect of his evidence?

A. I'm aware of it.

Q. Yes. Are you also aware that on 18 June, in the wake of the Stamford Plaza outbreak, he sent an email to that person --- that is, the person responsible for onboarding him, and that's a person who this Board has a statement from that was tendered this morning --- and in that email, he said:

> *I regret to inform you that I intend to cease my secondment as an Authorised Officer with DHHS effective immediately. The decision has come about due to the second outbreak of COVID-19 in the Stamford Hotel. I believe that DHHS is not and cannot provide me with a safe working environment. In saying that, I cannot risk my own health or my family's health.*

Are you aware that on 18 June, Mr Ashford sent that email?

A. I am aware of it now.

Q. Was it not brought to your attention prior to Mr Ashford giving evidence?

A. No.

Q. Mr Ashford was operating until 18 June as an Authorised Officer under your supervision and direction, was he not?

A. He wasn't under my supervision. We have a structure of management that includes Team Leaders, Senior Authorised Officers, and Deputy Commanders. My interpretation of the word "supervision" is not of that nature --- of that far removed from --- I would certainly say leadership, but I would not agree with supervision, if you're terming it in the way that I think you might be. But I'm happy to explain what my version of supervision would require.

Q. So you did agree earlier on, and as you say in your statement at paragraph 5, that your role was to supervise Authorised Officers, including senior Authorised Officers. Is that something different now, or is it a particular type of supervision?

A. No, I'm interpreting your language of supervision today as being in my --- supervision as you would a team leader who then has a number of people reporting to them directly, as in direct reports.

Q. I never suggested he was a direct report to you, and I don't want to get bogged down in semantics, but ultimately he was someone for whom you were responsible.

A. Yes.

Q. And he sent that email on 18 June, and I'll come back to the question: when did you first become aware that he had sent that email?

A. In the preparation for my appearance before the Inquiry.

Q. Okay. So I'll just back pedal. Were you aware of that email when he gave the evidence about that email?

A. I'm sorry? Was I aware of --

Q. Mr Ashford gave evidence some weeks ago now, Mr Smith, and the request for your statement came sometime after Mr Ashford had given evidence. I'm trying to work out whether, before the request for your statement was made, you already knew about it, or it was only in the process of preparing your statement. Are you able to assist us there?

A. I'm getting a bit lost in your question. Are you saying did I know before the evidence was given or after the evidence was given?

Q. That's exactly what I'm asking. Did you know before the evidence was given?

A. No, I did not.

Q. Did you follow his evidence when he was giving it?

A. No, I didn't.

Q. Was it only brought to your attention after you were requested to make a statement?

A. When --- are you asking when I became aware of the email?

Q. Yes.

A. Or are you asking --- right. So in the --- I wasn't aware of it before he had given his evidence.

Q. Okay. We've covered that. I'm now asking about whether you were aware of it at the time or shortly thereafter that he gave his evidence, or it's only been brought to your attention as part of the process of preparing your statement.

A. Well, my statement has been prepared over a number of weeks, so I can only help by saying that at some point in that process, it would have been brought to my attention.

Q. Okay. Are you aware, Mr Smith, that his email went on:

> *I have raised my safety concerns with other AOs, AO team leaders and DHHS team leaders on more than three occasions, both verbally and via email, the most recent being my last shift at the Mercure Welcome on Wednesday, 17 June.*

As the person ultimately responsible for him, Mr Smith, the concerns being expressed to you or the --- sorry, I withdraw that --- the concerns being expressed in this email should have been brought to your attention before you started preparing for this Inquiry. Do you agree with that?

A. Yes.

Q. And do you say that they were not?

A. That's right.

Q. Mr Ashford says quite clearly in his email:

> *The DHHS is not and cannot provide me with a safe working environment.*

Do you believe that the Department provided Mr Ashford with a safe working

environment?

A. Yes.

Q. Do you believe that the Department provided all Authorised Officers with a safe working environment?

A. Yes.

MR IHLE: I have no further questions for Mr Smith, Madam Chair. And I'm not aware of any applications to cross-examine.

CHAIR: Ms Harris?

MS HARRIS QC: Madam Chair, could I have leave to clarify one matter, just perhaps for the assistance of the Board? Mr Smith has referred to other documents that did refer to the *Charter*, if I could just ask him briefly what he means by that.

CHAIR: Yes, I will grant you that leave, Ms Harris.

CROSS-EXAMINATION BY MS HARRIS QC

MS HARRIS QC: Thank you, Madam Chair.

Mr Smith, you referred to a document called Annex 1 that is in the bundle of documents that were with your statement. There is one version --- there are multiple versions of that, and I can see that there is one version of that, version 2, that was approved on or authorised for release by yourself on 24 May 2020. Does that sound right? I can ask the operator to bring it up, because I think it may be useful to the Board. The number is DHS.0001.0013.0006.

So, Mr Smith, see your name is there in a row --

A. Yes.

Q. --- where the first column says version 2.0, and then "Authorised for Release, Murray Smith", and then there might be a bit of a typographical error in the date, but do you think that's intended to be 24 May 2020?

A. Yes.

Q. So you authorised the release of this version of the COVID-19 compliance policy and procedures?

A. Yes.

Q. Now, if I can ask you to go to --- Operator, it's page 84 of this document. It's appendix 16, 'Charter of Human Rights Obligations'. Thank you. Is this one of the aspects of the document that you were talking about, Mr Smith?

A. Yes, that's right.

Q. And if we can just scroll down the next page, that's intended, is it, to be a quick guide to the nature of the obligation of Authorised Officers to give proper consideration to the human rights of any person affected by their decision?

A. That's right.

Q. And, Operator, if I could ask --- I'm sorry, please go on?

A. I also think you will find that throughout the annexed document, there is reference to the *Charter of Human Rights* into each particular protocol that's recorded, when it's required to be considered. I'm not saying it's comprehensive; I'm saying that you will find it in other parts of the annex as well in terms of reference to the *Charter*.

Q. Thank you. Is one example of that appendix 23, guidelines for considering exemptions?

A. Yes.

Q. Operator, could you please go to page 101 of that document. So if we can look at --- the first paragraph summarises, gives a summary:

> *You are an officer authorised by the Chief Health Officer.... to exercise certain powers under the Act. You also have duties under the Charter of Human Rights and Responsibilities Act....*

In fact, I won't ask that this document is now tendered to the Board, but the following approximately 10 pages then deal, don't they, in some detail with the *Charter of Human Rights*. Is that right, Mr Smith, down to page 110?

A. Yes.

Q. And, for example, if one scrolls to the next page, Mr Operator --- Operator --- excuse me, I'm not sure if it's appropriate to call you "Mister" --- "proper consideration requires you to" --- and then it sets out what the meaning of giving a proper consideration is for the reader of the document?

A. Yes, that's right.

Q. And I won't go through the rest, but right at the very end, if I can go to page 110, there's an attachment that is a description of relevant human rights. Do you know

why those particular rights were described there in the summary?

A. Yes, on the basis they were the rights that were most likely to be affected as the result of the detention process. And equally in terms of the determination process, to undertake quarantine in an alternate location.

MS HARRIS QC: Thank you, Mr Smith, and thank you, Madam Chair. I have no further questions.

CHAIR: Thank you, Ms Harris. Nothing further, Mr Ihle?

MR IHLE: There's just one matter that arises from that, Madam Chair, and if you will just excuse me for one moment.

RE-EXAMINATION BY MR IHLE

MR IHLE: Mr Smith, the document that you've just been taken to was version 2 of annexure 1, and that's a document that you authorised on 25 May. Is that right?

A. Yes.

Q. There was an earlier version of that document, and I appreciate that that earlier version of the document was authorised, that being version 1, prior to your commencement in the role as Commander of COVID-19 Enforcement and Compliance, but that's a document you're nevertheless familiar with, isn't it?

A. Yes.

Q. That's a document dated 29 April?

A. Yes.

Q. Prior to that document, were there any other documents that spoke to the *Charter* rights and how Authorised Officers are to exercise their function, other than the one dealing with unaccompanied minors?

A. I couldn't answer that question. I'd have to --- if I --- given the documents were prepared, as you say, before my commencement, I do agree that I'm aware of the document you spoke about, but I'd have to check that.

Q. Yes. Well, just going off the face of it, though, you'd agree if version 1 was on 29 April, it's unlikely that there was a version before version 1?

A. I would agree that that's the --- yes, that that's version 1. However, I wouldn't say that that means that there wasn't other documents in existence to assist Authorised

Officers in making decisions, and that's why I'm asking or saying that I would need to check that, given that I wasn't in position at that time.

Q. Mr Smith, would you be so kind as to check that, and if you are able to identify a document prior to 29 April that deals with that, could the lawyers for the Department bring that to the attention of the Board?

A. Certainly.

Q. Thank you.

MS HARRIS QC: Could I perhaps assist the Board now with that issue? There may be other documents, but there certainly is one in Mr Smith's statement, Madam Chair. It's referred to in paragraph 57(b) of Mr Smith's statement. There are a number of references to policies and procedures, but that document, DHS.5000.0075.0010, dated 8 April, has a section on 'Charter of Human Rights Obligations' at page 10 of that document. And it has a table very similar to one that was shown to Mr Smith in evidence. I don't think I need, given that's in evidence before the Board, to take Mr Smith to that.

CHAIR: No.

MS HARRIS QC: Thank you, Madam Chair.

MR IHLE: I'm indebted to my learned friend.

I think that concludes the examination of Mr Smith, Madam Chair, and with our thanks, may he be excused?

CHAIR: Yes.

Thank you, Mr Smith. Thank you for your attendance at the Board, and you are now excused. You can turn off your microphone and camera. Thank you.

A. Thank you.

THE WITNESS WITHDREW

MR IHLE: Thank you, Madam Chair. The next witness that I call will be Melissa Skilbeck. I'm in the Board's hands as to whether we do that immediately or take a brief afternoon recess.

CHAIR: We'll perhaps take a 10-minute break whilst Ms Skilbeck is being brought in and ready to proceed. We will take 10 minutes.

MR IHLE: As the Board pleases.

ADJOURNED **[2.58 PM]**

RESUMED **[3.08 PM]**

CHAIR: Yes, Mr Ihle.

MR IHLE: Thank you, Madam Chair. I call Deputy Secretary Melissa Skilbeck.

CHAIR: Ms Skilbeck, I'll just get you to take your microphone off mute now, please. Are you able to hear me, Ms Skilbeck?

Could you just take your microphone off mute, please? I'm not sure if the operator can assist. You're still on mute at the moment.

MS HARRIS QC: Sorry, Madam Chair, I'm just trying to arrange some help.

CHAIR: Ms Skilbeck, I think --- thank you. We can hear you now. Are you able to hear and see me?

MS SKILBECK: I am, Madam Chair, thank you.

CHAIR: Thank you. And I understand that you wish to take the affirmation for the purposes of giving your evidence?

MS SKILBECK: I do.

CHAIR: All right, thank you. I'll hand you over to my associate for that to be done.

Thank you, Madam Associate.

MS MELISSA SKILBECK, AFFIRMED

CHAIR: Thank you, Ms Skilbeck. I'll hand you over to Mr Ihle now.

MS SKILBECK: Thank you.

MR IHLE: Thank you, Madam Chair.

EXAMINATION BY MR IHLE

MR IHLE: Good afternoon, Ms Skilbeck. Can you see and hear me?

A. I can, thank you, counsel.

Q. Thank you. Your name is Melissa Skilbeck?

A. It is. Yes, it is.

Q. You're the Deputy Secretary of Regulation, Health Protection and Emergency Management at the Department of Health and Human Services?

A. That is correct.

Q. And that's a position that you have held since 2016?

A. Yes.

Q. You are also, relevantly to today's proceedings, the State Health Emergency Management Coordinator?

A. That's right.

Q. And you have provided a statement to the Inquiry in response to a list of questions that were sent to you, and that statement that you've provided by way of answer to those questions is dated 4 September?

A. That's correct.

Q. And it comprises some 28 pages and 147 paragraphs?

A. It does.

Q. Have you had an opportunity to read that statement recently?

A. I have.

Q. And are the contents of that statement true and correct?

A. They are, thank you.

MR IHLE: Madam Chair, I tender the statement of Deputy Secretary Skilbeck dated 4 September.

CHAIR: Exhibit 125.

EXHIBIT #125 - STATEMENT OF DEPUTY SECRETARY MELISSA SKILBECK

MR IHLE: As the Board pleases.

Ms Skilbeck, in preparing your statement and indeed referred to within that statement you've had regard to a number of documents held by the Department?

A. I have.

Q. And those documents assist in the reading of your statement and the full answers that you've given there?

A. I believe so.

MR IHLE: I tender as a bundle, Madam Chair, the documents referred to in Ms Skilbeck's statement.

CHAIR: Exhibit 126.

EXHIBIT #126 – ANNEXURES TO STATEMENT OF DEPUTY SECRETARY MELISSA SKILBECK

MR IHLE: As the Board pleases.

Ms Skilbeck, in your statement, you've provided that where there is a health emergency, the Department, being your department, is the control agency. Can you tell us what the term "control agency" means with specific regard to the emergency framework?

A. Yes, I can do my best. Under the emergency framework, specifically, I think, defined in the State Emergency Response Plan, in which our Department State Health Emergency Response Plan is a subplan, a control agency and a support agency are defined. A control agency --- this won't be exact wording, but a control agency is responsible for the direction of a response to an emergency. And in the case of a health emergency, in effect in the case of things that would cover the portfolio of responsibilities our Department usually has, the control agency is the Department of Health and Human Services.

Q. Okay. So we've used the term and I've asked you about the term "control agency". Is there a difference between "control agency" and "lead agency"?

A. So lead agency, I don't believe, is a defined term within the emergency

management framework. It's a term of art, if you like, that we use among the public service ---

Q. Yes.

A. --- to mean the department in lead. Like, not a particularly technical definition of that term, as I understand it.

Q. So is lead agency and control agency in the emergency management framework, noting that one is a more colloquial use --

A. Yes.

Q. --- rather than a policy-based use, but do they essentially mean the same thing or are there differences?

A. I would actually struggle to answer that question, counsel, because I rarely hear the language "lead agency --"

Q. Okay.

A. --- in the course of an emergency. Most of us who are in any way familiar with the emergency framework will use the term "control agency". It is a well-known and well-trained, drilled into us, that term, because of the distinction between the control and support agencies.

Q. You said that they direct the response, that is, the control agency directs the response.

A. Yes.

Q. Does that in general terms mean that you are controlling the response as well insofar as any response can be controlled?

A. I think your caveat there is the important thing. We control, control the hazard is the language, the hazard in this case being a virus, a novel coronavirus. So, yes, in that sense we control, going down through our agency, the control agency, to mitigate, reduce the impacts of that hazard. The key role in the control agency in something as big as this particular emergency, "control agency" becomes something of a misnomer where really most of the activity is coordinating across the array of agencies and departments that have come together to respond as fulsomely as the Victorian public sector can to this emergency. So it is both control in a very specific sense of the word, the public health response to a novel coronavirus; and the coordination role --- little c "coordination", to make the distinction, because I think "Coordination" is defined in the SERP as well --- but coordination across the many agencies that have come to support the response.

Q. You just referred to the SERP, and earlier you referred to the State Health Emergency Response Plan. Can you describe what those two things are and where they sit in relation to the entire emergency management framework?

A. I will do my best. I always start with the statute, as a public servant.

Q. Yes.

A. So the *Emergency Management Act* defines the structure of class 1, class 2, class 3 emergencies, defines some of the accountability, indeed uses the term "control agency" there, and so sets that broad framework, literally.

The State Emergency Response Plan describes, for example, control agency, and allocates the types of emergencies to the agency that would be the control agency in those different circumstances, so it puts meat on the bones of the framework of the *Act*. Our State Health Emergency Response Plan, which is the Department of Health and Human Services document, which is our description of how we would respond as either a control agency or a support agency, because we have both roles --- support agency in almost all emergencies --- and we use that as a mechanism for describing how we would go about defining our role, and in particular it's focused at the audience of the many additional partners, to use a term, that we have to respond to a health emergency. So, health services, primary health, our environmental health colleagues, Ambulance Victoria actually is a co-author with us --- those sorts of things. So it's our way of saying, right, when we're either in the role of control agency or support agency, and this is how we're going to operationalise that set of responsibilities the SERP has defined for us within the framework the Emergency Management Act describes. Hopefully that's clear.

Q. No, that's very helpful, thank you. So what you've got --- you've described a number of cascading instruments there ---

A. Yes.

Q. --- we have the legislative instrument which is the *Emergency Management Act*, below that the State Emergency Response Plan, the SERP?

A. Yes.

Q. And as a subplan of the SERP we have the SHERP which is the State Health Emergency Response Plan.

A. Yes, that's correct.

Q. And that subplan, that is the SHERP for short --

A. Yes.

Q. --- that's a plan which is a DHHS document because it's directed to emergencies to which DHHS is responding either as the control agency or as a support agency?

A. That's correct. Now, it only is --- it's approved by the Emergency Management Commissioner to make sure that one of his responsibilities is to ensure that that cascade, and not only for the Department of Health and Human Services but all other agencies, is consistent. So it's endorsed by the Emergency Management Commissioner before it's in operation.

Q. Now, the SHERP itself outlines expressly its objectives, does it not?

A. It does.

Q. On page 2 of the SHERP --- I'm not sure whether you've got a copy of it there ---

A. I'm afraid I don't, no.

Q. We can bring it up if you like, but I'll read to you because I'm sure you're very familiar with it. It says at 1.2, "Objectives":

> *The objectives of this plan are to:*
> *- reduce preventable death, illness and disability in all health emergencies and other emergencies with health impacts*
> *- maximise health outcomes by providing treatment in a safe, timely and coordinated manner*
> *- [thirdly] provide timely, tailored and relevant information of warnings to the community*
> *- [fourthly] provide clarity on roles, responsibilities, escalation and communication channels to enable an effective and efficient health emergency response.*

That's consistent with your recall of the objectives of that document, isn't it?

A. Yes. Yes, it is.

Q. How does it go about seeking to achieve those objectives?

A. In a number of ways. It's a standing document. It's not activated by a particular event, because the first role we have is to identify an event as an emergency. I think a key part to note, and this will not be unique to our Department, but our Department is obviously managing emergencies, in a colloquial sense, every moment of the day and night.

Q. Yes.

A. That's our core business. And indeed it's our core business in health protection, public health, communicable disease response. We refer to them as "incidents" to try

to keep the distinction, but we're always responding to an incident that could become significant enough in terms of its consequences to the community, or to the health system, that it should be designated as an emergency that warrants this apparatus.

So the SHERP spends a fair bit of time describing, in a risk matrix format, at what point we ought to make that call, including --- and there's levels, tiers and stages everywhere in the emergency scheme, so apologies if I get the noun wrong, but --- there are different levels of an escalation within that to describe at what point we would, you know, advise the Emergency Management Commissioner that we think there is an emergency that may well turn into a major emergency, to use the language in the *Emergency Management Act*, or it's an emergency of more significance because of its consequences to others that warrants a stand-up, for example, of the State Control Centre. So it's defining that staging.

It's describing the roles that my role within the SHERP, as you described upfront, there's that horrific acronym, SHEMC, is to ensure that we at all times have people in each of the key roles standing, so that we stand ready to respond to an emergency.

So it describes that focus. It describes the presumptions around who would be escalated to controller of a class 2 emergency, class 2 being --- unfortunately in the *Emergency Management Act,* it's defined as "not 1 or 3", but a health emergency is a class 2 emergency.

We have an array of very different health emergencies that could trigger our role as control agency, and so there's hence the use of risk matrices and escalation to take into account what could be a very varied potential consequence to an emergency.

I think there's a fair bit of description in the SHERP as well around those partners that I've described and the way in which we consult --- not just consult, but work with them in peacetime, to use the language, to make sure that we're prepared. So underneath the SHERP --- I won't go through all of this, I promise --- underneath the SHERP there's a number of protocols that, for example, means we can call upon the private health system for an emergency department equivalent response, that we can call upon what's called a FEMO, a field emergency medical officer arrangement, which is a standing arrangement by the hospital, it's St Vincent's Hospital, to respond literally on the field with doctors. It's a state version of AUSMAT, if that helps at all.

Pharmacy Guild and others are included in a broad primary health consultative group so that we have that pre-existing relationship with the broader health sector, to assist us in any manner of emergency we may call upon them to assist, and that helps us to make sure everyone's got a common understanding. If we stand up in a meeting one day and saying, "We're now the control agency," we're not explaining what the control agency means.

Q. Is part of the reason for the SHERP for --- the reason for its existence to make it clear to all and sundry, when there is a health emergency, how your Department, as

the control agency, will structure its command matrix, if you like, and also how it will integrate with those other support agencies?

A. To the extent that's possible. I mean, it's obviously more --- it's generic because we don't know the specific emergency that it needs to apply to. The framework it uses is a very, very generic emergency response structure, quite deliberately so. Private sector uses it, public sector or emergency services organisations use it, known as AIMS, the Australian Interstate --- anyway, AIIMS, trust me --- Interstate Incident Management Scheme, I think.

But it's a common sense, once you know it, common sense structure of the functions that you should start with for responding to an incident or an emergency, including functions like intelligence, planning, logistics, communications, finance. So that's a good --- that's a first step in an emergency. It doesn't constrain, it's not intended to constrain designing the response to better suit the particular nature of the emergency and the response needed, but it sets you off on the first path. And as you noted, counsel, it means that that broader community of health sector participants have a first expectation of how we will set ourselves up.

Q. You say in your statement at paragraph 24, in relation to the Department of Jobs, Precincts and Regions being engaged to establish the program, being the Hotel Quarantine Program, "meant that the SHERP was implemented later than it ought to have been for the Program establishment." Can you tell us what you mean by that?

A. I should note at the outset, by "later" I'm referring to a matter of hours, given the very quick initial stages of the set-up of the Hotel Quarantine Program, but nevertheless, factually, on the fact that we were the control agency for the pandemic, the custom within the emergency management framework would be to charge the control agency with implementing an element of the response, which was the Hotel Quarantine Program, and thereafter the coordination I described would occur where clearly we would have, and anyone else who would have started this program, would have needed the assistance of an array of agencies. I think as occurred, DJPR --- sorry, I'll just use the acronym, but DJPR was asked by means --- I'm sorry, I'm not aware of the actual communications that triggered this, but they were asked to set up the Hotel Quarantine Program. I presumed it was largely because they have expertise in hotels and in that industry, and they were already involved in supporting that industry through the consequences of the pandemic due to tourism reductions. But thereafter, just as soon as they came into the State Control Centre arrangements, I think the arrangements between control agency and support agency were righted in the sense of being made consistent with the emergency management structures I've described.

Q. Okay. So you don't know precisely why DJPR was tasked, you just say you presumed it was for certain reasons?

A. Yes.

Q. Do you know who made that decision?

A. I'm afraid I don't.

Q. I want to come to the role of State Health Controller, because I understand you have a function as the State Health Emergency Management Coordinator in appointing a State Health Controller from time to time. Is that right?

A. That is correct.

Q. And throughout the pandemic response, you've made that appointment?

A. Yes, up until 15 July as part of this SHEMC role, yes.

Q. And the SHERP itself assumes as a starting position, does it not, that the Chief Health Officer will be State Health Controller in relation to health emergencies?

A. Yes, it does. Yes, it does. It uses the term --- either starting position or normally, yes.

Q. And you made a determination, when it came to appointing someone as the State Health Controller, to not appoint the Chief Health Officer?

A. I developed advice to the Secretary to that end, yes. Given the --- as both the SHERP and Concept of Operations, a document operationalised in the SHERP describes, it's my role to make that appointment consistent with the emergency --- the nature of the emergency and the response, and that was the driving determination for me making a recommendation for an appointment contrary to the presumption in the SHERP.

Q. So we know by reason of the SHERP not being activated --- that's the wrong term, isn't it. What's the correct term there? I've lost the term that you had used earlier. Sorry, I want to be sure I'm correct about this, but we talked about --- "implemented".

A. Yes.

Q. Given that it's clearly a health emergency that's emerging, did it not require a health-focused response?

A. So I used the language before about the hazard, the virus. Absolutely. And this is where being a class 2 emergency is unfortunately is bit more complex than a class 1. Fire and flood are class 1 emergencies. All the powers that are specific to a public health emergency, in particular a pandemic, that we have as under the *Public Health and Wellbeing Act*, not the *Emergency Management Act* --- in a very limited way, they talk to each other. But the powers for the Chief Health Officer under the *Public Health and Wellbeing Act* are fairly thorough, and that was the key to ensuring

control of the hazard. My view then, and quite frankly my view now, is that the overwhelming role that we needed for an effective response from the emergency management framework was one of coordination of logistics and other assistance.

So at the point where we --- as in, I was advising the Secretary and she and I were discussing this appointment, it was 1 February --- we had just --- the Commonwealth had just made an initial determination restricting entry into this country for certain folk, I think from Chinese provinces and thereafter a couple of other countries, and requiring them to self-isolate, by which I mean stay in their own homes. That required us to undertake additional logistics work that we could not do ourselves, so literally working on relief accommodation with someone literally who was in transit when this decision was made, arrives in our State, does not have accommodation suitable to self-isolating, needs assistance in transporting themselves from the airport in some circumstances. It's hard to think back, but in February there was a visceral panic around the prospect of this virus, and sadly some services were declined to visitors to our State.

As soon as the --- so one of the great benefits of the all-agencies approach to emergency management is there is a standing group, a state control team through the State Control Centre which is accessible to us, once we have a controller in place, that has all of the relevant agencies available. In this case, immediately the Department of Transport rectified any issue around transport from the airport to those who needed to self-isolate. We worked with DJPR as early as that, in fact a little bit earlier, on accessing appropriate private accommodation for people who needed to self-isolate. We already had significant impacts on tourism rolling out, and significant impacts on industry through confidence, if only confidence as well as, prospectively, future decisions being contemplated.

So that group, both the State Control Team and the State Emergency Management Team, which are all auspiced by the State Control Centre, provided that ready-made coordination/logistics work.

Very soon after the appointment of a Controller, you may recall that we had some significant issues with food and grocery supply, which was a consequence of responses to the hazard. And the emergency management framework includes resilience networks, it includes public and private sector people, including food and grocery network, that came in --- could be triggered straightaway to work on the wholesale issues around the food and grocery issue, and its consequent impact on food relief that we were already seeing which was relevant to assisting the people who needed to be in self-isolation. We needed to ensure they were accommodated and fed, if they could not do so through their own resources.

So that was the driving need for use of the emergency management framework. We have in the SHERP, and it's --- wherever else we can put it, a very clear statement that regardless of who the State Controller is, whether a control agency or support agency, the decisions of the Chief Health Officer under the *Public Health and Wellbeing Act* cannot be second-guessed or overridden by the State Controller.

So it was very important that we had full access to those powers, but we were accessing the benefits of the emergency management teams.

Q. Dr Romanes, who was the Public Health Commander, if I understand that correctly, provided a statement to the Inquiry. Have you read Dr Romanes' statement?

A. No, I have not.

Q. Okay. I just want to read to you --- it's now Exhibit 113. I just want to read to you about what he says about the decision to appoint a State Controller --- Health, that was not the Chief Health Officer. He says:

> *I reflect that it is possible that if the Chief Health Officer had been the State Controller --- Health for the COVID-19 public health emergency, public health expertise have been more embedded in the governance of the hotel quarantine program.*

Do you agree with that statement?

A. Respectfully to Dr Finn Romanes, no, I don't, in part because he was so active in ensuring as Public Health Commander, when he was in that role, or Deputy Public Health Commander, that the expertise and the evolving understanding of the virus was reflected in not only the Hotel Quarantine Program plan, Operation Soteria plan you've referred to prior, but also other planning for operations outside of the Hotel Quarantine Program. I think, while, theoretically, certainly --- there's a reason why the presumption in the SHERP is to have the Chief Health Officer in charge of a public health emergency, and if one was more constrained in scale, not impacting quite the extent of our community as it is and requiring such significant logistics and planning and programming of response activities and support of particular community services, for example, to cite something our Department has been doing extensively recently, those are very significant programming and logistics roles, they're not specific to public health knowledge.

Obviously, the entire driver for everything that every part of Government is doing in response to the pandemic is to reduce the serious public health risk that it so clearly presents. And understanding that and the dimensions of it is very important. Already on 1 February, the Chief Health Officer was engaged, as all Chief Health Officers were, with the AHPPC, the Australian Principal Health Protection Committee or thereabouts, all of the Chief Health Officers chaired by the Chief Medical Officer of the Commonwealth, which became the key public health authority --- little "a" authority --- in terms of intelligence and evolving understanding and recommendations as to the response of the emergency.

So our SHERP and arrangements don't take into account national decision-making processes, advice and then National Cabinet that came soon after, not that we knew

about it on 1 February. So as the response nationally evolved, the reasons I cite, and I think it's in an annexure to this statement a brief I gave to the Secretary to reflect our discussions over the previous weekend, was really only reinforced, in particular, just the personal time requirement on the Chief Health Officer and his relative expertise. We have only one Chief Health Officer under the *Public Health and Wellbeing Act* at any time. His expertise needs to be in AHPPC, in decision-making in the State of Victoria, and more extensively in terms of time requirements communications, because the key, as opposed to a fire that we put out with a hose, you know, the key tool we have to respond to a pandemic, particularly a novel coronavirus, is educating and changing behaviour in the community to reduce our risks. And that essentially is a communications task.

So as time went on, the sheer scale of responsibilities the Chief Health Officer had that no one else could fulfil reinforced, I think, the decision. Now, if we had a greater number of possible substitutes for the Chief Health Officer, perhaps I wouldn't have spent so much time thinking about it. But we needed all of the public health expertise we could, as directly as we could, on managing the hazard, the virus itself. So I think in the --

Q. Did you raise these questions, Ms Skilbeck, with the Chief Health Officer prior to making the appointment?

A. I discussed it with the Chief Health Officer and with the Secretary and with the Emergency Management Commissioner.

Q. And to your mind, was the Chief Health Officer in agreement with your decision to appoint someone other than him as the State Controller?

A. No, he was not.

Q. Would it be fair to say that he was against that decision?

A. Yes, he was, additionally. He referred to the presumption in the SHERP.

Q. Dr Romanes goes on to describe what he saw in the Hotel Quarantine Program in the following terms. Paragraph 84, for the Board's benefit:

> *From what I could see, the program was characterised and managed predominantly as an accommodational logistics program. I drew this view from observation of the appointment of senior leadership figures that did not have significant public health experience, and that the Operation Soteria governance meetings I attended did not involve the PHC [Public Health Command] initially, and did seem to me to focus heavily on logistics considerations. While the program had significant logistical implementation at that time, these were part of the challenge only and I felt that a public health consideration needed to be concurrently addressed.*

Did Dr Romanes ever raise those views with you?

A. No. But I'm familiar with the general --

Q. Me reading --- sorry, go on?

A. I'm familiar with them in general terms, counsel, and there were a number of mechanisms by which public health expertise was included in both the development of plans and procedures for Operation Soteria, and key decisions for Operation Soteria, including the plan itself. There was also, I think --- I caught some of the evidence of Professor Euan Wallace, and while he was the State Health Coordinator, he chaired a group I think you referred to as a working group regularly in your discussions, he chaired a group that included the Public Health Commander, which was Dr Annaliese van Diemen most often in that period, as well as the Operation Soteria Commander, the State Controller and a number of others --- I was not a member --- in order to bring together the expertise we had around health and welfare with the need to operationalise that.

So, public health expertise was brought directly into --- including the endorsement of the Operation Soteria plan in all its variations and versions, in its specific decisions made that were subsequently reflected in plans such as what to do if a traveller is positive on the 14th day, has COVID on the 14th day, what is the best public health management of that issue, particularly, as you may have heard in respect of Murray Smith's commentary, making decisions about circumstances in which quarantine could be done elsewhere, as in not in a hotel.

Initially all of those decisions was actually referred to the Public Health Commander, until the scale of those and the pattern of them became available, and that was delegated down to the Enforcement and Compliance Commander.

Likewise, various decisions were delegated down to the Operation Soteria Commander as we discerned the patterns and could become comfortable with the risk profile of certain decisions.

There was also significant liaison with both the Chief Health Officer and the Public Health Commander, and key discussions that we had around perhaps potential changes to the shape of the Hotel Quarantine Program, which came to nought but during May in particular, I was coordinating a piece of work that had been triggered by a pattern we had observed in testing results, where it appeared we were discerning almost all, all but .3 per cent, as it turned out, of positive cases in the day 3 test, which led us to think through how could we increase the capacity of hotel quarantine if we could reduce the number of days some people were in hotel and some people could go into a home environment, if in fact we were identifying so many of the positives on day 3? That was particularly driven by --

Q. Ms Skilbeck, my question was, did Dr Romanes ever raise those views with you. You started with "no".

A. Yes.

Q. I'm not sure these further discussions are particularly useful. I'm not saying that to be critical, but I'm just noting the time of the day, and there's a bit more to go.

A. Not a problem. Manage the time. Yes.

Q. Perhaps I'll jump to the next topic. That's a topic you may have just touched on in a couple of ways, but I want to ask you more generally, was there ever consideration for quarantining people in designated facilities other than hotels?

A. Only --- as far as I'm aware, only in respect of the consideration I was about to launch into, which was changing the mix of hotel-based quarantine with home-based quarantine for the same travellers.

Q. Was there ever any consideration of things like serviced apartments?

A. Not for hotel quarantine, no. There was ---

Q. And why do you say --- excuse me. Why do you say not for hotel quarantine?

A. Because serviced apartments were used and are still to this day used for what we refer to as emergency relief accommodation, so that is not people who are under the detention direction, but people under the self-isolation or case diagnosis direction --- the direction title has changed. So Victorians, resident in Victoria, who become COVID-positive but their living circumstances mean they cannot safely self-isolate in their own home. We arrange accommodation through a series of hurdles, but we arrange accommodation in often serviced apartments. Not only. There has been hotels as well. There's been motels. And I'm sure there's been some other types of accommodation suitable for the local area in which someone resides. But that's an emergency relief accommodation program.

It was managed under Operation Soteria because there are a number of very common platforms, literally computer platforms, that DJPR largely used to allocate accommodation to people. So it was more efficient to put both programs into the same operation. But I'm quite certain that we maintained a distinction, if only because of the efficiency, counsel, of --- there aren't that many rooms in apartment hotels, and the scale of hotel quarantine. We had 1,000 people on 1 April, we had 4,200 on 4 April. The scale of it would not have been manageable using apartment hotels.

I can't completely discount that we may have, in the course of agreeing for someone to --- through the Enforcement and Compliance Regulatory Scheme, agreeing to someone quarantining in a different place, so literally changing the Detention Notice to a different address to facilitate medical treatment. Usually it was medical treatment for those circumstances. It may well have involved a serviced apartment

near a particular hospital. But it would have been a very occasional event.

Q. So are you aware who made the decision that in Victoria, the quarantine program would be a hotel quarantine program?

A. No. My first awareness of the program was we already had hotels contracted. Aside from my observation that it's a practical and sensible use of accommodation stock, because of the scale.

Q. Okay. I want to move on to the question of ADF support, which is the question you were asked to address in your statement and you did. As I understand it, as provided in your statement, ADF personnel were involved in the formulation of the Operation Soteria plan?

A. Yes.

Q. When we say "ADF personnel were involved", are we able to say how many and at what rank?

A. I can't, no. They were Reservists. I met one with an excellent background, including architecture. But I think there were a number of ADF personnel assisting Operation Soteria, particularly once the Emergency Operations Centre was established on 17 April, but also in the very early days post-28 March.

Q. So there were some ADF personnel assisting with the development of the plan, there were some in the Emergency Operations Centre and in fact in paragraph 54 of your statement ---

A. They were the same people.

Q. --- you say --- and some embedded in the Public Health Command. Were they the same people as well?

A. No, they were not. Public Health Command, they were people with public health qualifications and expertise. There's quite an array of expertise in the ADF.

Q. Given the work that was falling on your plate in the wake of the mandatory detention decision of National Cabinet, if we can call it that --- whether we can call it a decision --- you were aware that both the Premier and the Prime Minister announced that there would be ADF support in relation to the implementation of the quarantine program?

A. I'm only aware of it given media commentary recently. It wasn't a key part of my work at the time.

Q. Are you aware that ADF provided on-the-ground support in relation to hotel quarantine or similar programs in other states?

A. Yes, yes.

Q. Why didn't that happen here?

A. Well, I'm not certain on that. We worked with the ADF in the ways I described, and they were very helpful to us. The arrangement of both contracting the hotels and the security guards and the cleaning, et cetera, everything that came with the hotel, had occurred through DJPR before I was engaged in the program. So that initial decision-making, I can't comment on, I'm afraid, counsel.

Q. You were asked in relation to your statement to provide any details of which you were aware of requests for or on behalf of your Department in relation to the deployment or potential deployment of ADF personnel within the Hotel Quarantine Program. At paragraph 59 and following, you detail, really, a series of events that start on 23 June in respect of your involvement and direct knowledge of ADF potentially being deployed for on site provision of security.

A. Yes, that's correct.

Q. Should we take that then that before 23 June, you were not privy to any discussions about the potential involvement of ADF being deployed for on site security?

A. Yes, you can.

Q. Were you aware that, even just in the few days prior to those discussions that you were involved in being had, that in fact the Chief Medical Officer of the Commonwealth, Dr Brendan Murphy, had offered, to the Chief Health Officer and the Deputy Chief Health Officer in Victoria, ADF assistance in lieu of private security guards?

A. I don't believe I was.

Q. As the State Health Emergency Management Coordinator, your primary role is in relation to coordinating this emergency response in Victoria. Is that fair?

A. No, it's not. That's really a reasonable description of the controller's task. I know the language is somewhat counter-intuitive. But my role as defined in the SHERP is to make sure those appointments are in place, to provide advice to the Secretary in relation to the Controller, and to provide executive administrative support, is the language, to each of those roles in the course of an emergency.

Q. So is that a way of saying, "I make sure the right people are in place for them to make the right decisions"?

A. Yes, in effect, and then I stand ready to sign a contract or an invoice should they

need resources to do their job.

Q. Yes. So this may or may not have been within your role description under the SHERP, but did you at any time reach out to interstate counterparts to see how they were running their quarantine programs?

A. Not one-on-one, but the Commonwealth agencies, chaired by the Australian Border Force, established a National Coordination Mechanism that brought all of the parties nationally together, initially just to coordinate the flight traffic for all of us and to assist them in assigning planes to cities, according to the capacity we had for hotel quarantine. But it also spawned a working group which our Operation Soteria Commander was part of, that was a very useful point of discussion between all of the equivalent roles around the country. I certainly was involved --- I sat through some of the National Coordination Mechanism meetings, which was my equivalent roles and more senior up, so there was some sharing of information early, which was more a sharing of some of the same complexities we were all dealing with and uncertainties around volumes of travellers. But as time went on, particularly that working group was a useful both support group and information source.

Q. So did any of that support and information feed into consideration about how we were doing things here and how we might do things better?

A. Yes. Yes, it did, at various times.

Q. Did that include discussions about the potential of ADF support personnel being deployed for on site security at all?

A. It certainly included an idea in my mind as to how, mechanically, ADF were used in New South Wales, being the most relevant comparable jurisdiction to us.

Q. You became aware, did you not, of course, of the outbreak that occurred at the Rydges Hotel, first notified on the 26th and then as events unfolded throughout that week of May, and then subsequently the outbreak that occurred at the Stamford Hotel; did it come to your attention in your role that some of the issues that were being seen there concerned security guards not efficaciously using PPE and clearly not understanding infection prevention and control measures?

A. It certainly included observations around --- from the infection prevention and control audit or review that had been done. Often it was excessive use of PPE, using too many gloves or using them for too long, that sort of thing. And particularly around the time of each of those outbreaks you noted --- particularly for Rydges, I was particularly keen that the CCTV that was available was used to get a picture of the environment, and that on that, we observed absence of 1.5m of physical distance being maintained during meal breaks.

Coincidentally, I think in the days before we were advised of the Stamford outbreak, DHHS staff at that site observed a shoulder-to-shoulder meeting room of security

guards post-shift, and intervened to make the point to their supervisor that should not be occurring. I was made aware of that by the State Controller once we were advised of the outbreak and the two were connected. But it was literally a day before, I think.

And I think as I've noted in my statement, I mean, my concern for that was that the messaging that we had as a Government in putting through to the community, 1.5 metres, wash your hands or sanitise your hands, I thought quite incessantly, was not reflected in the behaviour in those circumstances from the security guards. So for all of that communication, plus the work that we were doing specifically within the program, had not impacted behaviour to the extent we wanted, what else could we do to make the messaging more effective for that particular group of people?

So this is obviously we're heading in to June now, quite late. One of the many changes that we did, or the Operation Soteria team did was also being formed by behavioural insights unit, Department of Premier and Cabinet, whose expertise is how does one put a message in order to get the right behaviour or response, should we be missing something, because clearly the messaging has been very constant out to the community, and the breaches we had seen were not of complicated procedures. It was 1.5 metres, you know --- well, preferably not wearing gloves, but washing hands and sanitising. How did we make those messages more effective in the local sites?

Q. In paragraph 142 of your statement, you say that you've attempted to comment throughout your statement on matters where you think there were shortcomings or difficulties in the program. Now, without going chapter and verse through your statement, now sitting here where we are, what do you see were the main shortcomings in the program?

A. Counsel, I find that difficult to answer because for every week, we tried to improve on the week before. I know that can sound trite, but we genuinely did. Having been given absolutely no preparation time to develop a hotel quarantine program, we had to just jump in. We were very grateful for the starting framework of the SHERP that we've discussed, which meant we knew the first step. Then we knew we needed to continually develop both the regulatory scheme, enforcement and compliance, the operations, and keep up with the very readily changing understanding of this novel coronavirus, and keep doing that at each point that we could to improve how effectively we were quarantining people.

It would be wonderful if we could have stopped time in order to do all that learning in a much shorter period upfront, but that's not within my power or anyone's else's. We certainly, by very late April, early May, it was clear that the emergency management framework, for all its significant strengths that had got us to the starting point, was not going to be suitable for us in six or 12 months, which it was my bold assertion that we would still be doing hotel quarantine. And from that point, I coordinated work on how we would develop a program of hotel quarantine that was within a standard departmental framework.

We started to recruit people like Mr Murray Smith that you've met, and others that you will meet, who were recruited specifically for this task for 6 to 12 months, so that the tasks that we had abandoned, in effect, by grabbing emergency management staff and grabbing all of the regulatory functions of Health and Human Services to regulate the scheme, we could reduce that risk that we left by returning those staff to those essential roles, and we would have a dedicated team for doing hotel quarantine for 6 to 12 months, as I said, with a structure that looks more like a departmental structure, that coincided with DJPR and our own Department deciding that DJPR ought to relinquish their contracts to DHHS so we could streamline the contractual elements of the program, and in the weeks thereafter also bring the work that the staff of DJPR were doing in support of those services into the one program.

We were doing similar work, my colleagues that were in the Public Health Command were doing similar work, because we had staffed the public health response with the communicable disease team of my Health Protection Branch. We have other communicable diseases in the community and we needed to normalise that situation as well as the COVID response for 6 to 12 months.

So while the emergency management framework was very, very valuable in being able to take the first step, it was not going to be a medium- or long-term suitable framework for hotel quarantine, and thus from July, in fact, it has been in a departmental framework.

Q. That reference at paragraph 142:

> *I have attempted to comment throughout my statement on matters where I think there were shortcomings ....*

At least acknowledges that there were shortcomings. I just want to take you now to paragraph 34 where you were asked what were the aims of Operation Soteria, and you say:

> *The overarching objective of the enforced quarantine measures was to prevent the transmission of COVID-19 from returned travellers to wider members of the community ....*

Well, it clearly was unable to or did not achieve that overarching objective. Do you have any views or insights, given your significant emergency management experience, and the significant roles that you had, as to why that's the case?

A. I think that was our aim. It was, all of us involved in establishing the program were absolutely driven by the public health objective, and the fact that we had three points of transmission within the program was extremely disappointing to us all. I'm not sure whether it was possible for us to achieve a risk-free, or it is possible objectively to achieve a risk-free environment where coronavirus is in place, and I think more recent observations from other hotel quarantine and other jurisdictions in our neighbourhood suggests that the case.

But that has not, in those jurisdictions, led to the extraordinarily damaging cases and deaths that have come from --- according to the genomics evidence, have come from three travellers that we were quarantining.

I don't know the --- it is not known what the specific root of transmission from travellers to staff in the quarantine program was, and we can only keep improving, because hotel quarantine will be with us for some time, only keep improving all of those things that could possibly reduce the risk of transmission further, and obviously learn from the observations of wise counsel like Professor Wallace and others, and our public health colleagues, and other experts that are becoming more and more experienced in novel coronavirus to reduce the risk to the extent humanly possible. But it was a reminder that it's not possible to have nil risk in an environment where coronavirus exists.

Q. I just want to come back to the question that I asked, and that is whether you have any insights, given your significant experience in emergency management and the significant positions you had in relation to this emergency management, as to why those overarching objectives were not obtained here and have had the consequences as you've identified, that have been so significant for people in this state.

Are there any particular things other than what you've just said; that is, that we can't have a risk-free environment, that we were driven by public health objectives, is there anything tangible that we can hang our hat on there?

A. I have to say, counsel, if I knew something tangible to hang our hat on there, we would have acted upon it by now.

Q. Yes.

A. I don't know the specifics of --- I think it's --- I hope it's knowable, in terms of exactly what it was that were the circumstances of those points of transmission, and not the 20,300 other quarantined travellers that we accommodated. Clearly it was contrary to the intent of everyone involved, but whether it was something we could have managed, I would love to be clear about that, and we would have responded as quickly as we could, as we did to advice that we received from all of our learned colleagues.

Q. Yes. There's just one final topic that I want to take you to, Deputy Secretary, but can you just give me a moment. I just need to shut off my video for one second.

A. Okay.

CHAIR: Perhaps just whilst Mr Ihle is doing that, Ms Skilbeck, can I just take you back to an answer you gave with respect to --- I think you started talking about some discussions around the possibility of releasing people from the Hotel Quarantine Program --

A. Yes.

CHAIR: --- after day 3, and then the discussions focused around how we could reduce the number of people we were holding in hotel quarantine because of the information that was emerging about the small percentage of people that were actually testing positive.

A. Yes.

CHAIR: Where did those discussions go?

A. Ultimately nowhere, for a couple of reasons. Our initial observation that only 0.3 of a per cent of positive results were received in day 3, with different --- the cohort changed quite markedly over April to June, and by June, the positive case rate was higher. And the risk, therefore, of relying only on day 3 became unreasonable.

Secondly, using a greater amount of home-based quarantine required confidence in the community of the compliance of people in home-based quarantine, and that's not just that people stay in their own home, but others do not come within 1.5m of them, and actually further isolated. Electronic means of doing so, we looked at much greater compliance work in terms of police patrol, et cetera, but it was very difficult to provide the required confidence at the time, and it was a very emotionally held requirement, as is reasonable. So we couldn't do that.

CHAIR: Sorry, I was --

A. The other, the third --- sorry?

CHAIR: Sorry, when you say "an emotionally held requirement", what do you mean by that?

A. In a scientific way, you could say 0.1 or 0.3 per cent of potential non-compliance would be a reasonable outcome in a regulatory scheme. In the circumstance we were in, where public confidence around management of the virus required as close to perfection as possible, it was not acceptable in that circumstance. The missing piece that we had --- we've had expectations that testing technology was going to provide us with a very quick test that we would have instead of a result in 24 hours or more, we would have a result in 60 minutes, and it would not have significant false negatives. That was a key part of a proposal we had developed on the presumption that day 3 was providing us with overwhelmingly most of our positive cases. The proposal that we had developed was on day 7, do that quick test, verify --- because there's, you know, an incubation period that we need to take account of --- verify that there was an overwhelmingly negative status of the traveller, and then have the remaining part of the 14-day quarantine at home.

For the proportion of travellers that had a home in Victoria that was suitable for

self-isolation, which at most was probably half to 60 per cent.

CHAIR: Was that ---

A. So that was our proposition --

CHAIR: Was that assessment actually done, what the percentage of people was who had a stable home?

A. Yes, we kept a regular statistics and in fact reported them daily in a situation report, the resident jurisdiction of everyone in hotel quarantine. It varied somewhat, but broadly, it was 30 per cent interstate, 10 per cent no address. So either they had been away from Australia for so long they had no address to provide, or they had declined to provide it.

CHAIR: So does it follow from that that the remaining 60 per cent had stable addresses in Victoria?

A. It does. It does.

CHAIR: And does it follow from that that what you're saying is that you, and I mean that --- I don't mean that critically, I mean the group that were discussing this issue, of which you were obviously part --

A. Yes.

CHAIR: --- formed the view that there was no capacity to have or to anticipate that there would be compliance with self-isolation or quarantine at home using someone's home as the designated facility with a detention order directed to their homes?

A. Not to the extent required for public's confidence in the program. So it was a very high hurdle that we placed.

CHAIR: But rather than just a general self-isolation order, which was the first stage of the incoming international traveller cohort --

A. Yes.

CHAIR: --- was there thought given to creating a detention order in the form in which it was made for people to be compelled into hotel quarantine ---

A. Yes.

CHAIR: --- to make a similar order compelling them into, for that 60 per cent who had stable home addresses, compelling them into their home address?

A. Yes, there was. The assumptions that I put in place before we did the analysis

was the detention direction and notice that we were already using for hotel quarantine would be used, but with the address of the --- the home address of the particular traveller.

CHAIR: But that wasn't progressed?

A. No, it was not. And there was, coincidentally, a conversation at AHPPC that reinforced some of our analysis, particularly the compliance point about home quarantine, and a strong piece of advice came from AHPPC that now was not the time to progress that particular proposal or versions of it.

CHAIR: Do you know why?

A. Largely on the lack of confidence in the compliance of people isolating at home. The point you make around the differences in the legal force, and it was in the context of the equivalent in other jurisdictions of our self-isolation order, not the detention order. But nevertheless it was a point which meant the public health risk was considered unacceptable.

CHAIR: Sorry, just to finish that point, am I to understand that contemplating the use of the detention power of the Chief Health Officer or Deputy Chief Health Officer was not contemplated in Victoria to make that detention order into someone's home address using the ---

A. It was ---

CHAIR: Yes, but --- okay. So the answer is it was contemplated but you didn't have confidence that people would comply with it despite the $20,000 fine attached to a failure to comply with it?

A. Precisely. Yes, I'm afraid.

CHAIR: What was that lack of confidence based on?

A. I think by the stage that we were concluding our analysis, there was a significant amount of public commentary concerning the non-compliance of self-isolation, voluntary isolation. There was the observation by other jurisdictions and the discussion around AHPPC of significant non-compliance in their own jurisdictions. So it was an accumulation of that evidence, but also, I repeat, part of the confidence in the proposal we were putting together did rely on the use of a test that still is not available, which is a very reliable, next-to-none, no false negative result, quick-result test. And that does not yet exist.

CHAIR: No, I understand that. But just so that I'm really clear about the evidentiary basis upon which you come to a view that a strong --- a compulsion detaining someone into their home as a designated facility, the view was taken that people would not comply, despite the heavy penalties that would attach to failing to

comply?

A. Yes.

CHAIR: Although that wasn't --- obviously it was not tested in that way at all?

A. That's correct.

CHAIR: It was an assumption made because people weren't complying with the voluntary self-isolation order?

A. That is correct.

CHAIR: Thanks, Mr Ihle.

MR IHLE: Thank you, Madam Chair.

The one matter that I wanted to take up with you, Deputy Secretary, was around welfare and specifically communication to those that were detained, about what their rights and the policies that applied to them were. Are you aware of the evidence that's been given to this Board by Mr Hugh de Kretser, the Director of the Human Rights Resource Centre?

A. No, I'm afraid not.

Q. Just by way of summary, Mr de Kretser and his family were detained in June and into July after their return to Australia and they were detained at the Rydges Hotel. Mr de Kretser has told this board he made enquiries of the DHHS officers as to when they were to get fresh air breaks, and when he was dissatisfied with the lack of response, he actually wrote, whilst still detained, to the Department seeking a copy of its policies insofar as they concerned fresh air breaks.

A. Yes.

Q. Assuming that to be the case, he says that he was not provided with the policies. He subsequently requested them after being released from detention, on a number of occasions, and ultimately met a response when he was trying to prepare to give his evidence before this Board that he should lodge a Freedom of Information enquiry for them. You might appreciate immediately the frustration he expressed to the Board in that regard. Not to put too fine a point on it, but that's simply not good enough, is it?

A. I'm not sure whether appropriate communication is the --- I'm aware of Mr de Kretser's reputation, and I'm sure he would have been able to understand every nuance and detail of our protocols and details. But certainly communication to travellers around the considerations being made, as to whether a fresh air break can be provided or not, the extent to which it could in each site, certainly would have

been preferable. I'm afraid I'm not aware of the communication that occurred in each site, and I will specify fresh air breaks were obviously a point of frequent discussion and frustration, and all of us acutely aware of the human rights implications of it, as well as the public health risk created by it, and that balance that needed to be struck.

I recall one of the early Ombudsman enquiries was specifically on this point. It was something that was achievable to very different degrees depending on the physical set-up of the hotel, and particularly the lifts of the hotel, and the availability of safe spaces for people to walk, safe for both the travellers and for the staff with them.

Q. Yes.

A. It was a continual balancing act to get it right, and to prioritise a fresh air break for those who were most acutely in need, which was usually on a judgment of those with clinical expertise, you know, claustrophobia, PTSD of other detentions, those sorts of very acute, to lesser acute needs. So actually being able to provide general communication with confidence to any one traveller in any one hotel about the availability of fresh air breaks at their two weeks versus another's two weeks was actually quite difficult.

Q. Was there a general consensus or a view, as far as you're aware, within the Department to not tell people what the policies were around fresh air breaks?

A. I'm not aware of ever having that conversation, no; in fact we provided --- when we had to cease fresh air breaks for a period of time for operational reasons or immediately after, for example, the Stamford outbreak, we did advise travellers.

Q. I just want a document to be brought up, if I may. To the operator, it's document ID WIT.0001.0031.0052. Ms Skilbeck, this is the health and wellbeing standards that applied to the Hotel Quarantine Program from 8 May.

A. Okay.

Q. And if we can scroll through to criterion 42, which deals with fresh air --- sorry, criterion 4.2. Just waiting on the operator to scroll down. There. So if we can just highlight criterion 4.2, "Fresh air".

This, Ms Skilbeck, was the standard published by the Department as at 8 May, and you will see that in respect of fresh air, there are four specific dot points. I want to draw your attention to the third dot point there:

> *Individuals in mandatory quarantine should be allowed one hour of suitable exercise (or leisure time) in open air daily....*

And of course that's subject to the caveat of:

> *.... where it can be safely and practically implemented at the hotel (weather*

permitting)....

Taking into account those other considerations. This is a document that, insofar as I understand it, that had Mr de Kretser been provided with the policy he was asking for, he would have been given. Can you see any reason why he ought not have been given that document?

A. On the face of it, no.

Q. Thank you. That can come down. You touched upon an Ombudsman's enquiry that was launched. A number of questions were posed to the Department by the Ombudsman, were they not, in late April?

A. Yes.

Q. And indeed, the response was provided on 15 May, so one week after this policy had been proliferated and adopted, and you say in your statement that that's one complaint with which you were directly involved and that you reviewed the response before it was forwarded.

A. Yes, that's correct.

Q. Can you explain to the Board why the reference to individuals in mandatory quarantine should be allowed one hour of suitable exercise or leisure time in open air daily formed no part of your response to the Ombudsman?

A. I'm not aware that it didn't. I thought we had appended the standard as it applied at the time to our response to the Ombudsman in full.

Q. Well, perhaps we might bring that response up. It's part of the tendered bundle as part of the exhibits, and it's DHS.0001.0001.0040. And specifically if we can turn to the second page. You see, Ms Skilbeck, and I'll ask that we zero in on the three dot points just after the halfway mark of the page, this response with which you were directly involved and that you reviewed before it was forwarded on 15 May, a week after that wellbeing standard had been implemented, provided that:

This standard includes a criterion 4.2, Fresh Air, which states....

And you've stated three dot points. The first two are largely referable to the first two in the other document. But I want to know why, if you're able to explain to us, why there's no reference in your response to the policy standard of one hour of fresh air per day where possible.

A. I can't provide an explanation for that. I understood that to be a direct quote from the annex to the plan which was the 4.2, the fresh air standard that existed at the time. But it was the standard that existed at the time of the passenger --- the traveller that the Ombudsman was enquiring after. It was not the standard that would apply at the ti

me we were writing the response. So the Ombudsman's question was anchored on a particular traveller's experience in a particular hotel. So our answer was at that date. I don't know if that provides a response. I would need to check.

Q. Is that something you know, or is that something that you're trying to explain why that is missing here?

A. I know that that's the premise on which we developed the response, that it was pinned to --- because things were moving so fast, we pinned them to the date on which the traveller was --- the date of the traveller's stay that the Ombudsman was responding to by asking us the question.

Q. You understood the Ombudsman to be enquiring as to your systems, though, didn't you?

A. Well, the Ombudsman's query was fairly broad-ranging. I'm not sure I would have interpreted it that way. It certainly included systems, absolutely.

Q. And those systems, as at 15 May, were as I took you to in that standard 4.2?

A. I'm prepared to accept that. As I said, the intention would have been to have the standard as was current at the date of the traveller's accommodation that the Ombudsman had relayed to us.

MR IHLE: Yes. Thank you, Ms Skilbeck. They're the questions that I have for you. I understand --- I've been contacted by only one other party who may have questions. That is counsel for Unified Security. And if there's any application to be persisted with, I ask that that be made, Madam Chair.

MS ALDERSON: No, we don't persist.

CHAIR: Ms Skilbeck, just a couple of matters before I excuse you.

A. Yes.

CHAIR: Just to take you back to some of the questions and answers with respect to your answers in the wake of the outbreak. You recall Mr Ihle asked you some questions about that.

A. Yes.

CHAIR: And you spoke in response about endeavouring to address the behaviour that I understand in your assessment was a contributor to the outbreak, that related to inappropriate use of PPE and lack of social distancing.

A. Yes.

CHAIR: So I understood your answer to be in response to that that you brought in the Behavioural Insights Unit to make an assessment about what might change behaviour. So what I'm interested in understanding from you is whether or not, above and beyond that, there was an assessment made that what needed to happen on site was a much more effective permanent presence and overview of someone who was the recognised person on site with authority to direct and control behaviour and indeed someone with an infection prevention control expertise. So two parts, really, to that question.

A. Yes, so if I answer the second part first. The expertise in infection prevention and control was brought in on advice that having that expertise on site --- I'm not quite sure what the distinction between expertise and people who became informed as to the standards is, but we did not have particular recognised, accredited experts in infection prevention and control on site at all times. But to answer the first part of your question, I wouldn't want to leave the impression that a behavioural insights contribution was the most significant part of our response. It was not. It was the part that I was particularly keen on pursuing because --- I'm sorry, as an economist, I'm trained by my own profession and I'm particularly keen on what the incentives and the arrangements were for the behaviour, given our intent was to have behaviour different to what we have observed.

But in addition to all that, and at the same time, yes, we added a safety officer, a DHHS safety officer to each site. We commenced doing symptom checks of each individual, as opposed to relaying the message that one should not come to work with symptoms. We actually had the question asked at the beginning of each shift. There was an additional reminder, refresher of PPE and other IPC requirements at the beginning of each shift, just to keep the principles fresh in everyone's minds. And I think they were the key things. I'm sure I've missed something, but we tried to do a number of things that did not rely on people remembering the plan and the guidelines that were in place but to keep face-to-face reminding people of cautions they should take, procedures they should follow. So we did a number of things at once. It was one of those things where time was not on our side.

CHAIR: And the infection prevention and control advice that you were taking didn't --- well, the question I'm asking you is, did any of that advice tell you that you needed on site at each of these quarantine facilities somebody whose job it was to be the constant supervisor of the way in which infection prevention was addressed, not just with respect to security officers but across the entire site?

A. Not that I'm aware of. I can't say I would expect it either. It's really a behaviour that everyone has to be accountable for and everyone has to do at all time. It's not possible to supervise everyone's actions at all times that might impact infection potential.

CHAIR: Did you have the opportunity to listen to the evidence of Ms Simone Alexander earlier this week, who gave evidence with respect to the role that Alfred Health are now playing in the conduct of what's being referred to as the COVID

hotels?

A. Some of it, Madam Chair. Not all.

CHAIR: And did you have the opportunity to listen to what she had to say about the importance of having infection prevention and control expertise on site at all times?

A. Not that I recall, no.

CHAIR: All right. Just one final matter, Ms Skilbeck, and it goes to your role in the emergency management part of your role.

A. Yes.

CHAIR: I just want to understand with respect to planning, what planning are you able to direct us to with respect to the potential for a pandemic to impact upon the State of Victoria?

A. There is a --

CHAIR: Sorry, before I let you answer that, I don't mean in terms of strategic objectives or large-scale references to what achievements are aimed at. I'm much more interested to hear about the detailed planning that was in place.

A. So there is an influenza pandemic plan that we are accountable for, the Department is accountable for, both the Health Protection and Emergency Management parts of my division that is on the Emergency Management Victoria website, so publicly available.

CHAIR: Is that the document that was signed off in March this year? Is that the last iteration of that document?

A. No, this was the one --- sorry, I took your question to be what pre-existed the current pandemic. So that was the base case pandemic response plan that pre-existed.

CHAIR: Yes.

A. And then you're quite right, March we had a pandemic plan for the health sector, where taking into account what we knew of the novel coronavirus and some staging of the pandemic, it was more directly, in terms of the impact on the health sector, informed by the modelling that we'd had in January, February --- I think Professor Wallace alluded to it --- a very significant above-capacity demand on intensive and critical care in hospitals. So much of the triggers for the different stages was in those terms, which thankfully has not been the case, but indeed the triggers for those stages of response has been the broader community impact, not acute hospital care. But nevertheless, that's the closest plan to --- early in this

pandemic, taking into account what we knew of this particular virus at the time.

CHAIR: So in those documents that you're referring to, the only reference to --- that I've been able to find with respect to --- away from the public health system, with respect to individuals returning back through international ports and airports, points of entry, was directed to self-isolation?

A. Yes. Yes, that's correct.

CHAIR: Is that right? So there was no contemplation of any other form of quarantine?

A. Not by us, certainly not, no. It was --- the decision for mass quarantining of travellers in a compulsory determine framework was a surprise, certainly to me.

CHAIR: And were you part of any discussion up until that point at all in the period that you've been in your emergency management role about the potential for a pandemic, a highly infectious disease globally, what it might mean for the international points of entry into the State of Victoria, how that might impact on people's movements at all?

A. Yes. Yes, we did a number of --- over the recent, past years, we've done a number of exercising. Emergency management is very heavy on exercising scenarios, and public health scenarios are often versions of a pandemic. Of course, we have MERS and SARS in our not so distant past.

CHAIR: That's right.

A. And in each of those cases, they have --- this is not always going to be true, but they have come from elsewhere in the world. So, yes, it was in that context where there might be limitations on entry into the country, or self-isolation. But perhaps it's a lack of imagination, but we had not considered --- I can't recall us ever exercising a circumstance where we would be detaining travellers over time. I can recall us thinking of circumstances where we would corral a particular group of people for a short period of time for testing, for example, but not something that is similar to what we are now managing.

CHAIR: Thank you. Anything arising out of that for you, Mr Ihle?

MR IHLE: There's not, Madam Chair.

CHAIR: Right.

MR IHLE: Or indeed anyone else, before I excuse Ms Skilbeck? No. All right, thank you for your attendance at the Board and you are now excused. You can now turn off your camera and your microphone. Thank you.

A. Thank you, Madam Chair.

MR IHLE: Thank you, Ms Skilbeck.

A. Thank you, counsel.

THE WITNESS WITHDREW

MR IHLE: Madam Chair, that concludes the evidence for today. The schedule for sitting tomorrow is as at least envisaged on Tuesday. I can probably add some more detail to that. The first witness to be called in the morning is a Mr Michael Girgis, who is the General Manager of IKON Cleaning. Then we will be calling Ms Pam Williams and Ms Bamert, who are both Accommodation Commanders in relation to Operation Soteria. And Dr van Diemen, the Deputy Chief Health Officer.
A decision is still to be made in relation to Deputy Secretary de Witts, whose statement has come in through the course of the hearing today, but that will be conveyed to the parties as soon as that decision is made.

CHAIR: Thanks, Mr Ihle. We will adjourn until 10.00 tomorrow.

MR IHLE: As the Board pleases.

HEARING ADJOURNED AT 4.46 PM UNTIL 10.00 AM ON FRIDAY, 11 SEPTEMBER 2020

Index of Witness Events

Index of Exhibits and MFIs